Hillsborough County Health Care Plan

PROVIDER GUIDE

Hillsborough County Florida

HCFLGov.net

Hillsborough County Florida

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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). We would also like to thank you for your participation and support of the HCHCP managed care program, administered by Hillsborough County Health Care Services (HCS).

Hillsborough County has provided medical care to its 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 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."

HCS has the option to secure medical services from various facilities throughout Hillsborough County following the HCHCP's philosophy of providing 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 HCHCP 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 instructions 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.

How HCHCP Operates

Hillsborough County contracts with four Medical Service Organizations (MSOs) who manage four provider networks established in the county as well as one Behavioral Health Provider group with co-located primary care services. 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 HCS 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 HCHCP and depicted in each of the MSO and Overlay individual contracts, as well as the HCHCP Provider Guide. Participating providers must be Medicaid and Medicare certified providers.

Eligibility Requirements

Eligibility for HCHCP services is based on the following:

- Residency in Hillsborough County
- Assets within HSS guidelines
- Income at 175% or lower of Federal Poverty Guidelines at the time of enrollment or re-enrollment

Once determined eligible for the HCHCP, the member is enrolled in the appropriate plan.

Health Care Plans

- **Plan A** members are covered for all necessary medical services covered by HCHCP. The member's PCP must coordinate all services for these plan members and certain services require referrals and prior authorization from the medical management vendor.
- **Plan J** members are covered for all Plan A services with the exception of inpatient facility charges. Plan J members are enrolled in the Medicaid Medically Needy program.
- **Plan D** members require specific authorization from HCHCP for each service authorized. Plan D members are covered for only limited and specific services.

Medical Management

Hillsborough County has contracted with a medical management vendor to provide medical management and utilization review, which includes prior authorization of certain outpatient services, inpatient hospital admissions, admissions to a skilled nursing facility and inpatient rehabilitation. The medical management vendor also provides case management services and retrospective hospital chart reviews. The medical management vendor also provides all authorizations for referrals to specialists, home health care services, supplies, and durable medical equipment. Providers can visit the HCHCP's medical management vendor's website at: https://hchcp.kepro.com for a complete listing of those services that require prior authorization.

Appointment Availability/Access Standards

HCHCP 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, HCHCP 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 HCHCP staff nurses are available to help providers coordinate and arrange the delivery of covered services under the HCHCP policies and procedures.

The Role of the Primary Care Provider (PCP)

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

HCHCP is committed to ensuring that quality medical care will be available to all of our members. HCHCP'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 eyeglasses)
- Hearing Services – Audiology (excluding hearing aids)
- Family planning and counseling can be done at the PCP level or referred to the Hillsborough County Department of Health
- Screening and management of chronic conditions such as hypertension, diabetes, etc.
- Nutrition counseling
- Preventive diagnostics, e.g. TB screening
- Retinal eye exams for diabetics

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 HCHCP member to a network specialist, the PCP must request an authorization from the medical management vendor electronically. The electronic referral 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 supporting the request.

The authorization issued by the medical management vendor will specify which 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 medical necessity, certain outpatient procedures, all skilled nursing facility admissions, all inpatient rehabilitation admissions, routine stretcher transports, and home health care.

Prior authorization is not required for emergency admissions or for procedures listed as outpatient when performed in an inpatient setting.

Services requiring prior authorization may be periodically updated based on utilization reviews.

For a complete list of current procedures and services requiring prior authorization, providers can visit the HCHCP medical management vendor's website at HCHCP.KEPRO.com.

Network Transfers

Changing PCP assignment is allowed if a member relocates within Hillsborough County, or for other justifiable reasons. If the member wishes to change networks, the change is at the discretion of HCS.

It is the member's responsibility to request and sign a release of medical information to have medical records forwarded to the new PCP.

Covered Services

The services listed below are generally available through HCHCP, but each individual's designated health care "plan" (A, J, or D) will determine whether a particular service is available. 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 HCHCP requires prior authorization for select inpatient surgical procedures. For a complete list of all services requiring pre-certification, refer to HCHCP.KEPRO.com.

Skilled Nursing/Inpatient Rehabilitation

Skilled Nursing and inpatient rehabilitation services are covered but require prior authorization through the HCHCP's medical management vendor and are limited to a maximum of (45) days per episode of care.

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

HCHCP 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 to the providing specialist and a prior authorization from

the medical management vendor prior to performing outpatient surgical services. For a complete listing of services requiring prior authorization, providers can visit the HCHCP's medical management vendor's website at HCHCP.KEPRO.com.

Emergency Room Services

HCHCP covers emergency room services in a participating hospital's emergency room when required to prevent imminent loss of life, irreparable damage, or serious impairment of bodily function, and covers those services that are medically necessary to avoid severe pain and discomfort at participating emergency rooms only.

Primary and Specialty Care Services

Primary Care Services

Primary care services are those health care services that are provided, coordinated, and managed by a provider designated as a HCHCP PCP.

Primary care services include periodic medical screening visits, one physical exam every twelve months, family planning, 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 as indicated by the screening process.

HCHCP 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 HCHCP members prior to referring any member to a specialty physician.

Specialty Care Physician/Provider Services

Specialty care physician/provider services are 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 PCP. 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.

Telehealth/Telemedicine

Providers may utilize Telehealth/Telemedicine when medically appropriate and is in accordance with CMS guidelines.

Chiropractic Services

Chiropractic services are covered under HCHCP, 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 PCP or specialty physician/provider, and performed in a participating hospital's laboratory or radiology department are covered. Some outpatient diagnostic services require 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, 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, a provider must bill through the network medical service organization (MSO). Some radiology services require a prior authorization from the medical management vendor before services are rendered.

Ambulance Services

Ambulance transportation services are covered for an incapacitated HCHCP member when transported to a participating hospital. Non-emergent transports require prior 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, which may be able to provide:

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

More information about Sunshine Line can be found at HCFLGov.net/SunshineLine.

Durable Medical Equipment/Disposable Medical Supplies, Prosthetics and Orthotics

Durable medical equipment (DME) and disposable medical supplies (DMS), including orthotics and prosthetics are covered by HCHCP but must be supported by a prescription and documented medical necessity. For a complete listing of services requiring prior authorization, providers can visit the HCHCP medical management vendor's website at HCHCP.KEPRO.com.

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.

Prior 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.

HCS does not provide custodial care. Discharge planning is available for HCHCP members at all participating hospitals. The participating hospital will notify the home health agency discharge planner for HCHCP members requiring home health services.

Home Oxygen Services

Oxygen services are a covered benefit by HCHCP following Medicare standards.

IV Therapy

IV therapy is a covered service in both 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 HCHCP.

Dental Services

Dental services with no copays will include preventive care (cleanings, x-rays, etc.), full service dental care such as fillings, caps, and even dentures. Dental services shall not exceed $2500 per member per year. Orthodontia services are not covered.

Oral surgical procedures and services require a referral from a general dentist and prior authorization from the medical management vendor.

Routine Vision Care

Routine vision care services include one eye exam and glasses every other year. The limited benefit for services is:

- Annual vision exam $100
- Frames $150
- Single vision lensses $50
- Bifocal lenses $75
- Trifocal lenses $100
- Contact lenses $175

Eye prosthetics are also 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. HCHCP does not pay for outpatient counseling, residential, or long-term mental health therapy.

Psychotherapy is available from behavioral health specialists through Network primary care clinics. Clients are eligible for 24 visits per calendar year. No authorization is necessary for visits 1-12; a prior authorization by the PCP is needed for visits 13-24. Drug or alcohol diagnosis are excluded when used as the primary diagnosis.

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 and all related procedures require a PCP Referral and prior 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.

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.

Prescription Drug Services

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

All prescriptions must be filled through HCHCP contracted pharmacies.

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

Pharmaceutical Patient Assistance Program (PAP)/Mail Order Drug Program

HCHCP requires members to participate in the Patient Assistance Program (PAP) for certain brand name medications prescribed by HCHCP participating providers. HCHCP contracts with a PAP vendor to facilitate and provide these services for HCHCP 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 the application for medications that qualify for the PAP Program.

Formulary

HCHCP 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 HCHCP program because it can reduce spiraling drug costs and ensure the highest quality level 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
- Inadequate time to effect a safe transfer to another hospital
- A threat to the health or safety of the individual caused by the transfer

The EMTALA is mainly directed towards hospitals that accept Medicare and advertise emergency room treatment and are designed to protect individuals who visit the emergency room and do not have the means to pay for their own 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. Emergency care services are covered at participating HCS hospitals only.

Healthy Living Program

The Healthy Living Program provides guidance and resources for a healthy lifestyle through local, on-site services. Healthy Living offers an exercise room, educational activities, group exercise sessions, and health screenings at Healthy Living Centers throughout Hillsborough County. Free classes on topics such as fitness, nutrition, weight loss, hypertension, smoking cessation and other Public Health Services are also available through the Healthy Living Program. Services are available to HCHCP members, Hillsborough County residents and BOCC county employees.

Healthy Living Fitness Center Locations

Lee Davis Community Resource Center
Healthy Living Fitness Center
3402 N 22nd St. | Tampa, FL 33605

Plant City Community Resource Center
Healthy Living Fitness Center
307 N. Michigan Ave. | Plant City, FL 33566

SouthShore Community Resource Center
Healthy Living Fitness Center
201 14th Avenue SE | Ruskin, FL 33570

Public Health Services

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

Tuberculosis Treatment

Tuberculosis services are available at the Hillsborough County Department of Health. 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 Hillsborough County Department of Health located at
1105 E. Kennedy Blvd., Tampa. Members may also self-refer for this service.

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

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

Family Planning

Family planning services are available through Network providers.

HIV

HIV services are available at the Hillsborough County Department of Health. 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 Hillsborough County Department of Health 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 the 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 HCS 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 has been 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. All appeals must be submitted within three months from the date of denial.

First Level Appeals

First level appeals from primary care and specialty providers must be submitted through the network MSO. The MSO, the hospital, or overlay service contracted providers will submit the appeal directly to the TPA as described below.

Second Level Appeals

Second level appeals should be submitted directly to HCS - Records and Recovery Section for department review and further consideration 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

Claims or appeals should not be directly submitted to HCS unless requested to do so by HCS.

All appeals are required to be in writing and require supporting documentation including a HCHCP Appeal Form (located on the Provider Website) explaining the basis for the appeal. Supporting documentation means 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 HCHCP provider

The TPA and HCS respond 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.

- HCHCP Appeal Form
- Copy of the original claim
- Copy of the explanation of payment; or
- Letter of denial from the TPA is provided
- Detailed explanation of why the denied claim should be reconsidered
- Other documentation
  - Medicare/Medicaid denial
  - Other insurance payment/denial

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.

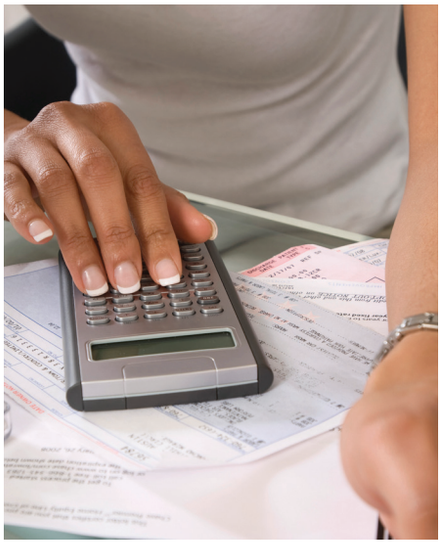
Providers who wish to appeal the second level appeal decision by the TPA, should provide a letter outlining the reasons for the request, and send all information with supporting justification to HCS for reconsideration.

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 HCS 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 HCS 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 HCHCP for verification and audit purposes. Once processed, the payment is sent to the applicable payee. Provider reimbursement is based on the agreement with the County.



Payment for Unfunded Member

An unfunded member meeting eligibility criteria may be approved for assistance with bills for inpatient provider treatment on a retroactive basis. Hospital facility charges may be covered on a retroactive basis for up to 30 days prior to the client's application date. HCHCP providers who have treated an unfunded member who is subsequently found to be eligible for retroactive assistance by HCS, must submit claims within 12 months of the date the member is found to be eligible for HCHCP.

It is the provider's responsibility to determine if an unfunded member has been approved for assistance from HCHCP. Eligibility information can be obtained by contacting a customer services representative at HCS Provider and Member Services (813-272-5040). The contracted hospital or MSO is also available to answer questions.

Financial Responsibility

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

Coordination of Benefits/Third Party Liability

Providers are legally and contractually obligated as network providers in HCHCP to seek payment from all identifiable sources. Because HCHCP 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 HCHCP as soon as possible to expedite filing claims to other payers. HCHCP will not supplement any other payer.

Third Party Recovery

HCHCP 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 of HCHCP that all providers shall be contracted with Medicare and Medicaid to provide services to patients who have Medicaid and Medicare.

- **Medicaid and Medicare**
  - When HCS becomes aware that a client has or may have Medicaid coverage, a Medicaid reimbursement process is initiated by HCS staff. After the client's Medicaid coverage status has been verified, the recovery process begins.
  - Pharmacies are notified to bill Medicaid for claims incurred and paid by HCHCP during the period covered by Medicaid. The provider is sent a list of claims potentially payable by Medicaid. If Medicaid denies payment for a claim, the claim can be rebilled to HCHCP. The pharmacy provider must send a copy

of the Medicaid denial (printout or screenshot) to HCHCP, Records and Recovery Section within 90 days of the notification to the pharmacy to avoid reversal of the claim by Records and Recovery Section staff. Pharmacy recovery is NOT done for Medicare and for most over the counter (OTC) medications.

- Claims paid to medical providers of primary care, hospital services, specialists provider services, home health care and other overlay providers by HCHCP during the period covered by Medicaid or Medicare will have eligible claims reversed by the third party administrator. When the reversal remit is received by the provider, the provider should bill Medicaid or Medicare. If the claim is denied by Medicaid or Medicare, the provider may appeal the claim reversal (see Appeals Process). If it is known that a service or procedure is not covered by Medicaid, the claim should not be reversed by the TPA.

- In instances where HCHCP initiates recovery on claims that are over 1 year old and providers cannot bill Medicaid electronically and proof of delayed determination of Medicaid eligibility has been supplied to the provider by the Records and Recovery Section, the provider may file a paper claim billed to the Medicaid Area 6 office.

- **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 claims eligible for billing to Medicaid under the Medically Needy Program coverage. These claims must be billed to Medicaid. If Medicaid denies payment of claim, claim may be rebilled to HCHCP using the normal claim submission process. The pharmacy provider must send a copy of the Medicaid denial (printout or screenshot) to HCHCP, Records and Recovery Section within 90 days of the notification to the pharmacy to avoid reversal of the rebilled claim by Records and Recovery Section staff. With certain exceptions, OTC medications are not to be reversed for Medicaid Recovery.
  - A list of medical claims is sent to the TPA with instructions to reverse claims. When the reversal remit is received by the provider, the provider should bill Medicaid. If the claim is denied by Medicaid, the provider may appeal the claim reversal (see Appeals Process If it is known that a service or procedure is not covered by Medicaid, the claim will not be reversed.

- **Other Third Party Payers**
  - When the provider is paid by any other payer for a claim previously paid by HCHCP, the provider will notify the Records and Recovery section. The claim will be scheduled for reversal by the TPA.

Medicare Fee Schedules

HCHCP utilizes Medicare Fee Schedules. The fees become 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 uploading 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 HCHCP Website at: **HCFLGov.net/HealthCare**

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

- Direct links to the TPA and the medical management vendor
- On-line claims status and eligibility verification
- Association sites
- Electronic version of the provider guide
- On-line screening and application processing for members
- And useful information for providers

Customer Service

Providers can also call (813) 272-5040 for customer service and select option 3. They may also verify member eligibility by calling (813) 272-5555.

Attachment (1)
Health Care Non-Covered Services

The following services and supplies are restricted as described or not covered by HCHCP 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
- 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 when a significant neurological deficit is present
- Dialysis: outpatient and inpatient if the purpose of admission is for dialysis only
- 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
- Detox
- Maternity: any treatment or supplies related to pregnancy or its complications
- Non-Formulary Medications: members are to be referred to PAP vendor; non-formulary medications may be covered in some instances
- Bone Stimulators
- 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
- Temporomandibular (TMJ) Treatment: neither passive nor 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 Department of Health once they have been diagnosed
- Wound Vacuums (available thru PAP programs)
- Life Vest – For cardiac stabilization

Attachment (2)
Key HCHCP Contact Information

Third Party Administrator (TPA):

Zenith American Solutions

POC: Cyndi Wilson

Phone: (813) 666-6908

Fax: (813) 962-1242

Website: edge.zenith-american.com

Customer Service: (813) 962-1960

Medical Management Vendor

KEPRO

Phone: 1-866-495-8388

Fax: 1-866-889-6516

Website: hchcp.kepro.com

Hillsborough County

Health Care Serivices

POC: Gene Earley

Phone: (813) 301-7356

Fax: (813) 272-7327

Website: HCFLGov.net/HealthCare

Customer Service: (813) 272-5040