# Provider Newsletter

## TNGA Medical Advisory Committee (MAC)

The TNGA MAC meeting was held February 9, 2016 in Macon, GA. The meeting was attended by the MAC members, TNGA local staff, the Executive Committee, multi-specialty clinical consultants, and the TNGA 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 comprised of providers representing all therapy disciplines throughout the state. TNGA recognizes the essential role of local specialty-specific input in order to provide quality clinical service, and address 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.

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## Children Intervention Services (CIS) New Rates for Physical Therapies and Occupational Therapies

The Centers for Medicare and Medicaid Services (CMS) has approved GA Medicaid's State Plan Amendment (SPA-GA-16-0002) for the Children's Intervention Services (CIS) Occupational and Physical Therapy Practitioner Rate Increase appropriated through House Bill (HB) 751. HB 751 established a rate increase for procedure codes 97001–97004, 97110, 97112, 97116, 97140, 97530 and 97535, effective July 1, 2016.

**To Whom Will It Apply?**

The HB 751 rate increase applies to services rendered by occupational and physical therapy providers enrolled in the Medicaid Children's Intervention Services (CIS) program to Medicaid eligible members from birth to twenty-one (21) years of age. If an eligible member turns 21 during the period of a treatment episode, claims will be paid based on the age of the member on the Date of Service.

| HB 751 RATE INCREASE FOR PROCEDURE CODES |
|---|
| 97001 – 97004 |
| 97110 |
| 97112 |
| 97116 |
| 97140 |
| 97530 |
| 97535 |

This increase does not apply to a hospital facility when the hospital is the both the billing provider and the rendering provider, it only applies to a hospital facility when the hospital is the billing agent on behalf of a CIS-enrolled therapist and he/she is recognized as the rendering provider that performed the outpatient therapy services.

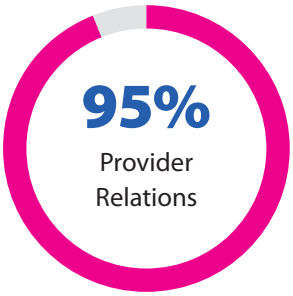
**How Will This Increase Impact TNGA Network Providers?**

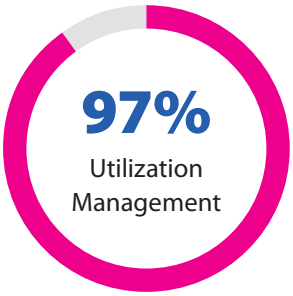
Effective Therapy Network of Georgia (TNGA) will process all claims for dates of service as of July 1, 2016 under the new rate. There is no additional action required on your part for retrospective payments of dates of service previously billed. All physical therapy and occupational therapy providers contracted with TNGA will be reimbursed the new rate based upon the Medicaid CIS enrolled status provided to the CMOs by the Department of Community Health (DCH). All claims will be adjudicated based on the latest information received and processed from DCH.

## 2016 Provider Satisfaction Results

TNGA completed our annual Provider Satisfaction Survey in the fall of 2016. The survey included questions about the administrative services TNGA provide to their Providers like Provider Relations, Utilization Management and Claims among others. These are the results.

We appreciative of all our network providers that responded to the survey, We value your comments regarding your experience with TNGA.



## Functional Limitation Reporting G-Codes

Since January 1, 2013, the Centers for Medicare and Medicaid Services (CMS) have applied a claims-based data collection requirement for outpatient therapy services for speech-language pathology, occupational and physical therapy disciplines, by requiring the reporting of functional limitation reporting (FLR) G-Codes on their claim form submissions.

To date Therapy Network of Georgia (TNGA) has not required the documentation of FLR G-Codes on the claims received from their Medicare providers. However, in our efforts to provide quality outcome reporting to our health plan clients the need to follow current CMS requirements is becoming increasingly more apparent.

### Stay Tuned

Our goal today is to share this information with you and prepare you for the next steps as we work toward a deadline of applying these same standards to our claims adjudication processes when you submit a claim for a Medicare member.

We would like to encourage all providers to begin voluntarily billing the FLR G-Codes so that you are prepared when this requirement is no longer optional, but becomes a mandatory requirement for claims payment.

Below are some helpful links regarding guidelines of Functional Reporting for therapy services. If you still have any other questions regarding this information, please contact your TNGA Provider Relations Representative at 1-855-825-7818, Option 2.

### Centers for Medicare and Medicaid Services

https://www.cms.gov/medicare/billing/therapyservices/downloads/functional-reporting-pt-ot-slp-services-faq.pdf

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1307.pdf

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/G-Codes-Chart-908924.pdf

https://www.cms.gov/Medicare/Billing/TherapyServices/Functional-Reporting.html

https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/FunctionalReportingNPC.pdf

https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/TherapyFunctionalReportingG-codes.pdf

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8005.pdf

### The American Occupational Therapy Association, Inc.

http://www.aota.org/Advocacy-Policy/Federal-Reg-Affairs/News/2013/Functional-Data-CY2013.aspx

### American Physical Therapy Association

http://www.apta.org/Payment/Medicare/CodingBilling/FunctionalLimitation/

American Speech-Language-Hearing Association

http://www.asha.org/Practice/reimbursement/medicare/Claims-Based-Outcomes-Reporting-for-Medicare-Part-B/

## Are You Currently Utilizing TNGA's Provider Web Portal?

The Provider Web Portal (PWP) is a dynamic web-based tool that allows providers to 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 TNGA 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, EOBs, 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.

## TNGA Website (mytnga.com)

Do you have questions about the TNGA auth or claims process? Do you want to know the most current updates from TNGA? There is a place where you can go to access this information. The TNGA website (http://mytnga.com) contains "all things TNGA". You can find things such as the TNGA Provider Manual, Authorization Forms, FAQs, etc. Please feel free to use this site as an information resource. In addition, your TNGA Provider Relations Reps are also available to assist you.

## TNGA (MAC)

(Continued from page 1)

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

- Continued development on the TNGA Auth / Developmental Delay Process
- Appropriate clinical documentation required for auth requests
- Implementation of new Clinical Guidelines – Milliman Guidelines
- Provider Satisfaction Survey Results
- Initiation of new Clinical Outcome Studies

The next TNGA MAC meeting is scheduled for June 28-30 , 2017 in Puerto Rico

## Medicaid Authorization Submission

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 ensure 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 at 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 at 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).

Other recommended resources are:

The CMO PA Presentation located on the GAMMIS site at www.mmis.georgia.gov, select the Provider Information > Provider Notices

## Global Period of Assigned Levels for a Patient with Developmental Delay

TNGA is updating its methodology used to administer authorization and payments for Development Delay Diagnoses.

- TNGA has adopted the use of publically available and evidence based, Milliman Care Guidelines (MCG) in combination with the patient's standardized test score and diagnosis when making the determination of a Level Assignment.
- Milliman provides the average number of visits for all patients with a given diagnosis.
- Milliman also provides the average number of visits for the healthiest 25%, the middle 50% and the sickest 25% for given diagnoses.
- TNGA does NOT specify the Number of Visits that a provider must include in the patient's Plan of Care, however, TNGA will advise a treating provider if their POC significantly deviates from the Milliman Care Guideline.

Upon receipt of the authorization request TNGA will issue the Level based upon the Plan of Care and Standardized Test Scores.

Level 1 One-time visit, Evaluation Only
Level 2 Within normal limits based on diagnosis and test score
Level 3 Mild severity level based on diagnosis and test scores
Level 4 Moderate Severity level based on diagnosis and test scores
Level 5 Severe impairment level based on diagnosis and test scores

Tertiary, Medically Complex patients are not covered by TNGA. Our UM team will assist providers in referring any patients identified as such to the health plan for appropriate case management.

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 plan of care (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.
- 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, along with all supporting documentation to TNGA's Toll-free Upgrade Fax Line at (855) 825-7818

### What Happens Next?

- 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 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)

# 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.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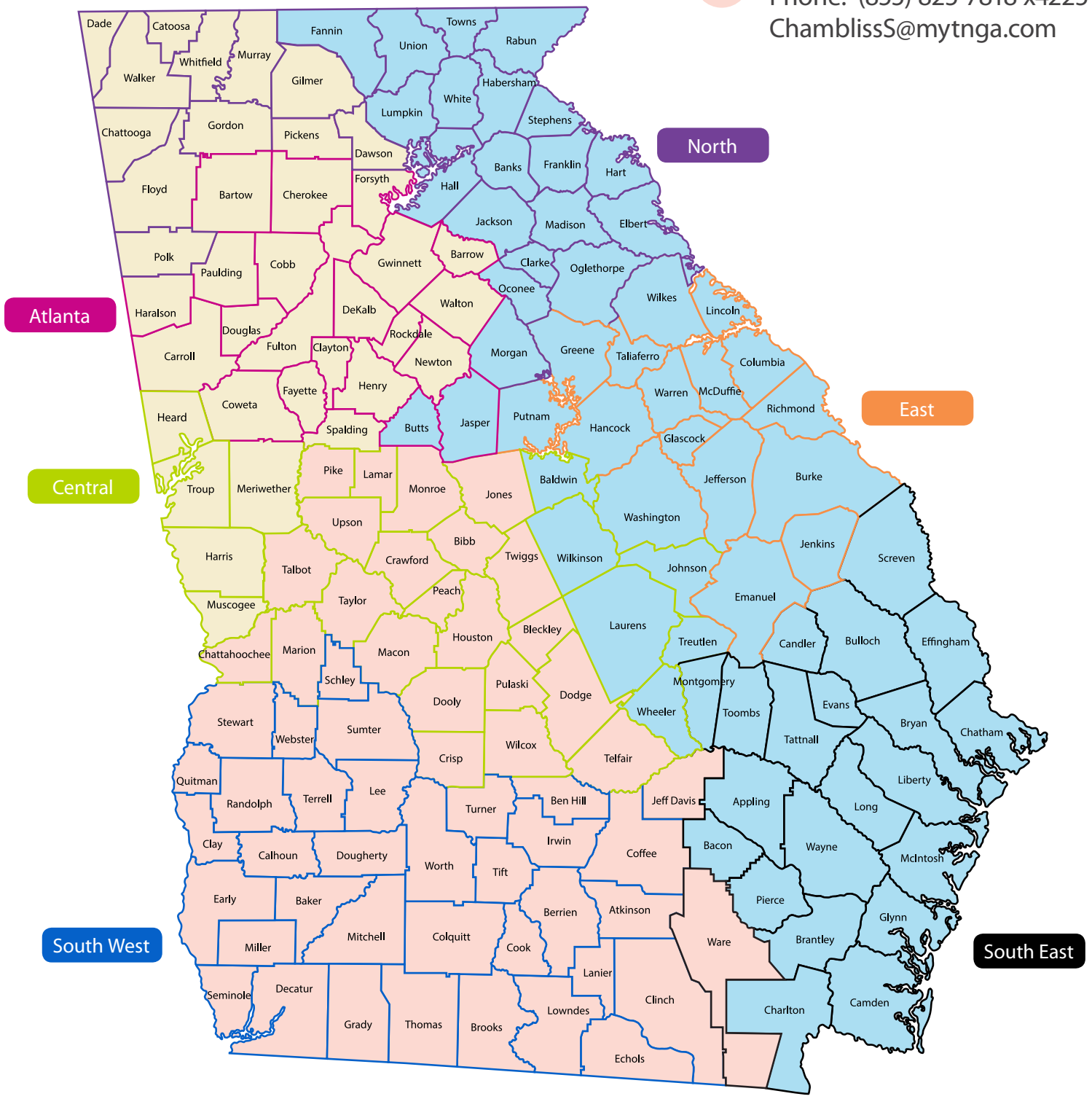

## We're Just A Phone Call Or Click Away

If you have any changes to your practice, including demographic or provider additions/ terminations, please notify your TNGA Provider Relations Representative.

### Referrals/Authorizations

1 (855) 825-7818 Option 1, then Option 1
Fax: 1 (855) 597-2697

### Claims

1 (855) 825-7818 Option 1, then Option 3

### Provider Relations

1 (855) 825-7818 Option 1, then Option 2

### To report suspected Fraud, Waste, and Abuse, or any Compliance issue:

1-866-321-5550

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**

# 2017 Annual Update to the Medicaid and Medicare Therapy Code List for OT & PT

The Current Procedural Terminology (CPT) Editorial Panel created **eight new codes (97161-97168) to replace the 4-code set (97001-97004)** for Physical Therapy (PT) and Occupational Therapy (OT) evaluative procedures. The new CPT code descriptors for PT and OT evaluative procedures include specific components that are required for reporting as well as the corresponding typical face-to-face times for each service.

**Evaluation Codes.** The CPT Editorial Panel created three new codes to replace each existing PT and OT evaluation code, 97001 and 97003, respectively. These new evaluation codes are based on patient complexity and the level of clinical decision-making – low, moderate and high complexity: for PT, codes 97161, 97162 and 97163; and for OT, codes 97165, 97166 and 97167.

**Re-evaluation Codes.** One new PT code, 97164, and one new OT code, 97168, were created to replace the existing codes – 97002 and 97004, respectively. The re-evaluation codes are reported for an established patient's when a revised plan of care is indicated.

Just as their predecessor codes were, the new codes are "always therapy" and must be reported with the appropriate therapy modifier, GP or GO, to indicate that the services are furnished under a PT or OT plan of care, respectively.

Effective 1/1/2017 the new PT & OT Evaluative procedure codes are listed in the charts below with their short descriptors* and the required corresponding therapy modifier:

| CPT Code | Short Descriptor | Modifier |
|---|---|---|
| 97161 | PT EVAL LOW COMPLEX 20 MIN | GP |
| 97162 | PT EVAL MOD COMPLEX 30 MIN | GP |
| 97163 | PT EVAL HIGH COMPLEX 45 MIN | GP |
| 97164 | PT RE-EVAL EST PLAN CARE | GP |

| CPT Code | Short Descriptor | Modifier |
|---|---|---|
| 97165 | OT EVAL LOW COMPLEX 30 MIN | GO |
| 97166 | OT EVAL MOD COMPLEX 45 MIN | GO |
| 97167 | OT EVAL HIGH COMPLEX 60 MIN | GO |
| 97168 | OT RE-EVAL EST PLAN CARE | GO |

NOTE: Please note that the short descriptors cannot be used in place of the CPT long descriptions which officially define each new PT and OT service.