Medicaid Hospice Provider Pertinent Information by Health Plan 2017 November		Aetna Better Health of Florida	Amerigroup Florida, Inc.	Community Care Plan	Humana, Inc	Magellan Complete Care	Molina Healthcare of Florida	PHC (Positive Healthcare)	Prestige Health Choice	Simply Health Care	Staywell Health Plans	Sunshine Health	UnitedHealthcare
Authorization For Hospice Services	ALL	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	MMA		Notification Only - None as of 1/1/2018		Inpatient Authorization Needed only						Yes	Yes	
	LTC		Yes		Yes							No	
Authorization Covers All Level of Care		Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	No - All authorizations are reviewed for medical necessity.	No - A notification is required for a change in level of care in order to update authorization details.	No- Authorization is either given as Inpatient LOC or as Outpatient Hospice in the home, depending on provider
Authorization MMA 651 (5-60 days)	MMA 651 Routine Home Care	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	MMA Authorization Made by (Preferred)	All methods accepted	FAX	FAX	n/a		Portal or FAX	FAX	All methods accepted	FAX	All methods accepted	FAX	n/a
	MMA Recertification	90 days		60 days		90 days	90 days	90 days	60 days	90 days	60 days	90 days	n/a
Authorization LTC 651 (61-90 days)	LTC 651 Routine Home Care 0-60 days	Yes	Yes	n/a	Yes	n/a	Yes	n/a	Yes	Yes	Yes	No	Yes
	LTC Authorization Made by (Preferred)	All methods accepted	dl-fltrcarespecialist@amerigroup.com	n/a	All methods accepted	n/a	Portal or FAX	n/a	All methods accepted	FAX	n/a	n/a	FAX
	LTC Recertification	90 days	dl-fltrcarespecialist@amerigroup.com		90 days		90 days		60 Days	90 days			After 12 months, every 60 days
Authorization MMA 651 (61+ days)	MMA 651 Routine Home Care 61+ days	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	n/a
	MMA Authorization Made by (Preferred)	All methods accepted	FAX	FAX	n/a	All methods accepted	Portal or FAX	FAX	All methods accepted	FAX	All methods accepted	FAX	n/a
	MMA Recertification	90 days		60 days	n/a	90 days	90 days	90 days	60 days	90 days	60 days	90 days	n/a
Authorization LTC 651 (61+ days)	LTC 651 Routine Home Care 61+ days	Yes	Yes	n/a	Yes	n/a	Yes	n/a	Yes	Yes	Yes	No	Yes
	LTC Authorization Made by (Preferred)	All methods accepted	dl-fltrcarespecialist@amerigroup.com	n/a	All methods accepted	n/a	Portal or FAX	n/a	All methods accepted	FAX	n/a	n/a	FAX
	LTC Recertification	90 days	dl-fltrcarespecialist@amerigroup.com	n/a	90 days	n/a	90 days	n/a	60 Days	60 days	n/a	n/a	90 days
Authorization MMA 652 Continuous Home Care	MMA 652 Continous Home Care	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	n/a
	MMA 652 Authorization Made by	All methods accepted	FAX	FAX	n/a	All methods accepted	Portal or FAX	FAX	All methods accepted	FAX	All methods accepted	FAX	n/a
	MMA 652 Recertification	30 days		60 days	n/a	90 days	90 days	5 days	5 days	90 days	60 days	5 days	n/a
Authorization LTC 652 Continuous Home Care	LTC 652 Continous Home Care	Yes	Yes		n/a	n/a	Yes	n/a	n/a	n/a	n/a	No	Yes
	LTC 652 Authorization Made by	All methods accepted	dl-fltrcarespecialist@amerigroup.com	N/A	All methods accepted	All methods accepted	Portal or FAX	N/A	N/A	FAX	N/A	N/A	FAX
	LTC 652 Recertification	30 days	dl-fltrcarespecialist@amerigroup.com	N/A	90 days	N/A	90 days	N/A	N/A	90 days	N/A	N/A	90 days
Authorization MMA 656 General Inpatient Care	MMA 656 General Inpatient Care	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	n/a
	MMA 656 Authorization Made by		FAX	FAX	All methods accepted	All methods accepted	Portal or FAX	FAX	All methods accepted	FAX	All methods accepted	FAX	n/a
	MMA 656 Recertification	10 days		60 days	90 days	30 days	90 days	5 days	60 days	90 days	60 days	90 days	n/a
Authorization LTC 656 General Inpatient Care	LTC 656 General Inpatient Care	Yes	Yes	Yes	n/a	n/a	Yes	n/a	n/a	Yes	n/a	No	n/a
	LTC 656 Authorization Made by		dl-fltrcarespecialist@amerigroup.com	N/A	All methods accepted	N/A	Portal or FAX	N/A	N/A	FAX	N/A	N/A	N/A
	LTC 656 Recertification	10 days	dl-fltrcarespecialist@amerigroup.com	N/A	90 days	N/A	90 days	N/A	N/A	90 days	N/A	N/A	N/A
Authorization MMA 657 Physician Services	MMA 657 Physician Services	No	Yes	No	No	Yes	Yes	Yes	No	No	Yes	Yes	n/a
	MMA 657 Authorization Made by	n/a	FAX	n/a	n/a	All methods accepted	Portal or FAX	FAX	All methods accepted	FAX	All methods accepted	FAX	n/a
	MMA 657 Recertification	N/A		N/A	N/A	90 days	90 days	60 days	60 days	90 days	60 days	10 days	N/A
Authorization LTC 657 Physician Services	LTC 657 Physician Services	No	Yes	N/A	N/A	Yes	Yes	N/A	N/A	N/A	N/A	No	N/A
	LTC 657 Authorization Made By	N/A	dl-fltrcarespecialist@amerigroup.com	N/A	All methods accepted	N/A	Portal or FAX	N/A	N/A	FAX	N/A	N/A	N/A
	LTC 657 Recertification	N/A	dl-fltrcarespecialist@amerigroup.com	N/A	90 days	N/A	90 days	N/A	N/A	90 days	N/A	N/A	N/A
Authorization MMA 658 Room & Board	MMA 658 R&B	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	N/A
	MMA 658 R&B Authorization Made by	All methods accepted	FAX	FAX	All methods accepted	All methods accepted	Portal or FAX	FAX	All methods accepted	FAX	All methods accepted	FAX	N/A
	MMA 658 R&B Recertification	90 days		60 days	90 days	90 days	90 days	60 days	N/A	90 days	60 days	90 days	N/A
Authorization LTC 658 Room & Board	LTC 658 R&B	No	Yes	N/A	Yes	N/A	Yes	N/A	N/A	No	N/A	No	N/A
	LTC 658 R&B Authorization made by	All methods accepted	dl-fltrcarespecialist@amerigroup.com	N/A	All methods accepted	N/A	Portal or FAX	N/A	N/A	FAX	N/A	N/A	N/A
	LTC 658 R&B Recertification	90 days	dl-fltrcarespecialist@amerigroup.com	N/A	90 days	N/A	90 days	N/A	N/A	90 days	N/A	N/A	N/A
Authorization MMA 185 Bed Hold	MMA 185 Bed Hold	N/A	Yes	No	N/A	Yes	N/A	Yes	Yes	N/A	Yes	N/A	N/A
	MMA 185 Bed Hold Auth made by	N/A	FAX	N/A	N/A	All methods accepted	N/A	FAX	All methods accepted	N/A	All methods accepted	N/A	N/A
	MMA 185 Bed Hold Recertification	N/A		N/A	N/A	90 days	N/A	5 days	10 days		60 days	N/A	N/A
Authorization LTC 185 Bed Hold	LTC 185 Bed Hold	Yes	Yes	N/A	Yes	N/A	Yes	N/A	N/A	N/A	N/A	N/A	N/A
	LTC 185 Bed Hold Auth made by	All methods accepted	dl-fltrcarespecialist@amerigroup.com	N/A	All methods accepted	N/A	Portal or FAX	N/A	N/A	N/A	N/A	N/A	N/A
	LTC 185 Bed Hold Recertification	90 days	dl-fltrcarespecialist@amerigroup.com	N/A	90 days	N/A	90 days	N/A	N/A		N/A	N/A	N/A
Authorizations - Received	When should the hospice expect to have an assedited authorization?	48 hours	48 hours next business day - no weekends	48 hours next business day - no weekends	48 hours	48 hours	48 hours, authorizations issued on Saturdays	48 hours next business day - no weekends	48 hours	48 hours	48 hours	24 hours next business day - no weekends	48 hours
	Auth Made by Plan to Hospice	fax	All	fax	MMA-Phone Call LTC-Fax	fax or portal	fax or via portal	It may be by phone, fax or email - dependent upon provider/requestor preference.	fax and phone	FAX	Phone and Fax	fax	
Mechanism for Determining Patient Hospice Care	How plans determine if a patient has had a previous hospice election before?	If our member historically, we check our internal claims records; if not a member prior to request, we asked the memberfamily	MMA. Authorization History LTC: CM Contact.	Review historical authorizations and paid claims data	Not Applicable	authorization and claims histories	Claims (history)	Our authorization/claims system HealthSuite	N/A as no auth required	Plan Auth System-Member History	Via the service authorization history and COB history	Election Form and Previous authorizations	Review prior notification history
	Determine if the patient has changed managed care plans?	Rely on state eligibility files	834 Files	Review of Panel Roster Report to transitioning plan	State eligibility file/HealthNet	Medicaid eligibility files	FILES	Our authorization/claims system HealthSuite and verification w/ Passport to confirm if member has other coverage such as LTC	FLMMIS and eligibility files	Plan system-Eligibility	Via daily eligibility files and case management transition of care report	Member eligibility	review member eligibility
	Determine highlow routine days?	Based on hospice provider notes/records	We do not authorize these services separately - one blanket authorization covers all days	By prior authorization and review of plan of care	Revenue codes	Medical necessity criteria based on clinical notes	Claims	Our authorization/claims system Health Suite	N/A as no auth required	N/a	Medical necessity guidelines	Claims processing system	N/A for Prior Authorization
	Determine if there has been a 60-day gap between hospice elections?	If our current member; we check our claims records; if not a member prior, we ask the memberfamily	MMA. Authorization History LTC: CM Contact.	Review historical authorization for hospice care and plan of care received from hospice provider	Not Applicable	authorization and claims histories	Claims	Our authorization/claims system Health Suite	N/A as no auth required	Member history	service authorization history and transition of care report	Previous authorizations	Review prior notification history
Patient Responsibility	PATIENT RESPONSIBILITY: Describe how the hospice provider should present the Patient Responsibility on SMMC LTC Program claims?	Hospice providers should present the patient responsibility on the UB04, box 39, value code 31 and include the full amount of the patient responsibility.	Value code 31 should be entered in box 39 with the amount of patient liability. The amount entered should be the gross amount for the entire month even when billing a partial month. The Medicaid Plans will provide calculation for partial days. If there is no patient responsibility, we providers bill $0.00 or [$0.01] if there clearinghouse required a dollar amount	N/A	Required to submit on hospice claim the value code 31	N/A	In box 39 on the UB04 hospices are to enter Value code 31 and the key in the amount of the patient minimum monthly responsibility.	We are MMA only. All of our members are QMB. There are no copay	N/A	Enter value code 31 in Box 39. Amount entered needs to be gross amount for the entire month even when billing partial months. If there is no patient responsibility enter $0.00. If provider's clearing house requires a dollar amount to be entered, enter $0.01	N/A	Value Code 31 with the full monthly patient responsibility	Hospice providers should be billing the Patient Responsibility on the claims hard copy with Value Code 31 and the SOC (Share of Cost) billed. Per our current Member liability instructions for these claims, it directs the claims processor to look for the Value Code and SOC from the claim image. Then based on the date of service billed, the Patient Responsibility, better referred to as the SOC, will be applied according to the date span in the Coinsurance field.
Patient Responsibility	Contact Information for Notice of Case Actions/Patient Responsibility	Elaine Bonga | 954-858-3279 | BongaE@aetna.com	LTCProvRelations@amerigroup.com	n/a	Linda Farian | 561-665-4372 | lfarian@humana.com |	n/a	Rebecca Quintana | 305-714-3450 | rebecca.quintana1@molinahealthcare.com | 562-499-0719	Shelley Self | 323-436-5008 | shelley.self@aidshealth.org | 888-235-9342	Amy Costa | 561-839-2550 | pnc@prestigehealthchoice.com |F: 855-358-5853	Patt Bliss | 813-830-6917 | Patt.Bliss@amerigroup.com |	Lawanda Curry | 813-206-1818 | lawanda.curry@wellcare.com | F: 813-206-7716	Elias Kranidis | 813-284-1262 | ekranidis@centene.com | F: 999-999-9999	The UnitedHealthCare Community Plan Customer Service | 800-791-9233 |
CLAIMS PROCESS	Please list the steps necessary for reprocessing denied claims. Be brief, list type of claim, codes needed, steps, means of contacting plan and time frames.	Itemized Bill • All claims associated with an Itemized Bill must be broken out per Rev code to verify charges billed on the UB match the charges billed on the Itemized Bill. (Please attach Itemized Bill that is broken out by Rev code with substitute.) Duplicate claim • Review request for a claim whose original reason for denial was "duplicate." • Provide documentation as to why the claim or service is not a duplicate such as medical records showing two services were performed. Corrected Claim • The corrected claim must be clearly identified as a corrected claim by writing or stamping "corrected" on the claim itself. Coordination of Benefits • Attach EOB or letter from primary carrier and forward to the Claims Department identifying as "corrected" claim. Proof of Timely Filing • For electronically submitted claims provide the second level acceptance report. • Refer to Proof of Timely Filing Requirements in your Provider Manual. Claim/Coding Edit • Aetna Better Health of Florida uses two (2) claims edit applications: Claim Check and iHealth. Please refer to the Provider Manual on the Aetna Better Health of Florida website, www.aetnabetterhealth.com/Florida, for more information on claim editing. Appeals must be received within 180 days of the date of service or discharge or within 45 days of the action resulting in need to file the appeal. Corrected claims must be received within 180 days of the date of service or discharge date. Aetna Better Healthf ofl Florida's Provider Relations Department will make reasonable efforts to resolve the request within 30 calendar days of receipt. That resolution may be: • Reprocessing claim and issuing a new EOP with new payment information, or • A determination that a formal dispute is required and issuing a letter to that effect, or A determination that reprocessing is not appropriate and issuing a letter to that effect.	To submit a payment dispute, please complete the payment dispute form located in Appendix A — Forms or online at providers.amerigroup.com/FL and submit to: Payment Dispute Unit Amerigroup Community Care P.O. Box 61599 Virginia Beach, VA 23466-1599 The network provider should file a payment dispute within 120 calendar days of the paid date of the EOP by submitting a written request with a written explanation of what is in dispute and why. Include supporting documentation, such as an EOP, a copy of the claim, medical records or contract page. Non-network providers should file a payment dispute within 120 calendar days of the paid date of the EOP by submitting a written request with supporting documentation, such as an EOP, a copy of the claim or medical records.	All appeals must be in writing on the CCP appeals form and appropriate information indicated.	Providers are to call Customer Service for claim review and advisement of any additional information needed to reprocess claim. Time frame is 12 months from the original process date for review and potential adjustment of the claim.	Review the reason for the denial; contact provider for additional information or to relay coding information; review/research policy guidelines for claim payment; If claim denied in error, reprocess claim; timeframe for completion is within 30 days. If claim denied correctly, a letter is sent to the provider within 30 days.	Providers disputing a Claim previously adjudicated must request such action within one (1) year of Molina's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.), all Claim disputes must be submitted on the Molina Provider Dispute/Appeal Form found on Provider website and the Provider Portal. The form must be filled out completely in order to be processed. Additionally, the item being resubmitted should be clearly marked as reconsideration and must include the following: Providers should submit the following documentation: ☐ All documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the reconsideration request. ☐ The Claim number clearly marked on all supporting documents Forms may be submitted via fax, secure email or mail: Claims Disputes/Reconsideration requested via the Provider Dispute/Appeal Form may be sent to the following address: Molina Healthcare of Florida, Inc. Attention: Grievance & Appeals Department PO Box 527540 Miami, Florida 33152-7450 Submitted via fax: (877) 553-6504 Secure email: MFL_ProviderAppeals@MolinaHealthcare.com Please Note: Requests for adjustments of Claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original Claim. For claims related issues, the Provider will be notified of Molina's decision in writing within sixty (60) days of receipt of the Claims Dispute/Adjustment request.	Claims must be submitted on the correct form UB-04. Codes used must match the plan's contracted fee schedule & begin w/ either 65* or G. All claims must match the authorization. Unclean claims will deny and provider will receive an EOB with rejection reason. Electronic claims are adjudicated within 7 days, paper claims within 30 days. Provider is notified via a paper EOB.	Submit corrected claim with bill type frequency 7. Submit electronically through EDI vendor or mail to Prestige Health Choice, PO Box 7367, London, KY 40742 within 180 days from original process date for par providers and 365 days for nonpar providers. Questions - call Provider Services at 800.617.5727	Provider needs to resubmit corrected claim. Can be resubmitted with bill type 817. Claim is required to be resubmitted within 180 day from DOS.	File a dispute via the online portal at https://florida.wellcare.com/login/provider (_https%3a//florida.wellcare.com/login/provider) or via phone, mail or fax to WellCare Health Plans, Inc. at 866-334-7927 or Fax 1-877-277-1808 Attn: Claim Payment Disputes P.O. Box 31373 Tampa, FL 33631-3370 Providers have one year from the date of the Explanation of Payment (EOP) from the plan to dispute claims. The following revenue codes billed on a UB04 can be disputed using the methods listed above: 651,652,658,656,655,657,652,658,651,658,656	There is a reconsideration request form located on SH.com that providers can use to request reprocessing of claims. They will need the information from the denied EOB e.g. (claim#, denial reason, etc...) These should be mailed to the plan, here is the link to the form: https://www.sunshinehealth.com/content/dam/centene/Sunshine/pdfs/Sunshine-claims-adjustment-form-02-12-14_comms.pdf Providers can call Provider Services at (866)796-0530 for assistance with denied claims. They will need to verify that they have initial claims status via the IVR, paper EOP or from utilizing SH.com provider portal. They can register for an account using the link: https://www.sunshinehealth.com/login.html Requests for reprocessing/reconsideration are usually processed 30-45 business days from date of receipt. Timely filing for reconsideration requests begins from the date claims are initially processed.	
Claims Contact	Contact Information for Reprocessing Claims Concerns	Claims Inquiry Claims Review (CICR) | 800-441-5501 | FLMedicaidProviderRelations@aetna.com | F: 844-235-1340	Provider Service Unit: 877-440-3738 and follow the prompts for Claims	Crystal Sanders | 954-622-3334 | crsanders@ccpcares.org	Customer Service | MMA/1-800-477-6931 or LTC/1-888-998-7735	Danyell Mosley | 314-387-4827 | dmosley@magellanhealth.com | F: 888-656-0374	Attention: Grievance & Appeals Department | 855-322-4076 | MFL_ProviderAppeals@MolinaHealthcare.com | F: 877-553-6504	Jeagena Al-Uqdah | 323-436-5000 x 5038 | Jeagena.Al-Uqdah@aidshealth.org | F: 844-223-9415	Provider Appeals | 561-839-2500 | pnc@prestigehealthchoice.com | F: 855.358.5853	Elayne Williford | 305-521-2830 | ewilliford@simplyhealthcareplans.com	Mary Pimentel | 813-206-1411 | mary.pimentel@wellcare.com | F: 813-283-3360	Provider Services | 866-796-0530 Ext. 41923 | F: 866-614-4955	The UnitedHealthCare Community Plan Customer Service | MMA 888-716-8787 or LTC 800-791-9233 |
Provider Relations	Contact Information for Provider Relations	Susan Waldman | 954-858-3526 | WaldmanS@aetna.com | F: 844-235-1340	LTCProvRelations@amerigroup.com	Donna Hamilton | 954-622-332 | dhamilton@ccpcares.org | F: 754-701-6953	Provider Customer Service | MMA 800-477-6931 or LTC 888-998-7735 | LTCprovidersrelations@humana.com	Anya Thornberry | 305-606-2409 | athornberry@magellanhealth.com | F: 888-656-0384	Elka Tapanes | 305-908-3500 | elba.tapanes@molinahealthcare.com | F: 562-499-0719	Gary Rivera | 954-622-3132 x 3288 | gary.rivera@phcplans.org |F: 888-965-7434	pnc@prestigehealthchoice.com	Erica Murphy | 813-425-8053 | emurphy@simplyhealthcareplans.com	Kelva Dixon| 904-348-5275| kelva.dixon@wellcare.com | Regions 1, 2, 3 4; Kathy Cornish| 407-551-1224| katherine.cornish@wellcare.com| Region 7; Christy Tatum | 813-206-3060| christy.tatum@wellcare.com | Regions 5, 6, 8; Jonathan Jackson | 305-628-7833 | jonathan.jackson@wellcare.com Regions 9, 10, 11	Local Provider Network Specialist (PNS) | 866-796-0530	Providers UHC Provider Advocate (varies) | Customer Service MMA 888-716-8787 or LTC 800-791-9233
If results achieved by the Provider Relations contact are unsatisfactory or communication has stalled, who within may the hospice provider contact for assistance?		Claudia Lamazares | Chief Operating Officer | 954-858-3208 | LamazaresC@aetna.com | F: 855-799-6190	Renee Thomas | Director of Provider Engagement | 813-530-6900 Ext. 77462 | Renee.Thomas@amerigroup.com	Natalia Penalver | Director of Provider Operations | 954-622-3308 | npenalver@ccpcares.org | F: 954-417-7155	Provider Relations Directors LTC-Ed Miller | 305-804-8354 | Emiller13@humana.com MMA Region 5,10,11 Katrina Knight Vera | 305-626-5266 | KKnight-vera@humana.com | F: 305-370-6668 MMA Region 1,6 Sharon Coleman | 813-281-6083 | Scoleman2@humana.com | F: 813-313-5682	Melete Pacas| Senior Director, System of Care| 786-577-2429 | mspacas@magellanhealth.com | 888-656-0364	Lissette Martinez | VP Network Management | 305-908-3515 | lissette.martinez@molinahealthcare.com | F: 562-499-0719	Shelley Self | Director of Claims Operations| 323-436-5008 | shelley.self@aidshealth.org | F: 888-235-8748	Mark Metrovich | VP Provider Network Management | 561-282-4218 | mmetrovich@amerihealthcarfdas.com	Director of Provider Relations by Region Dixie Hollis|R1,2,3,5,6,8| 813.425.8017 Nicole Bennett|R7,4| 407-402-2210 | nbennett@simplyhealthcareplans.com Jane Laguna (R9, 10, 11) | 305-521-2655	Duanna Dorsett, Sr. Director, Provider Relations | 813-206-6639 | duanna.dorsett@wellcare.com | F: 813-283-3225	LTC Local PNS, then Sandra Moore | Sr. Manager Contracting & Network Development | 813-286-6266 | samoore@centene.com | F: 877-262-5570	Felix Gonzalez | Vice President Network Programs | felix_m_gonzalez@uhc.com