# Provider Newsletter

## Check Eligibility and Validate 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. 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.

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## Rehabilitative vs Therapy Services In The Schools

What is the difference between rehabilitative services with medical necessity and those provided in schools? Reimbursement for rehabilitation services through Medicaid cannot be duplicated by other providers and must show medical necessity for specific treatment(s) of a medical disorder, impairment, or disease. School rehabilitative services are school-based services, and educational goals are primary. Comprehensive documentation for rehabilitation services is required for Medicaid reimbursement, other requirements varies per school district and state.

Therapy services in schools are funded by state, local, and federal dollars, and based on learning abilities and educational outcomes i.e. IEP's. An educator or parent refers the child for a formal assessment after the child completes classroom interventions, and observations. The assessment must demonstrate a deficiency and it becomes part of the IEP. The primary indicator of eligibility is based on the child's ability to learn and gain skills during the school-aged years.

For Rehabilitative services, the physician refers the patient for a medical problem where therapy goals, developmental milestones, and functional outcomes are monitored. Therapy services are determined by standardized assessments and clinical observations, and funded by private sources, insurance, and other third party payers.

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## Rehabilitative vs Therapy Services In The Schools

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CMS defines Medical Necessity as "a service that is reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member". The service must be consistent with the symptoms of the illness or injury, be provided within generally acceptable professional medical standards, not performed for the convenience of the patient or physician, and furnished at a safe level and in a setting appropriate to the patient's medical needs. Some insurers and health plans further define medical necessity, in addition to Medicare's definition, as services that prevent, diagnose, or treat conditions, illness, and injury; that are not part of scholastic or vocational training; and are not investigational (National Institute for Health Care Management, 1995; and Blue Cross Blue Shield Federal Employees Health Benefit, from Appeals Made Easy, 2001).

The challenge for clinician's is the balance between demonstrating Medical Necessity while providing quality of care. For health plans, and the school system cost savings is essential while providing its members with the services they need.

# REMINDERS TO AVOID CLAIMS DENIALS

1. For services related to an accident, please complete all the required fields;

2. For services in the Hospital, include the date of admission and discharge. Please also include the Hospital NPI;

3. If services were rendered in more than one Place of Service (POS), those services must be billed in different Claims;

4. All claims must include the Rendering Provider NPI in the filled 24J;

5. IMPORTANT, when billing electronically and the service was rendered in a POS that is not Office (POS 11), you must include the Postal Address in field 32. If the service was rendered in a Facility that is not one of the following POS, 12 (Home), 13 (Assisted Living Facility), 14 (Group Home), 33 (Custodial Care Facility) and 81 (Independent Laboratory) with modifier 90, you must include the Facility NPI in field 32a. When you bill in paper, Field 32 is always required and Field 32a will be filled based on the same rule previously described.

# Claims News & Notes

Remember that while a therapist does not need a referral from TNPR to evaluate a patient, they must submit the Intake Form and obtain a referral from TNPR in order to be reimbursed for the evaluation upon billing the network. Therapists need to obtain a referral for the evaluation after the evaluation is performed. This will eliminate claim denials.

It is very important that TNPR receive all claim encounters to accurately reflect the services that you are providing. Please submit claims for each date of service rendered. You may submit your claims via: Electronic Data Interchange (EDI) or via paper.

The following are some helpful reminders:

- Bill your claims using the TIN that you documented on your contracting documents with TNPR;
- Bill claims for Physical, Occupational, and Speech Therapy on separate claims. Do not mix your claims;
- Include the TNPR coordinating referral number (i.e. control number) to your Physical, Occupational, or Speech Therapy claims;
- Bill one control number with the coordinating services per claim;
- Accurately populate the fields for the Servicing provider and the Service location in the Claims and the Authorization.


# Law Against Health Care Fraud: Exclusion Provisions

Although most health care providers work hard to deliver quality care and submit correct claims for payment, some providers seek to exploit government health care programs for illegal personal gain. Health care fraud remains a serious problem for these programs. The U.S. Government Accountability Office has designated Medicaid as a program that is at high risk for improper payments. Improper payments "include those made for treatments or services that were not covered by program rules, that were not medically necessary, or that were billed for but never provided." There are a number of Federal and State laws to deter and punish those who fraudulently seek to obtain improper payments from Medicaid. Federal laws include, but are not limited to, the following:

Under Section 1128 of the Social Security Act, HHS-OIG has authority to exclude individuals from participating in Federal health care programs, including Medicaid, for various reasons. Exclusions can be mandatory, meaning the HHS-OIG has no choice about whether to exclude, or discretionary, which means the HHS-OIG does have a choice. Exclusion is mandatory for convictions of program-related crimes, convictions relating to patient abuse, felony convictions relating to health care fraud, and felony convictions relating to controlled substances. Exclusion is discretionary for loss of license due to professional competence or financial integrity, convictions relating to fraud, convictions relating to obstruction of an investigation or audit, misdemeanor convictions relating to controlled substances, and participation in prohibited conduct such as kickbacks and false statements.

As a Federal health care program, Medicaid will not pay for items or services furnished, ordered, prescribed, or supplied by an excluded individual or entity. If someone on a provider's staff has been excluded from participation in a Federal health care program, the provider should not bill any Federal health care programs for any items or services furnished, ordered, or prescribed by the excluded individual. "Furnished" is a key word that refers to items or services provided or supplied, directly or indirectly, by an excluded individual or entity.

It is in the best interest of providers to screen potential employees and contractors prior to employment or contracting to ensure they are not excluded from participating in Federal health care programs. In addition, providers should regularly check the exclusions database to ensure that none of the practice's employees or contractors have been excluded.

CMS has issued guidance to State Medicaid agencies that they should require providers to screen their employees and contractors for exclusions by checking the database on a monthly basis. The guidance further advises States to require all providers to immediately report any exclusion information discovered. The List of Excluded Individuals/ Entities (LEIE) database is available at http://exclusions.oig.hhs.gov/ on the HHS-OIG website. Both licensed and unlicensed individuals may be excluded, so it is best to check for both. In addition to checking the LEIE, providers should check the Exclusions Extract, which can be accessed by visiting https://www.sam.gov/ on the System for Award Management website.

# Medicare Part D Prescriber Enrollment… Time is Running Out


Beginning June 1, 2016, prescribers who write prescriptions for Part D drugs must be enrolled in an approved status or have a valid opt-out affidavit on file with Medicare in order for their prescriptions to be covered under Medicare Part D. Before opting out of Medicare, you should consider the following impacts:

- You will not be able to participate in a Medicare Advantage plan, which means that you will no longer be able to continue your participation in our Network and
- Your opt-out status lasts for two years and cannot be terminated unless within 90 days of your opt out designation

You can also contact the Medicare Administrative Contractor that services our area:

Florida First Coast Service Options
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021
888-845-8614
http://medicare.fcso.com/
http://medicareespanol.fcso.com/

To learn more about the options available to you, refer to the following chart:
http://healthnetworkone.com/partd-decision-chart

For more information on the prescriber enrollment requirements, visit:
http://healthnetworkone.com/partd-prescriber-enrollment

## CREDENTIALING NEWS

If you have any questions or concerns, you may contact the Credentialing Director, Amy Long, at (305) 614-0361.

### Expiration of Documents

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.

### Recredentialing Process

In order for your initial or recredentialing process to run smoothly, here are some helpful tips:

- Submit the credentialing applications timely
- Sign and Date the Consent & Release and Attestation pages
- Include all of the requested supporting documents (ie: License, DEA, CV, Malpractice Insurance, Accreditations, etc.)
- Ensure that supporting documents have been uploaded to CAQH, if applicable.
- Ensure that you have authorized HS1 Medical Management, Inc. or have CAQH set to "Global" so that we have access your information
- Ensure that your CAQH attestation is current

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

If you have any changes to your practice, including demographic changes, provider additions/terminations, etc. please notify your TNPR Provider Relations Representative by email or call us at: 1 (877) 614-5056 with any questions, comments or suggestions.

### Main Number

1 (877) 614-5056
Select 1 for Authorizations
Select 2 for Contract or credentials
Select 3 for Billing services

### Yaritza Laboy

LaboyY@mytnpr.com
(787) 922-0829

### Fredly Jimenez

JimenezF@mytnpr.com
(939) 285-7158

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

1 (866) 321-5550

# Annual Quality Improvement Documents

Annually the Quality Improvement (QI) Department develops Quality documents that include a QI Evaluation, Program Description, and Work Plan. The development of the Quality documents satisfies Health Plan and NCQA Accrediting body requirements. The QI 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.

Copies of the annual QI documents are available by contacting the QI department at the address below.

**2001 South Andrews Avenue**
**Fort Lauderdale, FL 33316**
**Phone: (800) 422-3672 Ext. 4701**
**Fax: (305) 614-0364**

# TNPR Uses Apollo Clinical Guidelines To Support Benefit Determinations

TNPR's UM decision making is based only on appropriateness of care and service and existence of coverage.

TNPR uses local and national Medicare coverage guidelines, the member's Health Plan designated Clinical Practice Guidelines, or if none applicable will use Apollo Clinical Guidelines to support benefit determinations related to medical necessity and investigational/experimental services.

For any medical necessity Non-Certifications, the Medical Director shall make an attempt to contact the requesting provider for peer to peer consultation. Applied Clinical Guidelines 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 Representative and a copy will be provided.

TNPR does not specifically reward practitioners or other individuals conducting utilization review for issuing recommendations for denial of coverage or services. UM decision makers do not get any financial incentives for UM decisions that result in underutilization.