



Polk County Board of County Commissioners

Polk HealthCare Plan

Frequently Asked Questions

▪ How is a request for service processed, and what is the expected turn-around times?

Providers should submit a request for a service utilizing the Polk HealthCare Plan's (hereafter referred to as Plan) designated Referral Form.

- Requests for service should be submitted to the Plan at least two (2) to three (3) business days prior to the actual scheduled date of service.
- If the request for service is considered a "clean request", which is defined as needing no other supportive documentation, the Provider should obtain the Treatment Authorization Form (TAF) within two (2) to three (3) business days.
- When the request for a service is denied, the process may take from three (3) to five (5) business days.
- If additional information is determined to be needed by the Medical Management Team (e.g.: clinicals), the Provider will receive a Request for Information Form from the Plan.
- If the service is then approved, the Plan will forward a TAF to the Provider's office by facsimile within two (2) to four (4) business days.
- In cases where the Provider has additional codes to add after a service has been approved, the Provider may be required to provide additional information or the authorization will be denied. Providers will have 30 calendar days from the date of service to inform the Plan of the additional codes.

▪ What does it mean when I receive a "Pending" Treatment Authorization Form with a reason listed as Date of Service Confirmation?

The service has been reviewed and is approved; however, it requires an actual date of service and/or date of discharge before the Plan can update the computer system. Providers must send via fax the actual date of service, so that the Plan's system can be updated with this information. Without updated information, reimbursement can not be processed by the Claims Department. Note: The Plan will not re-send an updated TAF to the provider unless requested.

▪ What happens if my request for a service is denied?

If the request for service is denied, the Plan will send a letter to the Provider outlining the reason for denial. The Provider can contact the Plan's Medical Management Team to obtain clarification regarding the reason for denial. Contact telephone numbers for the Medical Management Team Members are listed on the Plan's referral form.

▪ Why do I have to send in CPT and/or ICD9 codes?

The Plan is changing its utilization strategy which now requires Providers to obtain approvals for services prior to rendering services to members. Providers will only be reimbursed for services covered by the Plan. The attached sheet outlines the “Covered Services” and “Excluded Services” for Plan members.

The CPT and/or ICD9 code will determine if the benefit is covered by the Plan. The Provider must send CPT and/or ICD9 codes to obtain an approval or denial for services. Providers must list the code(s) to describe the diagnosis and related service in order to avoid duplication and delays that could increase the turn-around time for Provider reimbursement.

- **What length of time do I have to provide the Plan with the CPT and ICD9 codes to demonstrate medical necessity of the covered Plan services that are requested?**

CPT and/or ICD9 codes must be submitted in writing at the time the service is requested, within the time-line identified above. On average, the Plan makes an approval or denial determination within two (2) to three (3) business days. However, more complex cases may require a longer turn-around time, which allows the Plan to properly review and assess the request for services. More complex cases may take between three (3) to five (5) working days to process. Should the Provider fail to produce requested information to the Plan in a timely manner, this will delay the processing of the request and can subsequently prompt a denial by the Plan.

If a surgery or procedure is approved by the Plan and the Provider later needs to add another service code or change the original service code, the Provider must notify the Plan in writing as soon as possible, but no longer than 30 calendar days of the date of service. Note: The Provider must also supply the Plan’s Medical Management Team with the pertinent documentation to demonstrate the medical necessity or rationale for the change in order for an approval to be issued.

- **What happens to my request for approval of services if the CPT and/or ICD9 code is incorrect?**

If the Provider is requesting approval to provide a service and there is a question regarding the codes that have been submitted to the Plan, the Provider’s office will be contacted by the Medical Management Team to request clarification. It is necessary to obtain the accurate information in advance, to ensure Plan benefits can be determined, and to assure that claims are paid correctly and in a timely manner to our Providers.

- **What happens if the CPT and/or ICD9 codes provided at the time of the request needs to change, or additional codes added?**

The Provider is required to notify the Plan in writing. This should be done prior to the service rendered or immediately thereafter, but in no cases shall it exceed 30 calendar days of the date of service. Note: The Provider must also supply the Plan’s Medical Management Team with the pertinent documentation to demonstrate the medical necessity or rationale for the change or additional codes added, in order for an approval to be re-issued. This protocol applies to all services provided to Plan members, including, but not limited to office visits, in-office procedures, outpatient surgery and other procedures as appropriate.

▪ **What is the Plan’s policy with regard to retroactive requests for approval?**

Authorized medical services, testing, and procedures for Plan members are required to be pre-certified in accordance to Plan policy; therefore, the Plan will not approve retroactive requests for medical care/authorizations. However, if a prior authorization was issued, and after the procedure (e.g. surgery) is performed the Provider needs to add another service code or change the original service code, the Provider has 30 calendar days to provide the necessary documentation to demonstrate medical necessity.

▪ **How long do I have to submit an original claim, and how long do I have to re-submit my claim if I receive a denial?**

Plan providers who were contracted with the Polk HealthCare Plan prior to October 1, 2008 were allowed one (1) year to submit claims after the date of service was rendered, in accordance with their contract.

New Plan policy, in accordance with each medical provider’s contract for services now identifies that for all services rendered after October 1, 2008, claims must be submitted within 180 days after the date the service is rendered to a Plan member. All claims must be submitted on a CMS-1500 form in order to be accepted and processed for payment. The Plan will remit payment to the Provider within 45 days for “clean claims” received. If the claim is suspended, pending additional information, the Provider should make every attempt to immediately submit the information. When a claim is denied, the Provider has 45 days to re-submit the claim for processing.

▪ **When can I expect to know if my claim is denied or approved?**

As a general rule, all claims will be approved or denied for payment within forty-five (45) days from the date the Plan receives the claim. Remittance Vouchers are mailed to the address designated by the Provider.

▪ **What happens if my claim is denied?**

It is the responsibility of the Provider to submit accurate and correct billing information at the time a claim is submitted to the Plan for reimbursement.

- If the claim is denied due to incorrect CPT and/or ICD9 codes, the Provider must submit their request to make changes/modify their codes, utilizing the same process as outlined above. Medical documentation may be required to substantiate the requested change to previously approved services. Please contact the Medical Management Section if you have any questions. Contact telephone numbers for the Medical Management staff members are listed on the Plan’s referral form.
- If the claim is denied for one of the “Top 10 Reasons” or for any other reason (e.g. incorrect/missing information), Providers should make the appropriate changes and resubmit to the attention of the Plan’s Claims Management Section.
- If the claim is denied for lack of approval, the request for service must be re-submitted to the Medical Management Team as set forth above.

Listed below are the Plan’s “Top 10 Reasons for Claim Denials” based on claims history; they are as follows:

Ranking	Reason
1	Claim previously paid
2	Service not covered under patient’s health plan
3	Coverage not in effect for date of service(s)
4	Client # is incomplete/incorrect; does not match record
5	Missing authorization number

Ranking	Reason
6	Patient has other payer source
7	Authorization has not been obtained by hospital
8	Claim DX for emergency room services require authorization
9	*Claim exceeds 1 year filing limit – Effective 1/1/06-9/30/08
10	Date of service not within authorization date span

**Note: Current filing limit (Effective 10/1/08) is six (6) months.*

▪ **What can I expect from the Plan in the future?**

Although this is a *work in progress*, the Plan’s initiative is to assure that sufficient access to quality primary and preventive health care services is available for Plan members, and to coordinate care with specialists as appropriate. Over the next several months, the Plan will be making strides to work with local medical offices and groups, along with various medical association groups to introduce the Plan’s new design and invite feedback on the changes. Areas that will be targeted will include the following:

- ❖ Covered and Excluded Services
- ❖ Service Limits
- ❖ Accessibility of Care/Quality Health Measures
- ❖ Access to Care
- ❖ Emergency Room Diversion Strategies
- ❖ And more . . .

▪ **Will I be notified of future changes?**

All providers will be notified of Plan changes via fax or mail. If you wish to receive Plan notifications via email, please contact the Provider Services Section and ask to be placed on their email distribution list. If you have questions please call Paula McGhee, Provider Network Coordinator at (863) 519-2003.

▪ **How much notice will be provided to me when the Plan makes changes in the future?**

As a general rule, written notification of Plan changes will be sent to your office via fax or mail within two (2) weeks prior to the implementation date. In exceptional situations, the Plan may notify you regarding changes in a shorter time frame.

- **As a Primary Care Physician, how often will I be receiving the Plan’s monthly PMPM (per member per month) report?**

Each month, the Plan will provide all Primary Care Physicians with an updated listing, which indicates the members assigned to them. If you have questions, please contact Member Services at (863) 534-5386.

Attachment No. 1: The Plan has recently established a Utilization Review/Medical Management Committee, and Pharmacy and Therapeutics Committee. You may utilize the attached form to make a Physician Comment or Public Comment to one of those committees. As a Provider, this is your mechanism for public comment. *Please note: Due to the privacy of health information discussed during these meetings, the meetings are closed to the public.*

Polk HealthCare Plan Contacts

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