THERAPY NETWORK OF GEORGIA

Provider Manual

Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST)

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Welcome!

HN1 Therapy Network of Georgia (TNGA) welcomes your participation in the provider network. We are pleased that you have chosen to join our organization. As a participating provider, you play a central role in the delivery of covered services to our affiliated health plan members.

TNGA's provider manual is intended to serve as a reference guide to assist you and your staff in providing outpatient Physical Therapy (PT), Occupational Therapy (OT) and/or Speech Therapy (ST) services to our affiliated members. We hope that you will find the information included in this document to be concise and useful in your role as a therapy provider. The intention of this provider manual is not to dictate to the therapy provider the recommended plan of care, which remains entirely in your hands as a licensed, qualified practitioner.

TNGA will send you updates to this provider manual from time-to-time, as the need to amend the content is identified. Meanwhile, due to the rapid and frequent changes that occur in health care policy and regulations, you may come across a discrepancy between a current law and the process outlined by TNGA. In such instances, the most current policy adopted by the member's health plan, federal and/or state regulations and laws, and/or the terms of your Provider Agreement will supersede any such information contained in this provider manual.

Thank you for your participation in our provider network. We look forward to a long and mutually beneficial relationship with you.

Sincerely,

Gloria Gaston, M.D.
TNGA, Medical Director

Important Contact Information

The main telephone number for Therapy Network of Georgia (TNGA) is **1-855-825-7818**, which will give you the option of selecting the department you wish to reach. However, some functions have been issued dedicated telephone and fax numbers.

Department	Telephone	Fax
TNGA Main Telephone Numbers	**1-855-825-7818** or **305-614-0119**	**1-855-597-2697** or **305-614-0138**
Claims Processing (Outpatient Therapy ONLY)	**1-877-372-1273**	
Member Services	**Contact the Member Services Department at the member's health plan.**	
Provider Relations	**1-855-825-7818** or **305-614-0119**	**1-877-403-5544**
Referrals	**1-855-825-7818**	**1-855-597-2697**
Verification of Eligibility	**Contact the member's Health Plan for the most current eligibility information. Medicare member eligibility is also on theTNGA provider portal. For Medicaid eligibility, please access the DCH (GAMMIS) portal for information.**	

Contracting and Credentialing

Medicaid Providers

Providers wishing to contract with TNGA for the health plan's Medicaid members must first have an active Medicaid ID number in order to initiate the process. (This is not a requirement for providers contracting to see only Medicare members.) Providers needing to apply for a Medicaid ID number will need to submit an application via the Georgia Medicaid Management Information System (GAMMIS) site at: www.mmis.georgia.gov. The process can be started by accessing the Provider Enrollment tab for submission. Once the provider has received a Medicaid ID number, they will be eligible to start the contracting process with TNGA. All providers must have a unique Medicaid ID for each location at which they will be rendering/billing services. If you have specific questions regarding the enrollment process, please contact the Gainwell Technologies' Provider Call Center at **800-766-4456** or you may go to GAMMIS for more information (www.mmis.georgia.gov).

Providers with active Medicaid ID numbers wishing to contract with TNGA also must be credentialed. If a provider has been previously credentialed by TNGA within the past three years, they will be able to proceed with a contract with TNGA without any additional credentialing requirements. However, Medicaid providers requiring credentialing must be credentialed through The Georgia Department of Community Health's (DCH) Centralized Credentialing Process with their Credentialing Verification Organization (CVO) prior to being able to be contracted with TNGA. The credentialing application will need to be submitted via the Georgia Medicaid Management Information System (GAMMIS) site at: www.mmis.georgia.gov. The process can be started by accessing the Provider Enrollment tab for submission. Once the credentialing process is complete with the DCH CVO, providers will then be eligible for contracting with TNGA or adding the Medicaid line of business to an existing TNGA contract. Completion of the CVO credentialing process doesn't automatically initiate the contracting process with TNGA. The provider will need to submit all TNGA contracting documents to fulfill the contracting requirements. Receiving a valid Medicaid ID number does not necessarily mean that a provider has been credentialed by the DCH CVO. If you have specific questions regarding the CVO credentialing process, please contact the Gainwell Technologies' Provider Call Center at **800-766-4456** or you may go to GAMMIS for more information (www.mmis.georgia.gov).

Providers who are contracting with TNGA to see both Medicaid and Medicare members for the health plan will also need to complete the aforementioned credentialing process via the DCH CVO.

The DCH CVO also will perform re-credentialing for both current and new providers every three years. Providers requiring re-credentialing will be notified by DCH at least 90 calendar days in advance of the re-credentialing due date. If you are a current network provider belonging to more than one CMO and you have a different credentialing effective date with each plan, your re-credentialing due date will be based on the earliest initial credentialing or re-credentialing effective date. Therefore, initial re-credentialing with the CVO may be performed earlier than the three-year cycle due to the transition.

All Medicaid providers must follow the contract requirements of GA families regarding Covered Services, Statute and Regulations, Member Rights and Responsibilities, including, but not limited to EPSDT, which can be referenced at https://www.wellcare.com/Georgia/Providers.

Medicare Providers

Providers who will be seeing Medicare members will be credentialed directly by TNGA. All credentialing documents will be submitted to TNGA and processed by the TNGA credentialing staff. Upon completion of this credentialing process, the provider will be eligible to be contracted to see the Health Plan's Medicare population. The provider will receive written notification of their participation status from TNGA once the credentialing process is complete. The provider shouldn't' begin seeing members until they are notified by the Network Management Department that they appropriately loaded in the TNGA system and are Active. Every three years, TNGA will also manage the re-credentialing process for Medicare providers.

Referral Process

PROVIDER TYPE	EVALUATION	PHYSICAL THERAPIES: PT/OT/ST
Therapist (PT/OT/ST)	**Therapist must have a prescription** from the ordering physician (Primary Care Physician [PCP] or specialist). No referral or "preauthorization" is needed from TNGA for therapist to perform an evaluation. However, a valid authorization must be on file at the time of claims submission for payment, including claims for eval only services.	**A Children's Intervention Services (CIS) treating provider must request a referral via the DCH Portal after the patient evaluation. Medicare providers must submit their request via the TNGA PWP. The provider must submit the following with the Portal request.** • **IEP/IFSP if applicable (An IFSP-Individualized Family Service Plan, used in early intervention ages 0-3 or an IEP-Individualized Education Plan, used in special education ages 3-21 are each applicable if the patient has one)** • **Attestation Form (if the member does not have an IEP/IFSP–see the CIS Manual) *Note: The Attestation Form is not required for patients older than 21.** • **Letter of Medical Necessity (LMN) and/or Plan of Care (POC) with diagnosis signed/dated by the referring physician**

- **The POC must include the following:**
  - **Start and Stop Dates**
  - **Signature of the referring physician recorded on or after the recorded date of the treating therapist**
  - **The therapist that develops the POC must sign and date the document on the date it is completed. The therapist must sign and date the POC prior to the PCP's signature date. The PCP may sign and date the POC on the same date the therapist signs and dates the POC.**
- **Standardized Test Scores clearly denoted**

Non-CIS therapy providers must complete theTNGA Patient Intake Form (Attachment A) along with the corresponding ordering physician's prescription and all supporting documents to our Toll-free Referral Fax Line at **1-855-597-2697**.

TNGA's provider network is contracted for outpatient therapy (PT/OT/ST) services ONLY.

Inpatient services ARE NOT included in the scope of TNGA's referral process, and these services are subject to the patient's health plan referral policies and procedures.

Evaluations

Patient evaluations are covered for eligible members with a physician prescription for therapy. No advance notification to TNGA is necessary to initiate the evaluation. However, as soon as possible after the evaluation, an authorization must be obtained from TNGA before treatment begins. You will not be reimbursed for services prior to the effective date of this auth. You will also need to obtain an auth in the event the case is for the *evaluation only*. Referring physicians will be able to access the complete list of network therapy providers via the health plan's on-line provider directory, but you are encouraged to educate your referral sources of your participation in the program also.

Eligibility should be verified with the health plan for real-time information but it is also available on the TNGA Provider Portal. As noted in your contract, TNGA will not guarantee payment except for those patients actually eligible with the payer at the time of service, and reimbursement is subject to all other TNGA contract provisions.

Referral Process for Therapy Providers

Patients are entitled to all medically necessary, covered care as determined by the treating therapist in consultation with the referring physician's office and as authorized by TNGA.

In the event of a disagreement between a therapy provider and the referring physician and/or patient (for example, the patient demands treatment with no further clinical value), the case may be submitted to TNGA for clinical review and to Wellcare for final medical necessity determination, if applicable.

Communicating Referral Information to Therapy Network

	Hours of Operation	Phone Number
CIS Providers - via DCH Provider Web Portal	24 hours a day, 7 days a week	www.mmis.georgia.gov.
Medicare Providers – via the TNGA Provider Portal	24 hours a day, 7 days a week	https://therapynetwork.com/
Fax Requests (Non-CIS Providers ONLY)	24 hours a day, 7 days a week	**1-855-597-2697**
TNGA Call Center Provider Calls/Voice Mail Message	8:30 a.m.–5 p.m. Monday through Friday, with an on-call staff member for Providers and Members taking calls from 5 p.m. to 8:30 a.m.	**1-855-825-7818**

After completing your evaluation and before beginning treatment, you should request a referral/authorization. CIS and Medicaid Hospital providers should submit your referral requests via the DCH (GAMMIS) Provider Web Portal. Non-CIS providers should submit your referral requests via the TNGA Patient Intake Form (Attachment A) to our toll-free Referral Fax Line at **1-855-597-2697**. Medicare Provider should submit your referral requests via the TNGA Provider Portal.

You must submit the following information with the referral request:

- Attestation Form* (if the member does not have an IEP/IFSP)
- IEP/IFSP if applicable (An Individualized Family Service Plan, used in early intervention ages 0-3 or an IEP-Individualized Education Plan, used in special education ages 3-21 are each applicable if the patient has one)
- Letter of Medical Necessity and/or POC with Prescription from referring provider

- The POC must include the following
    - Start and Stop Dates
    - Signature of the referring physician recorded on or after the recorded date of the treating therapist
    - The therapist who develops the POC must sign and date the document on the date it is completed. The therapist must sign and date the POC prior to the PCP's signature date. The PCP may sign and date the POC on the same date the therapist signs and dates the POC.
- Standardized Test Scores clearly denoted in the clinical notes

Upon receipt of the referral request, TNGA will review and provide a referral number related to the therapy services that are to be provided. Providers using the GAMMIS portal for submission may also access their referral information on the GAMMIS portal using their GMCF Tracking Number. All referral requests also can be seen on the TNGA Provider Portal regardless of the means of submission.

* **Note: The Attestation Form is not required for patients older than 21.**

Please note the following when requesting a referral:

For medical diagnoses, we are looking for the diagnosis in medical terms (e.g., Cervicalgia). For therapy treating diagnosis, we are looking for the functional reason for therapy if not clearly evident in the medical diagnosis.

Any developmental delays noted should be measured using a recognized, standard assessment tool such as Peabody, Bailey's scales, Bruiniks Oferetsky Test of Motor Proficiency, Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP), etc.

If providing therapy to a child and the child is receiving any therapy service through the school system, this information must be provided (describe type and frequency of treatment) along with the Individualized Education Plan (IEP).

If the therapy is related to surgery, please identify the date and nature of surgery in the Plan of Care or Progress Notes.

If the therapy is related to a CVA, please submit the date of the CVA.

Please note that if any of the elements required are missing, TNGA will not approve the authorization request and will refer the request to the health plan for a recommendation of

denial. Failure to provide all required documentation could result in the delay of treatment of your patient. Retrospective requests will not be authorized. Per the CIS manual, retrospective requests may only be submitted if an “emergent need arises.” Claims should not be submitted to TNGA prior to a provider receiving confirmation that therapy services have been authorized by TNGA.

Assignment of Levels

Extended Episode Fees **(Case Rates)** are fixed rates over a period of time for all necessary and appropriate treatment. Under this model, TNGA does not dictate or specify exact treatment requirements or visit limitations. It is expected that the therapy provider will provide appropriate care, delivered efficiently and with the necessary patient (or parent/caregiver, as applicable) education to allow the patient to meet his or her goals from activities both inside and outside the clinic.

The assignment of levels is based on the diagnosis, the clinical record and the information contained within the evidence-based clinical guidelines, Milliman Care Guidelines (MCG), and the results of the standardized test scores. Based upon this information, TNGA will authorize levels of service. In the authorization process TNGA will provide you with “reasonable” or “expected” ranges in the number of visits. The provider may proceed with more or less visits than the “reasonable” or “expected” number contained within our authorization letter; however, actual visits should align with the Plan of Care. In general, levels are assigned as follows:

Assignment of Levels

- **Level 1 One-time visit, evaluation only/within normal limits (e.g. wheel chair eval, or after evaluating provider determines no other therapy needed)**
- **Level 2 Mild impairment level based on diagnosis/MCG and test scores**
- **Level 3 Moderate impairment level based on diagnosis/MCG and test scores**
- **Level 4 Severe impairment level based on diagnosis/MCG and test scores**
- **Level 5 Profound impairment level based on diagnosis/MCG and test scores**

Global Period of Assigned Levels

Each referral is assigned a specific period of time. The following are general time frames that are determined by the condition.

2 Months For all assigned levels *except Developmental Delay*
6 Months Developmental Delay

Global Period of Assigned Levels for Acute Care

All acute care cases will be assigned a level that is valid for a 60-day treatment period. TNGA will issue one Case/Auth# that will be valid for a 60-day treatment period. Examples of acute cases are most fractures and sprains and strains, most shoulder issues other than joint pain, most post-operative treatment, CVA older than 4 weeks, arthroscopies, and spinal stenosis. During the assigned 60-day treatment period, the provider should submit ALL claims for every date of service, as well as for every procedure performed, in order to ensure payment of assigned levels.

Global Period of Assigned Levels for a Patient with Developmental Delay

Members identified as developmental delay will be approved for a 180 day plan of care/treatment period which will encompass 3 separate case rate payments, as long as the member remains in active treatment per the POC. TNGA will send the Provider ONE Case/Auth# that is valid for the 180-day treatment period. The provider should continue to treat the patient for the 180-day treatment period, submitting claims for every date of service and for all procedures performed.

Payment of Levels for Developmental Delay

After receipt of the first claim encounter after issuance of the level by TNGA, the first case rate will be paid to the rendering provider. After receipt of the claims encounters during the initial 60-day period and after receipt of the first claim encounter following day 60 of the 180-day authorization period, the second case rate will be paid. The same is applicable after day 120. Payment of levels will be contingent upon the performance of the services and receipt of encounters consistent with the Plan of Care. 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

Although rare, providers may submit a request for an Upgrade. CIS providers may 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?" They must also enter the previous preauthorization number, which can be selected from the "drop-down" box. If it does not appear there, the provider must include the Preauthorization number in the "Comments" section of the PA Portal. **The provider must attach the TNGA Upgrade Request Form (Attachment C).**

Non-CIS and Medicare providers must submit an Upgrade Request via TNGA Upgrade Request Form (Attachment C) along with all supporting documentation, and fax the request to TNGA's Toll-free Referral Fax Line at **1-877-583-6440**.

TNGA will only issue authorizations for upgrades when a change in diagnosis or a change in test scores is submitted. (In rare clinical circumstances, upgrades may be authorized without a change in either diagnosis or test scores).

The Upgrade Request must include the following:

1. The completed TNGA Upgrade Request Form
2. New POC, signed and dated by the referring physician, in addition to the original Plan of Care
3. Change in Standardized Test Scores, or
4. Change in Medical Diagnosis
5. Documented patient progress in metrics/quantitative data

UPGRADES WILL NOT BE AUTHORIZED RETROSPECTIVELY (AFTER THE TREATMENT PERIOD).

Review Process for an Upgrade Request

TNGA will submit the Upgrade Request to the TNGA clinician (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 case# referencing the higher level.

If medical necessity is not established based on the information received a peer-to-peer consultation is offered to the treating provider. If after the peer-to-peer, a decision cannot be agreed upon, the request for an upgrade will be submitted to the Medical Director for review. If the Medical Director is in agreement with the clinician, TNGA will refer the case to WellCare Health Plan of GA for final determination.

Continuation of Care After 1st Global Period has Expired

In order to facilitate a new referral after a referral has expired, ALL of the following steps should be taken:

- Obtain a new or renewed physician prescription from the patient's Primary Care Physician (PCP) or ordering specialist.
- Perform a re-evaluation of the patient and request a referral via the DCH Portal. If you are not a CIS Medicaid Provider, you must submit the TNGA Patient Intake Form (Attachment A) via fax as instructed in this manual. If you are a Medicare Provider, the request should be submitted via the TNGA Portal. The re-evaluation and previous evaluation, if available, must be submitted to TNGA with the request.
- The IEP/IFSP if applicable
    - (An IFSP-Individualized Family Service Plan, used in early intervention ages 0-3 or an IEP-Individualized Education Plan, used in special education ages 3-21 are each applicable if the patient has one)
- The Attestation Form (if the member does not have an IEP/IFSP- see the CIS Manual)
- The Letter of Medical Necessity (LMN) and/or Plan of Care (POC) with diagnosis singed/dated by the referring physician
- The POC, which must include the following
    - Start and stop dates
    - Signature of the referring physician recorded on or after the recorded date of the treating therapist

- The therapist that develops the POC must sign and date the document on the date it is completed. The therapist must sign and date the POC prior to the PCP's signature date. The PCP may sign and date the POC on the same date the therapist signs and dates the POC.

- Standardized Test Scores clearly denoted

***Note: The Attestation Form is not required for patients older than 21.**

Non-CIS treating providers must complete the TNGA Patient Intake Form (Attachment A) along with the corresponding ordering provider's prescription and supporting documentation to our Toll-free Referral Fax Line at **1-855-597-2697**.

Upon receipt of the information listed above, TNGA will review the submitted documentation. TNGA will issue a new referral/authorization, and a new episode of care begins.

Multiple Case Referral Requests

If a therapy provider determines there should be two separate case referrals, instead of one, for a patient requiring different therapy disciplines (e.g. PT and ST), a separate authorization request, must be submitted including the referring physician's prescription for the separate discipline along with the evaluation of the patient.

TNGA will refer a request for a multiple case referral, or any subsequent, additional referrals for a patient who is already under a therapist's care for a separate case to a clinical peer reviewer. The clinical peer reviewer may then contact the requesting provider for a peer-to-peer discussion if the reasoning for the multiple or additional referrals is unclear.

In all instances, a requesting provider is always notified of the outcome of his or her request for a referral.

Any additional referral issued by TNGA is for a specified time period, beginning on the date of the additional patient evaluation.

In addition, please note the following with regard to multiple case referrals:

You will need to submit the ordering provider's prescription in order for TNGA to make the appropriate determination.

TNGA does not issue a separate episode level for symptoms associated with the main diagnosis. For example, for a therapy request for Status Post Total Knee Replacement,

TNGA assigns a level according to date of surgery. Concurrent requests for pain, including back pain, gait, instability, muscle weakness, etc. are all due to the main diagnosis, and TNGA will not issue a separate level.

Fixed Fee (no levels-fixed reimbursement)

Fixed Fee reimbursement provides for a fixed fee per patient per episode, regardless of diagnosis or the need for one or more types of therapy services (i.e. physical therapy, speech therapy or occupational therapy). *This Fixed Fee reimbursement is exclusive to providers with a multidisciplinary practice who have a fixed fee reimbursement schedule contractually.*

There are two episodes that can be issued in the Fixed Fee model.

A **Full Episode** is all services of one or more particular mode of therapy (physical, occupational or speech) within a 9-month period of time. This episode is issued for a patient who is receiving therapy services with the requesting provider as a new patient.

A **Transitional Episode** is for services for patients whose course of treatment is partially covered under a different contractual arrangement prior to or after the services incorporated under this agreement and/or for services provided to patients beyond the time period of the Full Episode Fee. This authorization is for a 3-month period

In the Fixed Fee reimbursement model there are **no upgrade requests**. The referral is issued for a full episode of care **or** a transitional episode of care. The reimbursement is fixed at the full episode reimbursement fee or the transitional episode reimbursement fee.

Members Enrolled in the Babies Can't Wait Program

If providing therapy to a child and the child is enrolled in the Babies Can't Wait Program, the treating provider must submit the Individualized Family Service Plan (IFSP), with each authorization request. The IFSP must indicate that the child is enrolled in Babies Can't Wait and requires therapy services. Services provided to a member who is enrolled in the Babies Can't Wait Program will be eligible for a fee-for-service reimbursement. This reimbursement is applicable to all free-standing, non-hospital network providers in accordance with your contract.

Therapy (PT/OT/ST) Practice Guidelines

When making medical necessity recommendations of denial for Medicaid and Medicare members, TNGA's clinical staff applies the applicable Clinical Guidelines. For Medicare members, TNGA's staff adheres to CMS coverage guidelines. For Medicaid members, TNGA's clinical staff applies the applicable Medicaid Benefit Policy Manual.

For any medical necessity recommendation of denial, the clinician shall make an attempt to contact the requesting provider for peer-to-peer consultation. In addition, the provider may request a copy of the clinical guidelines used to determine the recommendation of denial.

Claims Submission Protocols and Standards

TNGA offers three methods for providers to submit their claims.

Electronic Data Interchange (EDI)

TNGA's preferred method of claims receipt is EDI. The payer ID* numbers to submit your EDI claims to TNGA are:

- **Professional claims (837P): 65062**
- **Institutional claims (837i): 12k89**

***Please note that these payer ID numbers are listed as *HN1 (Health Network One) Therapy Network* in most EDI clearinghouse software.**

Please contact your billing software vendor and have them add the TNGA's payer ID number so your claims can be billed via EDI. If you don't currently have an EDI software vendor and would like some software options, please contact your TNGA Provider Relations Representative, for more information.

TNGA Provider Web Portal (PWP)

Therapy Network offers providers a multifunctional Provider Web Portal (PWP) that allows contracted providers to perform several tasks. Providers are able to submit their authorization requests, check auth status (regardless of the submission method), enter claims (via direct data entry (DDE)), check claims status of any received claims (regardless of the submission method), and generate on-line EOPs. Providers are also able to see member eligibility and copay information, however the health plan is the source of truth for the most current data.

Providers may request a TNGA PWP Account by going to https://therapynetwork.com/ and selecting "Web Portal", and then select the option "Request PWP Access". Once a provider has PWP account, they can return to this "web Portal" selection to log into the account ("Login to PWP")

If you are a registered user and you require assistance with accessing your account (i.e.: locked account, password reset), you can use the self-service options on the login page of the portal: "Unlock Account/Forgot Password" or "Forgot Username." The Account Owner at your practice should also be able to assist you with "lockout" and other issues regarding your account. If you have any other *technical issues* with your PWP account, please click

"Webmaster" at the bottom of the login page, or click "Questions/Comments Email HS1" on any page within the Provider Web Portal to send an email to webmaster@healthsystemone.com. These links are for Web portal technical support only. Please direct all other inquiries to your Account Owner or your TNGA Provider Relations Representative

Paper

If your practice is not able to submit claims via EDI or DDE, please submit your paper claims on either a CMS-1500 or UB-04 form to:

HN1 Therapy Network
Attention: Claims Processing Center
P.O. Box 350590
Fort Lauderdale, FL 33335-0590

Ordering, Prescribing or Referring (OPR)

Institutional and Professional claims must include the national provider identifier (NPI) of the ordering, prescribing, or referring provider (OPR), if applicable. Claims received from rendering providers and facilities for services that are ordered, prescribed, or referred **must contain the NPI of the Medicaid-enrolled ordering prescribing, or referring practitioner.** The OPR's NPI reported on the claim will be subject to validation against the Georgia Medicaid provider roster. Failure to report appropriately will result in a claim rejection.

How to Bill TNGA

- Always use a CMS-approved format, whether electronic or paper.
- The NPI of the rendering provider or supervising therapist is required on each claim submitted, in addition to the group NPI number.
- In addition to the rendering provider or supervising therapist's NPI, please include the NPI of the OPR.
- The NPI submitted on the claim, must be the same NPI you used when enrolling in the Georgia Medicaid program.

- Please ensure you submit your claims using the TIN you used when you contracted with TNGA.
- Always make sure to include the service location on the claim.
- Do not bill for different types of services on the same claim (e.g., do not list outpatient PT and outpatient OT on the same claim).
- Therapy providers must always document the appropriate TNGA Referral Number on the CMS-1500 form; the field is **Box 23** for **prior authorization**. Claims that do not include this information may be denied for payment.
- Therapy providers must always bill each episode of treatment separately so the referral number relating to the service you provided can be clearly identified on the claim.
- Therapy providers who have multiple referral numbers for the same member must list the referral number applicable for each episode of treatment on separate claims (e.g., if a member is provided therapy for shoulder and lower back at the same time).
- Medicare-recognized Part B providers MUST bill on a CMS-1500 or 837P form and MUST submit both the group NPI and the rendering NPI information per claim. On the CMS-1500 form, the fields are **Box 33a** for the **group NPI** and **Box 24j** for the **rendering NPI**.

TNGA Payment Policies

Services are reimbursed as described in the Provider Services Agreement and/or the applicable Payer's Plan Addendum of your contract. Any Extended Episode Fee (Case Rate) payments cover all services covered over a period of time and thus often will cover multiple dates of service. However, it is still necessary for a claim to be submitted for each date of service for a patient. This allows us to meet data reporting responsibilities to the health plan, enables us to give you accurate reports and profiles, and provides us with information needed for internal monitoring and review. A referral shall be in writing from TNGA. A notice in writing from any other person or entity, including a referral from a primary care physician, other provider or payer, shall not constitute a TNGA referral.
To meet timely filing requirements, therapy claims submitted for payment must be submitted within six months after the month in which services were rendered. Payment for therapy claims received beyond this time frame shall be denied for not meeting timely filing requirements.

Any question you may have regarding your contract or other issues not specifically related to referrals or claims may also be directed to TNGA's Provider Relations staff.

Reimbursement of Upgrades for Acute Care
If a member's referral is upgraded to a higher level after TNGA issued payment at the initial level (e.g., a referral for a service is issued at Level 2. However, after treatment has begun, the provider is granted an upgrade to Level 4), the initial payment (at Level 2 rates) will be recouped and a new payment (at Level 4 rates) will be issued to the provider; the provider will be reimbursed the full amount for the higher level, less the payment that they already received for the initial level. This payment will be made to the provider after the issuance of the higher level by the TNGA Referral Department**. See Timing of Claims Payment for a timeline.**

Upgrades may not be applied for retrospectively (after the 60-day treatment period has ended).

Reimbursement of Upgrades for Developmental Delay
If a member's referral is upgraded to a higher level after TNGA issued payment at the initial level (e.g. a referral for service is issued at Level 4; however, after treatment has begun, the provider is granted an upgrade to a Level 5), the initial payment (at Level 4 rates) will be recouped and a new payment (at Level 5 rates) will be issued to the provider; the provider will be reimbursed the full amount for the higher level, less the payment that they already received for the initial level.
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 reimbursed at the higher level during the 180-day treatment period.
Upgrades may not be requested retrospectively (after the 180-day treatment period has ended).

Claim Status Inquiry
For claims status inquires, the Provider Web Portal enables the provider to check the status of submitted claims 24/7. Most providers find this method to be the most efficient way to obtain the status on a submitted claim.
You can also call the TNGA Claims Department and speak to a TNGA Claims representative at **1-877-372-1273** Monday through Friday from 8 a.m. to 5 p.m. Please listen carefully to select the proper option.

Coordination of Benefits/Subrogation

TNGA will investigate and coordinate benefits, where applicable. TNGA may, from time to time, need to request information from its contracted providers in order to assist with this process.

If payment had been issued on a case for which TNGA later determines that other coverage is available (for example, TNGA authorizes and reimburses a provider for treatment to a health plan member suffering from lower back pain, and after payment is issued, TNGA is notified by the plan or the provider that the patient/member was involved in a car accident and covered under the automobile insurance policy), TNGA will exercise its rights to subrogation through the health plan.

Do Not Send outpatient PT/OT/ST Claims to the health plan.

Payments inadvertently made to you by the health plan are overpayments and MUST be returned.

Timing of Claims Payments

TNGA's claims payment turnaround standards are as follows:

Medicare Recipients:

- 95 percent of clean electronic claims for are paid within 15 calendar days from the date of receipt
- 95 percent of clean paper claims are paid within 30 calendar days of receipt

Medicaid Recipients:

- 95 percent of clean electronic claims are processed in 15 business days
- 95 percent of clean paper claims are paid within 30 calendar days of receipt

Claims Payment

Therapy Network of Georgia has partnered with vPay for payments to our providers. vPay offers vCard, a virtual payment faxed to your office and processed through your credit card terminal. vPay also offers an ACH (EFT) payment option. Both are free to TNGA providers. Your initial payment will be on vCard. However, you can contact vPay with that first transaction information by calling 855-388-8374 or emailing support@vpayusa.com to change to EFT, if you prefer. vPay EOP's will be sent via fax to providers

Claims Payment Dispute

When a provider can substantiate that additional reimbursement is appropriate, the provider may request an adjustment and resubmit their claim. Medicaid providers of TNGA have three months from the end of the month of payment to make a claims payment dispute. However, TNGA reserves the right to consider all requests received after the three months have been exhausted. Providers should submit the request with their Explanation of Payment and all claims-related documentation to TNGA. The adjustment request must include sufficient documentation to identify each claim identified in the request. TNGA may return incomplete requests without further action notifying the provider of the basis for the incomplete status and allows the provider 10 calendar days to resubmit the adjustment request.

For Medicare providers, TNGA adheres to the CMS guidelines that govern the reopening and revising of finalized claims. CMS stipulates that clerical errors (which include minor errors and omissions) are classified as "reopenings" instead of reconsiderations. Clerical errors include human and mechanical errors and include but are not limited to: mathematical or computational mistakes, inaccurate data entry, or denial of claims as duplicates.

In addition, if a Medicare health plan issues an adverse organization determination because it did not receive requested documentation and the party subsequently requests a reconsideration with the requested documentation, the organization must process the request as a "reopening." TNGA classifies these reopenings as an adjustment claim. Reopenings and/or adjustment requests can be made in writing or by telephone.

Please call the Claims Department at **1-877-372-1273** and speak with a TNGA claims representative to inquire or to request a claims adjustment.

Claims Appeals

Claims Appeals or redetermination requests not classified as a “reopening/adjustment” must be submitted in writing.

All claim appeals received will be processed within 30 days of receipt. The P.O. Box to submit a claim appeal or a “reopening” is:

Therapy Network

P.O. Box 350590

Fort Lauderdale, FL 33335-0590

Supplies and Equipment

- Off-the-shelf supplies are not reimbursed separately from the listed reimbursement.

  Custom splints made by hand therapists with a physician prescription are eligible for separate reimbursement. The CIS provider will submit a request for Custom Splint via the DCH Portal. They must respond "Yes" to the question on the portal *"Is this a Continuation from a previous PA?"*

- You must attach the Splint Intake Form (Attachment B) with materials used, and payment will be assigned according to the TNGA fee schedule.
- If you are not a CIS provider, you may fax the Splint Intake Form to our toll-free Referral Fax Line at **1-855-597-2697**.
- Other braces and splints, orthotics and prosthetics, and durable medical equipment are not included in our contracts with health plans. Providers should contact the health plan directly for the authorization process to obtain these items from a participating health plan provider.

Provider Complaint Process

Any participating provider can formally express their dissatisfaction with TNGA's policies, procedures or administrative functions by submitting a written dispute via fax or mail.

Fax: 1**-877-403-5544**

Mailing Address:

HN1 Therapy Network
P.O. Box 350590
Fort Lauderdale, FL 33335-0590

Provider must file a complaint within 30 days from the date of the incident resulting in the complaint.

- When a complaint cannot be resolved within five days, the Provider Relations Representative will acknowledge the complaint in writing and notify the provider that the issue will be resolved within 30 days of the original date of the complaint.
- Once resolved, the Complaint Resolution Outcome Letter will be sent to complainant describing the outcome determination.

Provider Trainings

All providers with TNGA are required to complete the *Provider Trainings***,** within thirty days of their contract effective date and annually thereafter. The trainings can be located via the web at **https://mytnga.com/trainings**. You may complete the trainings on any desktop or mobile device for ease of access and completion. Your attestation will confirm that your office has received all mandatory trainings for the year. Should you want a copy of the trainings for your office, they can be downloaded from the attestation page.

NOTE: For providers who function under more than one Tax ID; please be sure to complete an attestation for each Tax ID that is contracted with TNGA

Provider Code of Conduct

Therapy Network of Georgia's (TNGA) vision is to "develop and market products, through our family of companies that facilitates access for consumers and payers to quality and cost effective healthcare". Our extensive network of providers help to support this vision by providing quality service to our clients. To ensure that we meet this goal, the Organization has established a set of business conduct guidelines based on the Organization's code of ethics.

Providers Conduct

TNGA has built an all-encompassing specialty delivery system of quality therapists, providing the full service of benefits that meet our client's population. Our providers shall not abuse, neglect, exploit or maltreat members in anyway, whether by omission or through acts or by failing to deter others from acting. If the provider becomes aware that a member has been subjected to any abuse, neglect, exploitation or maltreatment, the Provider's first duty is to protect the member's health and safety.

Provider Education and Support

The provider network representatives, in addition to the provider manual, conduct ongoing training which may include webinars and web-based tutorials, as deemed necessary by the Client or state agency to ensure compliance with client or state agency program standards. These standards include annual distribution of general compliance, HIPAA, Cultural Competency, FWA and any health plan specific trainings as applicable. TNGA maintains evidence of annual training and all providers within our network are required to complete the training.

Provider Cultural Competency

TNGA's participating providers, and their staff, will ensure that services are provided in a culturally competent manner to provide to all contracted health plan's members and practitioners specific to local cultures, demographics, and ethnicity. TNGA has created the cultural competency policy to ensure that effective medical services are provided. TNGA]'s participating providers, and their staff shall not discriminate on the basis of religion, gender, race, color, age or national origin, health status, pre-existing condition or need for health care services, and shall not use any policy practice that has the effect of such discrimination. This policy recognizes Section 1557 of the Affordable Care Act (ACA) and all other applicable national, state and/or local laws that prohibit the practice of discrimination.

Policies and Procedures

Should you as a provider like to receive a copy of the specific Policy and Procedure that governs any of the processes discussed in this Provider Manual, you can request it through your Provider Service Representative, or by calling our Provider Service Call Center at 855-825-7818 and selecting Option 2, or via email to TNGA@mytnga.com or via the “Contact Us” link on our website: mytnga.com

Clinical Practice Guidelines

Clinical Practice Guidelines The organization uses Apollo, MCG (formerly Milliman Care Guideline), 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, MCG, or our Health Plan partner Clinical Guidelines are reviewed and approved by Health Network One Medical Advisory committee annually, and are available in both electronic and hard copy format. If a provider would like a copy of a specific guideline they may contact their assigned Provider Relations Representative and a copy will be provided

Provider Participation in Quality Improvement Procedures

HN1 TNGA has a comprehensive Quality Improvement Program, which includes the following:

- Quality Improvement (QI) Indicators that measure the outcomes of process of care and service, such as: referral timeliness, over-/underutilization rates, denial recommendations, denial overturns, inter-rater reliabilities, telephonic accessibility, etc.
- Recredentialing process that includes the timeliness of application and documentation submission by all participating providers in order to comply with the three-year recredentialing process.
- Peer review process that includes inter-rater reliability audits of providers, medical records reviews, approved practice guidelines and the Peer Review Committee process when a quality-of-care issue has been identified and researched that requires a determination to be made by a panel of peers.

All participating providers are obligated to comply with the requirements of the Quality Improvement Program.

Attachments

The following is a list of forms and referenced documents that are attached to this provider manual:

Attachment A: Therapy Intake Form

Attachment B: Splint Intake Form

Attachment C: Upgrade Request Form