Introduced by _____ Council Bill No. _____R 209-12_____

A RESOLUTION

authorizing an application for ancillary and facility Medicaid billing with HealthCare USA for reimbursement of certain healthcare services for qualified low income citizens.

BE IT RESOLVED BY THE COUNCIL OF THE CITY OF COLUMBIA, MISSOURI, AS FOLLOWS:

SECTION 1. The City Manager is hereby authorized to execute an application for ancillary and facility Medicaid billing with HealthCare USA for reimbursement of certain healthcare services for qualified low income citizens. The form and content of the application shall be substantially as set forth in "Exhibit A" attached hereto and made a part hereof as fully as if set forth herein verbatim.

ADOPTED this _____ day of _____, 2012.

ATTEST:

_____ _____

City Clerk Mayor and Presiding Officer

APPROVED AS TO FORM:

_____

City Counselor

HEALTHCARE USA
A Coventry Health Care Plan

INSTRUCTIONS

Please complete all sections of this application. If a section is not applicable, mark it N/A. Please print or type information. For questions, please contact the representative listed on the letter accompanying this application.

FACILITY TYPE

☐ Ambulance	☐ Hearing Aids	☐ Oncology Center
☐ Ambulatory Surgery Center	☐ Home Health	☐ Open MRI
☐ Audiology	☐ Skilled Nursing	☐ Optical Shop
☐ Birthing Center	☐ Home Infusion	☐ Orthotics & Prosthetics
☐ CORF	☐ Mom/Baby Visits	☐ PCP Clinic
☐ CT Scan	☐ Post Partum Visits	☐ PET Scan
☐ High Capacity	☐ Personal Care	☐ Pharmacy
☐ Sedation available	☐ Physical Therapy Home Visit	☐ Portable Diagnostic Imaging
☐ Diagnostic Imaging	☐ Speech Therapy Home Visit	☒ Public Health Dept (PHD)
☐ Dialysis	☐ Occ. Therapy Home Visit	☐ Radiology
☐ CAPD	☐ Hospice	☐ Rehabilitation Therapy Facility
☐ Hemodialysis	☐ Hospital	☐ Rural Health Center (RHC)
☐ Home Hemodialysis	☐ Laboratory	☐ Therapy – Occupation Outpatient
☐ Dietician	☐ Mammograms	☐ Therapy – Physical Outpatient
☐ Digital Mammograms	☐ MRA	☐ Therapy – Speech Outpatient
☐ Durable Medical Equipment	☐ MRI	☐ Ultrasound
☐ ESRD	☐ Sedation available	☐ Urgent Care
☐ FQHC	☐ High Capacity	☐ X-Rays

GENERAL INFORMATION

Name City of Columbia- Department of Public Health and Human Services CPD ID (internal use only) _____

Address 1005 West Worley Street

City/State/Zip Columbia, MO 65203 County Boone

Phone 573-874-7356 Fax 573-874-7758 E-mail mmdougla@gocolumbiamo.com

Tax ID Number 43-6000810 Facility NPI **1144207960** Website www.gocolumbiamo.com

Administrator Name/Title Mike Matthes, City Manager Phone 573-874-7254

Managed Care Contact Name Michelle Lewis Phone 573-874-6395

Please provide the above information on a separate piece of paper for each location under this TIN.

BILLING INFORMATION

Same as primary office? **X Yes** ☐ No If no, please complete the following:

Contact Name _____ Phone _____

Address _____ Fax _____

City/State/Zip _____ E-mail _____

Do you bill on a HCFA or UB Form? ☒ HCFA ☐ UB

CREDENTIALING INFORMATION

Same as primary office? ☒ **Yes** ☐ No If no, please complete the following:

Contact Name Michelle Lewis Phone 573-874-6395

Address 1005 West Worley Street Fax 573-874-77758

City/State/Zip Columbia, MO 65203 E-mail www.cocolumbiamo.com

OWNERSHIP AND CONTROL

Must provide this information for any individual or entity (including individual owning such entity)with 5% or more Ownership Interest in Facility. Attach additional sheets if necessary.

Owned By City of Columbia, MO

Address 701 East Broadway

City/State/Zip Columbia, MO 65205

Year Opened 1974 Percent Owned 100%

Type of ownership (check one)

___ Independent
___ Limited Partnership
X Government (non-Federal)
___ City-owned
___ Church-operated
___ Corporate Chain
___ Hospital-owned
___ State-owned
___ Non-governmental (not for profit)
___ Other
___ Joint Venture
___ Investor-owned (for profit)
___ County-owned

SERVICES

Facility treats work-related injuries/illness (if yes, complete Workers' Compensation Questionnaire) ☐ Yes X No
Total number of licensed beds 0
Do you offer 24/7 Emergency Department Services? ☐ Yes ☐ No ☒ N/A

List the hours of operation:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From/To	8 – 5	8 – 7	8 – 5	8 – 5	8 - 5		

List foreign languages spoken at facility language line and interpreters utilized

Does this office have other services for the disabled?
Text Telephony (TTY) ☒ Yes ☐ No American Sign Language (ASL) ☒ Yes ☐ No
Mental/Physical Impairment Services ☐ Yes ☐ No
Other Disability Services

LICENSURE/DEA (include current copies)

State License Number R7J47 State MO Expiration Date 1/31/2013
State License Number State Expiration Date

Federal DEA Certificate BH1990313 Expiration Date 10/31/2013
Other applicable narcotic certificate:
Certificate Number (State CDS) State Expiration Date

ACCREDITATION/CERTIFICATION (include current copies)

___ AAAHC
___ CAP
___ COLA
___ COA
___ AAAASF
___ CARF
___ HFAP
Other
___ ACHC
___ CHAP
___ JCAHO
___ DNV
X CLIA
___ CMS (State Audit Report)
___ None – please explain

Medicare Provider number **1144207960** Medicaid Provider Number **202777710**

An on-site visit may also be required.

PROFESSIONAL LIABILITY INSURANCE

Your current professional liability insurance certificate (declarations page or face sheet) showing carrier name, liability limits, provider name and expiration date of policy must be supplied.

Current Carrier Name CNA Policy Number : HMA 1040025803-10

Dates of Coverage From 10/01/2012 To 09/30/2013

Policy Limits Per Occurrence $1,000,000 Aggregate $2,000,000

PROVIDER SERVICE AREA

Please [✓] check all of the Missouri counties where the facility provides services.

	Adair		Dallas		Livingston		Randolph
	Andrew		Daviess		Macon		Ray
	Atchison		DeKalb		Madison		Reynolds
	Audrain		Dent		Maries		Ripley
	Barry		Douglas		Marion		Saint Charles
	Barton		Dunklin		McDonald		Saint Clair
	Bates		Franklin		Mercer		Saint Francois
	Benton		Gasconade		Miller		Saint Louis
	Bollinger		Gentry		Mississippi		Saint Louis City
X	Boone		Greene		Moniteau		Sainte Genevieve
	Buchanan		Grundy		Monroe		Saline
	Butler		Harrison		Montgomery		Schuyler
	Caldwell		Henry		Morgan		Scotland
	Callaway		Hickory		New Madrid		Scott
	Camden		Holt		Newton		Shannon
	Cape Girardeau		Howard		Nodaway		Shelby
	Carroll		Howell		Oregon		Stoddard
	Carter		Iron		Osage		Stone
	Cass		Jackson		Ozark		Sullivan
	Cedar		Jasper		Pemiscot		Taney
	Chariton		Jefferson		Perry		Texas
	Christian		Johnson		Pettis		Vernon
	Clark		Knox		Phelps		Warren
	Clay		Laclede		Pike		Washington
	Clinton		Lafayette		Platte		Wayne
	Cole		Lawrence		Polk		Webster
	Cooper		Lewis		Pulaski		Worth
	Crawford		Lincoln		Putnam		Wright
	Dade		Linn		Ralls		

ADDITIONAL INFORMATION

1. In the past 5 years has the facility ever had any of the following items involuntarily denied, revoked, suspended, not renewed, placed under probation, subject to disciplinary action or otherwise limited or curtailed; or has the facility voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to any of the following items?

For any "Yes" responses on 1-3, provide an explanation on a separate page.

A) State license	☐ Yes ☒ No
B) Medicare, Medicaid, or other local, state, and/or federal government program participation	☐Yes ☒ No
C) HMO, PPO, or other health plan participation	☐ Yes ☒ No
D) Other regulatory agency (OSHA, etc)	☐ Yes ☒ No
E) Accreditation organization (CLIA, JCAHO, etc)	☐ Yes ☒ No

2. In the past 5 years, has the facility ever been placed under temporary government ordered management? ☐ Yes ☒ No

3. In the past 5 years, has the facility ever permitted the appointment of a receiver for its business or its assets? ☐ Yes ☒ No

4. Do you understand that subject to proper confidentiality restrictions and authorizations, medical records might be subject to on site review by Coventry representatives for peer review, utilization review, and quality assurance purposes? **(If answered NO, please explain.)** ☒ Yes ☐ No

5. Would the facility be willing, if needed, to sponsor or provide educational programs for members of Coventry? ☐ Yes ☒ No

Affiliations with other health plans? If yes, please list Home State Health Plan, Missouri Care, MO Healthnet

The undersigned hereby certifies that the above information and all attachments provided to Coventry is truthful, correct and complete in all respects and the undersigned further understands the intentional submission of false or misleading information or the withholding of relevant information are grounds for termination or disapproval as a participating provider with Coventry. The undersigned hereby agrees to notify Coventry of any material changes in the above information within 30 days of change.

Signature _____ Date _____

Mike Matthes
Printed name of above person

City Manager
Title of above person

Coventry Health Care providers have the rights to:

- **Request status of application**
- **Correct erroneous information**
- **Review information submitted to support the credentialing application**
- **Notification of these rights**

TO: Applying provider
Re: Practice Ownership Form Attached

The Centers for Medicaid and Medicare Services (CMS) requires Coventry Health Care, Inc. and its subsidiaries to obtain certain information regarding the ownership and control of entities with which the health plan contracts for services for federal employees or federal health plans. Please review the attached form and return completed along with your contract. Incomplete forms will not be accepted. This form is required if you wish to participate with Coventry and their subsidiaries. You are also reminded that any changes to this information in the future must be reported to the health plan.

Thank you, in advance, for your cooperation during this process.

Provider and Subcontractor Ownership/Controlling Interest Worksheet

In order to comply with Federal law (42 CFR 420.200 - 420.206 and 455.100 - 455.106) health plans with Medicaid or Medicare business are required to obtain certain information regarding the ownership and control of entities with which the health plan contracts for services for which payment is made under the Medicaid or Medicare program or any line of business that provides healthcare for federal employees.. The Centers for Medicaid and Medicare Services (CMS) requires Coventry Health Care, Inc. and its subsidiaries to obtain this information to demonstrate that we are not contracting with an entity that has been excluded from federal health programs, or with an entity that is owned or controlled by an individual who has been convicted of a criminal offense, has had civil monetary penalties imposed against them, or has been excluded from participation in Medicare or Medicaid. Please complete the following information listed below . This form is required if you wish to continue to participate with Coventry's subsidiaries. You are also reminded that any changes to this information in the future must be reported to the health plan. **Use the back of this form if you need space to continue your responses**.

Name of Provider/Subcontractor City of Columbia, Missouri

Type of Provider/Subcontractor Local Public Health

Tax ID# 43-6000810 Facility NPI# **1144207960**

Primary Address 1005 West Worley Street, Columbia, MO 65203

Type of Ownership government (examples may include: partnership, corporation, government, limited partnership, corporate-owned, investor-owned, etc.)

List any person & their address that has a direct or indirect ownership interest of 5% or more in your entity.

List any person & their address who is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property assets thereof, in which whole or part interest is equal to or exceeds 5% of the total property and assets of the entity.

If the entity is a corporation, please list the officers and directors of the entity & their address. If the entity is a partnership, please list the partners & their address.

List any managing employees & their address. Managing employees are individuals such as general managers, business managers, administrators, or directors who exercise operational or managerial control over the entity or part thereof or directly/indirectly conduct the daily operations of the entity, or part thereof.

Mike Matthes, City Manager, 701 East Broadway, Columbia, MO
John Blattel, Finance Director, 701 East Broadway, Columbia, MO
Stephanie Browning, Director, 1005 West Worley, Columbia, MO
Scott Clardy, Assist. Director, 1005 West Worley, Columbia, MO

[__] CHECK IF YOU HAVE LISTED ADDITIONAL INFORMATION ON THE BACK OF FORM

I certify that the information contained above is true, complete, and accurate.

Signed _____ **Print** _____

Date _____ **Title** _____

Telephone Number _____ **Fax Number** _____

Coventry Workers' Compensation Services Information Form

Your responses to the questions below will help Coventry understand and correctly represent your practice as it pertains to the treatment of injured workers. If you have more than one office practice location and your responses differ between offices, please complete a form for each office. Coventry will not consider you or your practice as a direct participant in our workers' compensation network unless your provider agreement with Coventry supports participation in this product.

[x] Please check this box if you do not currently accept workers' compensation patients, or if you plan to discontinue your workers' compensation practice, or you are not certified/approved (if required by your state) to provide workers' compensation services.

[ ] Please check this box if you a) currently accept workers' compensation patients b) plan to continue your workers' compensation practice and c) are certified/approved (if required by your state, please also a provide a copy of that documentation) to provide workers' compensation services. Additionally, please address the following:

- My practice, for workers' compensation patients can best be described as (check the box that best applies)
  - ☐ Initial injury care for workers
  - ☐ Initial visit or referral care for area of specialty care only

- Accommodates urgent walk-ins ☐ Yes ☐ No

Provider Certification

I certify that the information on this form is true and correct. I understand that misrepresentation may result in my non-selection, or, if discovered after selection, in my termination as a participating provider. I understand that this form does not entitle me to participation in any Coventry Network, owned and operated by Coventry Health Care and/or its subsidiaries (collectively "Coventry"). I authorize the copy of my signature on this form to be as binding as the original. I agree that Coventry, its representatives, and any individuals or entities providing information to Coventry in good faith shall not be liable for any act or omission related to the evaluation or verification contained on this form. I further agree to notify Coventry in a timely manner of any change to the information requested on this form. Failure to update my information may result in termination as a network provider or in termination in the Workers' Compensation network product. I will retain a copy of this authorization for my own purposes.

A properly executed version of this document containing your actual signature, delivered by facsimile, is as valid as an original.

Practitioner/ Facility Health Care Professional Name (please print or type) _____

_____

Please check this box if all locations have the same responses [ ], or define below the Provider address applicable to this form if above responses differ by location. _____

_____

_____ _____

Signature **Date**

Mike Matthes City Manager

Printed name of above person **Title of above person**

Source: Health

Agenda Item No:

To: City Council
From: City Manager and Staff

Council Meeting Date: Nov 19, 2012

Re: HealthCare USA
Application for Ancillary and Facility

EXECUTIVE SUMMARY:

A resolution authorizing the City Manager to sign the Application for Ancillary and Facility Medicaid billing between the City of Columbia and HealthCare USA.

DISCUSSION:

This contract allows the Department of Public Health and Human Services to bill for approved clinical services provided for Health Care USA participants.

FISCAL IMPACT:

This is a renewal process and was anticipated in the FY2013 budget process. No appropriation is necessary.

VISION IMPACT:
http://www.gocolumbiamo.com/Council/Meetings/visionimpact.php

11.3 Goal: Columbia will be a healthy community. All residents will have timely access to appropriate health care. Effective prevention initiatives will contribute to a healthy community.

SUGGESTED COUNCIL ACTIONS:

Should the Council agree with the staff recommendation, an affirmative vote is in order.

FISCAL and VISION NOTES:					
City Fiscal Impact Enter all that apply		**Program Impact**		**Mandates**	
City's current net FY cost	$0.00	New Program/ Agency?	No	Federal or State mandated?	No
Amount of funds already appropriated	$0.00	Duplicates/Epands an existing program?	No	**Vision Implementation impact**	
Amount of budget amendment needed	$0.00	Fiscal Impact on any local political subdivision?	No	Enter all that apply: Refer to Web site	
Estimated 2 year net costs:		**Resources Required**		Vision Impact?	Yes
One Time	$0.00	Requires add'l FTE Personnel?	No	Primary Vision, Strategy and/or Goal Item #	11.3
Operating/ Ongoing	$0.00	Requires add'l facilities?	No	Secondary Vision, Strategy and/or Goal Item #	
		Requires add'l capital equipment?	No	Fiscal year implementation Task #	