



Medicare Provider Newsletter

2020 Q2

COVID-19 Update

As of March 11, 2020, our Organization declared the COVID-19 situation as an emergency and has since activated the Disaster Recovery Plan related to this infectious disease pandemic. **At this time, our operations remain fully operational and functional.**

The safety and well-being of our employees is of great concern, and the Organization has made the decision to close our physical offices in both Florida and Puerto Rico to all non-essential personnel. Employees not reporting to the office will continue to work via remote access until further notice and will have full access to computer systems and telephone systems to operate as they do every day. To be clear, we do not anticipate any impact to our daily operations, but we wanted to be transparent about the steps we are taking to minimize any disruptions in the wake of this pandemic.

Please continue to submit your authorizations and claims as normal, and reach out to your Provider Relations Representatives, as needed. Should you need to speak to someone via telephone, you can continue to utilize the same phone numbers to contact us. We are also encouraging you to follow and to stay up to date on the guidance from the: Centers for Disease Control and Prevention (CDC).

Please immediately report any incidents involving a COVID-19 infection, including but not limited to not being able to service a member due to a COVID-19 infection or your office closures due to a possible COVID-19 infection, by contacting us at 855-825-7818. Thank you for your support and understanding during these unprecedented times and we hope everyone remains safe and healthy.

COVID-19 Survey and PPE Assistance

On April 6, 2020, HN1/TNGA and its family of companies began a survey outreach to providers to assess current operational status as a result of COVID-19 and to address any needs of our providers. In response to the survey results, HN1/TNGA began purchasing PPE supplies for network providers. The first package of supplies was delivered to providers in our Florida network beginning April 29, 2020. Below is a table of Georgia distribution efforts as of June 17, 2020.



The purchase and distribution of PPE supplies is on-going and at no cost to our providers. The link to our survey is below. Please take the time to complete our survey to update us on the status of your practice during these critical times. You will also be able to let us know about any PPE needs that you have while completing the survey.

<https://mytnga.com/covid19survey>

Free HIPPA Compliant Telehealth available to all TNGA providers

Your commitment is to care for your patients. Our commitment is to enable your success - providing free access to an approved telehealth solution is one more way we do it. Utilizing telehealth, you can transform your practice into a 24/7 virtual care office without adding staff or equipment. In addition, you can video call patients on a HIPAA-compliant platform, while avoiding sick or at-risk patients visiting your office.

With dozens of vendors to choose from, selecting a telehealth solution can be an overwhelming task. Many of our providers have asked for our assistance in identifying an approved platform. We're pleased to announce a partnership with AllHealth CHOICE, a leader in telehealth.

You are under no obligation to use MyCharlie by AllHealth CHOICE, but if you choose to, **we'll cover the cost of a standard package until November 30, 2020**. The package is anything but standard - it includes everything you need to effectively and immediately deliver telehealth services.

All you have to do to take advantage of this offer is contact an AllHealth CHOICE representative at 844-334-0456 and let them know you are a TNGA provider.

ADVANTAGES:

Quick Set Up: Onboarding takes less than 24 hours.

Multi-Communication Channels: Use screen shares with patients/family members/specialty physicians and online chats during the virtual consultation.

Revenue Generation: Most telehealth visits are reimbursed like an in-office visit.

Easy to Use Dashboard: Patients access the platform via an app for both Android and iOS. Providers access their dashboard to add people to a virtual consult; screen share, chat, broadcast messages and use other functions.

We understand that many providers continue to endure long wait times to get started with telehealth, while others are concerned about the cost or compatibility. Our partnership with AllHealth CHOICE helps eliminate those barriers.

For more information, please contact an AllHealth CHOICE representative at 844-334-0456. You may also contact your TNGA Provider Relations Representative at 1-855-825-7818 for additional questions regarding this partnership.

Telemedicine Guidance and Attestation

In response to guidance issued by both the Center for Medicare and Medicaid Services (CMS) for administration of medical service during the COVID-19 pandemic, we implemented a telemedicine program to closely align our operations with CMS requirements.

The TNGA Medicare Telemedicine Guidance and Attestation can be found at:

 <https://mytnga.com/pdf/Telemedicine-Guidance-Attestation-Medicare-TNGA.pdf>

If you are providing telemedicine services for Wellcare Medicare members and have not submitted an attestation, please access the link above and send us your attestation to email address provided in the attestation. For group practices, you may send us an attestation that covers all practitioners in the group.

Relaxing telehealth regulations does not mean relaxing fraud enforcement

By Patricia Calhoun, Patricia Carreiro | FierceHealthcare

The COVID-19 pandemic rapidly expanded telemedicine use. Telehealth currently addresses everything from routine to pandemic-related care. To facilitate this expansion, federal healthcare programs have loosened, at least temporarily, telehealth restrictions. These eased restrictions, however, create increased opportunities for healthcare fraud and abuse, including Anti-Kickback Statute (AKS) and False Claims Act (FCA) violations.

Recent telehealth regulation changes and telehealth scrutiny

The Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services adjusted their telehealth requirements to expand

..... continued on page 3

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telehealth's ability to serve patients during the pandemic:

- Patients no longer need to reside in designated rural areas or have preexisting relationships with their providers.
- Patients can have their telehealth appointments from the convenience and safety of their homes without traveling to medical facilities.
- More services can now be offered via telehealth, including evaluations to determine continued eligibility for hospice care.
- Telehealth providers can waive patient deductibles and copayments without penalties for offering impermissible kickbacks.
- In some circumstances, Medicare and Medicaid no longer require physicians to be licensed in the state in which their patients are located.
- Providers can use a number of everyday communication technologies to provide telehealth services without being fined by HHS' Office for Civil Rights. Providers are, however, required to make good faith efforts to protect patients' privacy, including, among other things, enabling all available encryption and privacy settings and notifying patients of the increased risk of using such technologies.

Despite these changes, some constants remain, such as the scrutiny telehealth providers face from regulators, particularly for AKS and FCA violations.

In the past year, well before the rise of COVID-19, telehealth providers saw two of the biggest Department of Justice (DOJ) takedowns in history for rampant kickback and fraudulent billing schemes. First, in April 2019, the DOJ charged 24 telemedicine and durable medical equipment company executives and physicians for allegedly paying \$1.2 billion in illegal kickbacks and bribes related to prescribing unnecessary back, wrist, shoulder and knee braces.

Second, in September 2019, the DOJ charged 35 individuals in a \$2.1 billion fraudulent Medicare billing scheme involving alleged kickbacks to telehealth providers ordering genetic tests. Regulators made clear that COVID-19 will not reduce their focus on prosecuting wrongdoing.

For example, the DOJ recently arrested a Georgia man for his alleged role in a conspiracy involving unnecessary COVID-19 tests. Pandemic or not, the telehealth industry is firmly in the crosshairs of heightened government scrutiny and oversight.

Changed regulations may increase, rather than decrease, enforcement actions

While easing regulations lead many to assume a decrease in enforcement actions, enforcement actions may increase as regulators respond to new opportunities for fraud. Specifically, telehealth services make it easier for fraudsters to pose as physicians and lure patients into sharing their protected health information or installing malware on their devices.

The relaxed telehealth regulations greatly expand the number of patients for whom fraudulent claims can be submitted. Reduced cybersecurity requirements for telehealth communications increase the risk of hackers intercepting or stealing the protected health information necessary to submit fraudulent claims or commit healthcare identity theft.

Such practices will not go unchecked, and telehealth providers should establish protocols to keep from being unwittingly pulled into the crosshairs.

10 considerations to reduce the risk

- Establish mechanisms to verify patient identity.
- Establish or maintain protocols for informed consent and beneficiary initiation.
- Identify states that have waived in-state licensure requirements for telehealth, and establish protocols for disengaging telehealth with patients where the provider is not licensed in the patient state after the pandemic emergency is lifted.
- Establish practice standards for patient examinations and remote prescribing.
- Document and maintain patient encounter records, including all regularly mandated documentation (such as patient eligibility for hospice care).
- Properly code telehealth services to ensure coverage.
- Review vendor agreements and patient incentives to ensure compliance with the AKS, FCA and Civil Monetary Penalties Law.
- Ensure compliance with state credentialing and scope of practice requirements.
- Establish privacy and security protocols for telehealth offerings and related systems.
- Notify patients of the increased risk of privacy issues when using telehealth services and strongly consider using telehealth vendors willing to execute a HIPAA-compliant business associate agreement.

TNGA Medical Advisory Committee (MAC)

The TNGA MAC meeting was held May 14, 2020 at 6PM, via teleconference. 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.

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

- Updates on the on-going growth and GEO compliance of both the Medicare and Medicaid Networks
- Updates on on-going compliance with M/QI metrics.
- Synopsis of current status of network during COVID-19, including input from provider about how they were re-opening their practices
- Impending roll-out of company-sponsored telemedicine option for provider (AllHealth Choice)
- PPE being offered to providers to assist with practice operations.

 Our next MAC meeting is scheduled for **August 13, 2020**

Documentation Checklist

It is our goal to make the authorization process as easy as possible. Below is a checklist of some information that is to be included with the medical records which should help to decrease phone calls and the need for Peer Reviews.

- Pertinent medical history, not just the treatment Diagnosis
- Prior level of function, if applicable
- Specific level of skills for areas of concern
- Baseline information that is related to the goals
- Objective measures/test scores
- Level of overall impairment
- Short / Long term goals (Measurable and Functional)
- Updated goals (Progress reports/Re – evaluations)
- Specific Frequency and Duration
- Approved abbreviations
- Is your document legible?
- Did you document why there were missed visits?

If you have any questions about approved auth, you can contact the TNGA UM department for a peer to peer review at 855-825-7818, option 1, option 1. You may also contact your TNGA Provider Relations Representative.

Receiving your payment via V-Pay

TNGA Providers asked for an electronic payment solutions, and we listened. In late 2018, TNGA moved to electronic payments via V-Pay. Now, all provider payments are managed by V-Pay. The VCard gives providers a secure method to quickly receive payments. VCard is fast, pays in real time, improves revenue flow and is up to 10 days faster than checks. V-Pay also offers check and EFT options. If you have any questions about V-Pay, please contact V-Pay at 1-855-388-8374. If you have any claims questions, please contact TNGA at 877-372-1273.

Claims Authorization Requirement

TNGA does not require prior authorization in order for you to evaluate your patients. However it is imperative that you submit your plan of care (along with all supporting documentation) to obtain an approved authorization prior to submitting your claims for payment, even if it for an eval-only authorization. Instances where you have only evaluated the patient and will be submitting a claim also require an auth. Claims that are received where no approved referral has been issued will be denied.



Annual Quality Improvement Documents

Annually the Quality Improvement (QI) Department develops Quality documents, which includes a QI & UM Evaluation, Program Description, and Work Plan. The development of the Quality documents satisfies Health Plan and NCQA Accrediting body requirements. The QI & UM Evaluation analyze the QI department's previous year quality indicators, key accomplishments, identify any areas needing improvement, and develop action plans to improve results. The Program Description and Work Plan establish objectives, goals, QI activities, and the QI Program Structure for the current year.

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Clinical Practice Guidelines

ATA-FL uses Apollo, Milliman Care, or our Health Plan partner Clinical Guidelines (depending on the LOB) for Medical necessity determinations. These guidelines are based on appropriateness and medical necessity standards; each guideline is current and has references from the peer-reviewed medical literature, and other authoritative resources such as CMS Medicare. For any medical necessity Recommendation of Denial, the Medical Director shall make an attempt to contact the requesting provider for peer to peer consultation. The Apollo, Milliman Care, or our Health Plan partner Clinical Guidelines are reviewed and approved by HS1 Medical Advisory committee annually, and are available in both electronic and hard copy format. If a provider would like a copy of a guideline they may contact their assigned Provider Relations Rep and a copy will be provided.



Affirmative Statement about UM Decision Making

All clinical staff that makes Utilization Management (UM) decisions is required to adhere to the following principles:

- UM decision making is based only on appropriateness of care and service and existence of coverage.
- The organization does not specifically reward practitioners or other individuals for issuing denials of coverage.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.
- Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support benefit denials.