Simply healthcare | CLEAR HEALTH ALLIANCE

Simply Healthcare Plans, Inc. (Simply): Medicaid Managed Care | Medicare Advantage •
Clear Health Alliance (CHA): Medicaid Managed Care

Reference guide for nursing facilities

This reference guide includes relevant contact information, information on the claims appeal process, an overview of nursing facility responsibilities, and frequently asked questions. Nursing facilities will find this guide useful when members are transitioning into long-term care (LTC).

Authorization requests and authorization appeals

Initial authorization requests	
Submitting authorizations digitally is the most efficient way to submit your request. Log onto Availity.com and from the *Patient Registration* tab, select **Authorizations and Referrals** to submit your request. Use the Attachment button to attach the *Preadmission Screening* and *Resident Review (PASRR)*. If you are unable to submit the authorization digitally, fax it along with the *PASRR* and a cover sheet to the contact numbers below.	
Statewide Medicaid Managed Care Long-Term Care (SMMC LTC)	**844-285-1169**
Statewide Medicaid Managed Care Managed Medical Assistance (SMMC MMA)	**866-495-1986**
Medicare LTC pending preapproval	**866-811-0197**
Note: all nursing home services require authorization.	

Authorization appeals

Authorization appeals can be submitted from your Dashboard in the Authorization application on Availity.com. If you are unable to submit your authorization appeal digitally:

- Include clinical information and cover sheet indicating Appeal Request.
- Submit the appeal via:
  - Fax (Medicaid): **866-216-3482**
  - Fax (Medicare): **888-458-1406**
- Medicare appeals are submitted through QIO (Kepro). If the member misses the deadline to file with the QIO (Kepro), please contact Simply Healthcare Plans, Inc. (Simply) at **877-577-0115**.

Case management contacts

Notice of admissions, discharges, and transfers	
SMMC LTC phone	**877-440-3738**
SMMC LTC fax	**888-762-3220**
SMMC LTC email — status notifications and discharges	FLLTCNursingFacilityInquiry@anthem.com
SMMC MMA or SMMC LTC skilled care for status notification	DL-FLIPMCDPACRequests@simplyhealthcareplans.com
120-day (SMMC MMA custodial) benefit packet	DL-FLIPMCDCustodialRequests@anthem.com
120-day full Dual Special Needs Plans (DSNP) members pending approval for LTC	**Fax: 866-811-0197**
Medicare contacts for Simply	**dl-shp-IPMedicareTeam@anthem.com:** • Only use for delays or issues with SNF authorizations and transfers **Fax— 866-811-0197:** • Clinicals only • Notice of Medicare Non-Coverages (NOMNC) need to be delivered to the member, signed, and returned the same day as issued. • LTC pending preapproval requests **Fax — 866-811-0143:** • Part B therapy requests in the Nursing Facility
Medicare **prior authorization form** submission	Phone authorizations: **844-405-4297** Fax: **866-811-0143** Online submission: **Availity.com**
Discharge planning skilled nursing facility for MMA and Medicare (durable medical equipment [DME], home health (HH) coordination), and IV infusions)	Integrated Home Care Services: **844-215-4265** **Fax:** • MMA: **844-410-6889** • Medicare: **844-215-4265** • Include fax referral number
In-home requests for DME, home health, or infusion services	Integrated Home Care Services: **844-215-4265**

Provider Relations team contact information

If you have questions, issues, and concerns, please contact your assigned Provider Relationship representative, or contact the Provider Relations manager listed below.

Contact information	
Inservice, billing questions, Change of Ownership (CHOW), general contract/credentialing inquiries	If known, first contact your assigned Provider Relations representative or email: ltcprovrelations@simplyhealthcareplans.com
Re-credentialing documents only	AGPCred@amerigroup.com
Provider Relations escalations	LTCPREscalations@simplyhealthcareplans.com

Claims appeal process

The very best way to check the status of your claim is through the Claims Status application on Availity.com. Log onto Availity.com and from the *Claims and Payments* tab, select **Claims Status**.

If you disagree with our decision and have documentation to support your claim, you can file a dispute through the Claims Status application. After you've located your claim, select **Dispute**, and upload the supporting documentation directly to your claim.

If you are unable to check the status of your claim digitally, you can call Provider Services at **877-440-3738**, Monday through Friday, from 8 a.m. to 7 p.m. ET.

Submitting your payment dispute digitally leads to faster resolution. If you choose to submit a reconsideration in writing (within 90 days) mail a formal request to the health plan including all supporting documentation.

Disputes can be submitted in writing through the manual process of mailing the Payment Dispute Unit at:
P.O. Box 61599
Virginia Beach, VA 23466

A resolution to the Claims Payment Dispute will be rendered and communicated to the provider within 60 calendar days of receipt of the request. Check the status and check the progress of your claim dispute from your *Appeals Dashboard* on Availity.com. Access your *Appeals Dashboard* from the *Claims Status* application. If you are dissatisfied with the payment dispute resolution, submit a second level appeal in writing and mail it to the Dispute Unit address previously noted.

If you are dissatisfied with the second level appeal resolution, request a review from the Statewide Provider and Health Plan Claim Dispute Resolution Program (Capitol Bridge) by contacting FLCDR@capitolbridge.com or calling **800-889-0549**.
If not using the digital process to submit your appeal, include:

- Provider cover letter.
- Supporting documentation to overturn the claim such as medical records, authorizations.
- Claims report.

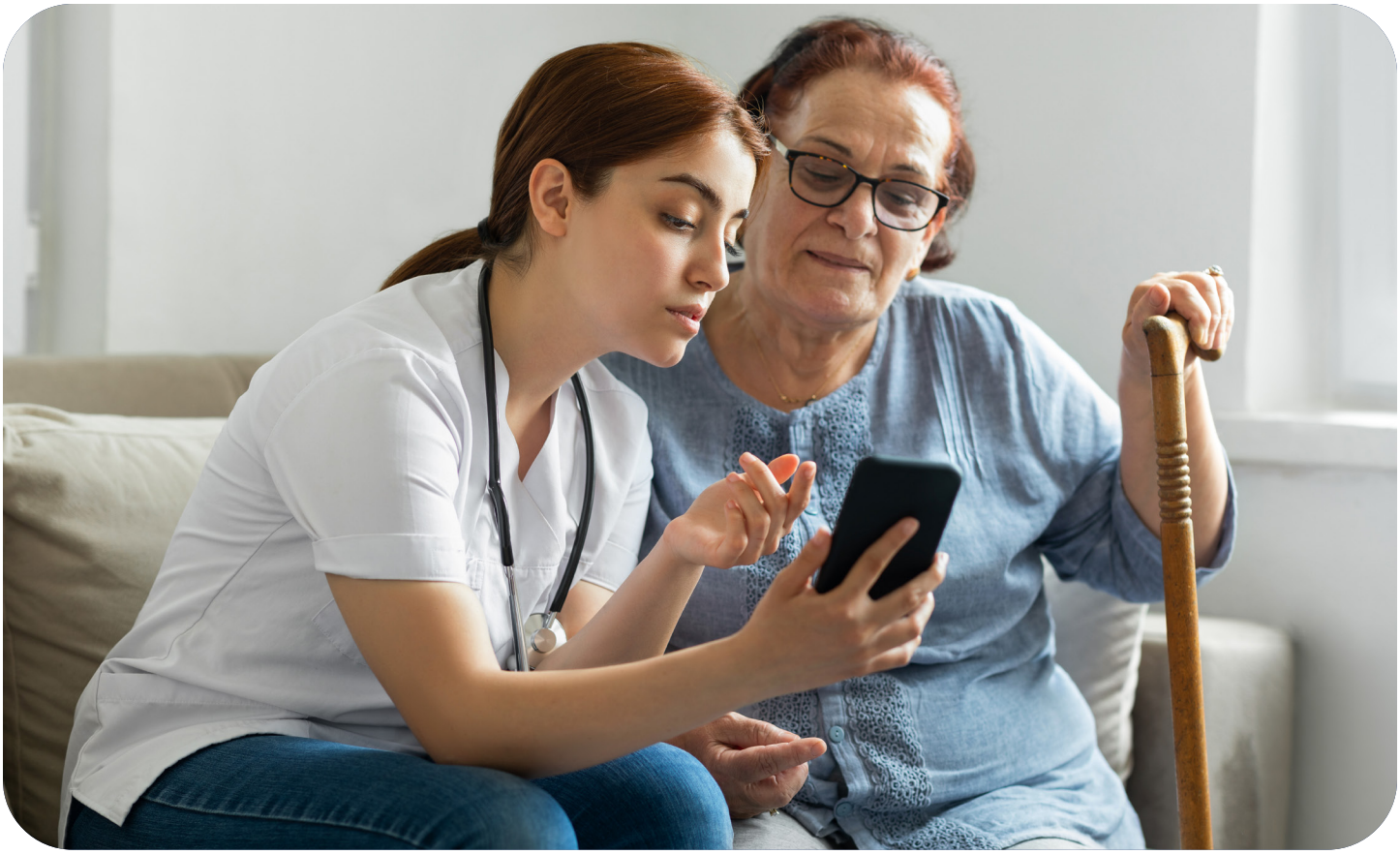
A level 1 appeal needs to be submitted 90 days from the date on the *EOP*.

A level 2 appeal needs to be submitted 30 days from the date on the first appeal decision.

Nursing facility responsibilities and reminders

- **Requirement for proper authorization, billing, and payment:** Notification of admission and discharges are required within 24 hours. This allows timely notification to the Department of Children and Families (DCF) for the 2515/2506:
  - To locate a member's case manager please send an email to FLLTCNursingFacilityInquiry@anthem.com
- **120-day SMMC MMA benefit:** Nursing facilities and Simply and CHA must coordinate and assist members with LTC enrollment. Once the nursing facility has the completed enrollment packet (form/consent/3008), the nursing facility is required to send the completed enrollment packet to Simply and CHA. Simply and CHA will forward it to DOEA/CARES:
  - Forward packet to DL-FLIPMCDCustodialRequests@anthem.com
- Per the Agency for Healthcare Administration's (AHCA) requirements, Simply and CHA must receive a PASRR, and the member must have a Medicaid Code (MI) level of care prior to issuing an authorization for LTC and MMA benefits. (see FAQs).
- Members admitted to hospice care will have a Medicaid Hospice (MH) code. Non-hospice will have a Medicaid Institutional Care (MI) Medicaid code:
  - Hospice providers are responsible to notify DCF to update Medicaid codes.
  - Simply and CHA can issue authorizations once the codes are updated.
  - Notification of a member enrolling and disenrolling from hospice (changes in level of care) must be communicated to case management to update authorizations timely.
- Timely notification to case management for discharge planning to coordinate a safe discharge should start at time of skilled nursing facility (SNF) admission.

- Admission for skilled nursing services clinical updates need to be submitted via fax to:
  - Medicaid: **866-495-1986**
  - Medicare: **866-811-0197**
- New authorizations are required when a member incurs an inpatient stay past midnight. All members are required to have authorization before admitting to the facility.
- Provider must verify member's eligibility and claims status via Availity.com.
- If the member's family or nursing facility disagrees with the member's patient responsibility calculated in the DCF website, those parties must work directly with DCF for re-calculations. Health plans are not able to determine patient responsibility.



Frequently asked questions (FAQ)

Q. What is the SMMC MMA 120-day benefit?
A. Nursing facility (custodial) is covered up to 120 days while the SMMC LTC application is being processed by the Department of Elder Affairs (DOEA) and the Comprehensive Assessment and Review for Long-Term Care Services (CARES). Simply and CHA and the nursing facility work together for member enrollment into SMMC LTC.

Q. What is meant by MI code?
A. An MI code is provided when DCF issues the member an institutional care program (ICP) level of care. The member's Medicaid code will have a MI series to include one of the following: MI I; MI M; MI S; MI T. Members must have a MI series code for authorization for custodial care under SMMC LTC and SMMC MMA 120-day benefit.

Q. Is a PASRR and the MI code required for the nursing facility to receive an authorization?
A. Yes, both are required for Simply and CHA to issue an authorization. This is applicable for SMMC MMA and SMMC LTC members.

Q. If member is SMMC LTC enrolled, do they still need an MI code?
A. Yes, all nursing home members will require a MI code prior to issuing a nursing facility authorization.

Q. Where can I find the member's MI?
A. The Florida Medicaid Management Information System (FLMMIS)

Q. When does a NF use the *2506 Form*?
A. When a SMMC LTC member who lives at home or ALF moves into a nursing facility, the *2506A Form* is used by Medicaid nursing facilities (NF) or Medicaid long-term care (LTC) managed care plans to communicate with the Department of Children and Families (DCF) regarding individuals seeking nursing facility services or requesting a change to their Medicaid eligibility file. The *2515 Form* should **not** be used; instead, the *2506A Form* should be completed and submitted to DCF.

Q. When is the *2515 Form* used?
A. When a SMMC LTC member is discharged from the nursing facility, and the discharge is to the community (ALF or private residence), then *2515 Form* should be completed by the LTC plan and submitted to DCF.

Q. What is a SNP?
A. Special needs plan (SNP) is a Medicare plan that covers the member's Medicare and Medicaid benefits. The SNP plan is responsible for the SMMC MMA 120-day benefit. Simply does have an SNP plan in approved counties.

Q. What do I do if the claim is processed with the wrong patient liability?
A. Check the DCF website, and if the claim isn't processed with the correct PL, please submit a claims appeal for adjustment, or contact your Provider Relations representative.

Q. Where can I find additional information?
A: Visit our provider website **https://provider.simplyhealthcareplans.com** to find our precertification look up tool, provider manuals, provider trainings, and more.

Q. How do I register for Availity?
Visit **Availity.com**.

Q. How do I learn more about submitting digital authorizations?
A. Use this link to take live or on-demand Authorization application training: **Availitylearning.learnupon.com/catalog/courses/3469833**

Q. Is there additional information available for using the Claims Status application?
A. Yes. Use this link to attend a live or recorded session to learn about the Claims Status application.

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