



THERAPY NETWORK
OF GEORGIA

Provider Manual

Physical Therapy (PT), Occupational Therapy (OT) and
Speech Therapy (ST)

TABLE OF CONTENTS

Table of Contents	2
Welcome!	3
Important Contact Information	4
Referral Process	5
Evaluations.....	6
Referral Process for Therapy Providers	6
Communicating Referral Information to Therapy Network	7
Assignment of Levels.....	8
Global Period of Assigned Levels	9
Continuation of Care after 1 st Global Period has Expired	12
Multiple Case Referral Requests.....	13
Therapy (PT/OT/ST) Practice Guidelines.....	13
Claims Submission Protocols and Standards	16
TNGA Payment Policies.....	18
Reimbursement of Upgrades.....	19
Claim Status Inquiry	20
Coordination of Benefits/Subrogation.....	20
Timing of Claims Payment.....	20
Supplies and Equipment	23
Provider Complaint Process	24
Quality Improvement	25
Provider Participation in Quality Improvement Procedures	25
Attachments	26

WELCOME!

HN1 Therapy Network of Georgia (TNGA) welcomes your participation in the provider network. We are pleased that you have opted to join our organization. As a participating provider, you play a central role in the delivery of covered services to our affiliated health plan members.

TNGA's provider manual is intended to serve as a reference guide to assist you and your staff in providing outpatient Physical Therapy (PT), Occupational Therapy (OT) and/or Speech Therapy (ST) services to our affiliated members. We hope that you will find the information included in this document to be concise and useful in your role as a therapy provider. The intention of this provider manual is not to dictate to the therapy provider the recommended plan of care, which remains entirely in your hands as a licensed, qualified practitioner.

TNGA will send you updates to this provider manual from time-to-time, as the need to amend the content is identified. Meanwhile, due to the rapid and frequent changes that occur in health care policy and regulations, you may come across a discrepancy between a current law and the process outlined by TNGA. In such instances, the most current policy adopted by the member's health plan, federal and/or state regulations and laws, and/or the terms of your Provider Agreement will supersede any such information contained in this provider manual.

Thank you for your participation in our provider network. We look forward to a long and mutually beneficial relationship with you.

Sincerely,

Denisse Monserrate, M.D.
TNGA, Chief Medical Officer

IMPORTANT CONTACT INFORMATION

The main telephone number for Therapy Network of Georgia (TNGA) is 1-855-825-7818, which will give you the option of selecting the department you wish to reach. However, some functions have been issued dedicated telephone and fax numbers.

<u>Department</u>	<u>Telephone</u>	<u>Fax</u>
TNGA Main Telephone Numbers	1-855-825-7818 OR 305-614-0119	1-855-597-2697 OR 305-614-0138
Claims Processing (Outpatient Therapy ONLY)	1-877-372-1273	
Member Services	Contact the Member Services Department at the member's health plan.	
Provider Relations	1-855-825-7818 OR 305-614-0119	1-877-403-5544
Referrals	1-855-825-7818	1-855-597-2697
Verification of Eligibility	Contact the member's health plan.	

REFERRAL PROCESS

PROVIDER TYPE	EVALUATION	PHYSICAL THERAPIES: PT/OT/ST
<p>Therapist (PT/OT/ST)</p>	<p>Therapist must have a prescription or script from the ordering physician (Primary Care Physician [PCP] or specialist).</p> <p>No referral or “preauthorization” is needed from TNGA for therapist to perform an evaluation.</p>	<p>The treating CIS provider must request a referral via the DCH Portal after the patient evaluation. The provider must submit the following with the Portal request.</p> <ul style="list-style-type: none"> • Attestation Form (if the member does not have an IEP/IFSP) • IEP/IFSP if applicable (An IFSP-Individualized Family Service Plan, used in early intervention ages 0-3 or an IEP-Individualized Education 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 <p>The Non-CIS treating provider must complete the TNGA Patient Intake Form (Attachment A) along with the corresponding ordering provider’s prescription to our toll-free Referral Fax Line at 1-</p>

855-597-2697.

Therapy Network's provider network is contracted for outpatient therapy (PT/OT/ST) services ONLY.

Inpatient services ARE NOT included in the scope of TNGA's referral process and these services are subject to the patient's health plan referral policies and procedures.

Evaluations

Patient evaluations are covered for eligible members with a physician prescription for therapy. No advance notification to TNGA is necessary. Referring physicians will be given complete lists of network therapy locations, but you are encouraged to educate your referral sources of your participation in the program.

Eligibility should be verified with the health plan. As noted in your contract, TNGA will not guarantee payment except for those patients actually eligible with the payer at the time of service, and reimbursement is subject to all other TNGA contract provisions.

Referral Process for Therapy Providers

Patients are entitled to all medically necessary, covered care as determined by the treating therapist in consultation with the referring physician's office.

In the event of a disagreement between a therapy provider and the referring physician and/or patient (for example, the patient demands treatment with no further clinical value), the case may be submitted to TNGA for clinical review and to WellCare for final medical necessity determination, if applicable.

Communicating Referral Information to Therapy Network

	Hours of Operation	Phone Number
CIS Providers: DCH Provider Web Portal	24 hours a day, 7 days a week	www.mmis.georgia.gov
Fax Requests Non-CIS Providers ONLY	24 hours a day, 7 days a week	1-855-597-2697

As soon as possible after completing your evaluation, you may request a referral via the DCH Provider Web Portal. Please submit the following information with the portal request:

- Attestation Form (if the member does not have an IEP/IFSP)
- IEP/IFSP if applicable (An Individualized Family Service Plan, used in early intervention ages 0-3 or an IEP-Individualized Education 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

Providers not enrolled in CIS must complete the TNGA Patient Intake Form (Attachment A) along with the corresponding ordering provider’s prescription to our toll-free Referral Fax Line at 1-855-597-2697.

Upon receipt of the referral request, TNGA will provide a referral number related to the therapy services that are to be provided.

Please note the following when requesting a referral:

For medical diagnoses, we are looking for the diagnosis in medical terms (e.g., 723.1 Cervicalgia). For therapy treating diagnosis, we are looking for the functional reason for therapy if not clearly evident in the medical diagnosis.

Any developmental delays noted should be measured using a recognized, standard assessment tool such as Peabody, Bailey's scales, Bruiniks Oferetsky Test of Motor Proficiency, Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP), etc.

If providing therapy to a child, and the child is receiving any therapy service through the school system, this information must be provided (describe type and frequency of treatment) along with the Individualized Education Plan (IEP).

If the therapy is related to surgery, please identify the date and nature of surgery in the Plan of Care or Progress Notes.

If the therapy is related to a CVA, please submit the date of the CVA.

Please note that failure to request a referral could result in nonpayment for your services. Claims should not be submitted to TNGA prior to a provider receiving confirmation that therapy services have been authorized by TNGA.

Assignment of Levels

Extended Episode Fees (Case Rates) are fixed rates over a period of time for all necessary and appropriate treatment. Under this model, TNGA does not dictate or specify exact treatment requirements or visit limitations. It is expected that the therapy provider will provide appropriate care, delivered efficiently and with the necessary patient (or parent/caregiver, as applicable) education to allow the patient to meet his or her goals from activities both inside and outside the clinic. The only acceptable course of action is to always provide appropriate care and follow the upgrade process where necessary.

The assignment of levels is based on the diagnosis, intensity of services normally required for patients with like characteristics, patient utilization and circumstances to date. In general, levels are assigned as follows:

- **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, includes Evaluation

- **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, includes Evaluation
- **Level 4** Severe diagnosis; THR, TKR, TSR, CVA less than four weeks; Developmental Delays, Rotator Cuff Repair, includes Evaluation
- **Level 5** Severe and catastrophic cases (will be reviewed by a Clinical Consultant), includes Evaluation

Global Period of Assigned Levels

Each referral is assigned a specific period of time. The following are general time frames that are determined by the discipline.

- 2 Months For all assigned levels *except Developmental Delay*
 6 Months Developmental Delay

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 a 60-day treatment period. Examples of Acute Cases are 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 (Attachment C). The Upgrade Request must include the current progress summary report, which should include:

- Patient deficits in strength (MMT), range of motion (ROM), etc., expressed objectively
- Specific treatment goals defined objectively with time frame to achieve goal
- Relevant factors may include date of surgery or a significant change in condition

In addition, please note the following regarding the upgrade process:

- When requesting an upgrade of an assigned level, you will need to submit the Evaluation, Plan of Treatment, and Progress Summary.
- For the benefit of the member, all providers utilizing the upgrade process should not discontinue or delay their treatment to the member.
- If at any time the provider would like to further discuss an Upgrade Request or issue, please call the Referral Department to request a peer-to-peer review with our clinical consultant who reviewed the Upgrade Request.

If a provider is not enrolled in CIS, they must complete the TNGA Intake Form (Attachment A) and fax the request to TNGA's toll-free Referral Fax Line at 1-855-597-2697.

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 consultation a decision cannot be agreed upon, the request for an upgrade will be submitted to WellCare Health Plans of GA for final determination.

Upgrades may not be applied retroactively (after the 60-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. CIS providers 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 (Attachment C).

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.

If a provider is not enrolled in CIS, they must complete the TNGA Upgrade Request Form and fax the request to TNGA’s toll-free Referral Fax Line at 1-855-597-2697.

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 the information received, a peer-to-peer consultation is offered to treating provider. If after the peer-to-peer consultation a decision cannot be agreed upon, the request for an upgrade will be submitted to WellCare Health Plans of GA 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 retroactively (after the 180-day treatment period has ended).

Continuation of Care after 1st Global Period has Expired

In order to facilitate a new referral, ALL of the following steps should be taken:

- Obtain a new or renewed physician prescription from the patient's Primary Care Physician (PCP) or ordering specialist.
- Perform a re-evaluation of the patient and request a referral via the DCH Portal (if you are not a CIS provider, you must submit the TNGA Patient Intake Form (Attachment A) via fax as instructed on Page 7). Submit re-evaluation and previous evaluation, if available, to TNGA.
- 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.

Multiple Case Referral Requests

If a therapy provider determines there should be two separate case referrals instead of one for a patient under different therapy disciplines (e.g., PT and ST), a separate Intake Form along with the referring physician's prescription for the separate discipline must be submitted following the evaluation of the patient.

TNGA will refer a request for a multiple case referral, or any subsequent, additional referrals for a patient who is already under a therapist's care for a separate case to a clinical peer reviewer. The clinical peer reviewer may then contact the requesting provider for a peer-to-peer discussion if the reasoning for the multiple or additional referrals is unclear.

In all instances, a requesting provider is always notified of the outcome of his or her request for a referral.

Any additional referral issued by TNGA is for a specified time period, beginning on the date of the additional patient evaluation.

In addition, please note the following with regard to multiple case referrals:

- You will need to submit the ordering provider's prescription in order for TNGA to make the appropriate determination.
- TNGA does not issue a separate episode level for symptoms 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. are all due to the main diagnosis, and TNGA will not issue a separate level.
- If, after treating a member for several weeks, you find that the initial level is not sufficient, you have the option to initiate the upgrade process.

Fixed Fees (no levels-fixed reimbursement)

Fixed fee reimbursement provides for a fixed fee per patient per episode, regardless of diagnosis or the need for one or more types of therapy services (i.e., physical therapy, speech therapy or occupational therapy). *This referral process is*

exclusive to providers with a multidisciplinary practice who have a fixed fee reimbursement schedule contractually.

There are two episodes that can be issued in the fixed fee model.

A **Full Episode** is all services of one or more particular mode of therapy (physical, occupational or speech) 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.

A **Transitional Episode** is for services for patients whose 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 patients beyond the time period of the Full Episode Fee.

In the fixed fee reimbursement model, there are **no upgrade requests**. The referral is issued for a full episode of care **or** a transitional episode of care. The reimbursement is fixed at the full episode reimbursement fee or the transitional episode reimbursement fee.

Babies Can't Wait Enrolled Members

If providing therapy to a child, and the child is enrolled in the Babies Can't Wait Program, the provider must submit the Individualized Family Service Plan (IFSP), which must indicate that the child is enrolled in Babies Can't Wait. Services provided to a member who is enrolled in the Babies Can't Wait Program will be eligible for a fee-for-service reimbursement.

Therapy (PT/OT/ST) Practice Guidelines

When making medical necessity recommendations of denial for Medicaid and Medicare members, TNGA's clinical staff applies the applicable Clinical Guidelines. For Medicare members, TNGA's staff adheres to CMS coverage guidelines. For Medicaid members, TNGA's clinical staff applies the applicable Medicaid Benefit Policy Manual.

For any medical necessity recommendation of denial, the clinical consultant shall make an attempt to contact the requesting provider for peer-to-peer consultation.

In addition, the provider may request a copy of the clinical guidelines used to determine the recommendation of denial.

CLAIMS SUBMISSION PROTOCOLS AND STANDARDS

TNGA offers three methods of claims submission for providers to submit their claims.

EDI:

TNGA's preferred method of claims receipt is Electronic Data Interchange (EDI). TNGA utilizes Emdeon (WebMD) as their clearinghouse for the receipt of all EDI claims. The payer ID* numbers to submit your EDI claims to TNGA are:

- **For professional claims (837P): 65062**
- **For institutional claims (837i): 12k89**

***Please note that these payer ID numbers are listed as *HN1 (Health Network One) Therapy Network* with Emdeon.**

You do not need to be an Emdeon client to bill your claims via EDI to TNGA. Please contact your billing software vendor and have them add the TNGA payer ID number so your claims can be billed via EDI. For more information on how to submit your claims for TNGA via EDI, please visit the Emdeon website at www.emdeon.com.

DDE:

Therapy Network offers providers a multi functioning Provider Web Portal that allows contracted providers to perform several features. Providers are able to submit their claims via Direct Data Entry (DDE) as well as to check claims status of their previously submitted claims (regardless of the submission method).

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@hn1therapynetwork.com. Include your contact name, TIN, provider contact name, provider contact email, provider contact phone number, and fax number.

Once you have a Provider Web Portal account, if you are having technical issues (e.g., locked accounts, password re-sets, etc.), please send an email to webmaster@healthsystemone.com.

PAPER:

If your practice is not currently able to submit claims either via EDI or DDE, please submit your paper claims on either a CMS-1500 or UB-04 form to:

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

OPR (Ordering, Prescribing or Referring)

Institutional and Professional claims must include the national provider identifier (NPI) of the ordering, prescribing, or referring provider (OPR), if applicable. Claims received from rendering providers and facilities for services that are ordered, prescribed, or referred **must contain the NPI of the Medicaid-enrolled ordering prescribing, or referring practitioner**. The OPR's NPI reported on the claim will be subject to validation against the Georgia Medicaid provider roster. Failure to report appropriately will result in a claim rejection.

How to bill TNGA (key points):

- Only send to TNGA claims for outpatient therapy services that have a date of service of February 1, 2014, or later.
- Always use a CMS-approved format, whether electronic or paper.
- The NPI of the rendering provider or supervising therapist is required on each claim submitted, in addition to the group NPI number.
- In addition to the rendering provider or supervising therapist NPI, please include the NPI of the ordering, prescribing and referring provider.
- The NPI submitted on the claim, must be the same NPI that you have used when enrolling in the Georgia Medicaid program.
- Please ensure you submit your claims using the TIN you used when you contracted with TNGA.

- Always make sure to include the service location on the claim.
- Do not bill for different types of services on the same claim (e.g., do not list outpatient PT and outpatient OT on the same claim).
- Therapy providers must always document the appropriate TNGA Referral Number on the CMS-1500 form, the fields are **Box 23** for **prior authorization**. Claims that do not include this information may be denied for payment.
- Therapy providers must always bill each episode of treatment separately so the referral number relating to the service you provided can be clearly identified on your claim.
- Therapy providers who have multiple referral numbers for the same member must list the referral number applicable for each episode of treatment on separate claims (e.g., if a member is provided therapy for shoulder and lower back at the same time).
- Medicare-recognized Part B providers **MUST** bill on a CMS-1500 or 837P form and **MUST** submit both the group NPI and the rendering NPI information per claim. On the CMS-1500 form, the fields are **Box 33a** for the **group NPI** and **Box 24j** for the **rendering NPI**.

TNGA Payment Policies

Services are reimbursed as described in the Provider Services Agreement and/or the applicable Payer's Plan Addendum of your contract. Any Extended Episode Fee (Case Rate) payments cover all services covered over a period of time and thus often will cover multiple dates of service; however, it is still necessary for a claim to be submitted for each date of service for a patient. This allows us to meet data reporting responsibilities to the health plan, enables us to give you accurate reports and profiles, and provides us with information needed for internal monitoring and review. A referral shall be in writing from TNGA. A notice in writing from any other person or entity, including a referral from a primary care physician, other provider or payer, shall not constitute a TNGA referral.

To meet timely filing requirements, therapy claims submitted for payment must be submitted within six (6) months after the month in which services were rendered. Payment for therapy claims received beyond this time frame shall be denied for not meeting timely filing requirements.

Any question you may have regarding your contract or other issues not specifically related to referrals or claims may also be directed to TNGA's Provider Relations staff.

Reimbursement of Upgrades for Acute Care

If a member's referral is upgraded to a higher level after TNGA issued payment at the initial level (e.g., a referral for a service is issued at Level 2; however, after treatment has begun, the provider is granted an upgrade to Level 4), the initial payment (at Level 2 rates) will be recouped and a new payment (at Level 4 rates) will be issued to the provider; the provider will be paid the full amount for the higher level, less the payment that they already received for the initial level. This payment will be made to the provider after the issuance of the higher level by the TNGA Referral Department. See Timing of Claims Payment for a timeline.

Upgrades may not be applied retroactively (after the 60-day treatment period has ended).

Reimbursement of Upgrades for Developmental Delay

If a member's referral is upgraded to a higher level after TNGA issued payment at the initial level (e.g., a referral for service is issued at Level 4; however, after treatment has begun, the provider is granted an upgrade to a Level 5), the initial payment (at Level 4 rates) will be recouped and a new payment (at Level 5 rates) will be issued to the provider; the provider will be paid the full amount for the higher level, less the payment that they already received for the initial level.

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.

The payment of the upgrade of the 1st level and all subsequent levels will be made to the provider after the issuance of the higher level by the TNGA Referral Department. See Timing of Claims Payment for a timeline.

Upgrades may not be applied retroactively (after the 180-day treatment period has ended).

Claim Status Inquiry

For claims status inquiries, the Provider Web Portal enables the provider to check the status of your submitted claims 24/7. Most providers using this method find it the most efficient way to obtain the status on a submitted claim.

You can also call the TNGA Claims Department and speak to a TNGA Claims representative Monday through Friday from 8:00 a.m. to 5:00 p.m. at **1-877-372-1273**. Please listen carefully to select the proper option.

Coordination of Benefits/Subrogation

TNGA will investigate and coordinate benefits, where applicable. TNGA may, from time to time, need to request information from its contracted providers in order to assist with this process.

If payment had been issued on a case for which TNGA later determines that other coverage is available (for example, TNGA authorizes and reimburses a provider for treatment to a health plan member suffering from lower back pain, and after payment is issued, TNGA is notified by the plan or the provider that the patient/member was involved in a car accident and covered under the automobile insurance policy), TNGA will exercise its rights to subrogation through the health plan.

Do Not Send Outpatient PT/OT/ST Claims To The Health Plan.

Payments inadvertently made to you by the health plan are overpayments and must be returned to them.

Timing of Claims Payment

TNGA's claims payment turnaround standards are as follows:

Medicare Recipients:

- 95 percent of clean electronic claims for are paid within 15 calendar days from the date of receipt.
- 95 percent of clean paper claims are paid within 30 calendar days of receipt.

Medicaid Recipients:

- 95 percent of clean electronic claims are processed in 15 business days.
- 95 percent of clean paper claims are paid within 30 calendar days of receipt.

Claims Payment Dispute:

Medicaid providers of Therapy Network of Georgia (TNGA) have 3 months from the end of the month of payment to make a claims payment dispute. However, TNGA reserves the right to consider all requests received after the 3 months have been exhausted.

For Medicare providers, TNGA adheres to the CMS guidelines that govern the re-opening and revising of finalized claims. CMS stipulates that clerical errors (which include minor errors and omissions) are classified as “reopenings” instead of reconsiderations. Clerical errors include both human and mechanical errors and include but are not limited to: mathematical or computational mistakes, inaccurate data entry, or denial of claims as duplicates.

In addition, if a Medicare health plan issues an adverse organization determination because it did not receive requested documentation and the party subsequently requests a reconsideration with the requested documentation, the organization must process the request as a “reopening”. TNGA classifies these reopenings as an adjustment claim. Reopenings and/or adjustments requests may be requested in writing or by telephone.

Please call the Claims Department at 1-877-372-1273 and speak with a TNGA claims representative to inquire or to request a claims adjustment.

Claims Appeals:

Claims Appeals or redetermination requests not classified as a “reopening/adjustment” must be submitted in writing.

All claims appeals received will be processed within 30 days of receipt. The PO Box to submit a claim appeal or a “reopening” is:

Therapy Network

P.O. Box 350590
Fort Lauderdale, FL 33335-0590

SUPPLIES AND EQUIPMENT

- Off-the-shelf supplies are not reimbursed separately from the listed reimbursement.
- Custom splints made by hand therapists with a physician prescription are eligible for separate reimbursement. The CIS provider will submit a request for Custom Splint via the DCH Portal. They must respond “Yes” to the question on the portal, “Is this a Continuation from a previous PA?”
- You must attach the Splint Intake Form (Attachment B) with materials used, and payment will be assigned according to the TNGA fee schedule.
- If you are not a CIS provider, you may fax in the Splint Intake Form to our toll-free Referral Fax Line at 1-855-597-2697.
- Other braces and splints, orthotics and prosthetics, and durable medical equipment are not included in our contracts with health plans. Providers should contact the health plan directly for the authorization process to obtain these items from a participating network provider.

PROVIDER COMPLAINT PROCESS

Any participating provider can formally express their dissatisfaction with TNGA's policies, procedures, or administrative functions by submitting a written dispute via facsimile or mail.

Facsimile: 1-877-403-5544

Mailing Address:

HN1 Therapy Network
P.O. Box 350590
Fort Lauderdale, FL 33335-0590

The provider must file the complaint 30 days from the date of the incident resulting in the complaint.

- When your complaint cannot be resolved within five days, the Provider Relations Representative will acknowledge the complaint in writing and notify you that the issue will be resolved within 30 days of the original date of your complaint.
- Once resolved, the Complaint Resolution Outcome Letter will be sent to complainant describing the outcome determination.

QUALITY IMPROVEMENT

Provider Participation in Quality Improvement Procedures

HN1 TNGA has a comprehensive Quality Improvement Program, which includes the following:

- Quality Improvement (QI) Indicators that measure the outcomes of process of care and service, such as: referral timeliness, over-/underutilization rates, denial recommendations, denial overturns, inter-rater reliabilities, telephonic accessibility, etc.
- Recredentialing process that includes the timeliness of application and documentation submission by all participating providers in order to comply with the three-year recredentialing process.
- Peer review process that includes inter-rater reliability audits of providers, medical records reviews, approved practice guidelines and the Peer Review Committee process when a quality-of-care issue has been identified and researched that requires a determination to be made by a panel of peers.

All participating providers are obligated to comply with the requirements of the Quality Improvement Program.

ATTACHMENTS

The following is a list of forms and referenced documents that are attached to this provider manual:

- Attachment A:** Therapy Intake Form
- Attachment B:** Splint Intake Form
- Attachment C:** Upgrade Request Form