



Provider Presentation

2015

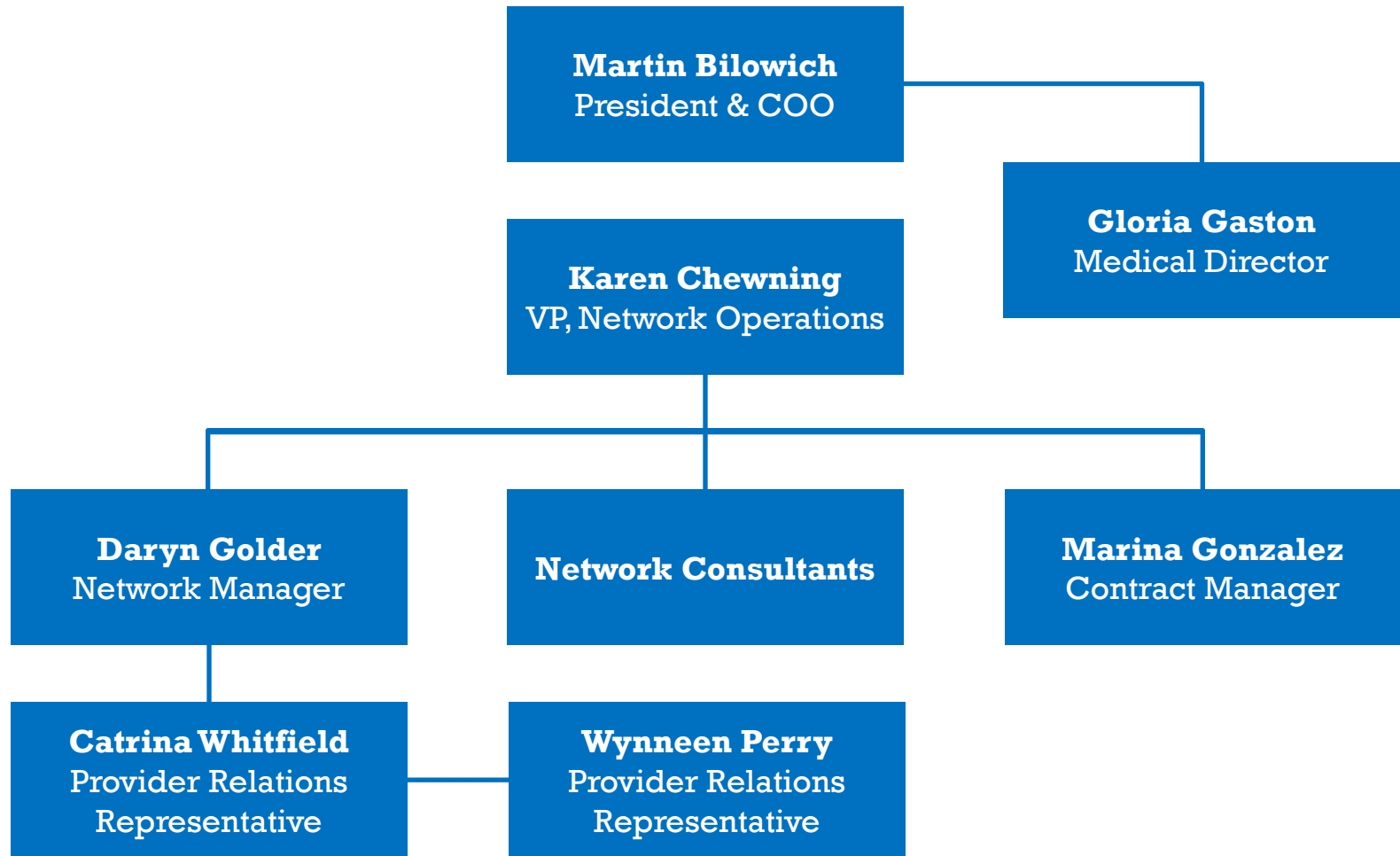
Proudly serving *Georgia Families*® and *PeachCare for Kids*® members.



Who is Therapy Network of Georgia?

- TNGA is a provider network company focused on contracting with independent therapy providers (PT/OT/ST) and psychiatrists in order to arrange for outpatient rehabilitative services on behalf of health plans and their assigned members.
- TNGA and its affiliated companies provide rehabilitation services to over 1.2 million health plan members through its 1,100+ contracted provider locations.
- TNGA and its affiliated companies operate in four different U.S. markets and cover all lines of business (Medicaid, SCHIP, Medicare, Commercial HMO, Commercial PPO).
- TNGA is a privately owned organization. Its owners are also the founders and operators of the company. For more than seven years, TNGA and its affiliated companies have contracted with nine different health plans to provide therapy network management services.

TNGA's Provider Relations Organizational Structure



What is the relationship between WellCare of Georgia and TNGA?

TNGA is contracted with WellCare of Georgia to coordinate the provision of outpatient therapy (PT/OT/ST) services to WellCare members through a network of therapy providers contracted with TNGA for their Georgia Families[®], PeachCare for Kids[®] and Medicare Advantage members.

Therapy Network Operations Overview

- Mixed Model: Open Access and Fee for Service for Members enrolled in *Babies Can't Wait*
 - ▣ Members do not need a referral from PCP, they only require a written script from referring physician
- Case Rate Payment Methodology
 - ▣ Reduces Administrative Activities
 - ▣ No additional authorization prior to evaluation
 - ▣ No “chasing” of payments as in a Fee-for-Service model
- Utilizes practicing GA licensed therapists and physicians for review of any Provider Appeals and Peer Review with its contracted providers.
- TNGA's affiliated networks maintain a provider retention rate of over 96% and does not limit the participation of providers

Contracting Options

- Full Service Agreement
- Providers care for the entire WellCare enrolled membership
 - Providers are reimbursed the global case rate fee for the enrolled WellCare population EXCEPT for those members enrolled in *Babies Can't Wait*
 - Claims paid for members enrolled in *Babies Can't Wait* are reimbursed Fee for Service
- *Babies Can't Wait* Fee for Service Agreement
 - Providers only care for the *Babies Can't Wait* enrolled members
 - Providers are reimbursed 100% of the GA Medicaid Fee Schedule

Case Rate Payment Model

- Case Rate Payment puts the provider in the “driver’s seat”.
- They are not restricted by a set number of visits/patients.
- The provider receives full payment immediately after first claim is submitted prior the completion and billing of remaining visits.
- Claims Payment turnaround time is 15 days for Electronic Submission and 30 days for Paper Submission.
- There is no recoupment of the payment if member does not complete the recommended course of treatment (e.g., members who switch CMOS, or move out of geographic accessibility to the provider).

Fee for Service – *Babies Can't Wait*

- If a member is enrolled in the *Babies Can't Wait* early intervention program the rendering provider will receive fee for service reimbursement
- Fee for Service reimbursement is paid at 100% of the current Georgia Medicaid Fee Schedule
- The provider shall submit the Individualized Family Service Plan (IFSP) to TNGA when requesting a referral to see a member enrolled in *Babies Can't Wait*

Requesting a Referral in the Case Rate Model

- The treating provider requests a referral via the DCH Portal after the patient evaluation. The provider submits the following with the Portal request:
 - Attestation Form (if the member does not have an IEP/IFSP)
 - IEP/IFSP if applicable (An IEP-Individualized Education Plan used in early intervention ages 0-3 or an IFSP-Individualized Family Service Plan, used in special education ages 3-21 are each applicable if the patient has one)
 - Letter of Medical Necessity with Prescription from referring provider
 - Plan of care
 - Standardized Testing

Assignment of Levels

- **Level 1** – One-time visit, Evaluation Only (e.g., Wheelchair Consultation, after evaluation provider determines no other therapy needed)
- **Level 2** – Mild to moderate diagnosis, including most fractures and spinal sprains and strains
- **Level 3** – Moderate to more severe diagnosis; most shoulder issues other than joint pain, most post-operative treatment, arthritis, fractures, MS, CVA older than 4 weeks, Arthroscopies, Spinal Stenosis
- **Level 4** – Severe diagnosis; THR, TKR, TSR, CVA less than four weeks; Developmental Delays, Rotator Cuff Repair
- **Level 5** – Severe and catastrophic cases (will be reviewed by a Clinical Consultant)

Global Period of Assigned Levels for Acute Care

- All Acute Care Cases will be assigned a Level that is valid for a 60 day treatment period.
- TNGA will issue ONE Control Number that will be valid for the 60 day treatment period.
- Examples of Acute Cases
 - Most fractures and spinal sprains and strains, most shoulder issues other than joint pain, most post-operative treatment, MS, CVA older than 4 weeks, Arthroscopies, and Spinal Stenosis
 - The Provider will continue to treat the patient for the 60 day treatment period submitting claims for **every date of service, for every procedure performed.**

Request of an Upgrade for Acute Care

There may be instances when a level is issued, but the treating provider realizes that the intensity of services required is greater than anticipated. The provider may request an Upgrade of the Level originally issued.

An Upgrade Request is a request for a higher level than what was originally issued based on the member's medical need. It may only be requested during the referral time period of the original level.

How to Request an Upgrade for an Acute Care Case

- The provider will submit a request for an Upgrade via the DCH Portal. They must respond “Yes” to the question on the portal *“Is this a Continuation from a previous PA?”*
- The provider must attach the TNGA Upgrade Request Form.
- The Upgrade Request must Include the current progress summary report, which should include:
 1. Patient deficits in strength (MMT), range of motion (ROM), etc. expressed objectively
 2. Specific treatment goals defined objectively with time frame to achieve goal
 3. Relevant Factors may include date of surgery or a significant change in condition

Approval Process of an Upgrade Request for Acute Care

- The Upgrade request will be reviewed by a clinical consultant.
- If a higher level is issued, the difference in payment amount between the original assigned level and the upgraded level will be paid.
- If medical necessity is not determined based on information received, a peer-to-peer consultation is offered to treating provider.
- If after the peer-to-peer a decision cannot be agreed upon, the request for an upgrade will be submitted to the health plan for final determination.
- Upgrades may not be applied retrospectively (after the 180 day treatment period has ended).

Global Period of Assigned Levels for a Patient with Developmental Delay

- Members identified as developmental delay will be approved for a 180 day plan of care/treatment period, which will encompass 3 separate level payments as long as the member remains in active treatment per the POC.
- TNGA will send the Provider ONE Control Number that is valid for the 180 day treatment period.
- The Provider will continue to treat the patient for the 180 day treatment period submitting claims for every date of service, for all procedures performed.

Payment of Levels for Developmental Delay

- TNGA will pay the Provider for the 1st Level upon the receipt of the first claim following the Evaluation.
- TNGA will pay the Provider for the 2nd Level upon the receipt of the first claim following day 60 of the 180 day treatment period.
- TNGA will pay the Provider for the 3rd Level upon the receipt of the first claim following day 120 of the 180 day treatment period.
- It is very important that the provider submit ALL claims for all dates of service and each claim must include all procedures performed.

The Upgrade Process for Developmental Delay

- If a provider has a member requiring a greater intensity of services, the provider may request an Upgrade.
- The provider will submit a request for an Upgrade via the DCH Portal. They must respond “Yes” to the question on the portal *“Is this a Continuation from a previous PA?”*
 - The provider must attach the TNGA Upgrade Request Form.
 - The Upgrade Request must Include the current progress notes, which should include:
 - The actual measurements of the delay using a standardized tool and complete documentation of any improvement achieved in therapy.

Approval Process of an Upgrade Request for Developmental Delay

- TNGA will submit the Upgrade request to the Clinical Consultant (a licensed therapist in the same discipline) for review.
- Upon approval of the Upgrade request TNGA will modify the existing referral to a higher level.
- The Provider will receive via facsimile the Control Number referencing the higher level. If medical necessity is not determined based on information received, a peer-to-peer consultation is offered to treating provider.
- If after the peer-to-peer a decision cannot be agreed upon, the request for an upgrade will be submitted to the health plan for final determination.

Payment of Levels when an Upgrade is Approved for Developmental Delay

- If at any time during the 180 day treatment period the provider requests an Upgrade and TNGA increases the level assigned, the current level *AND* all subsequent levels will be paid at the higher level during the 180 day treatment period.
- Upgrades may not be applied retrospectively (after the 180 day treatment period has ended).

How will the Treating Provider be Notified of a Referral?

- TNGA will fax the treating therapist a referral indicating the Level and the referral period
- All Routine requests must be processed within 14 days, however, TNGA is processing routine requests on an average of 3-5 days
- Expedited Requests are completed within 24 hours for Medicaid members and 72 hours for Medicare members

How to Request Another Level After First Treatment Period Has Ended

If a member requires further therapy after the first level authorization period has expired you may request another level. Follow these steps:

1. Obtain a new or renewed physician prescription from the patient's PCP or ordering physician.
2. Perform a re-evaluation of the patient and request a referral via the DCH Portal.
3. Attach re-evaluation and previous evaluation, if available.

Upon receipt of the information listed above, TNGA will review the submitted documentation. TNGA will issue a new level and a new episode of care begins.

Patients who Require more than one Type of Therapy During Same Treatment Period

- If a patient requires treatment for more than one type of therapy during the same treatment period, such as both Occupational *and* Speech Therapy, follow the steps outlined below:
 1. Request two separate authorizations via the DCH Portal.
 2. You must include the referring physician's prescription for both disciplines with each request.
 3. All requests of this kind, for more than one level, will be submitted to a clinical consultant for review of medical necessity.

TNGA does not issue a separate episode level for symptoms or conditions associated with the main diagnosis. For example, for a therapy request for *Status Post Total Knee Replacement*, TNGA assigns a level according to date of surgery. Concurrent requests for pain, including back pain, gait, instability, muscle weakness, etc., would be considered related to the main diagnosis, and TNGA will not issue a separate level.

Fixed-Fees

(No Levels-fixed Reimbursement)

- Exclusive to providers with a multi-disciplinary practice (PT/OT/ST) who have a fixed fee reimbursement schedule contractually.
 - ▣ Fixed Fee Reimbursement provides for a fixed fee per patient/per episode, regardless of the need for one or more types of therapy services (i.e., PT/OT/ST)
- Two Episodes can be issued in the Fixed Fee Model:
 - ▣ Full Episode—includes all services of one or more particular mode of therapy (PT/OT/ST) within a nine (9) month period of time.
 - ◆ This episode is issued for a patient who is receiving therapy services with the requesting provider as a new patient.
 - ▣ Transitional Episode—is for services for patients whose current course of treatment is partially covered under a different contractual arrangement prior to, or after, the services incorporated under this Agreement and/or for services provided to a patient beyond the time period of the Full Episode Fee.
 - ◇ In the fixed fee reimbursement mode there are no upgrade requests.

Claims Submission

■ Electronic Claims Submission


- Payer ID for professional claims (837P): 65062
- Payer ID for institutional claims (837i): 12k89

■ Claims Payment Turnaround –

30 days for Paper, 15 days for Electronic

■ Direct Data Entry

- Providers are able to submit Claims via Direct Data Entry
- Providers may access the Web Portal by logging into www.healthsystemone.com. For questions concerning the Web Portal or to request a Provider Web Portal account, please send an email to providerportal@hnltherapynetwork.com
- ✓ The Web Portal may also be used to check Claims Status

 Claims Questions? Contact a TNGA Claims Representative at 855-825-7818, Option 3.

Paper Claims Submission

HN1 Therapy Network
Attention: Claims
Processing Center
P.O. Box 350590
Fort Lauderdale, FL
33335-0590

TNGA's Website

- In addition to the Provider Web Portal, TNGA provides global access to information on our website at:

- ◇ <http://www.hnltherapynetwork.com/georgia.html>

Here you will find the following information:

- ◆ TNGA Provider Manual
- ◆ Current Provider Bulletins
- ◆ Provider Service Agreements and Addendums
- ◆ Patient Intake Form
- ◆ Patient Upgrade Form
- ◆ Patient Splint Form
- ◆ Other Provider Training Information and Materials as Needed

TNGA Quality Reporting

TNGA's Utilization Management Department is NCQA Certified



- Staffing Adequacy Report
- Authorization Statistics
- Level 3 (Medical Director) Denials to Health Plan
 - ➔ Number and percent that Health Plan upheld
 - ➔ Number and percent that Health Plan overturned
- Inter-rater reliability reports
 - ➔ Clinical Staff
 - ➔ Non-clinical Staff
- Over and under utilization Analysis
- Case Management referrals for coordination with Health Plan, for:
 - ➔ Appropriateness of care
 - ➔ Continuity of care
 - ➔ Individualized treatment plans
- Provider Satisfaction Surveys Conducted Annually

Medical Advisory Committee

■ Purpose:

- To Evaluate and Make Recommendations to TNGA's Executive Management on the quality of care and service issues related to the provision of Physical Therapy Speech Therapy and Occupational Therapy services to the TNGA affiliated beneficiaries.

■ Structure:

- The MAC reports to TNGA's Board of Directors. Quorum shall consist of three (3) voting members being present at a meeting.
- Voting Members are five (5) practicing community-based Therapists (Physical Therapy, Speech Therapy and Occupational Therapy) across the state of Georgia
- Ad-hoc specialty advisors, as applicable

Important TNGA Contact Numbers

Department	Name	Title	Toll-Free Telephone and Fax	Email
Provider Relations	Daryn Golder	Network Manager	T 678-985-5402 F 305-614-0369	golderd@mytnga.com
Provider Relations	Marina Gonzalez	Contract Manager	T 855-825-7818 Ext 4134	gonzalezm@mytnga.com
Provider Relations	Catrina Whitfield	Provider Relations Representative	T 855-825-7818 Option 5 F 305-614-0369	whitfieldc@mytnga.com
Provider Relations	Wynneen Perry	Provider Relations Representative	T 855-825-7818 Option 5 F 305-614-0369	Toll-Free Numbers Claims Status/Inquiries 855-825-7818, Option 2 Authorization Status/Inquiries 855-825-7818, Option 3
Referrals/ Authorizations	Jennifer Abreu	Team Leader	T 855-825-7818 Option 2 F 855-597-2697	



THE THERAPY NETWORK
OF GEORGIA