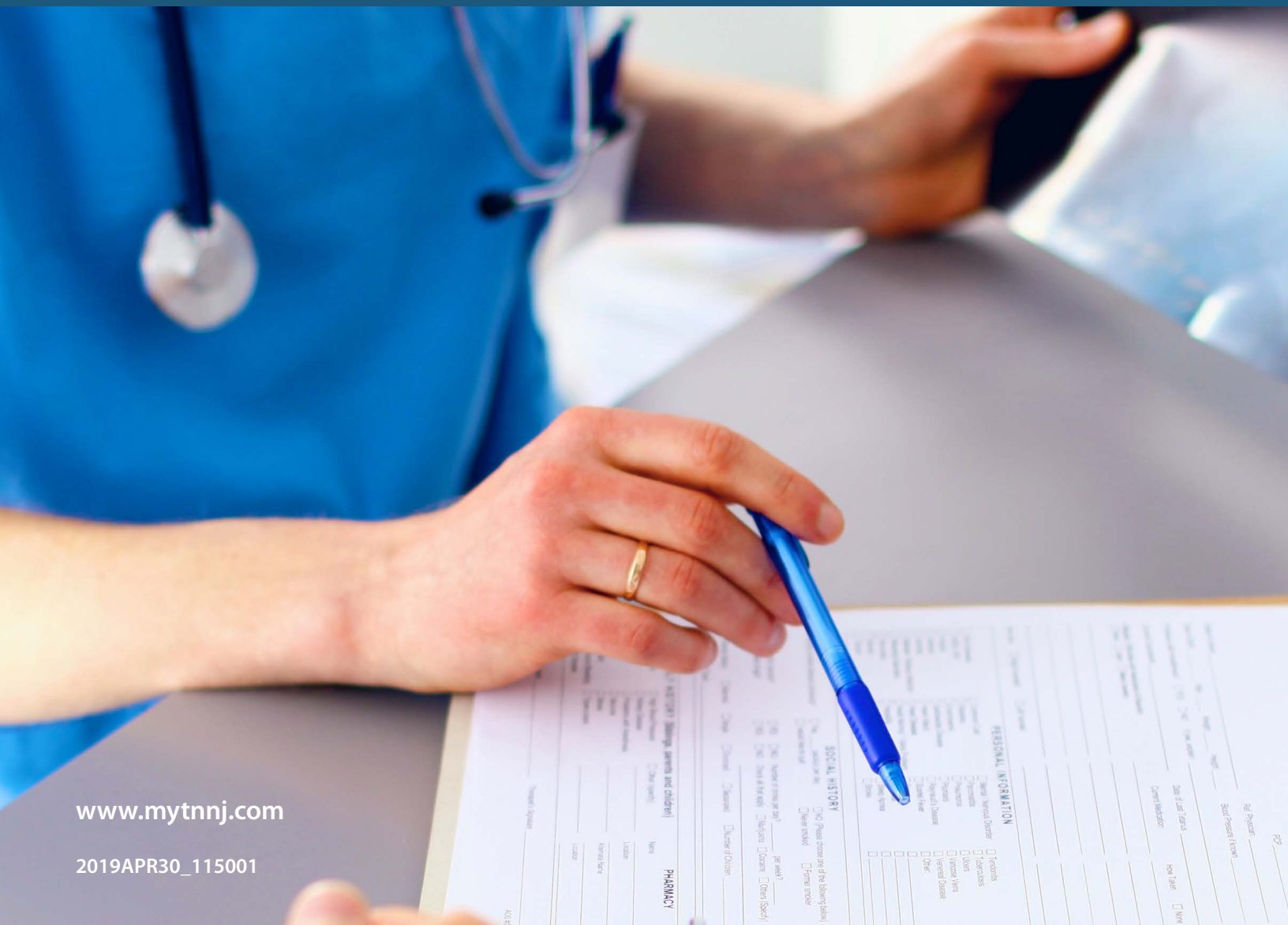
THERAPY NETWORK
OF NEW JERSEY

Provider manual for our therapy professionals



www.mytnnj.com

2019APR30_115001

Welcome to TNNJ's provider manual for participating physical, occupational and speech therapists.

We developed a provider manual to meet your needs

HN1 Therapy Network (HN1TN) welcomes your participation in the provider network. We are pleased that you have opted 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.

TN'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. This provider manual does not address clinical decision-making, which remains entirely in your hands as a licensed, qualified practitioner.

TN 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 TN. 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,

Arvind Baliga, M.D.
Medical Director

Important Contact Information

The main telephone number for Therapy Network (TN) 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
TN Main Telephone Numbers	1-855-825-7818	
Claims Processing (Outpatient Therapy ONLY)	1-877-372-1273	
Member Services	Contact Member Services at the member's health plan.	
Provider Relations	1-855-825-7818	1-877-403-5544
Referrals/Authorizations	1-855-825-7818	1-855-825-7820
Verification of Eligibility	Contact the member's health plan.	

Authorization Process

Provider Type	Evaluation	Physical Therapies: PT/OT/ST
Therapist (PT/OT/ST)	Therapist must have a prescription or script from the ordering physician (Primary Care Physician [PCP] or specialist). No preauthorization is needed from TN for therapist to perform an evaluation.	**Therapist must complete the TN Intake Form** (Attachment A) and submit via fax to TN's Authorization department for issuance of authorization for episode of treatment. Use a separate Intake Form for PT, OT or ST.

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

Inpatient services ARE NOT included in the scope of TN's authorization process and are subject to the patient's health plan authorization policies and procedures.

Evaluations

Patient evaluations are covered for eligible members with a physician prescription for therapy. No advance notification to TN is necessary. Referring physicians will be given complete lists of network therapy locations, but you are encouraged to educate your referral sources of your participation in the program.

Eligibility should be verified with the health plan. As noted in your contract, TN 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 TN contract provisions.

Authorization 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.

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 TN for clinical review and the member's health plan for final medical necessity determination, if applicable.

Communicating Referral/Authorization Information to Therapy Network

	Hours of Operation	Phone Number
TN Referral Coordinator	Monday through Friday, 9:00 a.m. to 5:00 p.m. ET	1-855-825-7818
Fax Requests	24 hours a day, 7 days a week	1-855-825-7820
Voice Mail Message	24 hours a day, 7 days a week	1-855-825-7818

As soon as possible after completing your evaluation, fax the information requested on the applicable TN Patient Intake Form (Attachment A or C as appropriate) along with the corresponding ordering provider's prescription to our **Toll-free Referral Fax Line at 1-855-825-7820**. You may also call it in through our main number and select the option of speaking to a TN Referral Coordinator. Upon receipt of an appropriately completed Patient Intake Form, TN will provide an authorization number related to the therapy services that are to be provided. Please note the following regarding the TN Patient Intake Form:

For medical diagnoses, we are looking for the diagnosis in medical terms (e.g., M542 Cervicalgia). It is not necessary but may be helpful to include the ICD-10 code. 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, etc.
You do not need to answer questions for therapies you will not be doing. (For example, if you are doing physical therapy, you would not answer the questions under occupational or speech therapy.)

If providing therapy to a child, and the child is receiving any therapy service through the school system or a Birth-to-3-year-old program, this information must be provided (describe type and frequency of treatment). If the therapy is related to surgery, please identify the date and nature of surgery on the Intake Form. If the therapy is related to a CVA, please submit the date of the CVA.

Please note that failure to submit a completed Patient Intake Form to TN could result in nonpayment for your services. Claims should not be submitted to TN prior to a provider receiving confirmation that therapy services have been authorized by TN.

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, TN 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. A therapy provider may not limit access to appropriate services because of what is perceived to be an inadequate fee. Some patients will need more while some patients require fewer visits than expected for the fee provided. The only acceptable course of action is to always provide appropriate care and follow the upgrade process where necessary.

The assignment of levels is based on diagnosis, intensity of services normally required for patients with like characteristics, patient utilization and circumstances to date. In general, levels are assigned as follows:

Level 1 One-time visit
Level 2 Mild to moderate diagnosis, including most fractures and spinal sprains
Level 3 Moderate to more severe diagnosis; most shoulder issues other than joint pain, most postoperative treatment
Level 4 Severe diagnosis; THR, TKR, TSR, CVA less than four weeks
Level 5 Severe and catastrophic cases

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 discipline.

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. TN will issue ONE Control Number that will be valid for a 60 day treatment period. Examples of Acute Cases are most fractures and spinal

sprains and strains, most shoulder issues other than joint pain, most post-operative treatment, MS, CVA older than 4 weeks, Arthroscopies, and Spinal Stenosis.The Provider will continue to treat the patient for the 60 day treatment period submitting claims for every date of service, for every procedure performed.

Request of an Upgrade for Acute Care

There may be instances when an level is issued, but the treating provider realizes that the intensity of services required is greater than anticipated. The provider may request an Upgrade of the level originally issued. An Upgrade Request is a request for a higher level than what was originally issued based on the member's medical need. It may only be requested during the referral time period of the original level.

How to Request an Upgrade for an Acute Care Case

The provider will submit a request for an Upgrade using the Upgrade Request Form. The provider must attach the TN Upgrade Request Form. The Upgrade Request must include the current progress summary report, which should include:

- Patient deficits in strength (MMT), range of motion (ROM), etc. expressed objectively
- Specific treatment goals defined objectively with time frame to achieve goal
- Relevant Factors may include date of surgery or a significant change in condition
- In addition, please note the following regarding the upgrade process:
- When requesting an upgrade of an assigned level, you will need to submit the Evaluation, Plan of Treatment, and Progress Summary.
- For the benefit of the member, all providers utilizing the upgrade process should not discontinue or delay their treatment to the member.
- If at any time the provider would like to further discuss an upgrade request or issue, please call the Referral Department to request a peer-to-peer review with our clinical consultant who reviewed the upgrade request.

Approval Process of an Upgrade Request for Acute Care

The Upgrade request will be reviewed by a clinical consultant. If a higher level is issued, the difference in payment amount between the original assigned level and the upgraded level will be paid.

If medical necessity is not determined based on information received, a peer-to-peer consultation is offered to treating provider.If after the peer-to-peer a decision cannot be agreed upon, the request for an upgrade will be submitted to Amerigroup Health Plan of NJ for final determination. Upgrades may not be applied retrospectively (after the 60 day treatment period has ended). If TN determines not to upgrade the level request, it should not be discussed with the member.

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 or care. Financial incentives for UM decision makers do not encourage decisions that result in underutilization. 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 level payments as long as the member remains in active treatment per the POC. TN will send the Provider ONE Control Number that is valid for the 180 day treatment period.The Provider will continue to treat the patient for the 180 day treatment period **submitting claims for every date of service, for all procedures performed.**

Payment of Levels for Developmental Delay

TN will pay the Provider for the 1st level upon the receipt of the first claim following the Evaluation.TN will pay the Provider for the 2nd level upon the receipt of the first claim following day 60 of the 180 day treatment period. TN will pay the Provider for the 3rd level upon the receipt of the first claim following day 120 of the 180 day treatment period. 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 for Developmental Delay

If a provider has a member requiring a greater intensity of services, the provider may request an Upgrade. The provider must submit the TN Upgrade Request Form.

The Upgrade Request must Include the current progress notes, which should include the actual measurements of the delay using a standardized tool and complete documentation of any improvement achieved in therapy.

Approval Process of an Upgrade Request for Developmental Delay

TN will submit the Upgrade request to the Clinical Consultant (a licensed therapist in the same discipline) for review.

Upon approval of the Upgrade request TN will modify the existing referral to a higher level. The Provider will receive via facsimile the Control Number referencing the higher level.

If medical necessity is not determined 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 Amerigroup Health Plan of NJ for final determination. If TN determines not to upgrade the level request, it should not be discussed with the member.

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 or care. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Payment of Levels when an Upgrade is Approved for Developmental Delay

If at any time during the 180 day treatment period the provider requests an Upgrade and TN increases the level assigned, the current level AND all subsequent levels will be paid at the higher level during the 180 day treatment period.

Upgrades may not be applied retrospectively (after the 180 day treatment period has ended).

Re-evaluations

In some cases, patients may require significant, additional covered therapy beyond the initial duration of the authorization issued. In these instances, the provider may request a new authorization for an additional, extended time period.

In order to facilitate a new authorization, ALL of the following 3 steps should be taken:

1. Obtain a new or renewed physician prescription from the patient's Primary Care Physician (PCP) or ordering specialist.
2. Perform a re-evaluation of the patient and fill out a new Therapy Intake Form.
3. Submit re-evaluation and previous evaluation, if available, to TN.

Upon receipt of the information listed above, TN will review the submitted documentation. If the new authorization is approved, TN will renew the authorization cycle.

Multiple Case Authorization

If a therapy provider determines there should be two separate case authorizations instead of one, a separate Intake Form along with the physician's prescription for the separate discipline must be submitted following evaluation.

TN will refer a request for a multiple case authorization, or any subsequent, additional authorizations 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 justification for the multiple or additional authorizations is unclear.

In all instances, a requesting provider is always notified of the outcome of his or her request for authorization.
Any additional authorization issued by TN 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 authorizations:

- You will need to submit the ordering provider's prescription in order for TN to make the appropriate determination.
- TN 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, TN 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 TN will not issue a separate level.

If, after treating a member for several weeks, you find that the initial level is not sufficient, you have the option to initiate the upgrade process.

Home Therapy Cases

For therapy providers that provide medical services to members in the home, it is important to notify TN of any and all of the following circumstances:

- If you cannot reach the member you have accepted for therapy within 48 hours
- If you need to start treating the member after evaluation, please do not wait for a level to start treating the patient — call TN Monday through Friday from 9:00 a.m. to 5:00 p.m., and a level will be assigned immediately

- If a member is getting nursing home health services by a home health agency
- If a member is bedridden

Please remember when a home therapy case has been faxed to you and you have agreed to treat the member, TN must be notified within 24 hours of fax receipt, except in cases of hospital discharges. In those cases, TN will contact you immediately to confirm acceptance.

Therapy (PT/OT/ST) Practice Guidelines

When making medical necessity recommendations and determinations for Medicaid members, TN's clinical staff applies the Apollo Medical Review Criteria and Clinical Guidelines. For Medicare members, TN's staff adheres to CMS coverage guidelines. 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. For any medical necessity recommendation of denial, the medical director shall make an attempt to contact the requesting provider for peer-to-peer consultation.

TN's practice guidelines are available in both electronic and hard-copy format. If you would like a copy of a guideline, contact your assigned Provider Relations representative or the Utilization Management department, and a copy will be provided.

Claims And Reimbursement

Therapy Network's preferred method of claims receipt is EDI (Electronic Data Interchange). TN utilizes Emdeon (WebMD) as their clearinghouse for the receipt of all EDI claims.

The payer ID numbers to submit your EDI claims to TN are:

- **For professional claims (837P): 65062**
- **For institutional claims (837i): 12k89**

*Please note that these payer ID numbers are listed as Health Network One with Emdeon.

TN also offers providers the convenience of a Web based Provider Portal for all contracted providers. Providers may use the WebPortal for all of their claim needs including claims submission using Direct Data Entry functionality (DDE). Please contact webmaster@healthsystemone.com to ensure you are set up to use the WebPortal.

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

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

You do not need to be an Emdeon client to bill your claims via EDI to TN. Please contact your billing software vendor and have them add the TN payer ID number so your claims can be billed via EDI. For more information on how to submit your claims for TN via EDI, please visit the Emdeon website at www.emdeon.com.

How to bill TN (key points):

- Only send to TN claims for outpatient therapy services that have a date of service of
- December 15, 2013 or later.
- Always use a CMS-approved format, whether electronic or paper.
    - 837P for edi professional claims and 837i for edi institutional.

- Paper claims may only be submitted on an original CMS-1500 form for professional claims and the CMS-1450 (UB-04) form for institutional claims. Copies of claim forms are never acceptable on an initial claim submission and will be returned.
- The NPI of the rendering provider or supervising therapist is required in each claim submitted in addition to the group NPI number.
- Please ensure you submit your claims using the TIN you used when you contracted with TN.
- Always make sure to include the service location in the claim.
- Do not bill for different types of services in the same claim (for example, do not list outpatient PT and outpatient OT on the same claim).
- Therapy providers must always document the appropriate TN Authorization Number in the claim. Claims that do not include this information may be denied payment.
- Therapy providers must always bill each episode of treatment separately so the authorization number relating to the service you provided can be clearly identified in your claim.
- Therapy providers who have multiple authorization numbers for the same member must list the authorization number applicable to each episode of treatment in 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 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.

Reimbursement

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 we need for internal monitoring and review.

To meet timely filing requirements, therapy claims submitted for payment must be received within 180 days of the date of service. Payment for therapy claims received beyond 180 days from the date of service filing will be denied appropriately.

Failure to obtain required authorization allows TN to reduce compensation up to 50 percent at the sole and absolute discretion of TN. An authorization shall be in writing from TN. 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 TN authorization.

Be reminded that any question you may have regarding your contract or other issues not specifically related to referrals or claims may also be directed to TN's Provider Relations staff.

Reimbursement of Upgrades

If a member's authorization is upgraded to a higher level after TN issued payment at the initial level (e.g., an authorization 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. See Timing of Claims Payment for a timeline.

Claim Status Inquiry

For claims status, you can log in to the Provider Web Portal by going to www.healthsystemone.com. For questions or to request a Provider Web Portal account, please send an email to webmaster@healthsystemone.com. Kindly include your contact name, TIN, provider contact, provider contact email and provider contact phone number. The Provider Web Portal is avaialbe to all contracted provider 24 hours a day/7 days a week and is the best method for meeting your Claims Inquiry needs. However, for those providers who need to speak to a representative you can call the TN Claims Customer Service Center and speak to a TN Claims representative Monday through Friday from 8:30 a.m. to 5:00 p.m. at **1-877-372-1273.**

Coordination of Benefits

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

Do not send outpatient PT/OT/ST claims to the health plan. Payments inadvertently made to you by the health plan are overpayments and have to be returned to them.

Timing of Claims Processing

TN's claims turnaround standards are as follows:

- 90 percent of electronic claims are paid within 30 calendar days from the date of receipt.
- 90 percent of paper claims are paid within 40 calendar days of receipt.
- 99 percent of all paper or electronic claims are paid within 60 calendar days of receipt.
- 99.5 percent of all claims are paid within 90 calendar days of receipt.

100 percent of all Medicare claims are processed within 60 days.

Claims Payment Dispute

All providers of Therapy Network have 3 months from the date of the EOP/EOB to dispute a processed claim. However, TN reserves the right to consider all requests received after the 3 months has expired. Please utilize the Claims review form located as an attachment in this handbook to mail and dispute your claim. For your conveniencve you may also call a Claims representative at 1-877-372-1273 to inquire about your processed claims and/or to request a claims adjustment.

Medicaid providers of Therapy Network have 3 months from the end of the month of payment to make a claims payment dispute. However, TN reserves the right to consider all requests received after the 3 months have been exhausted.

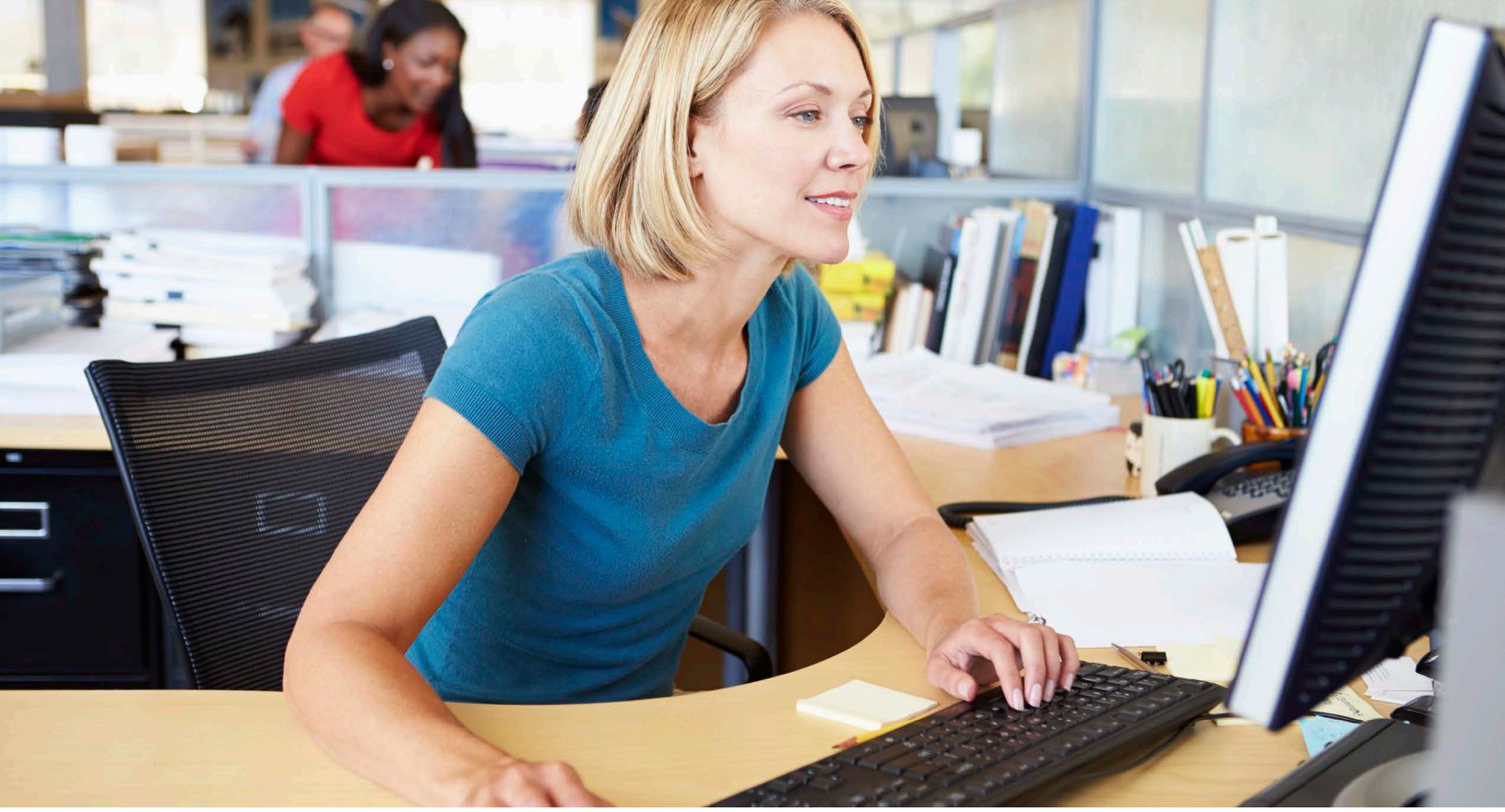
For Medicare providers, TN adheres to the CMS guidelines that govern the re-opening and revising of finalized claims. CMS stipulates that clerical errors (which include minor errors and omissions) are classified as "reopenings" instead of reconsiderations. Clerical errors include both human and mechanical 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". TN classifies these reopenings as an adjustment claim. Reopenings and/or adjustments requests may be requested in writing or by telephone.

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

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. Fax in the specific request by completing the Splint Intake Form (Attachment B) with materials used, and payment will be assigned according to the TN fee schedule.
- Other braces and splints, orthotics and prosthetics, and durable medical equipment are not included in our contracts with health plans and should be referred to the health plan's designated, participating network providers (noted in the health plan-specific information attached) by the physician.



Provider Complaint Process

Any participating provider can call the Provider Relations department with a formal expression of dissatisfaction pertaining to network administrative issues, claims and/or billing practices, contracting issues, accessibility of providers, network adequacy, etc.

- If your complaint cannot be resolved at point of contact, the Provider Relations representative will provide a call-back date within five days.
- When your complaint cannot be resolved within five days, the Provider Relations representative will acknowledge the complaint in writing and notify you that the issue will be resolved within 30 days of the original date of your complaint.
- Once resolved, a Complaint Resolution Outcome Letter will be sent to you and the provider describing the outcome determination.
- If you are not satisfied with the determination, your Provider Relations representative will provide you with an Administrative Dispute Resolution Process Form upon request.

Provider Relations Department

Therapy Network of New Jersey
P.O. Box 350590
Fort Lauderdale, FL 33335-0590

Telephone: 1-855-825-7818
Fax: 1-877-403-5544

Provider Appeal Process

If the outcome of a complaint is not to your satisfaction, you can request to initiate one of the two appeal processes:

1) Administrative Dispute Resolution Process

This can be initiated for any unsatisfactory complaint determination by the network involving contractual compliance, capitation check, accessibility of referral networks, Provider Relations complaints, incorrect demographics, etc.

Contract the Provider Relations department to receive an Administrative Dispute and Resolution Form to begin this appeal process.

2) Provider Claims Appeal Process

Any provider can initiate the Claims Appeal Process by completing the New Jersey Department of Banking and Insurance Health Care Provider Application to Appeal a Claims Determination on or before the 90th calendar day following receipt of the disputed claim determination, the basis of the appeal. Therapy Network of New Jersey (TNNJ) will render a determination of the appeal within 30 days of receipt. If this is not a satisfactory appeal determination, this claim issue can be referred to arbitration through the Commissioner of Banking and Insurance. The disputed amount must be $1000.00 or more and can be the aggregation of the disputed amounts for purpose of meeting the threshold requirements.

Contact the Provider Relations department to initiate this process by completing the Health Care Provider Application to Appeal a Claims Determination Form.

To contact the Provider Relations Department, use the following information:

Therapy Network of New Jersey
P.O. Box 350590
Fort Lauderdale, FL 33335-0590

Telephone: 1-855-825-7818
Fax: 1-877-403-5544

Quality Improvement

HN1 TN 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: authorization 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 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.

Disclaimer: This manual pertains to Therapy Network of New Jersey policies only and is only a supplementary tool for Amerigroup providers. For details on Amerigroup policies, procedures and benefits, reference the Amerigroup provider manual at the following website: providers.amerigroup.com.

www.mytnnj.com

THERAPY NETWORK
OF NEW JERSEY