Network Growth

As WellCare continues to grow, we continue to contract providers to meet the needs of an expanding population. The TNGA Provider Relations team has continued its outreach efforts throughout the state, continuing to add providers to the TNGA network. As a result of these efforts, there has been a significant increase in the provider network, especially in the metro areas that service larger portion of the Wellcare membership.

As of 2016, WellCare Medicare has expanded it’s sale efforts into McDuffie and Meriweather counties. In order to meet member needs as a result of this growth, we have continued our renewed contracting efforts in these counties and the adjoining counties.

The TNGA network is always open to new providers who are interested in servicing Wellcare members statewide. If you have any colleagues that may be interested, please have them contact us at 1-855-825-7818 or they may select the “Join the Network” option a mytnga.com

Plan of Care/Plan of Treatment Guidelines

As per CMS the guidelines for a Plan of Care (POC)/Plan of Treatment (POT) should be followed for proper care of our patient’s and reimbursement. Services must be relevant and specific to the therapy rendered. The assessment must include support for medical necessity. It must be carefully and thoroughly documented.

The POC must be established before treatment is initiated and it is established as soon as it is developed. It must include the physician’s signature / date signed as well as signed/dated by the therapist that developed the POC. Signatures must include professional designation of each. The physician must certify the POC within 30 days of it being developed. Students and/or assistants do not sign the Plan of Care and are not to perform the assessment. Medicaid does not accept co-signatures by student’s or assistants.

The Plan of care must be written based on the results of the evaluation/ re-evaluation. The POC must contain at a minimum diagnosis, measurable treatment goals, frequency /duration of treatment, medical history, premorbid conditions and recent hospitalizations. The POC should also include a discharge plan and HEP information. Treatment goals must be written based on area(s) of impairment. It is important to note that the above mentioned information are the minimum requirements by CMS.
Global Period of Assigned Levels for a Patient with Developmental Delay

TNGA has changed the methodology used to administer authorization for Development Delay Diagnoses. 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.

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 and it 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, along with all supporting documentation to TNGA’s Toll-free Upgrade Fax Line at (855) 825-7818

What Happens After You Submit It?

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

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).
The Georgia Department of Community Health (DCH) implemented Phase II of the Centralized Prior-Authorization (PA) Portal for the Outpatient Therapy Community. DCH requires that all providers submit their prior-authorization requests through the Georgia Medicaid Management Information System (GAMMIS) site at www.mmis.georgia.gov.

Below are some tips that may assist you with this process:

- In order to insure accuracy of auth dates, please indicate the member’s eval date in the “Comments” section for all new episodes since the portal does not allow for retroactive start dates.
- If you would like to verify the status of your auth, you can check on the GAMMIS portal under the Provider Workspace using the GMCF Tracking ID that you received during the submission process.
- Edits to authorizations can only be done when the auth is still in a pending status. You can use the “Edit Request” or “Withdraw Request” options on the GAMMIS portal.
- If you are unable to load supporting document to the GAMMIS portal, please contact HP @ 800-766-4456, Option 1 and then select the option for “Web Portal Navigation”
- If you are not a CIS provider and seeing TNGA / WellCare members, you can contact HP @ 800-766-4456 to find out the process of adding CIS (COS 840) to your file in order to submit auths via the GAMMIS portal or you can see the GAMMIS site for more information(www.mmis.georgia.gov)
Fraud, Waste, and Abuse (FWA)

To detect and prevent Fraud, Waste, and Abuse (FWA), it is important to know the laws. Two laws that are important for Providers to understand are the Anti-Kickback Statute and the Stark Statute (Physician Self-Referral Law).

The Anti-Kickback Statute prohibits knowingly and willfully soliciting, receiving, offering, or paying remuneration (including any kickback, bribe or rebate) for referrals for services that are paid, in whole or in part, under a Federal health care program (including Medicare Program). For more information, refer to 42 U.S.C. Section 1320A-7b(b) on the internet.

The Stark Statute prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of his or her family) has:

- An ownership/investment interest; or
- A compensation arrangement (exceptions apply).

For more information, refer to 42 U.S.C. Section 1395nn on the internet. Below is a further breakdown of these two laws/regulations, as provided by the Office Inspector General (OIG).

<table>
<thead>
<tr>
<th>THE ANTI-KICKBACK STATUTE (42 USC § 1320a-7b(b))</th>
<th>THE STARK LAW (42 USC § 1395nn)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prohibition</strong></td>
<td>• Prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies</td>
</tr>
<tr>
<td>Prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate Federal health care program business</td>
<td>• Prohibits the designated health services entity from submitting claims to Medicare for those services resulting from a prohibited referral</td>
</tr>
<tr>
<td><strong>Referrals</strong></td>
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<tr>
<td>Referrals from anyone</td>
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<tr>
<td><strong>Items/ Services</strong></td>
<td><strong>Referrals from a physician</strong></td>
</tr>
<tr>
<td>Any items or services</td>
<td></td>
</tr>
<tr>
<td><strong>Items/ Services</strong></td>
<td><strong>Designated health services</strong></td>
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<tr>
<td><strong>Intent</strong></td>
<td></td>
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<tr>
<td>Intent must be proven (knowing and willful)</td>
<td>• No intent standard for overpayment (strict liability)</td>
</tr>
<tr>
<td></td>
<td>• Intent required for civil monetary penalties for knowing violations</td>
</tr>
<tr>
<td><strong>Penalties</strong></td>
<td>Civil:</td>
</tr>
<tr>
<td>Criminal:</td>
<td>• Overpayment/refund obligation</td>
</tr>
<tr>
<td>• Fines up to $25,000 per violation</td>
<td>• False Claims Act liability</td>
</tr>
<tr>
<td>• Up to a 5 year prison term per violation</td>
<td>• Civil monetary penalties and program exclusion for knowing violations</td>
</tr>
<tr>
<td>Civil/Administrative:</td>
<td>• Potential $15,000 CMP for each service</td>
</tr>
<tr>
<td>• False Claims Act liability</td>
<td>• Civil assessment of up to three times the amount claimed</td>
</tr>
<tr>
<td>• Civil monetary penalties and program exclusion</td>
<td></td>
</tr>
<tr>
<td>• Potential $50,000 CMP per violation</td>
<td></td>
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<tr>
<td>• Civil assessment of up to three times amount of kickback</td>
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<tr>
<td><strong>Exceptions</strong></td>
<td><strong>Mandatory exceptions</strong></td>
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<tr>
<td>Voluntary safe harbors</td>
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<tr>
<td><strong>Federal Health Care Programs</strong></td>
<td><strong>Medicare/Medicaid</strong></td>
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<tr>
<td>All</td>
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</tbody>
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*This chart is for illustrative purposes only and is not a substitute for consulting the statutes and their regulations.
Our Reps and their Territories

The relationship TNGA has with its providers is important to the overall operation of the Network. We make routine visits to our providers to assist with any issues as well as get any feedback on what may happening in their respective therapy communities. We also want to make sure that you are able to contact a dedicated Provider Relations Representative any time that you need to.

Wynneen Perry  
Cell: (404) 692-8707  
perryw@mytnga.com

Daryn Golder  
Cell: (678) 982-5402  
golderd@mytnga.com

Catrina Whitfield  
Cell: (706) 834-6924  
whitfieldc@mytnga.com
Network PCP Outreach

The relationship between member’s PCP and our therapists is very important to the effective operation of the TNGA network. Since the PCP is the gatekeeper of the member’s care, it is important that they have the tools to access the TNGA network.

Over the last several months, The Provider Relations Department has been doing an extensive outreach to the PCP’s that manage the Wellcare member population. PCPs have been given a snapshot of the TNGA network in their respective areas, important links to accessing our Therapy providers and TNGA Referral Coordinator contact information to assist them in being able to better refer their members. We will also be following up with the PCP network to confirm that they understand all the resources that they have available to them in order to access the TNGA network.

Our hope is that this outreach will assist them in being to better access YOU for the care of their members.

Medicare Credentialing Only

TNGA is still responsible for credentialing providers who are Medicare only, as that credentialing will not be completed through the Centralized Credentialing Process. As credentialing documents expire, you will receive requests to submit copies of your current licenses, DEA’s and Malpractice Insurance.

To be proactive, you can fax them to (305) 614-5055 as soon as you receive the new documents and we can update our records accordingly. If you participate with CAQH, you can upload these documents to your profile and we can obtain them directly from the Pro View site. If you have any questions or concerns, you may contact the Credentialing Director, Amy Long, at (305) 614-0361.
TNGA Medical Advisory Committee (MAC)

The TNGA MAC meeting was held May 12, 2016 in Atlanta, Georgia. The meeting was attended by the MAC member provider as well as the TNGA local staff, the Executive Committee, the clinical consultants, the TNGA Medical Director and the WellCare medical director.

As a part of the on-going effort to incorporate the ideas and recommendations of network providers, TNGA has established a medical advisory board comprise of provider representing all therapy disciplines from various regions of the state. TNGA recognizes the essential role of local specialty-specific input in order to provide quality clinical, service, and operational issues that can affect both the local network providers and the health plan members. The MACs is authorized by the TNGA Executive Committee to review and provide recommendations that will continuously improve the quality of care and services provided to the Health Plan(s), their members and the providers who render therapy services.

There were a variety of topics covered at the last TNGA MAC. The committee discussed:

- The implementation and on-going development of guidelines / protocol for common complex therapy rendered
- Formulation of provider communications (including the TNGA Newsletter)
- The demographic make-up and service needs of the Medicare and Medicaid members currently serviced by WellCare
- The 30% Network growth in the last 6 months
- The comprehensive network plan in place to address any potential network complaints or issues

If you have a topic for the MAC, please send an email with your topic to:

Pamela Owens,
Director of Quality Improvement
owensp@healthsystemone.com

Daryn Golder
Network Director for TNGA
golderd@mytnga.com

Are You Currently Utilizing TNGA’s Provider Web Portal?

The Provider Web Portal is a dynamic web-based tool that allows providers check claim status, submit claims and as well as check referral status (Medicare members only). Authorizations for Medicaid members should be checked on the GAMMIS Centralized PA Portal. This portal is a tool that will help both front-end and back-end office operations to manage your inquiries and save time from needing to call for status. The PWP access allows your practice to have multiple users to access TNGA claims, referrals, etc. To set up a Web Portal account, please access the TNGA website (http://mytnga.com) and select the option “Request PWP Account” or you may also contact TNGA Provider Relations.