THERAPY
NETWORK OF PUERTO RICO

Provider Newsletter

2019 Q4

How Can I Help Prevent Fraud and Abuse?

- Validate all member ID cards prior to rendering service;
- Ensure accuracy when submitting bills or claims for services rendered;
- Submit appropriate Referral and Treatment forms;
- Avoid unnecessary drug prescription and/or medical treatment;
- Report lost or stolen prescription pads and/or fraudulent prescriptions; and
- Report all suspicions of fraud by contacting:

CALLING: 1 (800) 595-9631 or contact a TNPR Provider Relations representative who will forward your inquiry to the Compliance Department

MAILING: TNPR Compliance Department
2001 South Andrews Avenue
Fort Lauderdale, FL 33316

FAXING: 1 (866) 276-3667

Authorizations requests

As you all you all know, since June 2019 all authorization requests must be submitted with the required supporting documentation.

- Initial Request – Provider Web Portal(PWP) request or fax Intake form, RX and Evaluation POC
- Consecutive Episodes After Initial Request – Intake form or PWP Request, RX and Re-evaluation & POC (if initial documentation was not received, HS1 will need all evaluations from previous episodes)
- Upgrade Request – Upgrade form, RX and Re-evaluation & POC (if initial documentation was not received, HS1 will need all evaluations from previous episodes)
- Lymphedema Request – Intake form or PWP request, RX, Evaluation POC and pictures (Required, if bilateral)
- Multi-Body Parts Request – Intake form or PWP Request, RX (Must have new medical order for each body part not included in the original RX) and Evaluation POC

If any of the above elements are missing, unclear or illegible, TNPR may not approve the authorization request and the case may be referred to the health plan with a recommendation for denial. Failure to provide all required documentation could result in the delay of treatment of your patient. Retrospective requests will not be authorized. All authorization forms have been updated and loaded into www.mytnpr.com for your ease of use. You must complete an authorization request via the Provider Web Portal or use the latest version of the intake documents. To ensure timely processing, please attach the critical elements to your authorization.

Therapy Network of Puerto Rico congratulates all therapists in their week! TNPR appreciates your work and continuous participation in our Provider Network.

UM Documentation Checklist

Please submit your request via the web portal. We have improved out system to allow you to attach documents, and if you need to fax a request, make sure you use the latest version of the Intake Form. To ensure timely processing, please attach the critical elements to your authorization. Before you submit the request always make sure that you have attached your documents as follows:

	INTAKE FORM OR PWP REQUEST	UPGRADE FORM	RX	EVALUATION & POC	RE-EVALUATION & POC	PICTURES
INITIAL REQUEST	X		X	X		
CONSECUTIVE EPISODES AFTER INITIAL REQUEST	X		X		X*	
UPGRADE REQUEST		X	X		X*	
LYMPHEDEMA REQUEST	X		X			X**
MULTI-BODY PARTS REQUEST	X		X***	X		

* If initial documentation was not received, HS1 will need all evaluations from previous episodes.

** Required, if Bilateral

*** Must have new medical order for each body part not included in the original Rx.

Make sure that all notes in your documentation are legible, and that you document missed visits, and any reason on goals not being achieved.

Keep your demographic information updated!

Keep your contact and demographic information updated to ascertain that the provider directory reflects correct information at all times. Please if you have any changes such as, but not limited to; address, pone, fax, additions or terminations of a provider you may contact your provider representative or call to our provider call center at: 1-877-614-5056, and selecting Option 2.

Claims & Billing Reminders

Pay close attention to the following items when submitting claims:

- Please provide correct patient information. Patient information should reflect how your patient is registered with their respective health plan.
- Submit all services performed on the same date of service on the same claim. DO NOT split out your claim submissions.
- Provider Information including but not limited to Rendering Provider, Referring Provider, and Billing Provider.
  - Please note that Service Facility Location and Billing Provider Info addresses can not be a PO Box.
- ICD-10, place of service, date of service, units, billed amount.
- TNPR Authorization number.
- Supporting documentation of the service where required by TNPR.
- Options to submit a claim to TNPR:
  - Electronically through your preferred clearinghouse
  - TNPR Provider Web Portal (PWP)
  - Paper using a CMS-1500 form.

Note: Very important that you meet with the HIPPA 5010 regulation as established in CMS. HIPAA electronic transaction standards adopted to replace the current version 4010/4010A standards. Every standard has been updated, from claims to eligibility to referral authorizations.

Clinical Practice Guidelines

Entities that use 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 Representative and a copy will be provided.

Important things to remember when submitting credentialing documents

- Submit your credentialing applications timely
- Sign and Date the Consent & Release and Attestation pages
- Include all of the requested supporting documents (e.g. License, DEA, CV, Malpractice Insurance, Accreditations, etc.)

EFT & Regulatory Trainings

- If you have not yet completed your Electronic Funds Transfer (EFT) agreement, please contact your Provider Service Representative.
- Please make sure to complete all Regulatory Trainings. For your convenience there are electronically in our Web Portal in the following link: www.mytnpr.com/training

Changes?

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.

Select 1 for Authorizations

Select 2 for Contract or credentials

Select 3 for Billing services

How to use modifier 25

Modifier 25 identifies a significant, separately identifiable evaluation and management (E/M) service. The Centers for Medicare & Medicaid Services (CMS) has established that physicians and qualified non physician practitioners (NPP) should use CPT modifier 25 to designate a significant, separately identifiable E/M service, provided by the same physician, to the same patient, on the same day as another procedure or other service. Effective on November 1, 2019 providers must submit support documentation of the service whenever billing modifier 25.

- E&M codes (except 99201 – 99205) billed on the same day as a procedure, received without a modifier 25 will be denied by TNPR.
- E&M codes (except 99201 – 99205) billed on the same day as a procedure, even when including a modifier 25, MUST be submitted with the appropriate medical record documentation, otherwise will result in a denial of this line item in the claim.

Submission of medical record documentation does not guarantee payment of these services unless it's substantiated when documentation is reviewed. TNPR will utilize CMS NCCI edits to review the medical records for claims billed for an evaluation and management procedure code on the same day as any other procedure is performed. CMS provides many tools for assisting providers on proper billing of their claims and proper documentation needed.

Here are some helpful links to CMS to assist you:

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf
- https://www.ama-assn.org/amaone/cpt-current-procedural-terminology
- https://gm1.geolearning.com/geonext/fcso/coursesummary.CourseCatalog.geo?id=22506712393

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

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Phone: 800-422-3672 Ext. 4701
Fax: 305-614-0364