# Provider manual

## Resources, policies and procedures for provider participating with TNPR

THERAPY NETWORK OF PUERTO RICO

mytnpr.com | 1-877-614-5056

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# Welcome to TNPR

Dear Therapy Network of Puerto Rico provider,

Receive a warm greeting from Therapy Network of Puerto Rico! We reiterate our promise to be alongside our provider community, facilitating the necessary support to your day to day operations, so you know you can count on us come rain or shine. We thank you for trusting our team, and for your continuous support throughout the years.

This TNPR Provider Manual is intended to serve as a reference guide to assist you and your staff in understanding all required administrative procedures related to the Physical Medicine & Rehabilitation (PM&R), and Physical Therapy (PT), Occupational Therapy (OT) and/or Speech Language & Pathology (SLP) services you provide to our contracted health plan's affiliated members. We hope that you will find the information included in this document to be concise and useful in your role as a Physiatry/Therapy provider. This Provider Manual does not address clinical decision-making, which remains entirely in your hands as a licensed, qualified practitioner.

This Provider Manual is regularly reviewed, and updated as needed in order to be of assistance and support for the end user. It is important that all contracted providers keep up to date with the latest version of this Provider Manual as your participation agreement with TNPR contains an obligation to comply with the processes and procedures presented in this manual.

We invite you to access the Provider Recourses area of www.mytnpr.com to access the latest version of this provider manual.

Sincerely,

**Your Therapy Network of Puerto Rico Team**

# Contact Information

| Department | Telephone | Fax |
|---|---|---|
| TNPR Main Telephone Number | (877) 614-5056 | (877) 403-5544 |
| Referral/Authorizations | (877) 614-5056<br>Select Option #1 | (800) 615-0148 |
| Provider Relations | (877) 614-5056<br>Select Option #2 | (877) 403-5544 |
| Claims Processing | (877) 614-5056<br>Select Option #3 | (877) 453- 1220 |

For Member Services and the most current member eligibility information, please contact the Member's Health Plan's Member Services Line.

Also, you can send your question to our Provider Relations email: TNPRProviderRelations@mytnpr.com.

Please do not submit questions via email containing member PHI.

**Provider Relations Department Direct Numbers**

| Name | Title | Phone Number |
|---|---|---|
| Yaritza Laboy | Provider Service Representative | 787-983-1864 |
| Fredly Jimenez | Provider Service Representative | 787-983-1835 |
| Marla Camareno | Provider Service Representative | 954-478-6404 |
| Ricardo Grover | Network Director | 787-473-2819 |

# Physiatrist Services

**Physiatry**

Patient evaluations are covered for eligible members. No advance notification to TNPR is necessary, as long as the Physiatry service performed is listed on the Approved Code List (ATTACHMENT A).

Referring clinicians will have access to each member health plan active providers through the directory for Physiatry provider location information; however, 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, TNPR will not guarantee payment except for those patients actually eligible with the payer at the time of service, and subject to all other TNPR contract provisions.

**Authorization Process for Physiatry Providers**

Physiatry providers do not require a pre-authorization from TNPR, as long as the service(s) provided are listed on the Approved Code List (ATTACHMENT A).

If the service is not on the Approved Code List, the Physiatry provider must complete the Provider Web Portal Intake Form (Provider Web Portal: https://asp.healthsystemone.com/hs1providers/login) and submit to TNPR for review (ATTACHMENT B).

# Therapy Services

**Therapy Evaluations**

Patient evaluations are covered for eligible members with a physician prescription for therapy. No advance notification to TNPR is necessary. Referring clinicians will have access to each member health plan active providers through the directory for 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, TNPR will not guarantee payment except for those patients actually eligible with the payer at the time of service, and subject to all other TNPR contract provisions. It is essential that communication with the referring physician occurs after the patient evaluation and continues throughout their course of treatment.

**Clinical Requirements for Therapy Services**

Patients are entitled to all medically necessary, covered care as determined by the treating therapist in consultation with the referring physician.

Extended Episode Fees (Case Rates) are fixed rates over a period of time of 60 calendar days for all reasonable necessary service and appropriate treatment. Under this model, TNPR does not dictate or specify exact treatment requirements or visit limitations. It is expected that the therapy providers will render the appropriate care, delivered efficiently and educate in order to assist the member reach the plan goal. The following conditions apply:

- Services are required because the individual need skilled therapy services
- A plan for furnishing such services has been established by a physician/NPP or by the therapist providing such services and it is periodically reviewed by a physician/NPP
- Services are furnished while the individual is or was under the care of a physician
- The patient functional limitations(s) need to be reported as part of the therapy plan of care and expressed as part of the patient's long term goals.

A therapy provider may not limit access to appropriate services because of what is perceived to be an inadequate fee. Providers can always access to the upgrade process if applicable.

In the event of a disagreement between a therapy provider and/or patient (for example, the patient demands treatment that is of no further clinical value), the case may be submitted to TNPR for clinical review and the member's health plan for final medical necessity determination.

**Authorization Process for Therapy Services**

After completing your member's evaluation, it is recommended to promptly request the authorization via the Provider Web Portal. Please complete in all sections and submit with the evaluation and with the corresponding ordering provider's prescription.

In the event you can't access the Provider Web Portal you may submit your request via fax (1-800-615-0148) and make sure you use the updated version of the Intake form. (See Attachment B and/or C) We encourage the use of the web portal to guarantee real time decision and eliminate transmission errors.

Upon receipt of an appropriately completed Therapy Intake Form and supporting documentation, TNPR will review and provide an authorization number related to the Therapy Services if applicable.

Please note that failure to submit a completed Therapy Intake Form to TNPR could result in non-payment for your services. Claims should not be submitted to TNPR prior to a provider receiving confirmation that Therapy services have been authorized by TNPR.

**Documentation Requirements for Authorizations**

Please submit all supporting documents with your request via the Provider Web Portal (PWP). The PWP allows you to attach documents in a variable of formats (PDF, Photos word, Adobe). To ensure timely processing, please attach the critical elements to your authorization request as documented in the grid below.

**Table 1**

| | 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 | | X** |
| Multi-Body Parts Request | X | | X*** | X | | |

* If Initial documentaion 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

**Table 2**

| Element | Critical Elements |
|---|---|
| Intake Form (please use the provider web portal) | • Complete in all sections<br>• Rendering provider must be a physical, occupational or speech pathologist with active Medicare/Medicaid participation |
| Medical Order (RX) or Referral Form | • Only MDs and Podiatrist<br>• Must include patient name, date, Dx code or treatment area or condition, service (PT, OT, SPL, Splint), Signature, license number and NPI number |
| Evaluation | Must be written by a participant Therapist:<br><br>• Documents must be legible. Use accepted medical abbreviations.<br>• Include diagnosis which should be specific and relevant to the problem to be treated.<br>• Document the necessity for a course of therapy through objective findings to support subjective -patient self-reporting. (Pain, range of motion , muscle strength , balance, tolerance, functional status (objective or subjective) test, special test, sensation, posture)<br>• Pertinent medical and social history, not just the treatment Dx.<br>• Prior level of function, if applicable.<br>• Goals (Measurable and Functional).<br>• Plan of care (POC)<br><br>RE-EVALUATION: Must be written by a participant Therapist. Needs to include new clinical findings, a significant change in the patient condition, or failure to respond to the therapeutic interventions outlined in the plan of care and established goals. Must contain all the elements of the initial POC with any changes to the treatment plan, new goals, or reason why the original goals were not met. |
| Plan of Care (POC) | The plan of care shall be consistent with the related evaluation, which may be attached and is considered incorporated into the evaluation. A POC must contain:<br><br>• Diagnoses<br>• Treatment Goals (Goals should be measurable and pertain to identified functional impairments).<br>• Type, amount, duration and frequency of therapy services<br>• Signature, date, and professional identity of the therapist who establish the plan<br>• Plan of Care, must be signed and dated by the referring physician<br><br>***POC written by PMR will be accepted under the following circumstances: in case the POC written by PMR MD doesn't include any of this sub-elements, the RPT must complement it by documenting the missing information.** |

**Re-evaluations**

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

In order to facilitate a new authorization, provider should:

- Obtain a new or renewed physician prescription from the patient's Primary Care Physician, or ordering Specialist;
- Perform a re-evaluation of the patient;
- Fill out a new Therapy Intake Form;
- Submit re-evaluation and previous evaluation, if available, to TNPR.

Upon receipt of the information listed above, TNPR will review the submitted documentation. If the new authorization is approved, TNPR will renew the authorization cycle. This will be consider a 2nd episode of therapy. If a 3rd request for therapy is received, case will be assigned to a Therapy Consultant, the Consultant will determine if an additional episode meet medical necessity. The following scenarios can occur after the documentation is reviewed:

- If the service is reasonable and medical necessity is established the case is approved.
- If the documentation does not meet medical necessity, a Peer to Peer call is attempted to discuss with the provider. During the Peer to Peer discussion the provider may offer new or relevant clinical information, enough to approve the case for a new episode.
- If after Peer to Peer discussion or attempts, the case still does not meet medical necessity the Therapy Consultant may determine that it should be referred for denial (RFD) to the Health Plan. Case will be sent to the TNPR Medical Director to confirm the RFD prior sending it to the Health Plan. Final determination (approval or denial) is made by the Health Plan.

**Upgrade Process**

There may be instances when a higher level than originally assigned may be justified due to changes of the member's condition and other medical factors requiring more intensive treatment relative to the basic diagnosis, or in other cases. For these cases a review process that could result in a higher level is available. However, TNPR will have final determination regarding the Level that is assigned. If necessary, a peer-to-peer consultation may be requested by a therapy provider.

Requests for upgrade of the assigned level can be made by filling out the Upgrade Request Form (Attachment C) indicating the nature of the request, the # visits scheduled, the # visits completed and date of last evaluation and submitting Evaluation and Plan of Care or Progress notes. Any request for an upgrade must be submitted while the authorization is still active. No extension to the authorization period will be granted due to an upgrade request. Upgrades will not be authorized retrospectively.

A TNPR clinician will review the request. Upon approval, TNPR will approve the upgrade request.

If medical necessity for upgrade is not established based on the information, a peer to peer is offered to the treating provider. If after the peer to peer a decision cannot be agreed, the request for an upgrade will be submitted to the Medical Director for review.

It is important that the evaluation and progress notes follow appropriate standards of documentation. (See Table 2 – Critical Elements).

**Multiple Case Authorization**

If a physician determines that a member requires therapy for more than one condition he/she must state so in the prescription. If a therapy provider after the evaluation determines that the patient require therapy for different non related condition the therapy provider must obtain referring physician's prescription for the separate condition.

TNPR 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/additional authorization is unclear. In all instances, a requesting provider is always notified of the outcome of his/her request for authorization.

TNPR does not issue a separate Episode Level for symptoms or conditions associated with the main diagnosis. For example, a therapy request for Status Post Total Knee Replacement TNPR assigns a level according to date of surgery. Concurrent request for pain including back pain, gait instability, muscle weakness, etc. are all due to the main diagnosis. For required documentation please refer to table 1.

**Home Therapy Cases**

For Therapy providers that render services to members at home, it is important to notify TNPR of any / all of the following circumstances:

1. If you cannot reach the member you have accepted for therapy within 48 hours.
2. If a member is getting Nursing Home Health Services by a Home Health Agency
3. If a member is bedridden.

For 2nd and 3rd circumstances, services must be coordinated by Health Plans via Home Care Agency only.

Please remember that when a home therapy case has been accepted by the provider to treat the member, TNPR will send the approval notice with the member information to schedule the evaluation.

Evaluation must be performed as follows:

- Urgent, hospital discharge, post-surgery and SNP cases within 48 hours of the acceptance of the case.
- Routine/standard cases within 7 days.

If you need to start treating the member after evaluation Please do not wait for a level to start treating the patient.

**Lymphedema Therapy**

Our current lymphedema therapists are RPT's or ROT's, certified on lymphedema therapy by agencies providing this continuous education. At Therapy Network PR, we consider this certification as a subspecialty for the profession. Therefore, the provider should submit evidence of education and certification. For this service, claims will be paid under FFS according to Medicare rates. If the provider has not been validated as certified for this service by TNPR, the service will be paid as case rate. Provider will be individually educated about the specific requirements for this service.

**Vestibular Therapy**

Our current Vestibular Rehabilitation therapists are RPT's certified on VRT by agencies providing this continues education. At Therapy Network, we consider this certification as a subspecialty for the profession. Therefore, the provider should submit evidence of education and certification. For this service, claims will be paid under case rate model. Provider will be individually educated about the specific requirements for these service.

**Clinical Guidelines**

To establish medical necessity, TNPR uses the Medicare National and Local Coverage Determinations Guidelines.

The assignment of Levels is based on diagnosis, intensity of services normally required for patients with like characteristics, patient utilization and circumstances to date. Based upon this information, TNPR uses evidence based clinical guidelines including Apollo Manage Care for Physical/Occupational/Speech Therapy and Rehabilitation Care to determine such levels. In general, levels are assigned as follows:

| | |
|---|---|
| **Level 1** | One (1) time visit (evaluation or education only) |
| **Level 2** | Mild to moderate diagnosis including most sprains (muscles and tendon and strains (ligaments) |
| **Level 3** | Moderate, most fractures, shoulder issues other than join pain, some post-operative treatment, facial paralysis, chronic CVA. |
| **Level 4** | Severe, THR, TKR, TSR, ORIF, Spine Fusion less than 16 weeks, and CVA less than 16 weeks, Nerve grafting, tendon repair. |
| **Level 5** | Severe and catastrophic cases, paraplegia, quadriplegia, complicated or extended treatments |

# Requests for Orthosis

In order to approve a custom made upper extremity orthosis the provider:

- Should have a physician prescription.
- Should complete the Splint Form Request (Attachment D). The form is located at www.mytnpr.com under Providers Resources/Forms.
- Off-the-shelf supplies are not covered.
- Should attach the medical prescription/referral. Upon receipt, a level will be issued according to TNPR Fee Schedule.

Other orthotics not included in Attachment D and prosthetics, durable medical equipment, are not included in our contracts with the Health Plans and should be referred to the member's Health Plan.

# Credentialing

Provider and all therapists employed by and/or associated with provider, including covering therapists must meet all credentialing and re-credentialing requirements as may be established by TNPR in order to treat members. Also Facilities and all facility locations associated with provider shall meet all credentialing and re-credentialing requirements as may be established by TNPR.

Note: Please notify us when you employ new therapists so that they may be credentialed. They may not render services to TNPR members until they have been fully credentialed. This requirement also applies for a new facility location or when relocating an existing facility.

Below are a few helpful hints to improve your credentialing success and minimize delays during this process.

1. Start early. Be aware that credentialing can take extra time if incomplete documents are received;
2. Pay attention to the details. Ensure that the credentialing applications are filled out properly.
   i. Include your current practice and all prior professional work history since graduating school in mm/dd/yyyy format on all start/end dates;
   ii. Provide the complete and proper school names with the education dates and degree(s) earned;
   iii. Include your current medical malpractice Declaration Page. If multiple providers are covered under a group, submit a roster on company letter head. If you do not have insurance, you will need to provide a dated and signed waiver form;
   iv. Provide hospital affiliations, if applicable. If you do not have hospital privileges, submit an admitting arrangement form;
   v. Attach a Collaborative Practice form and/or your Protocols if you are a mid-level provider;
   vi. Submit a copy of any certifications if you have a sub-specialty;
   vii. Sign and date "Consent & Release" and "Attestation";
   viii. Complete, sign and date the Disclosure of Ownership forms; do not leave any sections blank. Read and understand the question prior to marking it N/A.

# Claims and Reimbursement

## CLAIM SUBMISSION

TNPR offers providers 3 methods to submit claims:

### Electronic Data Interchange

TNPR's preferred method of claims submission is via Electronic Data Interchange (EDI). Please be advised this is through the clearing house Inmediata (aka Secure EDI). The payer ID to submit EDI claims to Inmediata is **"TNPR1"**. For more information on how to submit your claims via EDI, please contact Inmediata Business Integration Solutions at (787) 774-0606.

### Direct Data Entry

TNPR Providers may also use the HS1 Provider Web Portal (PWP) to submit claims via Direct Data Entry (DDE). The PWP provides your office with the ability to check claims status 24/7, regardless of the method of submission (paper, electronic, Web Portal entry). If you wish to sign up, please visit www.mytnpr.com/pwp to register for an account.

### Paper

However, if your practice is unable to submit claims electronically via EDI or DDE, please send the original CMS 1500 forms to:

**Therapy Network of Puerto Rico**
**Attention: Claims Processing**
**P.O. Box 350590**
**Ft. Lauderdale, FL 33335**

If you do not currently have the capability to submit claims electronically to TNPR and want to implement this process for your practice, please contact Inmediata Business Integration Solutions at (787) 774-0606.

## PAYMENT OPTIONS

TNPR's preferred payment methodology is via Electronic Funds Transfer (EFT), which guarantees that your funds are deposited straight into your bank account. TNPR has partnered with VPay to establish electronic funds transfer (EFT) payments to our providers. Another payment option is the innovative virtual credit card (vCard), which offers you the opportunity to receive transaction information via fax for you to process a funds transfer in your merchant terminal as you would with a credit card. To enroll in these options you need to contact VPAY at 855-388-8374 or email support@vpayusa.com. Lastly, although not recommended, you may also receive your payment via traditional paper check.

## KEY POINTS WHEN SUBMITTING CLAIMS

- Always use a CMS approved format, whether electronic or paper
- Only original red & white CMS 1500 paper claims will be accepted. Photo copies will be rejected and returned to sender.
- The NPI Number of the rendering provider or supervising therapist is required on each claim submitted in addition to the group NPI number.
- Please ensure that you submit your claims using the TIN that you used when you contracted with TNPR.
- 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 for the same date of service.
- Please separate calendar years of service.
- Submit complete 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 cannot be a PO Box.
- Include the ICD-10, place of service, date of service, units, billed amount.
- Include the TNPR Authorization number.
- Include 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) via direct data entry
  - Paper using an original CMS-1500 form

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

**Evaluation and Management Payment**

For reimbursement of higher levels of E/M codes (including but not limited to 99204, 99205, 99214, 99215) TNPR requests submission of medical documentation to substantiate the E/M code being billed. Supporting documentation will be reviewed by a clinician to substantiate all the services billed. The clinician will determine the appropriateness of payment based upon the medical documentation. Claims meeting the criteria for the billed codes will be paid accordingly. Any claim in which our clinician determines that the submitted documentation does not substantiate the services will be paid as determined upon the documents review. If your claim is denied due to E/M coding rules, in order to be re-considered, your claim must be resubmitted with the required medical record documentation to substantiate the service.

When reviewing your explanation of payment (i.e. 835), if you require additional information regarding the denial of a claim, detailed claims payment information can be found by logging on to the Provider Web Portal at www.mytnpr.com. In consistency with CMS protocol you should not bring your patient back on a different date of service to perform other services outside of the E/M visit for the express purpose of billing. It is important that you do not split your bill for the same date of service in an attempt to separate out the E/M service from the other procedures performed outside of the E/M. This practice will result in further denial and delay. All codes should be billed together for the same date of service on the same claim.

The web portal allows for attachments to be sent as well. The provider has the option to send their high level E & M either on an original CMS 1500 claim form with the supporting documentation or using the web portal and attaching the supporting documentation to their claim.

These claims must be submitted via paper to the following address:

Therapy Network of Puerto Rico
Attention: Claims Processing
P.O. Box 350590
Ft. Lauderdale, FL 33335-0590

**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 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. TNPR requests submission of medical documentation to substantiate the separately identifiable E/M code. Any claim for E/M codes **billed with or without a modifier 25** billed the same day as a procedure, received without the appropriate medical record documentation will result in a denial of this line item in the claim. In consistency with CMS protocol you should not bring your patient back on a different date of service to perform other services outside of the E/M visit for the express purpose of billing. It is important that you do not split your bill for the same date of service in an attempt to separate out the E/M service from the other procedures performed outside of the E/M. This practice will result in further denial and delay. All codes should be billed together for the same date of service on the same claim.

The web portal allows for attachments to be sent as well. The provider has the option to send their high level E & M either on an original CMS 1500 claim form with the supporting documentation or using the web portal and attaching the supporting documentation to their claim.

For claims in paper, please submit to the following address:
Therapy Network of Puerto Rico
Attention: Claims Processing
P.O. Box 350590
Ft. Lauderdale, FL 33335-0590

**Use of Modifiers for PT, OT or SLP Services**

The 3 therapy modifiers in effect according to provider's specialty are:

- GP – services delivered under an outpatient physical therapy plan of care.
- GO – services delivered under an outpatient occupational therapy plan of care.
- GN – services delivered under an outpatient speech-language pathology plan of care.

Also, particularly for physical and occupational therapy, you must submit the following modifiers:

**CQ Modifier:** Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant.
**CO Modifier:** Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant.

## REIMBURSEMENT

### Physiatry Reimbursement

Services are reimbursed as described in the Provider Services Agreement and/or the applicable Payer's Plan Addendum of your contract.

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 TNPR's Provider Relations Staff.

### Therapy 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 (60 days), 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 12 months of the date of service. 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 TNPR's Provider Relations Staff.

### Reimbursement of Upgrades

If a member's authorization is upgraded to a higher level after TNPR issued payment at the initial level (for example, an authorization for a service is issued at Level 2, however, after treatment has begun, the provider is granted an upgrade to Level 3) the initial payment (at Level 2 rate will be adjusted and a new payment at Level 3 rate) will be issued to the provider. (See Timing of Claims Payment for timeline)

## CLAIM STATUS INQUIRY

For claims status, please use in the Provider Web Portal the "Claim Search" tool that allows you to search all claims for services rendered by your Practice/Group, across all Master Plan Contracts and Locations. Use the search filters to refine your search. You can also call the TNPR Claims Customer Service Center and speak to a TNPR Claims Representative Monday through Friday from 8am to 5pm at (877) 614-5056, and select Option 3. Please note that you should wait at least 30 days from the date of claims submission before making a claim status request. This will allow for full claims cycle time.

## 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. 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 Non contracted providers have the right to request a reconsideration of the plan's denial of payment. Provider have 60 calendar days from the remittance notification date to file the reconsideration. Must include a signed waiver of liability form holding the enrollee harmless regardless of the outcome of the appeal. You may obtain a copy of this waiver using the following link: https://www.cmsgov/Medicare/Appeals-and-Grievances/MMCAG /Downloads/Appendix-7-Waiver-of-Liability-Notice.pdf.

Should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement; and must mail the reconsideration to the plan.

# Provider Trainings

TNPR providers, are required to complete regulatory and contractual provider trainings within Thirty (30) days of their contract effective date, and annually thereafter. These trainings can be accessed via our website at: https://mytnpr.com/trainings/.

Providers can easily complete these trainings from any desktop, laptop or mobile device and choose how to see the training information, either in an "outline" text format, or as a multiple slide presentation.

These trainings can also be downloaded, or print out for your records, nonetheless, trainings will be available in our webpage for as long as they remain valid. Providers are require to attest to having completed required trainings.

You will be able to submit this attestation to us by selecting all the checkboxes next to each training, and then "clicking" on the submit button at the bottom of the page.

NOTE: practices with multiple providers will need to have each provider attest to having received the annual trainings.

# Code of Conduct

Therapy Network of Puerto Rico's (TNPR) 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**

TNPR has built an all-encompassing specialty delivery system of quality physicians, 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, conducts 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. TNPR maintains evidence of annual training and all providers within our network are required to complete the training.

**Provider Cultural Competency**

TNPR'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. TNPR has created the cultural competency policy to ensure that effective medical services are provided.

TNPR'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, by calling our Provider Service Call Center at 1-877-614-5056 and selecting Option 2, via email to TNPRProviderRelations@mytnpr.com or via the Contact Us link in our mytnpr.com website.

# Fraud, Waste and Abuse

How to prevent Fraud, Waste 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, Waste and Abuse by contacting:
  - TNPR Hotline: 1 (866) 321-5550
  - Write: Att. Marjorie Henderson, Special Investigative Unit (SIU)
  - 2001 South Andrews Avenue, Fort Lauderdale, FL 33316
  - Email: SIU@healthsystemone.com
  - Fax: 1.866.276.3667 (Dedicated Compliance line) or
  - Contact your TNPR Provider Relations representative who will forward your inquiry to the Compliance Department

# Quality Improvement

TNPR 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 recommendations overturns, inter-rater reliability, telephonic accessibility, etc.
- Recredentialing process that includes the timeliness that comply with the three-year recredentialing process.
- Annual review and approval of practice guidelines.
- A Peer Review Committee that reviews quality-of-care issue that requires a determination made by a panel of peers.

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

# Medical Advisory Committee

As part of our operational structure we have a Medical Advisory Committee. This Committee includes representation of community providers that represents all specialties contracted in our Network and the Management team of Therapy Network of Puerto Rico. On a quarterly basis we meet together and discuss metrics, new rules, policies and procedures and the status of the Network.

# Provider Web Portal

Our main source of contact with our providers is via the Provider Web Portal (PWP) https://asp.healthsystemone.com/hs1providers/Login. This will allow you to be more effective, self-sufficient and paperless. You may find the following options available via the PWP:

- **Fill the Intake Form** – Facilitating faster data entry, and adding Therapy- specific data elements (such as standardized clinical test scores).
- **Claims Direct Data Entry** – We have expanded access to our Claim Entry page. You can submit your professional (CMS1500) and institutional (UB04) claims using our online Direct Data Entry page. No need to submit claims on paper anymore, just click the [Claim Entry] button on the left navigation menu.
- **Document Attachments** – you are able to upload multiple documents with your Intake Form or Claims Entry.
- **Search Member Eligibility**
- **Search the status of referral requests**
- **Search the status of your latest claims**
- **Generate EOP/RA reports for claims already processed**
- **News and Information** – Here you may find all important information of the different processes for your practice.

# Attachments

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

**Attachment A:** Approved code list
**Attachment B:** Therapy Intake Form
**Attachment C:** Upgrade Request Form
**Attachment D:** VPay Form

# References


- Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services (Rev. 10269, 08-07-20)
- OUTPATIENT REHABILITATION THERAPY SERVICES: COMPLYING WITH DOCUMENTATION REQUIREMENTS ICN: MLN905365 April 2019
- EVALUATION AND MANAGEMENT SERVICES GUIDE MLN906764 February 2021
- Apollo Manage Care for Physical/Occupational/Speech Therapy and Rehabilitation Care
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/signature_requirements_fact_sheet_icn905364.pdf


THERAPY NETWORK OF PUERTO RICO