Health Care District
OF PALM BEACH COUNTY

Health Care District of Palm Beach County

District Cares Program Network Provider Handbook Manual

1515 N Flagler Dr #101, West Palm Beach, FL 33401

District Cares Program Provider Handbook Manual			
Policy #:	DC5000.01A	Effective Date:	8/1/2024
Business Unit:	District Cares	Original Effective Date:	1/1/2019
Approval Group:	District Cares Policy	Document Owners(s):	Valena Grbic, M.D. Angela Swenson

Dear Provider,

Welcome to the District Cares Voucher Program provider network. Thank you for your support and participation in our community's shared mission of providing access to health care. This Provider Handbook is your resource for information about the District Cares Voucher Program and the administration of our healthcare access delivery system.

This handbook provides guidelines for:

- Program Administration
- Patient Eligibility
- Healthcare Access
- Referral and Authorization Process
- Specialty Care Guidelines
- Trauma Program Guidelines
- Claims and billing Guidelines

The District Cares Voucher Program is administered in partnership with Community Care Plan (CCP) serving as the third-party administrator (TPA), providing Network Contracting, Credentialing, Claims Administration, and Provider Services.

We look forward to working together to provide quality healthcare services to our patients.

For additional information or questions about our Program, please visit our website: www.hcdpbc.org or contact CCP Provider Operations team toll-free at (855) 819-9506.

Sincerely,

Darcy J Davis	*Candice Abbott*	*Dr. Belma Andric*	*Dr. Valena Grbic*
Darcy J. Davis Chief Executive Officer	**Candice Abbott** SVP and Chief Operation Officer	**Belma Andric, MD, MPH** Chief Medical Officer, VP & Executive Director of Clinic Services	**Valena Grbic, MD** District Cares Medical Director

Health Care District
OF PALM BEACH COUNTY

QUICK REFERENCE *for* PROVIDERS

The CCP Provider Operations (PO) Department is available 8:00 a.m. - 5:00 p.m. Monday through Friday to answer any questions.

Provider Services and Contracting	**855-819-9506 or CCP.Provider@ccpcares.org** **M-F 8 am-5 pm**
Provider Credentialing	ccp.credentialing@ccpcares.org or **844-618-5773**
Provider Portal (PlanLink)	https://e-apply.ccpcares.org to request access
Provider Portal (PlanLink) Authorizations	Prior auth request: http://planlink.ccpcares.org/ To check the status visit http://planlink.ccpcares.org/ or **844-410-6782**
PlanLink Questions/ Support	http://planlink.ccpcares.org/ or **844-514-1494**
Enrollee Eligibility Verification	**844-410-6782 or** http://planlink.ccpcares.org/

✓ ***Provider Services and Contracting (855-819-9506)***
- For any questions regarding contracting please contact the PO Hotline at 855-819-9506 or email: CCP.Provider@ccpcares.org

✓ ***Provider, Practice, and Facility Updates***
- Please submit any provider, practice, or facility updates to CCP within 30 days of any change in status. Examples include, but are not limited to: Name changes, TIN changes, Roster updates, Location updates.
- These changes should be submitted via e-mail to: CCP.Provider@ccpcares.org

✓ ***Enrollee Eligibility Status Verification (844-410-6782)***
- Online verification of enrollee eligibility available: http://planlink.ccpcares.org or
- Guest Portal Select Guest Eligibility see under the blue log-in button at: https://epiclink.mhs.net/planlinkCCP/common/epic_login.asp

✓ ***Authorizations (844-410-6782)***
- Submit online authorization requests: http://planlink.ccpcares.org. Note that specialist referrals (specialist office visits) must originate from the Health District community health care centers.
- All services, except for emergency room visits, observation stays, dialysis, low-tech imaging (X-rays, ultrasounds), screening mammograms, laboratory, and inpatient trauma, require an approved prior authorization.
- The ordering provider must submit all authorizations.
- Online verification of authorization status: http://planlink.ccpcares.org or contact Community Care Plan at: 844-410-6782.

✓ ***Claims Processing (844-410-6782)***

- All claims must be submitted electronically.
  - Clearinghouse: Availity
  - Payer Name: Community Care Plan (Palm Beach Health District)
  - Payer ID: PBHD1 *(the last digit is the number one)*
  - Claims Registration: www.Availity.com
- Online verification of claim status:
  - Online verification of claim status is available at: http://planlink.ccpcares.org
  - Guest Portal: Select Guest Eligibility to see claim status under the blue log in button at: https://epiclink.mhs.net/planlinkCCP/common/epic_login.asp
- Provider claim reconsiderations must be submitted electronically via PlanLink. For third-party billing companies with no PlanLink access, use the Provider Claim Appeal Form available at: www.ccpcares.org

✓ ***Credentialing (844-618-5773)***

- All provider credentialing and re-credentialing questions or requests, please contact CCP's Provider Operations Department by phone or email at: ccp.credentialing@ccpcares.org.

✓ ***PlanLink Questions and Support (844-514-1494)***

- Provider Portal, please visit: https://e-apply.ccpcares.org/ to request access.
- For questions about how to use PlanLink or Guest Claims send an email to: **PlanLink@ccpcares.org** or call Community Care Plan at 844-410-6782.

✓ ***Guest Portals***

- You can check member eligibility and claim status online without a log in by using our Guest portals. You will get the same real-time information that a live agent would provide. Simply go to www.ccpcares.org, click Provider Portal, then select either **Guest Eligibility** or **Guest Claims**, located under the blue log in button at: https://epiclink.mhs.net/planlinkCCP/common/epic_login.asp
- For questions about how to use PlanLink or Guest Claims send an email to **PlanLink@ccpcares.org** or call Community Care Plan at 844-410-6782.

✓ ***Contracted Labs***

- Quest Diagnostics

Should you have any questions, please contact our Provider Operations Hotline at 1-855-819-9506 or email: CCP.Provider@ccpcares.org

Health Care District
OF PALM BEACH COUNTY

Table of Contents

SECTION 1: INTRODUCTION

The Health Care District of Palm Beach County administers the District Cares Voucher Program for specialty healthcare services for qualifying low-income Palm Beach County residents who are established patients within the medical safety net of the Health Care District Community Health Centers.

Specialty care network access through the program is available to qualified patients who are uninsured and do not qualify for any other public assistance or private health coverage program. The District Cares Voucher Program is a payer of last resort and is not an insurance plan.

All specialty care must be ordered by a Health Care District community health center provider and provided by a participating District Cares Network provider in Palm Beach County, including coordination of care for Trauma patients.

District Cares healthcare access (based on covered services) includes:

- Emergency Room Services
- Inpatient – Hospital Care
- Inpatient – Rehabilitation (Trauma)
- Outpatient – Cardiac Rehabilitation
- Outpatient – Diagnostics
- Outpatient – Surgery
- Outpatient – Therapy
- Outpatient – prenatal obstetric care
- Durable Medical Equipment / Supplies
- Home Care
- Orthotics
- Prosthetics
- Laboratory Services
- Specialty Provider Services

Purpose

The Health Care District has established policies, procedures, and guidelines to assist in the administration of medical specialty services for Voucher Program recipients. This Provider Handbook outlines those procedures and guidelines.

Scope

This handbook is subject to periodic changes and updates. Updates will be posted on the website (www.hcdpbc.org/for-providers) and/or communicated via notices by the Community Care Plan (CCP). If you have any questions concerning the handbook, please contact the CCP Provider Operations Department at (855) 819-9506.

Confidentiality Statement

It is the policy of the Health Care District that medical records, claims information and complaints pertaining to patients and providers remain confidential. The authorized release of any information is used only for the resolution of medical problems or to enhance the health of patients. The Health Care District will ensure compliance with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA).

Health Insurance Portability and Accountability Act (HIPAA)

In 1996, the U.S. Congress enacted The Health Insurance Portability and Accountability Act, or HIPAA. As its name implies, HIPAA concerns itself principally with changes to make it easier for workers to change employers without losing health insurance coverage. HIPAA also addresses how health information is to be used by participants in the healthcare system. HIPAA sets standards that certain businesses (covered entities) must follow to ensure that patient information is kept secure and private. It also addresses how healthcare transactions are to be conducted electronically. As a health Program, the Health Care District is subject to these Federal standards for privacy, security and electronic transfer of health information.

- In accordance with the limitations placed upon it by HIPAA, the Health Care District will only ask for the minimum amount of information necessary to determine eligibility, authorize treatment, review utilization, and perform other Program functions.
- HIPAA permits a covered entity to disclose health information without authorization for treatment, payment and healthcare operations functions. A provider is therefore permitted to share patient health information necessary to receive payment from the Health Care District in accordance with the provider agreement. In addition, a covered entity is permitted to disclose an individual's health information for the operations functions of another covered entity without authorization when both entities have or had a relationship with that individual. Operations functions include activities to improve health and reduce costs, develop protocol, perform case management and care coordination, and related functions. A provider is therefore permitted to share patient health information with the Health Care District for utilization review, quality management, and related functions.
- Covered entities are permitted to convey health information by fax machine. Fax machines used for such purposes should be located where access is limited to those whose jobs require it. Fax numbers should be verified periodically. When faxing information to the Health Care District, appropriate staff should be notified and receipt should be verified.
- Unencrypted electronic files should not be used to convey health information by e-mail or Internet. Such information should be conveyed by encrypted email, fax machine or mail.

Quality and Risk Management

The mission of the Health Care District is to provide patients with high-quality healthcare in an environment of minimal risk, assess opportunities for improvement and improve the care and services provided to patients. It is expected for contracted providers to have a strong commitment to quality services and quality improvement processes.

SECTION 2: PROGRAM ELIGIBILITY

Introduction

The Health Care District of Palm Beach County maintains eligibility guidelines for enrollment in the District Cares Voucher Program.

I. District Cares Program Eligibility

Specialty medical care is available to uninsured residents of Palm Beach County who do not qualify for any other public assistance or health insurance coverage and meet income requirements defined by Federal Poverty Level Guidelines (FPL).

Potential recipients for the District Cares Voucher Program must be established with a Health Care District Community Health Center as their medical home and in need of specialist care referral.

If qualified, recipients receive one (1) year of health access coverage from the date of eligibility determination. No ID card is issued, a Program Welcome Letter is mailed the patient address on file. Patient eligibility is available and verified through PlanLink, our electronic provider portal.

To schedule an appointment, call the Health Care District Patient Service Center at 561-642-1000.

II. District Cares Trauma Program Eligibility

Medical care is available to qualifying low-income Palm Beach County residents who are uninsured and do not qualify for any other public assistance or private health coverage program; and who meet income and residency requirements and qualify as a Trauma Patient at a designated Trauma Center.

"*Trauma Patient"* means any person who has incurred a single or multi-system life threatening blunt, penetrating or burn injury in the Trauma Service Area (TSA) that meets Trauma Alert criteria, Palm Beach County Interfacility Trauma Transfer criteria and/or Trauma Registry criteria as defined in the Palm Beach County Trauma Transport Protocols.

To determine eligibility for District Cares Trauma program coverage, injured patients will be screened for eligibility at the Trauma Center and also undergo the formal application eligibility process and verification by the Health Care District to determine if the patient has any other insurance coverage for services provided at the Trauma Center including; automotive, worker's compensation as well as eligibility for government or entitlement programs including Medicare and Medicaid.

Screening and determination for Trauma Patient eligibility for another source of primary coverage is the sole responsibility of the Trauma Center via the Patient Attestation form completed at the time of admission and upon completion of the District Cares Voucher Program application. Documented proof of Trauma Center attempts to verify patient eligibility and coverage for other primary coverage may be requested by the Health Care District during the application or at any time thereafter. Recognizing that not all trauma patients are able to complete an application in a timely manner or at all due to the nature and severity of injuries, submission of completed Hospital Attestation is acceptable to be

submitted with the District Cares Voucher Program application for initiation of the District Cares eligibility process. This form attests that the required screening process occurred for any other coverage eligibility options related to the trauma injury.

The application and hospital attestation form must be submitted to the Health Care District when the patient is at a Trauma Center. Applications received after discharge from admission will not be considered for eligibility for the District Cares Voucher Program.

Patients seen in the Emergency Department (ED), meet the qualifying trauma event guidelines, and are on the Trauma Registry are eligible for the District Cares Voucher Program. If the patient is discharged on the same day as the ED visit, HCD will accept the application submitted within five (5) business days of the date of service.

Determination of eligibility will require patient/family contact and cooperation with the Health Care District to verify the related application supporting documents.

If a patient is approved for District Cares within the application timeframe, the Trauma Patient eligibility period will begin on the date of the traumatic injury/admission date. District Cares Trauma recipients receive 1 (one) year of coverage from the traumatic injury/admission date. No ID card is issued, and a Welcome Letter is mailed to the member's address on the application. Patient eligibility information is available to the Trauma Centers and verified through PlanLink, the electronic provider portal.

For continued care coordination for needed specialty care follow-up related to the Trauma event and treatment plan, trauma patients must establish care with the Health Care District Community Health Center as the patient's medical home after discharge and can be scheduled at any Health Care District Community Health Center.

Clinic appointments can be made by calling 561-642-1000

III. Behavioral Health Eligibility

Behavioral Health patients will receive coordination of care as they transition from a participating network behavioral health facility and must establish care at a Health Care District Community Health Center to be considered for the Voucher Program eligibility.

SECTION 3: HEALTHCARE ACCESS

Introduction

This section outlines healthcare access available to patients enrolled in the District Cares Voucher Program and District Cares Trauma Program, and are subject to change. Coverage is limited to approved and authorized services. Referral and authorization requests must be submitted via CCP Provider Portal, PlanLink. Please refer to the Quick Reference for Providers section on page 2.

Purpose

The purpose of the Healthcare Access Section is to provide an overview of the Programs' covered services.

Healthcare Access

Covered services rendered by participating providers/facilities are subject to the provisions of this Provider Handbook and the terms of respective service agreements with the District.
For all Provider Bulletins, Notices, and Newsletters related to benefits, coverage determinations, and guidelines, please see the Health Care District website at https://www.hcdpbc.org/for-providers/bulletins-notices-newsletters.

Service Area

All services must be performed in Palm Beach County. Services rendered to District Cares patients outside of Palm Beach County will be considered non-covered services by the District, unless approved and authorized by the Health Care District.

Medical Records

All Specialty Care office/consult notes and operative/procedure reports must be faxed to the referring Health Care District Community Center provider for all encounters.

Health Care District Community Health Center Locations	Phone Number	Fax Number
Belle Glade	561-642-1000	561-642-1096
West Boca	561-642-1000	561-642-1095
Delray Beach	561-642-1000	561-642-1093
Jupiter	561-642-1000	561-642-1091
Lake Worth	561-642-1000	561-370-1090
Lantana	561-642-1000	561-642-1089
Lewis Center	561-642-1000	561-804-1088
Mangonia Park	561-642-1000	561-642-1087
West Palm Beach	561-642-1000	561-642-1086

Program Benefits

All Program Benefits apply to the eligibility period.

I. District Cares Program Benefits

SERVICE	AUTHORIZATION INDICATOR	LIMITATIONS
Inpatient – Hospital Care	Yes / Required	Ten (10) Inpatient days per year for medical/rehab/behavioral (combined).
Inpatient – Rehabilitation	Yes / Required	Ten (10) inpatient days per year for medical/rehab (combined).
Outpatient - Cardiac Rehabilitation	Yes / Required	One 12-week (24 visits) occurrence
Observation Stay	No / Not required	Two twenty-three (23) hour stays per eligibility year. Must meet medical necessity protocols.
Durable Medical Equipment / Supplies	Yes / Required	Must be medically necessary. The accumulated cost of the rental of DME is not to exceed the purchase price.
Home Care / Home Infusion	Yes / Required	Combined forty-five (45) day limit skilled nursing care and home infusion.
Dialysis	No / Not Required	Dialysis covered for chronic renal failure from the 1st through 90th day of treatment only. Dialysis treatments within the home are not covered.
Emergency Room	No / Not required	Six (6) emergency room visits per eligibility year. • If the emergency room visit results in an inpatient admission, it will not count towards the six (6) ER visit limit as these services are billed as inpatient.
Orthotics	Yes / Required	Restricted to joint immobilization as medically necessary.
Prosthetics	Yes / Required	One (1) prosthetic per limb per lifetime. One (1) prosthetic eye per lifetime.
Outpatient – Diagnostic, high-tech (MRI/CT/PET/SPECT)	Yes / Required	Must meet medical necessity protocols and authorization requirements. Must be done at Independent Diagnostic Testing Facilities or Lakeside Medical Center

SERVICE	AUTHORIZATION INDICATOR	LIMITATIONS
Outpatient – Surgery	Yes / Required	Must meet medical necessity protocols.
Outpatient - Therapy	Yes / Required	Combined modality (physical therapy, occupational therapy, and speech therapy) limit of 30 visits per eligibility year at free-standing participating network facilities or provider offices only. The Health Care District Community Health Center provider orders initial outpatient therapy evaluations for one (1) visit. The physical therapy provider must obtain additional Physical Therapy visits via the PlanLink provider portal.
Colonoscopy/EGD	Yes / Required	Must meet medical necessity protocols and current evidence-based guidelines.
Gynecology	Yes / Required	Provided at Health Care District Community Health Center. Treatment for complex and/or advanced women's health medical conditions is available through the specialist network and referred by the Health Care District Community Health Center OBGYN specialist.
Specialist Provider Care	Yes / Required	Specialist care must be ordered and referred by a Health Care District Community Health Center provider, provided by a participating network provider, and meet medical necessity protocols. Access limit is six (6) total visits* per specialty per eligibility year, which may include up to two (2) telemedicine visits. *Return visit to Health Care District Community Health Center PCP after 3 specialist visits for evaluation of continued care and treatment plan. The six (6) visit limit does not apply to Oncology or specific conditions for Ophthalmology defined below.

SERVICE	AUTHORIZATION INDICATOR	LIMITATIONS
Ophthalmology	Yes/Required	Note: Ophthalmology diagnostic codes that are excluded from 6-visit limit: WET AGE-RELATED MACULAR DEGENERATION (AMD) • H35.3211 RIGHT ACTIVE • H35.3221 LEFT ACTIVE • H35.3231 BILATERAL ACTIVE DRY AGE-RELATED MACULAR DEGENERATION (AMD) • H35.3112 RIGHT INTERMEDIATE • H35.3122 LEFT INTERMEDIATE • H35.3132 BILATERAL INTERMEDIATE CENTRAL RETINAL VEIN OCCLUSION (CRVO) • H34.8110 RIGHT WITH MACULAR EDEMA • H34.8120 LEFT WITH MACULAR EDEMA • H34.8130 BILATERAL WITH MACULAR EDEMA BRANCH RETINAL VEIN OCCLUSION (BRVO) • H34.8310 RIGHT WITH MACULAR EDEMA • H34.8320 LEFT WITH MACULAR EDEMA • H34.8330 BILATERAL WITH MACULAR EDEMA DIABETES-RELATED CONDITIONS • E11.3411 TYPE 2 DM SEVERE with ME (RIGHT) • E11.3412 TYPE 2 DM SEVERE with ME (LEFT) • E11.3413 TYPE 2 DM SEVERE with ME (BILATERAL) • E11.3511, E11.3512, E11.3513, All Diabetic Codes • H35.81 RETINAL EDEMA • H43.1-3 VITREOUS HEMORRHAGE
Oncology	Yes / Required	Must meet medical necessity protocols
Pharmacy Benefits	N/A	Medications are available through HCD Pharmacy. See Section 4 - Pharmacy Limitations and Exclusions.
Laboratory Services	No	Quest Laboratory is the only in-network contracted provider for outpatient laboratory services. Laboratory services with any other provider are considered a non-covered benefit. See Section 4 - Program Limitations and Exclusions.

II. Trauma Program Benefits

SERVICE	AUTHORIZATION INDICATOR	LIMITATIONS
Initial Inpatient Trauma Admission	No / Not Required	Limited to admissions at Level 1 Trauma Centers Delray Medical Center (DMC) and St. Mary's Medical Center (SMMC) only. There is no cap on the number of days covered during initial inpatient trauma admission, but the total length of the admission will count against the ten (10) day inpatient benefit period cap for medical/rehab/behavioral*. *If the initial inpatient trauma admission length exceeds ten (10) days, the patient will have exhausted their inpatient facility benefit for the benefit period.
Inpatient – Rehabilitation	Yes / Required	"Inpatient Rehabilitation Benefit" means all covered services provided for the care and treatment of a trauma member admitted as an inpatient to a participating rehabilitation facility- Pinecrest Rehabilitation Hospital at Delray Medical Center and Inpatient Rehabilitation Facility at St. Mary's Medical Center. Trauma recipients receiving the inpatient rehab benefit must meet the criteria outlined in Definition of Trauma Member and Determination of Trauma Eligibility under Section 2(II). Inpatient rehabilitation authorization requests must be submitted via PlanLink Portal with documentation supporting medical necessity and submitted at least 24 hours before anticipated inpatient discharge. Inpatient rehab benefit is included in the ten (10) day inpatient benefit period cap for medical/rehab/behavioral.
Outpatient – Surgery (including Trauma)	Yes / Required	Must meet medical necessity protocols
Following discharge from the initial inpatient trauma admission, Trauma recipients must establish care with a Health Care District Community Health Center provider to follow the District Cares Gatekeeper Model for continuing care coordination per the District Cares Health (*see* Section 3: Healthcare Access).		

III. District Cares Obstetrics Program Benefits

CODE	SERVICE	VISIT LIMITATIONS
59025	Fetal Non-stress test	Sixteen (16) visits per Benefit Period
76802	Ultrasound, pregnant uterus, multiple	One (1) visit per Benefit Period
76805	Ultrasound, pregnant uterus, after first trimester	One (1) visit per Benefit Period
76810	Ultrasound, pregnant uterus, multiple	One (1) visit per Benefit Period
76811	Ultrasound, pregnant uterus fetal anatomical exam	One (1) visit per Benefit Period
76812	Ultrasound, pregnant uterus, multiple	One (1) visit per Benefit Period
76813	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation.	One (1) visit per Benefit Period
76814	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation (List separately in addition to code for primary procedure)	One (1) visit per Benefit Period
76815	Ultrasound, pregnant uterus, limited	Three (3) visits per Benefit Period
76816	Ultrasound, pregnant uterus, follow up	Three (3) visits per Benefit Period
76817	Ultrasound, pregnant uterus, transvaginal	Three (3) visits per Benefit Period
76818	Fetal biophysical profile; w non-stress testing	Eight (8) visits per Benefit Period
76819	Fetal biophysical profile; w/o non-stress testing	Two (2) visits per Benefit Period
76820	Doppler velocimetry, fetal; umbilical artery	Two (2) visits per Benefit Period
76821	Doppler velocimetry, fetal; middle cerebral artery	Two (2) visits per Benefit Period
99201 - 99205	Office visit, new patient	One (1) visit per Benefit Period
99211 - 99214	Office visit, established patient	Ten (10) visits per Benefit Period
J2790	RhoGam full dose; 300 micrograms	One (1) visit per Benefit Period
J2788	RhoGam mini-dose; 50 micrograms	One (1) visit per Benefit Period
96372	Injection for RhoGam	One (1) visit per Benefit Period

IV. Behavioral Health Program Benefits

<table>
<tr><th>SERVICE</th><th>AUTHORIZATION INDICATOR</th><th>LIMITATIONS</th></tr>
<tr><td>Behavioral Health - Inpatient</td><td>Yes / Required</td><td>Seven (7) Inpatient days per eligibility year for behavioral health support in designated and participating neurobehavioral hospital.</td></tr>
<tr><td>Behavioral Health – Outpatient</td><td>Yes / Required</td><td>
<table>
<tr><th>CPT Codes</th><th>Description</th><th>Visit limit</th></tr>
<tr><td>99202</td><td>New patient office or other outpatient visit, 15 min</td><td rowspan="8">No more than six (6) visits in combination with all evaluation and management codes</td></tr>
<tr><td>99203</td><td>New patient office or other outpatient visit, 30 min</td></tr>
<tr><td>99204</td><td>New patient office or other outpatient visit, 45 min</td></tr>
<tr><td>99205</td><td>New patient office or other outpatient visit, 60 min</td></tr>
<tr><td>99212</td><td>Established patient office visit, 10 min</td></tr>
<tr><td>99213</td><td>Established patient office visit, 20 min</td></tr>
<tr><td>99214</td><td>Established patient office visit, 30 min</td></tr>
<tr><td>99215</td><td>Established patient office visit, 40 min</td></tr>
<tr><td>90791</td><td>Psychiatric Diagnostic Evaluation w/o Medical (therapist)</td><td rowspan="2">Limit of one (1) visit for each new BH condition (dx) up to maximum of two (2) new diagnoses per eligibility period</td></tr>
<tr><td>90792</td><td>Psychiatric Diagnostic Evaluation w/ Medical (MD, PA, ARNP)</td></tr>
<tr><td>90832</td><td>Psychotherapy with patient, 30 Min.</td><td rowspan="6">No more than twelve (12) visits in combination with all psychotherapy codes.</td></tr>
<tr><td>90834</td><td>Psychotherapy with patient, 45 Min.</td></tr>
<tr><td>90837</td><td>Psychotherapy with patient, 60 Min.</td></tr>
<tr><td>90846</td><td>Family Psychotherapy w/o pt 50 min</td></tr>
<tr><td>90847</td><td>Family Psychotherapy w/pt 50 min</td></tr>
<tr><td>90853</td><td>Group Psychotherapy</td></tr>
<tr><td>90839</td><td>Psychotherapy crisis - first 60 min</td><td rowspan="2">No more than four (4) visits in combination with 90839 and 90840</td></tr>
<tr><td>90840</td><td>Psychotherapy crisis -each additional 30 min. To be used with CPT code 90839</td></tr>
</table>
</td></tr>
</table>

SECTION 4: LIMITATIONS AND EXCLUSIONS

Introduction

The District Cares Voucher Program does not cover everything that the Centers for Medicare & Medicaid cover.

As a community voucher program (not insurance), the District Cares program has limitations, exclusions and non-covered services in order to ensure access to healthcare services for all eligible patients while operating within a program budget.

The District Cares Program provider and facility network is the source for specialty medical services for program-eligible established patients of the Health Care District community health centers. The Program will make every effort to provide eligible patient recipients with needed specialty care. Still, it cannot guarantee that all services will be covered based on program guidelines or provided when a provider gap exists within the provider network. In the event of a covered service or provider gap, patients will be given the option to see a specialist as self-pay or will be referred to a community health service partner when applicable.

Service limitations indicate a limit by the amount of a service or the length of the time for the service. These service exclusions refer to non-covered services under the District Cares Program or District Cares Trauma Program.

Pharmacy Limitations and Exclusions

- HCD Pharmacy Formulary information can be found at Pharmacy - hcdpbc.org. Covered Formulary medications must be filled at the Health Care District Pharmacy. A prescription must be accompanied by supporting clinical documentation to be dispensed
- Infertility Medication
- Chemotherapy drugs unless prior authorized and on the Health Care District's Pharmacy Formulary
- Rogaine (Minoxidil) for hair restoration
- Pharmaceuticals when a patient assistance program is available
- Medications that are not medically necessary or medically appropriate
- Inpatient drug
- Drugs that are not recommended or approved for general use by the Food and Drug Administration
- Drugs that are experimental or investigative
- Prescriptions refilled in excess of the amount specified by the physician
- Appetite suppressants or any drugs for weight control
- Refilling of a prescription before its refill date or one-year after issuance (6 months for controlled drugs)

Program Limitations and Exclusions

- Acupuncture
- Allergy testing and immunotherapy
- Alternative and holistic healthcare services
- Ambulance
- Amniocentesis
- Any injury resulted from being arrested, in custody of law enforcement or incarcerated, being guarded by a law enforcement officer or under house arrest
- Any patient treated in a hospital while under arrest, in custody of law enforcement or incarcerated, being guarded by a law enforcement officer, or under house arrest
- Any service provided or received without having been referred and authorized by the Health Care District
- Any services in connection with education and treatment for learning or developmental disabilities
- Balloon Sinuplasty procedures
- Bone Stimulators
- Carpal tunnel surgical procedures
- Chelation therapy
- Chiropractic treatment or services
- Comfort items are not covered by the District (include but not limited to): heating pads, hot water bottles, ice collars, and other hot/cold treatments not primarily for medical treatment, bathroom/bathtub rails and seats, bedside commode, hot tub, whirlpools and similar devices, items generally used as a complete set, when obtained separately, e.g., hospital bed frames, mattresses, bed rails, accessories and restraints and related equipment
- Complications related to non-covered services
- Cosmetic, medical, surgical, and non-surgical treatments and procedures provided primarily for cosmetic purposes, which shall include but are not limited to: (1) surgery to the upper and lower eyelid; (2) penile implant; (3) augmentation mammoplasty; (4) reduction mammoplasty for male or female or other cosmetic procedures to the breast, (5) removal of breast implants, except in post mastectomy surgery; (6) full or partial facelift; (7) dermabrasion or chemical exfoliation; (8) scar revision; (9) otoplasty; (10) surgical lift, stretch, or reduction of the abdomen, buttocks, legs, or arms; (11) silicone, Hyalgan or any other injections to any part of the body for cosmetic purposes; (12) rhinoplasty; (13) hair transplant; and (14) tattoo removal
- Cost of services performed in a non-participating facility without prior authorization
- Custodial, domiciliary, convalescent or rest care and care in a skilled nursing facility
- Dental services
- Devices not covered by the District (include but not limited to): all hearing aids and devices, artificial kidney machines, routine maintenance or adjustments of devices, home dialysis machines, feeding tubes and pump for a patient with complications related to gastric bypass and items which Medicare has identified as being primarily for patient comfort, convenience and/or hygiene, rather than for true medical treatment or necessity
- Diabetic shoes, diabetic shoe inserts or any item related to diabetic footwear
- Dialysis for chronic renal failure after 90 days of treatment (chronic renal failure initial 90 days are covered). Dialysis treatments within the home are not covered
- DME and supplies are not covered for patients while in the hospital
- ECP (External Counter Pulsation)

- ECT (Electroconvulsive Therapy)
- Equipment not covered by the District (include but not limited to): wheelchair accessories such as power attachments, batteries, and battery chargers, specialty wheelchairs including electric, lightweight, heavy-duty, custom-made equipment, repairs, maintenance or comfort hygiene, walker attachments, patient lifts and supplies and roll about chairs
- Evaluation and management of congenital conditions
- Eyeglasses or contact lenses
- Fertility and infertility testing and procedures including but not limited to artificial insemination or invitro fertilization, embryo transplantation, human chronic gonadotropin (HCG) injections or reversal of sterilization procedure
- Foot/toe joint arthrodesis in absence of acute traumatic injury
- Foot care, such as removal of warts, corns, or calluses, including, but not limited to, podiatric treatment of bunions, toenails, flat feet, fallen arches, hammertoes, and chronic foot strain
- Gastric stapling, gastric bypass, gastric banding, and other surgical experimental and/or investigational procedures for the treatment of eating disorders, obesity, weight loss and/or weight management to include diet programs and any variants thereof or exercise programs
- Genetic testing, counseling and other related services
- Hair analysis, health or beauty aids
- Hearing aids
- Home-based or out-of-center sleep studies
- Hospice
- Hygienic and preventive maintenance care of the foot that is ordinarily within the realm of self-care and in the absence of an underlying systemic conditions such as metabolic, neurologic or peripheral vascular disease; or in the absence of injury, infections, fractures, foreign body or ulcers. That may include observation and cleansing of the feet; hydrotherapy; paraffin baths; foot massage; use of skin creams to maintain skin tone; reduction/removal of corns and calluses; trimming of dystrophic mycotic nails, removal of warts
- Hyperbaric services for wound care
- Immunizations required for travel and physical examinations needed for employment, insurance, or governmental licensing
- Joint replacements unless related to a current traumatic injury
- Nerve conduction studies
- Neuro-psych services outside of network participation and covered services
- Optometry Services
- Organ transplants and any related service to transplants
- Orthotics (except for joint immobilization or follow-up related to trauma care)
- Out-of-county medical services provided or received unless previously approved
- Pain Management. Services may be covered for treatment or management of pain by use of injectables when medically necessary
- Prenatal (maternity) hospital-based obstetric services and services not outlined in the section 3 (III) are not covered
- Private duty nursing services
- Research, experimental, medical, surgical or psychiatric procedures and pharmacological regimes or clinical trials
- Sclerotherapy

- Services associated with aiding a patient in the home, such as homemaker, domestic or cleaning services
- Services provided by a family member
- Services provided in a hospital setting when the patient leaves against medical advice (AMA)
- Services received prior to the eligibility effective date or after the termination date
- Sex change operations or any sex change-related services including services for sexual transformation
- Services associated with sexual dysfunction or inadequacies
- Spinal corrective surgery for congenital spinal scoliosis
- Spinal decompression, spinal stabilization, disc replacement surgery, cervical, thoracic or lumbar spinal fusion, foraminotomy, laminectomy or discectomy associated with chronic degenerative disc disease or spinal stenosis. Emergency treatment associated with acute spinal cord injury, progressive neurological deficit and cauda equina syndrome will be considered on a case-by-case basis. Surgical treatment of spinal conditions after fracture, dislocation (associated with mechanical instability), locked facets or displaced fracture fragment, spinal infection, tumor, epidural hematoma or other mass lesion confirmed by high-tech imaging studies; or synovial cyst causing spinal cord or nerve root compression with corresponding neurological deficits, where symptoms failed to respond to 12 weeks of continuous conservative therapy may be considered. Conservative treatment during course of illness includes NSAIDS or acetaminophen or other anti-inflammatory medications, home exercise or PT, and activity modification.
- Spinal surgery in persons with prior spinal surgery for pain management, including pseudoarthrosis, unless an acute condition exists (e.g., spinal cord injury, cauda equina syndrome)
- Stem cell transplants
- Termination of pregnancy unless medically necessary and in accordance with Florida law
- Transportation
- Travel, whether or not recommended by a physician
- Treatment for acne, or non-symptomatic and non-malignant lesions, which may include but are not limited to warts, moles, lipomas, or cysts
- Treatment of work-related injuries when not covered by Workers' Compensation
- Treatment for military service-connected conditions and disabilities for which the Veterans Administration healthcare system provides care to which the patient is entitled
- Treatment of Temporomandibular Joint Disease (TMJ)
- Treatment of varicose veins of the extremities
- Urgent Care clinic services
- Vision training, eye exercises, orthoptics, or surgery performed primarily to correct or improve myopia, presbyopia, or astigmatism

SECTION 5: CUSTOMER SERVICE

Introduction

This section explains general information with respect to Provider Services for the District Cares Voucher Program and District Cares Trauma Program.

Purpose

The purpose of the Customer Service section is to assist providers with general information about the Program.

Customer Service Department

Community Care Plan (CCP), our third-party administrator is informed in all aspects of the Health Care District's Voucher Program and should be utilized as a primary resource for claims questions, authorization status, network status, contracting, credentialing or other general information about the Program.

For any questions, please call Community Care Plan Customer Experience Team at 844-410-6782.

Referral, Authorization and Claim status information is available 24/7 through PlanLink, the Provider Portal. For any questions, CCP is available 8:00 a.m. - 5:00 p.m. Monday through Friday.

Participating Provider(s) shall utilize electronic platforms such as PlanLink and or other electronic resources as they become available as the primary and required source of secure real - time web portal access for clinical information, referrals and authorization status.

Eligibility Verification

A patient's eligibility in a District Cares Voucher Program is subject to termination at any time; e.g., patient may become eligible for Medicaid or other coverage. District Cares (including Trauma) participating providers should check and verify patient eligibility at any time using the PlanLink provider portal or via Guest Eligibility available at https://planlink.ccpcares.org/.

Providers are responsible for verifying a patient's eligibility and coverage prior to rendering services. Providers may not bill patients for services denied due to lack of coverage, medical necessity, or authorization.

When services may not be covered, the Provider is responsible for notifying patients of their financial responsibility in advance. The patient must acknowledge in writing that they will be responsible for payment when such services are rendered.

For more information about PlanLink, visit Community Care Plan - Provider Portal, PlanLink (ccpcares.org).To register for PlanLink portal access, please visit https://e-apply.ccpcares.org.

District Cares Voucher Program Letter

Patients are issued a District Cares Voucher Eligibility Welcome Approval Letter by mail and or at the time of enrollment. Patients are advised to maintain on file and present the letter when referred to a participating provider to verify eligibility, authorization and coverage information for covered services.

Patients' Rights and Responsibilities

The Health Care District is committed to quality healthcare for all patients. Each patient has rights and responsibilities under this program regarding the provision of services and the management of their healthcare.

Providers must provide patients with a summary of Patient’s Rights and Responsibilities at registration.

Patient Complaints

The Health Care District’s Patient Relations Department is available for patient complaints and will attempt to resolve reported issues. This process can be initiated by calling the Health Care District at (561) 642-1000.

Fraud

If you become aware that any potentially fraudulent act has been or is being committed, please notify our office. Fraud is defined as the following: "Intentional misrepresentation, by an individual or entity, which results in an unauthorized service." If you have any questions regarding fraud or if you wish to report a suspected fraud, please call 1-866-633-7233 or contact our Customer Service Department at (561) 642-1000.

SECTION 6: PROVIDER SERVICES

Introduction

This section summarizes the process for maintaining partnership privileges and outlines the standards and professional responsibilities of participating providers.

Purpose

The purpose is to outline the standards and professional responsibilities of participating providers.

Provider Services Department

Community Care Plan (CCP), our third-party administrator, Provider Services Department is designated to assist providers with the operating policies, procedures and guidelines of the District Cares Voucher Program.

If you have any questions or require additional information, please contact the Provider Services Department at (855) 819-9506 or visit the website at www.ccpcares.org.

Credentialing and Contracting

Each provider seeking participation status with the District Cares Voucher Program must apply with all the necessary documentation and a signed Participating Provider Agreement.

- For new contracts, please email CCP.Provider@ccpcares.org
- New credentialing or re-credentialing request, please email credentialingdept@ccpcares.org.
- Upon verification by CCP, the information is submitted for approval by the District.

Participating Agreement Standards

By signing a Health Care District Provider Agreement, providers are required to comply with all applicable federal and state laws, licensing requirements and professional standards. The Health Care District may exercise its options to terminate a participating provider with or without cause. Please refer to your Provider Agreement for additional information.

Patient Panel

Participating providers are required to give a sixty (60) day prior written notice to CCP when closing or re-opening its patient panel to new and transferring patients. This is to ensure a cohesive transfer of care when applicable for District Cares Voucher Program recipients.

Notices Obligation

The participating provider is responsible for receiving or providing the appropriate notices as outlined in this Provider Handbook and under the Provider Agreement with the Health Care District.

Adding/Terminating Practice Providers

If you add a provider, or if a provider leaves your practice, please notify the CCP Provider Services Department in writing within fifteen (15) days of any change in status or upon seven (7) days of request.

A representative will provide your office with all the necessary information to process the change. Provider rosters should be provided quarterly to CCP Provider Services Department at (855) 819-9506 or CCP.Provider@ccpcares.org.

Malpractice / Liability Coverage

When a physician chooses not to carry malpractice coverage, there are certain statutory obligations that must be fulfilled. Physicians are required to either post a notice in their office reception area or provide in a written statement to any person to whom medical services are rendered that they do not carry malpractice insurance as defined under Florida Statue, Chapters 458.320 and 459.0085. If you elect not to carry malpractice insurance, notify CCP Provider Services Representative in writing one week prior to the change.

Tax ID Number / practice demographic changes

Notify the Provider Services Department immediately of any changes in your tax identification number, practice name, telephone/fax number, service or billing locations. This will ensure that your practice is documented and all payments made are properly reported to the Internal Revenue Service.

Network Specialty Physician Guidelines

The following outlines the major responsibilities for physicians who participate as network specialty physicians:

1. Provide services to District Cares patients upon referral by Health Care District Community Health Centers Primary Care Provider as authorized.
2. Participating Provider(s) must utilize electronic platforms such as PlanLink and/or other electronic resources as they become available as the primary and required source of secure real - time web portal access for clinical information, referrals and authorization status.
3. Report all office notes to include findings and recommendations back to the referring Health Care District Community Health Centers Primary Care Physician by fax. For detailed information please refer to Section 3, Medical Records.
4. Follow the District Cares Utilization and Quality Management guidelines.

Availability and Accessibility

Providers must have availability of provider's staff or call service 24/7. Other clinical staff must be available Monday through Friday, 8 a.m. to 5 p.m.

Acceptable Wait Time

Professional evaluation must be provided within one hour of the scheduled appointment time. In the event a delay is unavoidable, the patient must be informed and offered the option for an alternative appointment if they are unable to wait.

Telephone Accessibility

As a participating provider you are responsible for assuring that all telephone calls are handled in a courteous and efficient manner. Messages should be triaged, acknowledged and returned by the physician or appropriate staff.

Accessibility Monitoring

Compliance with the availability and accessibility standards are monitored on a regular basis through random sampling, review of patient complaints and patient satisfaction surveys to ensure patients have reasonable access to healthcare providers and services.

Non-Discrimination

Providers must not differentiate or discriminate in the treatment of patients as to the quality of services delivered because of race, sex, sexual orientation, age, religion, national origin, health status, or source of payment, and to observe, protect and promote the rights of patients.

Medical Record Requirements

Complete medical records whether in paper or electronic format must be maintained in accordance with accepted professional practice standards, state and federal requirements. Consistent and complete documentation in the patient's medical record ensures communication, coordination and continuity of care, and promotes efficient and effective treatment. The medical record shall include the quality, quantity, appropriateness and timeliness of services performed and referrals supplied by the treating physician, clinician, or supplier.

The following standards are required for appropriate medical record documentation:

Element	Standard
Structure	
Organized in a consistent manner	• Clearly organized • Chronological order • Stored in a manner that allows for easy retrieval • Does not contain information for other patients

Element	Standard
Legible Entries	• Must be complete and legible to someone other than author • Content is presented in standard form that allows a reader, other than author, to review without using a separate legend/key
Personal Data	• Patient's name, identifying information, address, employer, marital/partnership status and applicable phone numbers are included • Patient's self-reported race, ethnicity and preferred language are documented
Patient Identification	• Patient's name or identification number must be included on each page
Signatures/Initials & Credentials	• Author's signature must be legible and include the author's professional credentials (stamps are not acceptable); may be automated by EMR system • Initials may be used as long as healthcare professional's credentials is included
Dated Entries	• Date of service must be on all entries
Medical History	
Medical Problem List	Medical problem list must be present, including: • Past medical history • Chronic or significant acute medical conditions • Significant surgical conditions • Significant behavioral conditions • For children and adolescents (18 years and younger), prenatal care, birth, surgery and childhood illnesses should be documented
Medication List	Medication list must be present, including: • Medications • Dosage • Frequency • Dates of initial and/or refill prescriptions • Over-the-counter medications, herbal remedies, supplements, etc.
Allergies and/or Adverse Reactions	• Allergies and/or adverse reactions to drugs • If patient has no known and/or adverse reactions, this must be noted in the record
Coordination of Care	Documented evidence of continuity and coordination of care for ancillary services and diagnostic test ordered
Consult Continuity of Care	Documented evidence of all referred specialty care, diagnostic and therapeutic services, such as: • Specialty care consult records • Physical therapy notes • Hospital records

Element	Standard
Advance Directive	• Documentation of whether a patient has completed an Advanced Directive (18 years and older) • Provider shall not, as a condition of treatment, require the patient to execute or waive an advance directive in accordance with Section 765.1100, F.S.
Medical Care	
Chief Complaint or Purpose of Visit	• Reason for the patient encounter • Referring provider, if applicable • Use subjective, objective, assessment and plan (SOAP) note format when applicable
Working Diagnosis(es)	• Must be a confirmed diagnosis(es) • Past and present diagnoses should be accessible to the treating and/or consulting provider • Patient's progress, response to and changes in treatment and revisions of diagnosis(es)
Services	• Documentation of all services provided • Significant medical advice given to the patient by telephone, whether during or after office hours, should be documented and initialed/signed appropriately • Discussions with the patient concerning the necessity, appropriateness, and risks of proposed surgery, as well as discussions concerning treatment alternatives, should be documented
Preventive Health/Risk Screening	• Reflect recommendation of age-appropriate preventive care guidelines • May not be applicable for all providers

The provider site maintains a system in place that provides for the collection, processing, maintenance, storage, retrieval and distribution of medical records. A person in the office is designated as being responsible for medical records. The responsibilities include, but may not be limited to, the following:

1. Confidentiality, security and physical safety of medical records
2. Timely retrieval of individual records upon request
3. The unique identification of each patient's medical record
4. Supervision of the collection, processing, maintenance, storage, retrieval, and distribution of medical records
5. Maintenance of a consistent organized medical record format
6. Policies are in place that address the following regarding medical records:
    a. Retention of active medical records
    b. Retirement of inactive records
    c. Timely entry of data in medical records
    d. Release of information contained in medical records
    e. HIPAA notification contained in medical records

Advance Directives

Advance Directives are witnessed documents which indicate a patient's choice about his/her future medical treatment. These documents also allow the patient to designate someone to make decisions about the patient's medical treatment should they be unable to make those decisions for themselves. Records should contain documentation that the patient was provided written information concerning the patients' rights regarding advance directives and whether or not the patient has executed the advance directives.

Medical Records Transfers

Upon receipt of a signed Release of Medical Records Form by a patient, a parent or guardian of a minor, or a personal representative of a deceased patient, participating providers must transfer copies of medical records within one week.

Medical Records Charges

Photocopy charges are not reimbursable. Please refer to your Provider Agreement for additional information.

Confidentiality and Release of Patient Information

It is the responsibility of all District providers to maintain the confidentiality of the patient's medical records and health information. A patient's medical record may be used for many purposes; however, it is the provider's responsibility to safeguard information and release only upon receipt of the patient's written permission, except when:

- Information is required by law - subpoena, court order, or other legal process.
- Information is needed to assist another healthcare provider who is currently involved in the care of the patient.
- Information is required by the Health Care District for the purpose of claims payment, quality assessment and/or utilization review.

SECTION 7: CLAIMS / BILLING

Introduction

The District maintains standards for the submission and adjudication of claims. This section summarizes the submission, payment and collection processes maintained by the District.

Purpose

The purpose of the Claims/Billing section is to assist providers in understanding the Health Care District's procedures for claims.

Claims Submission and Timely Filing

All claims must be submitted to CCP electronically no later than 180 (one hundred and eighty) days from the date of service. Claims are reimbursed in accordance with contract provisions, limitations, and rates. Any service not properly authorized or not considered a covered service under the plan shall be denied reimbursement. Additionally, providers may not bill patients directly for services denied due to lack of coverage or authorization. See Section 3: Health Care Access for service authorization requirements and Section 4: Limitations and Exclusions for non-covered benefits and services.

Claims submitted must be "clean" which is defined as follows. A "clean claim" is an original, accurately completed claim with all necessary information provided. Claims must be submitted for payment on appropriate industry standard claim forms [HCFA1500 or UB04]. In addition, each claim must satisfy the following:

1. Separate Claim Form for each patient;
2. Separate Claim Form for each provider/physician rendering service;
3. Separate Claim Form for each site location rendering service;
4. Separate Claim Form for each authorization received from the Health Care District.

All claims, including claims for reconsideration or corrected claims, must be submitted electronically within the timely filing limits of 180 (one hundred and eighty days) from the date of service to our Third-Party Administrator (TPA), Community Care Plan (CCP).

- Clearinghouse: Availity
- Payer Name: Community Care Plan (Palm Beach Health District)
- Payer ID: PBHD1 *(the last digit is the number one)*
- Claims Registration: www.Availity.com

Claim status can be checked anytime at http://PlanLink.ccpcares.org/ via PlanLink (for providers with login credentials) or via Guest Claims. Please allow 30 days from the date of submission before requesting status of a claim.

For more information about PlanLink, visit Community Care Plan - Provider Portal, PlanLink (ccpcares.org) To request PlanLink portal access, please visit https://e-apply.ccpcares.org and follow the instructions found there.

National Correct Coding Initiative

For a consistent and standard based approach to coding and reimbursement, the Health Care District will implement those CMS National Correct Coding Initiative (NCCI) edits not otherwise addressed by existing District reimbursement policies.

NCCI edits are available at: www.cms.hhs.gov/NationalCorrectCodinitEd. Accurate coding will help ensure payments are made correctly and eliminate the need for future recoupment.

Coding

CCP will only accept standard codes for reimbursement, which must be valid at the time the claim is submitted. These standard codes include ICD codes for diagnoses and procedures, CPT, and HCPCS codes. Claims received with invalid/incorrect codes will be denied. Claims resubmitted with current/valid codes are also subject to the timely filing deadline (180 days from the date of service).

Coordination of Benefits (COB)

District Cares Voucher Program is needs-based coverage and the District is always the payor of last resort. In the event that a member has other insurance coverage for services rendered, including automotive or worker's compensation coverage, the provider is responsible for confirming all insurance coverage for services rendered to a member and pursuing payment for those services from other primary payor(s) prior to pursuing payment from District Cares Voucher Program. CCP will not issue payment on any services that are not authorized when required or a covered benefit under the District Cares Voucher Program, and providers must comply with all Program requirements, including prior authorization and timely filing to be considered for payment. For automobile claims, an exhaust benefit letter is required within the timely filing period of 180 days from the date of service for payment consideration. Exhaust Benefit Letter must be uploaded through PlanLink provider portal.

Subrogation

The District may exercise its right to recover medical expenses from any third party alleged to be legally responsible for bodily injury or illness to a patient.

Payment

CCP shall make payment on properly documented "clean" claims in a timely manner for eligible patients in accordance with authorization requirements and for covered services.
Preferred payment method is EFT. Electronic Funds Transfer Request Form can be found at ccpcares.org.

Both payments and denials are documented on the remittance advice. All denials include a "not covered reason code". An explanation of all applicable codes will appear on the remittance advice. The remittance advice will be available online at http://PlanLink.ccpcares.org/.

Payment Methodology

CCP reimburses providers as specified in their provider agreement. If you have any questions about your provider agreement, contact CCP Provider Services Department at (855) 819-9506.

Payment Recovery

CCP routinely audits claim payments within one year of the date of service. If CCP determines that a payment has been made in error, a notification letter will be sent to the provider.

Providers may request a redetermination in writing within thirty-five (35) days of the notification. CCP will review redetermination requests within 45 days of receipt. If the initial determination is reversed, a revised determination letter will be sent to the provider and no recoupment will be made.

Payment will be recouped for the denied service/claim on future claims. The amount recouped will be indicated on the provider's remittance advice along with the overpayment reason. CCP may submit a written Request for Payment notice to the provider. The provider must pay the overpayment amount within forty-five (45) days of the receipt of the written request.

Resubmitting a Claim

Claims may be resubmitted electronically via PlanLink within sixty (60) days of the denial notice for claim reconsideration. Resubmitted claims are also subject to the timely filing deadline (180 days from the date of service). Community Care Plan (CCP) reviews all resubmitted claims and the outcome is considered final.

Note: Do not resubmit a claim to the TPA if it has been paid or denied, as this will create a duplicate claim denial.