Provider Newsletter

Códigos de Evaluación

A partir del 1ro de febrero de 2017 se estará denegando toda reclamación recibida sin la debida documentación que evidencie el nivel de complejidad del código facturado. Esto aplica a los siguientes códigos: 99204, 99205, 99214, 99215, 99223, 99291, 99306, 99233 y 99310.

Las facturas deben ser sometidas en papel junto con la evidencia clínica a la siguiente dirección:
Therapy Network of Puerto Rico
P. O. Box 350590
Ft. Lauderdale, FL 33316

Las guías promulgadas por CMS para la facturación de estos códigos se pueden acceder en el siguiente enlace: http://medicare.fcso.com/landing/233030.asp. Se puede comunicar con su representante de servicio para aclarar cualquier duda sobre esta notificación.

Relevo de Retención de Hacienda

Todo proveedor que haya sido otorgado un Relevo de Retención de parte del Departamento de Hacienda debe hacernos llegar el mismo a la mayor brevedad posible para evitar que se le realice la retención obligada del 7%. Los mismos pueden ser enviados vía fax al 1-305-614-0163, o enviados vía correo electrónico a su Representante d, quien diligentemente verá que sea procesado en el Departamento de Finanzas. Todo relevo de retención recibido será procesado, y si fuese el caso de que se recibe posterior al tiempo establecido para reemitir las debidas retenciones al Departamento de Hacienda será responsabilidad del proveedor gestionar dicho recobro directamente con el Departamento de Hacienda a la hora de someter su planilla de contribuciones sobre ingreso. Evite contratiempos haciéndonos llegar éste documento a tiempo.

Cambios en Códigos de Evaluación

A partir del 1ro de enero de 2017 se requiere que todo proveedor comience a utilizar los nuevos códigos para evaluación y reevaluación de terapia física y ocupacional según promulgados por CMS. Los códigos 97001, 97002, 97003 y 97004 han sido eliminados y reemplazados por los nuevos códigos según detallados en la tabla a continuación:

Código CPT	*Descripción Corta*	*Modificador*
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
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

La regulación oficial (CR9782) sobre éste cambio puede ser accedida en los siguientes enlaces:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3654CP.pdf

http://www.cms.gov/Medicare/Billing/TherapyServices/index.html

Validating Your Patients Information With Their Health Plan

Please ensure that you are checking eligibility and validating your patients information with their health plan when they come in for treatment. Please ensure that you when you bill your claim to the specialty network you are billing your claims using the member ID number, member name, member address, member date of birth that is reflected in the eligibility file of your patients affiliated health plan.

Claims that are billed with patient information other than what we have received from your patient's health plan results in claims delays to include claim denials if we cannot validate your patient.

If your patient indicates the information on file with their health plan is incorrect, it is imperative that they are working with their health plan on getting their information corrected. This will assist you in faster turnaround time and avoiding claim denials.

EDI 835 Health Care Payment/ Remittance Advice

The 835 EDI remittance advice may at times be limited in the ability to provide the explanation codes specific to your submitted claim. When reviewing your 835 remittance advice and you have question with regards to specific claims, please log into your web portal account. The web portal will contain detailed information with regards to your specific claim inquiry and the specific network rules. If you are not a web-portal user, we encourage you to contact your network representative to find out how to get a web portal account.

Claim Submission Reminder

It is very important that the specialty network receives all claim encounters to accurately reflect all services that you are providing to your patients. Please submit claims for each date of service with the services you rendered to your patient. Remember without a record of your claim encounter – it is as if the patient never received a service from you.

New Medicare and Medicaid PT and OT evaluation and re-evaluation procedure codes for 2017

CMS is terminating procedure codes 97001, 97002, 97003, 97004 as of 12/31/2016. These codes are being replaced with procedure codes 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168 effective 1/1/2017.

The official instruction, CR9782, issued to your MAC regarding this change is available at:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3654CP.pdf

The therapy code list of "always" and "sometimes" therapy services is available at:
http://www.cms.gov/Medicare/Billing/TherapyServices/index.html

http://ahca.myflorida.com/medicaid/review/Reimbursement/2017_01_01_Physical_Therapy_Fee_Schedule.pdf

http://ahca.myflorida.com/medicaid/review/Reimbursement/2017_01_01_Occupational_Therapy_Fee_Schedule.pdf

Patient access to Medical Records

This article is of a general nature and is not intended to be, nor should it be construed or relied upon, as legal advice.

In early 2016, the Office of Civil Rights (OCR) issued guidance for healthcare providers regarding an individual's right to access his/her health information under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations. The guidance consisted of a fact sheet and FAQs addressing patients' right to access their medical records (collectively, the Access Guidance).

The Access Guidance sets forth requirements healthcare providers must follow when responding to a patient's (or a patient's personal representative's) request for access to his/her medical records. According to OCR, its hope is that the Access Guidance will "engage and empower patients to take control of their healthcare decisions" and put patients in the "driver's seat" regarding their health.

HIPAA provides patients with the right to access their protected health information (PHI) maintained by a healthcare provider in a designated patient record set, such as medical records, billing and payment records, and insurance information. Patients have the right to request, inspect, and/or obtain a copy of their PHI, as well as to direct the healthcare provider to transmit a copy of their PHI to a designed third party or entity of the patients' choice. A patient's right of access is subject to certain exceptions, such as for psychotherapy notes and information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

The Access Guidance was issued because, according to OCR, although HIPAA has always provided individuals with a right to access their health information, healthcare providers have not always understood this right and, in OCR's experience, created obstacles for individuals attempting to exercise their rights. The Access Guidance addresses various aspects of the right to access, including, the mechanics of providing access (e.g., form, format, manner, cost, etc.), an individual's right to direct PHI to another person, and the interplay with state laws.

The Access Guidance clarifies that pursuant to a right to access, an individual can direct the healthcare provider to transmit his/her PHI directly to another person or entity designated by the patient and, importantly, such direction does not require a formal HIPAA authorization. Rather, an individual's right to direct his/her information to a third party is complete so long as it is in writing, signed by the patient, clearly identifies the designated person, and where to send the PHI.

OCR also uses the Access Guidance to clarify how state law and HIPAA interact with respect to fees charged for access requests. Where state law provides individuals a greater right of access to their medical records when compare to HIPAA, then the healthcare provider must also follow state law. This includes state laws that prohibit fees to be charged to individuals for copies of medical records, requires that a free copy of medical records be provided to an individual or requires fees less than HIPAA allows to be charged for copies.

When providing a patient with a copy of his/her PHI pursuant to an access request, a healthcare provider may charge an individual a reasonable, cost-based fee, provided that the fee includes only the cost of: (i) Labor for copying the protected health information requested by the individual, whether in paper or electronic form; (ii) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; [and] (iii) Postage, when the individual has requested the copy, or the summary or explanation, be mailed; (iv) Preparing an explanation or summary of the protected health information, if agreed to by the individual.

On the flip side, HIPAA overrides state laws that authorize higher or different fees from those allowable under HIPAA when a patient requests access to his/her records. Examples of practices that may be permitted under a state law but are prohibited under HIPAA's right of access include: (1) fees for search and/or retrieval and (2) per-page fees for electronic records. For example, HIPAA's prohibition on charging a per-page fee for electronic records would override Ohio law authorizing healthcare providers to charge a per-page fee, dependent on the total number of pages requested, for electronic records.

The challenge faced by healthcare providers when setting fees for records requests is that the fees permitted under a state law for medical records copies may not be aligned with fees permitted under HIPAA. For ease of administration, a healthcare provider may consider implementing a uniform fee structure that is consistent with both the fee limitations under the right of access and any applicable state law requirements.

Estamos A Solo Una Llamada O Un Click

Si usted tiene algún cambio a su práctica, incluyendo cambios demográficos, adiciones o terminaciones de proveedor, etc. Por favor notifique a su Representante de Relaciones del Proveedor (TNPR) por correo electrónico o llámenos al: 1 (877) 614-5056 con cualquier pregunta, comentarios o sugerencias.

Número Principal

1 (877) 614-5056
Seleccione 1 para Autorizaciones
Seleccione 2 para Contratos o credenciales
Seleccione 3 para servicios de Facturación

Yaritza Laboy

LaboyY@mytnpr.com
(787) 922-0829

Fredly Jimenez

JimenezF@mytnpr.com
(939) 285-7158

Para reportar sospecha de Fraude, Desperdicio, y Abuso, o cualquier problema de conformidad:

1 (866) 321-5550

UM DEPARTMENT

Tips for a Productive Peer to Peer Review

Written by: Amy Baez, MOT, OTR/L OT Clinical Advisor

Occasionally an upgrade request may result in a provider or consultant requesting a Peer to Peer Review with the treating therapist. This is an opportunity to provide additional information or clarify any confusion regarding a patient that may not be clear to both parties involved. Here are 5 helpful ways to prepare the treating therapist for the call so the review is a productive and positive experience:

Notify the Therapist in Advance

Both parties can reduce the time spent on a call if both parties are aware and prepared. Reviews are conducted with the evaluating or treating therapist, not the clinic staff or owner.

Schedule the Call during Downtime

It can be challenging to find a time when a therapist is not busy, but patients deserve the undivided attention of their therapist. The call should not be during a treatment time with another patient.

Have Reports Ready

The therapist should have any documentation readily available including assessment scores, short and long-term goals, and the treatment plan.

Educate the Therapist about Case Model

The therapist will be better prepared to understand the reimbursement of the case model if explained in advance of the call.

Advocate for the Patient

The call is the time to discuss the patient's individual care. The call is more productive and outcomes are more positive when the therapist remains focused on patient for which she or he is treating.