THERAPY NETWORK OF FLORIDA

Community Care Plan
The Health Plan with a Heart

Community Care Plan - Behavior Analysis

Provider Reference Manual

Table of Contents

Authorizing Services (Medicaid Ages 0-21)

SERVICE EXCLUSIONS

Any Medicaid member 21 years old and over. All services specifically mentioned in the Florida Medicaid Behavior Analysis Services Coverage Policy Section 5.0 Exclusions. Exclusions to highlight are personal care assistance, companion, chaperone, or shadow; caregiver or childcare; Services in PPEC; Travel time; Services by more than one BA provider unless determined to be medically necessary, prior authorized and indicated in the approved behavior plan; Any services not included on the Florida Behavior Analysis Fee Schedule.

SERVICES REQUIRING AN AUTHORIZATION

Behavior Assessments, Behavior Reassessments, Behavior Intervention/Treatment, Modification Request and all codes on the Florida BA Fee Schedule require prior authorization by Therapy Network. Providers must submit via the Provider Web Portal at https://asp.healthsystemone.com/hs1providers. However, fax is available as an emergency backup via TN fax at 1-855-470-4490.

Please refer to the Behavior Analysis Services Coverage Policy located on the Florida Agency for Health Care Administration website (AHCA.Myflorida.com) for specific details on required documents. We have posted additional reference forms such as intake form, recommended reporting templates and checklists to help you on our website at https://therapynetwork.com/ba. In addition, the rendering providers MUST submit at least the following with the authorization request:

REQUESTING AUTHORIZATION FOR THE BEHAVIOR ASSESSMENT

Required Documents

- Prescription or Referral Form
    - By an independent physician or practitioner qualified to assess and diagnose disorders related to functional impairments.
    - Includes the diagnosis
    - Includes an order for BA services
- Comprehensive Diagnostic Evaluation (CDE)

REQUESTING AUTHORIZATION FOR THE BEHAVIOR INTERVENTION/TREATMENT (INITIAL)

The Behavior Assessment and Behavior Plan must be signed by the Lead Analyst and the recipient's parent or caregiver.

Submit the Full Behavior Assessment which should include:

- Patient information
- Reason for referral - To include the treatment diagnosis
- Medical and developmental history, including medications prescribed to ameliorate behaviors
- Relevant family history

- Clinical interview
- Review of recent assessments/reports (file review)
- Detailed information about the school name, time frame, classroom type, IEP recommendation, 504 plan and services
- Must identify behavioral deficits that interfere with a major life activity including the events and subsequent interactions that elicit and sustain targeted behavior.
- Assessment procedures and results (administration, scoring and reporting)
- 2 core standardized behavior instruments required (required once a year):
    - Vineland-3 Comprehensive Parent Interview Form for all recipients, plus the Maladaptive Behavior Domain for recipients age 3 years and older.
    - Behavior Assessment System for Children, Third Edition, Parenting Relationship Questionnaire (BASC-3 PRQ), for all recipients ages 2 years through 18 year.
    - Additional assessment tools may be used at the lead analyst's discretion

Submit the Behavior Plan which should include:

- Identifying the functions of behavior based on a Functional Analysis (FA), brief FA, Precursor FA or conditional probability
- Treatment setting
- Proposed treatment targets, goals (both short-term and long-term) and/or objectives related to medically necessary behavioral interventions
- Type of Treatment: Focused or Comprehensive
- For each target, goal, and/or objective
    - Definition in observable, measurable terms
    - Direct observation and measurement procedures
    - Current level (baseline)
    - Behavior reduction or acquisition procedures
    - Condition(s) under which behavior is to be demonstrated and mastery criteria
    - Date of introduction
    - Estimated date of mastery
    - Plan for generalization
    - Timely reporting of progress, including statements as to whether goal or objective is met; not met; or, modified (with explanation)
- Parent/guardian/caregiver training
    - Proposed targets, goals, and objectives (as above)
    - Training procedures
    - Date of introduction
    - Estimated date of mastery
- Number of units requested
    - Number of units for each procedure code
    - Medical necessity for units requested
- Actual schedule that is set to see the child including:
    - Days of the week
    - Hours of the day
    - Service codes for those hours, to include supervision
        - Example. Requesting 20 hours per week.
            - Monday, 9-2pm : 97153
            - Tuesday, 9-12pm : 97153, 12-2pm: 97155
            - Thursday, 9-2pm: 97153; 1-2pm: 97156

- Friday, 9-12pm: 97154 P; 12-2pm: 97153 XP

*We understand that this schedule may vary depending on the child, family and therapist. This is just used as a guide to help TNFL understand when the child may be seen.

- Supervision plan, including name(s) of authorized supervisor(s), and list this in the schedule.
- Care coordination with parents/caregivers, schools, state disability programs, and others as applicable.
- Transition (fading) plan
- Crisis management plan
- Discharge plan

Please refer to our website at https://therapynetwork.com. for recommended templates to help guide you with the information to submit.

BEHAVIOR REASSESSMENT

The Behavior Reassessment is required every 6 months.

As a reminder, the core standardized behavior instruments are only required on an annual basis unless a new behavior emerges or additional hours are requested.

Include a brief narrative discussion of progress from the last authorization period to include graphs (maladaptive behaviors, replacement behaviors, intervention integrity measures for parent training).

- Be submitted at least 10 days but not more than 30 days prior to the last day of the previously certified service.
    - Example - If your previous authorization ends on 4/30, submit the request no earlier than 4/1.

BEHAVIOR TREATMENT FOR BEHAVIOR INTERVENTION/TREATMENT FOR CONTINUATION OF SERVICES

Must include the following information:

- Data reflecting progress of all behaviors targeted for improvement.
    - Each behavior under treatment must have its own data table and corresponding graph.
- A narrative discussion of progress and a statement of justification for continuation of care at the intensity level requested
    - **If significant clinical progress is not made over the course of an authorization period, the provider must explain why clinically significant progress was not made and treatment changes to promote progress.**
- Session notes
    - **The notes must be signed and dated by the rendering practitioner and must include:**
        - Date, time, location, and duration of services
        - Maladaptive behaviors observed during the session
        - The replacement/compensatory skills targeted during the session
        - Description of the recipient's response to the treatment interventions
        - Protocol modification, changes to goals/objectives, and/or therapist directions provided during the session, if included
        - Explanation if recipient's parent or guardian is not present during BA service delivery

- Participants, including observers, teachers, parents, caregivers, or other health care providers if present
- Upon receipt of the information listed above, TN will review the submitted documentation for medical necessity. TN will then issue a new authorization and a new authorization period begins.
- **CRITICALLY IMPORTANT**: All documentation must reflect the **individual** assessments, needs, and interventions of the recipient.
- **Failure to provide all required documentation could result in the delay of treatment of your patient**.

REQUEST FOR A MODIFICATION OF AN EXISTING BEHAVIOR TREATMENT AUTHORIZATION

- TN will only consider a request for a modification when there is a change in the member's clinical status necessitating and increase in the previously approved service(s).
- Modifications will not be authorized retrospectively (after the treatment period has ended).
- The provider must submit the Modification request via fax to TNFL at 1-855-470-4490
- The Modification Request must include the following:
    - The completed TN Modification Request Form
    - Changes in condition noted
    - Updated Behavior Plan to include updated treatment targets, goals, and/or objectives related to medically necessary behavioral interventions
    - Any updated test scores (if completed)
    - Change in Medical Diagnosis
    - Any relevant session notes
    - Number of units requested
    - Number of units for each procedure code
    - Updated schedule for the child to be seen
    - Medical necessity for units requested.

REVIEW PROCESS FOR ANY REQUEST

Once a request has been received, and further review is required, the information will be submitted to a BCBA Clinician for review.

IF MISSING INFORMATION

- If any documentation is missing or more information is required, the case will be pended and a fax notification will be sent to the requesting provider with the information needed.

IF APPROVED

- The case approval is available Via the Provider Web Portal at https://therapynetwork.com, **Select "Web Portal" from the banner and "Login to PWP" from the dropdown**.
- The provider will also receive the authorization via facsimile with the Authorization Number referencing the service units for each of the CPT codes requested and the authorization period

- If the request is for a modification, TN will update the existing authorization to reflect the approved number of service units and fax that information to the provider.
- For approvals the turnaround time is:
    - Standard/Routine requests are completed within 5 calendar days.
    - Expedited/Urgent* requests are completed within 2 calendar days.
      ***Note**: The definition of expedited/urgent request: One in which waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in seriously jeopardy.

IF NOT APPROVED

- If medical necessity is not established based on the information received, a peer-to-peer consultation with a BCBA clinician is offered to the treating provider prior to the final decision.
- If after the peer-to-peer, a decision cannot be agreed upon, the request will be submitted to the Medical Director (BCBA-D) for review.
- If the Medical Director is in agreement with the TN clinician, based on TN delegated responsibilities, the case will be referred to the health plan with recommendation for denial.
    - TN will inform the provider the case has been sent to the Health Plan for the final decision. The Health Plan will notify the provider of that final decision.
- Authorization requests received without the required information will be referred to the health plan with recommendation for denial.
- For Recommendations for denials the turnaround time is**:
    - Standard/Routine requests are completed by TN within 4 calendar days.
    - Expedited/Urgent requests are completed by TN within 1 calendar day.
      ****Note**: The turn-around-time for a recommendation is tighter, allowing time for the health plan to process the request and issue the denial.

COORDINATING CARE WITH OTHER THERAPY DISCIPLINES (SPEECH, OCCUPATIONAL AND PHYSICAL THERAPY

Coordination of care between providers, especially when a patient is receiving Speech, Occupational or Physical Therapy and Behavior Analysis Services is essential. It ensures the child benefits fully from each service by avoiding overlap or conflicts and fostering a more comprehensive approach to treatment. This collaboration also allows each provider to share insights and adjust treatment plans as needed enhancing the child's overall progress and well-being. It is an expectation that you collaborate with other providers and document the outcome. If you experience any difficulty coordinating care with other therapy providers, please contact therapy network for assistance.

If a patient is identified as needing Speech, Occupational or Physical therapy and you need assistance in coordinating care after outreaching to the PCP, we can also help.

Peer to Peer

A Peer to Peer is offered when the documentation provided does not support the requested services. A reviewing clinician (BCBA or BCBA-D) will outreach the treating provider to obtain further clinical information to justify the services.

Outcomes of Peer to Peer

- If the Therapy Network clinician agrees with the provider, the case will be fully approved
- The Provider may request to withdraw current request and resubmit with further documentation to support medical necessity.
- If the Therapy Network clinician and provider do not agree the case is referred to the Medical Director BCBA-D. If the Medical Director is in agreement with the TN clinician, and based on the TN delegated responsibilities, the case will be referred to the health plan with recommendation for denial.

Documentation

TREATMENT PLAN DOCUMENT

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

DOCUMENTATION TIPS

- Refrain from using ambiguous information
- Pertinent medical history, not just the treatment Diagnosis
- Prior level of function, if applicable
- Clear definitions of the maladaptive behaviors
- Any requests for more than 40 hours
- For lack of progress, explain the causes or obstacles and the plans to update the current plan to address the issues.
- Updated goals as needed to demonstrate continued progress
- Short / Long term goals (Measurable and Functional)
- Individualized treatment plans and session notes. (Template versions, multiple child names, etc)
- Must include data about parental guardian participation in services
- Documentation of coordination of care efforts if the child is receiving other therapy services such as Speech, Occupational and Physical Therapy.

Services in the School

Authorization requests for services to be delivered in a school must include the recipient's Individualized Education Plan (IEP), with the following exceptions:

- In the absence of an IEP, or if the IEP does not contain BA services, the provider must include:
- Documentation justifying the requested services
- An estimated timeframe of when an IEP will be completed or updated
- If a school does not conduct IEPs, a 504 plan may be submitted in its place.
- If a school does not conduct either, the provider must include documentation that includes the name of the school and an explanation that neither plan is available.

Reimbursement

Providers are required to submit claim encounters for all services rendered for each and every visit, and those services are to be reported in the form of a claim to TNFL. The claim encounters ensure that the Plan's members are receiving behavior analysis services as authorized by TNFL per the BA Treatment Plan established by the provider. TNFL uses this claims data to pay claims to our providers, monitor adherence to the Treatment Plan, but also to submit as encounters to our health plan partners. Our health plans are required to submit this same encounter data to the state's Medicaid program. The state uses the encounter data to review and ensure that BA therapy services are delivered to the Plan's Medicaid members.

Claims

CLAIM SUBMISSION

Providers have three ways to submit a claim under TNFL.

- The preferred method of claim submission is EDI through the clearinghouse Smart Data Solutions, using Payer ID is 65062 for professional claims and 12k89 for institutional claims.
- The second preferred method is DDE through our provider Web Portal. Providers may use the HN1/HS1 Web Portal. Please visit https://therapynetwork.com to register for an account.
- If your office is unable to submit claims using a clearinghouse or our provider web portal, then you may submit a paper claim on an original CMS 1500 form for professionally billed claims or a UB04 claim form for institutionally billed claims.

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

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

For status of claims, please use our provider web portal. Our Web Portal providers may use the portal to check status of your submitted claims 24/7 regardless of the method of submission (paper, electronic, Web Portal entry). Please visit https://therapynetwork.com to register for an account.

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

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

CLAIMS PAYMENT ADJUSTMENT

All Medicaid of TNFL have 365 days from the date of the EOP/EOB to request an adjustment for a processed claim. However, TNFL reserves the right to consider all requests received after the 365 days has expired.

For your convenience, you may call a Claims representative at 1-877-372-1273 to inquire about your processed claims and/or to request a claims adjustment.

DO NOT SEND ANY CLAIMS TO THE HEALTH PLANS

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.

TIMING OF CLAIMS PAYMENT

Our Claims Department processes claims in the order they are received. TNFL strictly adheres to state and federal claims processing guidelines for Medicaid lines of business.

PROVIDER CLAIM COMPLAINT

TNFL processes provider complaints concerning claims issues in accordance with s. 641.3155, F.S. TNFL allows providers ninety (90) days from the date of final determination of the primary payer to file a written complaint for claims issues. TNFL resolves all claims complaints within ninety (90) days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.

Patient Responsibility

Providers may confirm member eligibility by contacting Community Care Plan's website at https://ccpcares.org or 1-855-819-9506.

Member Services

TNFL is not delegated member services. If members have questions or concerns regarding their eligibility, benefits or out of pocket costs, please have them call the Health Plan telephone number located on the back of their Health Plan Member ID card.

Continuity of Care

MEDICAID

Continuation of Care (COC) period is up to 90 days from the date that the member switched to Community Care Plan Medicaid from another MMA plan. The COC period ends when the old authorization expires or when the 90 days ends; whichever comes first. You are not required to obtain an authorization from TNFL to continue providing these services during the Continuation of Care Period. If you are NOT a participating provider with HN1/TNFL, please refer the member to their Primary Care Physician or ordering Physician so that they may refer the member to a participating therapist. Members may also contact the health plan to locate a participating therapist.

TNFL allows plan members to continue receiving medically necessary services from a not-for-cause terminated provider and processes provider claims for services rendered to such enrollees until the enrollees select another provider, for up to sixty (60) days after the termination of the provider's contract or until the member is able to locate a new provider, whichever comes first. Notwithstanding the provisions in this Section, a terminated provider may refuse to continue to provide care to an enrollee who is abusive or noncompliant.

Fraud, Waste, and Abuse and Compliance Training

This supplemental training is intended to provide you with the methods for reporting Compliance, Ethics, and Fraud Waste and Abuse violations (suspected or confirmed).

To complete the training please visit our website: https://therapynetwork.com and select the TNFL FWA & Compliance training. At the end of the training you will be required to attest that you have completed the training.

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

Fraud, Waste & Abuse Hotline:
866-321-5550 (Toll-Free)

Mail your report to:
Special Investigative Unit (SIU)
Attn: Marjorie Dorcely
2001 S. Andrews Avenue
Fort Lauderdale, Florida 33316

Fax your report to:
(866) 276-3667
Attn: Marjorie Dorcely
This is a dedicated Compliance line

Email your report:
SIU@healthnetworkone.com

Credentialing, Demographic Changes on Provider Termination

BEHAVIOR ANALYSIS PROVIDERS

All BA providers, or BA providers associated with a group, including covering providers must meet all credentialing and recredentialing requirements as established by TNFL.

Lead Analysts may not render services to Community Care Plan members until they have been fully credentialed.

Any BA provider may not render services to Community Care Plan Managed Medicaid members if they do not have a state Medicaid Number.

Note: Please provide TNFL with an updated roster of all BA providers upon adding or terminating providers.

FACILITIES AND ALL FACILITY LOCATIONS

Facilities are not credentialed directly under Behavior Analysis. Individual Lead Analyst must be credentialed with TNFL in accordance with the credentialing requirements established by TNFL.

DEMOGRAPHIC CHANGES OR PROVIDER TERMINATION REQUIREMENTS

Participating practices are required to notify TNFL immediately when:

A. A lead analyst, BCaBA, RBT or licensed mental health provider has been terminated or is no longer treating patients at a specific location**
B. A location is closing or relocating
C. Demographic information is changing

** The Provider Service Agreement states, you are required to notify TNFL of any terminations 90 days prior to the termination. Non-Participating providers shall not evaluate, re-evaluate or treat beneficiaries managed by TNFL until they are credentialed by TNFL.

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.

Provider Trainings

All providers with TNFL, are required to complete the Provider Trainings, within thirty days of their contract effective date and annually thereafter. The trainings can be located via the web at: https://therapynetwork.com.

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.