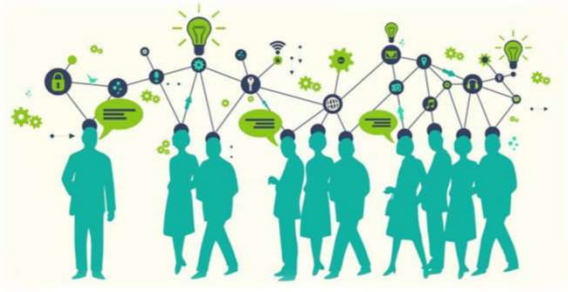
PTPN
Office Managers' Association (OMA) Meeting

November 2019



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Medicare Updates

Medicare MBIs

- CMS removed SSN/sensitive information from Medicare beneficiary ID numbers, new numbers called MBIs
- Transition period to allow time to get used to billing with new info
  - Ends December 31, 2019
- Starting on January 1, 2020 (regardless of DOS), claims will be denied unless billed with MBI
- https://www.cms.gov/Medicare/New-Medicare-Card/index.html

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Medicare Updates

Medicare MBIs – Claim Denials

- Most claims will be denied, only a few exceptions
- Will reject all eligibility transactions submitted with HICNs (old numbers)
- Claims reject codes for e-claims
  - A7 - acknowledgment rejected for invalid information
  - 164 - entity's contract/member number
  - IL – subscriber
- Reject codes for paper claims
  - 16 – claim/service lacks information or has submission/billing error(s)
  - N382 – missing/incomplete/invalid patient identifier

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Medicare Updates

Medicare MBIs – Denial Exceptions

- Plan Exceptions
  - Appeals
  - Adjustments
  - Reports
  - Retrospective reporting
- Fee-for-service Exceptions
  - Appeals
  - Audits
  - Claim status query
  - Span-date claims
  - Incoming premium payments

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Medicare Updates

CMS Final Rule 2020 - Basics

- First "threshold" for PT & SP, separate one for OT (after which you must bill with KX modifier)
  - $2,080
- Chart review request "threshold"
  - $3,000
- Fee schedule
  - Reimbursement in 2020 should remain about the same
- Part B deductible
  - $198

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Medicare Updates

CMS Final Rule 2020 - MIPS

- Threshold to qualify unchanged for 2020
  - $90k in allowable charges
  - 200 patients per year
  - 200 professional services (line items on your claims)
- Group vs. individual
  - The threshold measured by group or individual, you choose
- https://qpp.cms.gov/participation-lookup

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Medicare Updates

CMS Final Rule 2020 - MIPS

- Penalties & Bonuses
  - 2019 reporting → 2021 payment
  - 2020 reporting → 2022 payment
- 2020 reporting
  - Potential bonus if you have more than 45 points
    - Up to 9% possible bonus
  - Potential penalty if you have less than 45 points
    - Up to 9% possible penalty

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Medicare Updates

CMS Final Rule 2020 - MIPS

- 4 components
  - Cost & Interoperability – 0%
    - Both N/A for therapy providers, weight assigned to Quality
  - Improvement Activities – 15%
  - Quality – 85%

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Medicare Updates

CMS Final Rule 2020 - MIPS

- 2020 Reporting
  - Claims-based
    - Report on 70% of Medicare claims
  - Registry or QCDR
    - Report on 70% of all patients
- Claims, Registry, QCDR
  - Claims – only small practices (15 or less therapists) and individual therapists can use
  - Registry & QCDR – anyone can use

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Medicare Updates

CMS Final Rule 2020 – Assistant Modifiers

- PTAs and OTAs to bill with specific modifiers to indicate they performed at least 10% total minutes of treatment
  - Modifier CQ for PTAs
  - Modifier CO for OTAs
- Beginning 1/1/2020, must bill with these modifiers
  - Payment will not be affected in 2020 or 2021
- Beginning 1/1/2022, payment for PTA & OTA services to reimburse at 85% of applicable Part B payment

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Medicare Updates

CMS Final Rule 2020 – Assistant Modifiers

- Only applicable when Assistants are treating separately from therapists
  - If treating together, reimbursement should be full rate
- CMS to allow separate reporting on different line items of claims. Example:
  - Line 1 of claim – therapist treatment
  - Line 2 of claim – Assistant treatment (add modifier)
- No requirement to add documentation in chart that says why Assistant was or wasn't used

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Medicare Updates

Home Health

- Summer 2018, PTPN asked members about influence of Home Health on your outpatient therapy practices
- PTPN worked with APTA & APTA met with CMS Aug 2018
- PTPN shared ICN examples with CMS March 2019
- CMS responded in their Home Health proposed rule July 2019

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Medicare Updates

Home Health

- 11/1/19 CMS released 2020 Home Health final rule
  - Effective 1/1/2021, requires Home Health Agencies to notify CMS within 5 calendar days of the start of care
    - 2021 – Request for Anticipated Payment (RAP)
    - 2022 – Notice of Admission (NOA)
  - Establishes the beneficiary under Medicare home health period of care
- Should allow Medicare MACs to post this information on their portals
- No proposal on when Home Health Agencies to submit end of care

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PTPN Medicare Webinar

Mitch Kaye (QA Director) & Nancy Rothenberg (Vice President) will be hosting a Medicare webinar!

December 2019 or January 2020

Keep an eye out for invitations via email!

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FOTO MIPS Webinars

- FOTO QCDR & Wrapping up 2019 MIPS
  - Wed Dec 4 at 1:00 – 2:00 EST
- FOTO QCDR & Transitioning to 2020 MIPS
  - Tues Dec 10 3:00 - 4:00 EST
  - Wed Dec 11 12:00-1:00 EST
- Invitations to follow from FOTO

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Regulatory Compliance

HIPAA

- Posted Notice of Privacy Practices
- Some important policies
  - Access to Private Health Information (PHI)
  - Patient rights
  - Business Associate agreements
  - PHI breaches (including e-breaches)
  - Workstation privacy & passwords
  - Backup plans & disaster recovery
- Annual HIPAA In-services

HIPAA Health Insurance Portability & Accountability Act

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Regulatory Compliance

OSHA

- Some important policies
  - Bloodborne Pathogens exposure determination, control, cleanup
  - Hepatitis B vaccinations
  - Hazardous Waste identification, communication, cleanup
  - Chemical Inventory & SDSs
  - Emergency evacuation, fire prevention, First Aid
  - Safety self-audits
  - Incident reporting & recording
- Annual OSHA In-Services

OSHA® Occupational Safety and Health Administration

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Regulatory Compliance

Corporate Compliance

- Some important policies
  - Documentation guidelines
  - Fraud, waste, and abuse - areas of risk
  - Conflict of interest
  - Anti-kickbacks
  - Internal chart review program
  - Open lines of communication
  - Responding to compliance violations
- Annual review of policies

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Professional Liability

Malpractice Case

- HPSO & CNA Recommendations
  - Consult with referring doctor
  - Get informed consent in writing
  - Pay attention to co-morbidities and specific risk factors
  - Document all patient-related discussions
  - Provide proper clinical support & supervision for assistants, aides, students; don't let them perform service beyond scope of practice
  - Give annual performance reviews for all therapy staff
  - Ensure clinical practices comply with therapy professional associations, state practice acts, facility protocols
  - Review policies & procedures on regular basis with new and existing staff, ensure policies are effective and align with actual practices

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FOTO

New CA FOTO Contact

- Jonea Mohn
  - Started August 2019
    - jmohn@fotoinc.com
    - 800-482-3686 x247
- Cynthia Stancil no longer PTPN contact

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Triwest (Southern & Eastern States)

Veterans plans

- Optum awarded management of VA Community Care contract in eastern & southern states (Regions 1-3)
  - VAPC3 & VA Choice transitioning to Community Care eventually
- Regions 1 & 2 (MA, NJ, NY, PA, MI, OH) have started transition
- No transition date for region 3 (FL, GA, TN) yet
- Triwest involved in transition
- **California/western states (Region 4) still have Triwest contract, will remain unchanged**

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Triwest (Southern & Eastern States)

Veterans plans

- Initial Authorizations
  - Might come from VA, Optum, or Triwest – validate the source
  - Bill whoever sent authorization
- Additional authorizations
  - If Triwest appoints, send Second Authorization Request (SAR) to Triwest
  - If VA appoints, send Request for Service (RFS) to VA
    - Once transition over, only send RFS to VA
- More information
  - https://vacommunitycare.com
  - Optum's CCN Provider Services Department:1-888-901-7407
  - https://www.triwest.com/en/provider/news--updates/provider-transition-information/

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Anthem

AIM Specialty Health UM Program - CA

- Originally set to roll out mid-2019
- Delayed multiple times
- New launch date February 1, 2020
  - No prior auth needed through AIM until re-launch date
- Sept & Oct 2019 Anthem denials
  - Incorrectly went out stating pre-auth required
  - Anthem to fix issue without need for provider action

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Anthem

AIM Specialty Health UM Program – Southern & Eastern States

- Started 11/1/2019 in GA, NY, OH
- Medicare patients
  - New rollout date April 2020
    - Members don't need prior-auth through AIM until new rollout
  - Members in FL, NJ, and NY will still need prior-auth in meantime
- More information (all states including CA)
  - https://aimproviders.com/rehabilitation
  - rehabprogram@aimspecialtyhealth.com
  - Portal Login Issues: (800) 252-2021

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Health Net (CA)

- PTPN aware of some issues with Health Net
  - Claims projects from transition to Centene system still ongoing
  - General claims denials
  - Database fixes
  - Letters requesting additional documentation
- Still working with Health Net contacts to remedy issues
- If you are experiencing issues that you have tried to work on but were unsuccessful, contact your Provider Services Rep

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Health Net (CA)

HEDIS Medical Records Collection

- Chart review requests from Datafied
- Starts 12/1/2019 through 5/8/2020
- Assess the quality of care given to Health Net patients
- Send in charts within 5 days, Datafied will follow up until response received
- Questions – contact Health Net HEDIS team
  - 1(800) 640-3545
  - HEDIS@healthnet.com (unsecure email)

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Preferred Employers (CA)

- Contract ended 9/1/19
  - Still sending some additional authorizations for existing patients
    - Should honor old contracted rate if approval/auth says “PTPN” (not Homelink)
  - Claims address
    - PO Box 9000
      Daphne, AL 36526

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PTPN Contract Updates

Optum Health Allies (not Optum)

- Contract ending 12/31/19

Adva-Net name change

- In 2018 PTPN learned of name change to Paradigm
- Paperwork (auths, etc.) to reflect change soon

Access Medical Group/IPA (CA) management change

- Was Network Medical Management
- Now Prospect Medical

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Newest Vendors

activbody

ATHENA PHYSICIAN SERVICES, INC. Medical Billing & Consulting

LW Consulting, Inc.

Save a Life: The Importance of Implementing an AED Program at Your Practice - from AED Superstore and PTPN

Tuesday, November 19, 12PM Pacific
Register at: https://attendee.gotowebinar.com/register/513970411507940621

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MarketingPro Minute

FREE marketing tips, most recently:

- 3 ways the internet can help you write better marketing copy (September 2019)
- Use print marketing to connect with millennials (October 2019)
- Access archive on ptpn.com
  - Practice Marketing > click link to "Publications" in the 2nd paragraph > PTPN MarketingPro Minute

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New Medicare Beneficiary Identifier (MBI) Get It, Use It

MLN Matters Number: SE18006 Reissued
Related Change Request (CR) Number: N/A
Article Release Date: August 19, 2019
Effective Date: N/A
Related CR Transmittal Number: N/A
Implementation Date: N/A

Note: We reissued this article on August 19, 2019, to show that all new Medicare cards have been mailed, to encourage providers to use MBIs now to protect patients' identities, to emphasize that providers must use MBIs beginning January 1, 2020, and to explain the rejection codes providers will get if they submit a HICN after January 1, 2020.

PROVIDER TYPE AFFECTED

This Special Edition MLN Matters® Article is for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment MACs (DME MACs) and Home Health and Hospice MACs, for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Use MBIs now for all Medicare transactions. The Centers for Medicare & Medicaid Services (CMS) finished mailing new Medicare cards. The new cards without Social Security Numbers (SSNs) offer better identity protection. Help protect your patients' personal identities by getting their MBIs and using them for Medicare business, including claims submission and eligibility transactions.

Starting January 1, 2020, even for services provided before this date, you must use MBIs. With a few exceptions, Medicare will reject claims you submit with Health Insurance Claim Numbers (HICNs.) Medicare will reject all eligibility transactions you submit with HICNs.

There are 3 ways you and your office staff can get MBIs:

1. Ask your Medicare patients

Ask your Medicare patients for their new Medicare cards when they come for care. If they didn't get a new card, give them the Get Your New Medicare Card flyer in English or Spanish.

2. Use your MAC's secure MBI look-up tool

You can look up MBIs for your Medicare patients when they don't or can't give them. Sign up for the Portal to use the tool. You can use this tool even after the end of the transition period – the

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Medicare Learning Network®

tool doesn't end on December 31, 2019. Even if your patients are in a Medicare Advantage Plan, you can look up their MBIs to bill for things like indirect medical education.

You must have your patient's SSN for the search and it may differ from the HICN, which uses the SSN of the primary wage earner. If your Medicare patient doesn't want to give the SSN, tell your patient to log into mymedicare.gov to get the MBI.

If the look-up tool returns a last name matching error and the beneficiary's last name includes a suffix, such as Jr. Sr. or III, try searching without and with the suffix as part of the last name.

3. Check the remittance advice

We'll also return the MBI on every remittance advice when you submit claims with valid and active HICNs through December 31, 2019. Get the MBI from the remittance advice and save it in your systems to use with your next Medicare transaction.

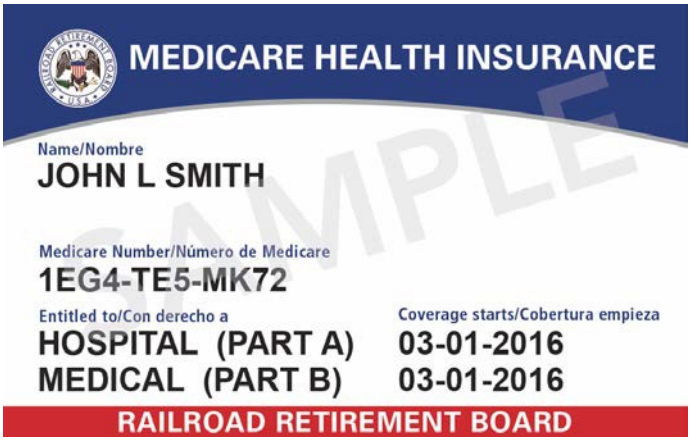
BACKGROUND

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required CMS to remove SSNs from all Medicare cards by April 2019. CMS replaced the SSN-based HICN with a new, randomly generated MBI. The new MBI is noticeably different than the HICN. **Just like with the HICN, the MBI hyphens on the card are for illustration purposes: don't include the hyphens or spaces on transactions.** The MBI uses numbers 0-9 and all uppercase letters except for S, L, O, I, B, and Z. We exclude these letters to avoid confusion when differentiating some letters and numbers **(for example, between "0" and "O").**

The Railroad Retirement Board (RRB) also mailed new Medicare cards with MBIs. The RRB logo will be in the upper left corner and "Railroad Retirement Board" at the bottom, but you can't tell from looking at the MBI if your patient is eligible for Medicare because they're a railroad retiree. You'll be able to identify them by the RRB logo on their card, and we'll return a "Railroad

Retirement Medicare Beneficiary" message on the Fee-For-Service (FFS) MBI eligibility transaction response.

RRB Issued Medicare Card



Use the MBI the same way you used the HICN. Put the MBI in the same field where you've always put the HICN. This also applies to reporting informational only and no-pay claims. **Don't use hyphens or spaces with the MBI to avoid rejection of your claim.** The MBI replaces the HICN on Medicare transactions including Billing, Eligibility Status, and Claim Status. The effective date of the MBI, like the old HICN, is the date each beneficiary was or is eligible for Medicare. After January 1, 2020, we will reject claims submitted with HICNs, with few exceptions. You will get:

- Electronic claims- Reject codes: Claims Status Category Code of A7 (acknowledgment rejected for invalid information), a Claims Status Code of 164 (entity's contract/member number), and an Entity Code of IL (subscriber)
- Paper claims- paper notice; Claim Adjustment Reason Code (CARC) 16 "Claim/service lacks information or has submission/billing error(s)" and Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/invalid patient identifier"

The beneficiary or their authorized representative can request an MBI change. CMS can also change an MBI. An example is if the MBI is compromised. There are different scenarios for using the old or new MBIs:

FFS claims submissions with:

- Dates of service before the MBI change date – use old or new MBIs.
- Span-date claims with a "From Date" before the MBI change date – use old or new MBIs.
- Dates of service that are entirely on or after the effective date of the MBI change – use new MBIs.

FFS eligibility transactions when the:

- Inquiry uses new MBI – we'll return all eligibility data.
- Inquiry uses the old MBI and request date or date range overlap the active period for the old MBI – we'll return all eligibility data. We'll also return the old MBI termination date.
- Inquiry uses the old MBI and request date or date range are entirely on or after the effective date of the new MBI – we'll return an error code (AAA 72) of "invalid member ID."

When the MBI changes, we ask the beneficiary to share the new MBI with you. You can also get the MBI from your MAC's secure MBI lookup tool.

Exceptions

There are a few exceptions when you can use either the HICN or MBI on or after January 1, 2020:

- Appeals – You can use either HICNs or MBIs for claim appeals and related forms.
- Claim status query – You can use the HICN or MBI to check the status of a claim (276 transactions) if the earliest date of service on the claim is before January 1, 2020. If you are checking the status of a claim with a date of service on or after January 1, 2020, you must use the MBI.
- Span-date claims – You can use HICNs or MBIs for 11X-Inpatient Hospital, 32X-Home Health (home health claims and Request for Anticipated Payments [RAPs]) and 41X-Religious Non-Medical Health Care Institution claims if the "From Date" is before the end of the transition period (December 31, 2019). If a patient starts getting services in an inpatient hospital, home health, or religious non-medical health care institution before December 31, 2019, but stops getting those services after December 31, 2019, you may submit a claim using either the HICN or the MBI, even if you submit it after December 31, 2019. Since you submit home health claims for a 60-day payment episode, you can send in the episode's RAP with either the HICN or the MBI, but after the transition period ends on December 31, 2019, you have to use the MBI when you send in the final claim that goes with it.

The MBI doesn't change Medicare benefits. **Protect the MBI as Personally Identifiable Information (PII); it is confidential like the HICN.**

Medicare Advantage and Prescription Drug plans continue to assign and use their own identifiers on their health insurance cards. For patients in these plans, continue to ask for and use the plans' health insurance cards.

ADDITIONAL INFORMATION

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

To sign up for your MAC's secure portal MBI look-up tool, visit https://www.cms.gov/Medicare/New-Medicare-Card/Providers/MACs-Provider-Portals-by-State.pdf.

The MBI format specifications, which provide more details on the construct of the MBI, are available at https://www.cms.gov/Medicare/New-Medicare-Card/Understanding-the-MBI.pdf.

A fact sheet discussing the transition to the MBI and the new cards is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TransitiontoNewMedicareNumbersandCards-909365.pdf.

DOCUMENT HISTORY

Date of Change	Description
August 19, 2019	We reissued this article to show that all new Medicare cards have been mailed, to encourage providers to use MBIs now to protect patients' identities, to emphasize that providers must use MBIs beginning January 1, 2020, and to explain the rejection codes providers will get if they submit a HICN after January 1, 2020.
March 6, 2019	We revised this article to add language that the MBI look-up tool can be used to obtain an MBI even for patients in a Medicare Advantage Plan. All other information remains the same.
December 10, 2018	The article was revised to update the language regarding when MACs can return an MBI through the MBI look up tool (page 1). All other information remains the same.
July 11, 2018	This article was revised to provide additional information regarding the format of the MBI not using letters S, L, O, I, B, and Z (page 2).
June 25, 2018	This article was revised to provide additional information regarding the ways your staff can get MBIs (page 1).
June 21, 2018	The article was revised to emphasize the need to submit the MBI without hyphens or spaces to avoid rejection of your claim.
May 25, 2018	Initial article released.

Presented by HPSO and CNA

Physical Therapists Medical Malpractice

Case Study with Risk Management Strategies

Medical malpractice claims may be asserted against any healthcare provider, including physical therapists and their employers. This case study involves a physical therapy business owner and an employed physical therapist.

Case Study: Physical Therapist: : Improper informed consent obtained; failure to obtain the degree of knowledge and skill to perform dry needling; improper management over the course of treatment; failure to supervise and monitor patient. **Physical Therapy Owner:** Failure to assure that clinical staff are qualified; failure to maintain proper policies and procedures on informed consent.

Total Incurred: Greater than $72,000
(Monetary amounts represent only the payments made on behalf of the insured physical therapy firm.)

Summary

The patient was a 50-year old female diagnosed with radiculopathy of the cervical region, soft tissue disorder, and stiffness of the upper neck. She was referred to the insured physical therapy facility in hopes of increasing flexibility, mobility, strength and/or conditioning for restoration of functional mobility. Her history included a prior neck surgery (C5, C6 fusion). She was a nurse practitioner and had just returned to work from the fusion, on light duty. The patient had undergone 3-4 therapy sessions when an employed physical therapist (PT) inquired if she would be willing to try a dry needling procedure. The patient had been treated at the facility many times for prior injuries and even had dry needle therapy several times at the facility, so she agreed to the therapy.

On the day of the incident, the patient told the PT that she understood the risks and benefits related to dry needling, but no informed consent was formally acknowledged. Following the treatment, the patient reported less tension and feeling better after the dry needling and she claimed to have a 50% reduction in pain. However, within a half hour of leaving the physical therapy facility, the patient began to have shortness of breath.

She called the PT that performed the dry needling and she described her symptoms as burning in her chest with shortness of breath. The PT instructed her to go to the emergency department (ED). The patient refused to go to the ED at that time and stated that she would go if she felt her condition was getting worse.

Several hours later, the patient's husband brought her to the ED because the patient's symptoms had worsened. When she arrived at the ED her pulse oximetry level was 88% on room air. An x-ray was performed, and it revealed bilateral pneumothorax. She was admitted after chest tube placement and her pneumothorax resolved within 48 hours.

On follow-up after being discharged from hospital, the patient reported being tired and looked pale. Follow-up chest x-rays confirmed that the patient's pneumothorax had resolved, despite her continued complaints of shortness of breath.

The patient reported that she was depressed and was having trouble going to work. She was placed on short-term leave so that she could recover at home. Three weeks after hospital discharge, the patient fully recovered and was released to go back to work.

When the physical therapy facility found out about the patient's hospital admission due to the pneumothorax, several attempts were made to contact the patient. She never returned to the facility and filed a lawsuit against our insured physical therapy business owner and the treating PT.

Risk Management Comments

The patient was a highly compensated individual and could not work for several weeks due to her pneumothorax. Because of her recovery process, the patient claimed a loss of income of approximately $10,000. The patient also claimed that due to her recovery process she failed to reach her productivity goals and lost her job, claiming an additional loss of $30,000. She sued for pain and suffering, which was estimated at $175,000, plus medical costs that were greater than $25,000.

While defense experts were of the opinion that the case was largely defensible, there were nevertheless several areas that the PT and business owner were liable. Examples of liability included:

- There was little documentation to support an informed consent process with the patient. Since the patient had dry needle therapy performed at the facility in the past, the PT had decided not to go through an informed consent process.

continued...

CNA HPSO

- It had been at least five years since physical therapy facility's written policies and procedures were last reviewed and updated.

Resolution

Before discovery could be completed in the case, the plaintiff counsel was pressuring for a settlement of $500,000.

When defense counsel investigated the rush to settle the claim further, they found that the patient had lost her license to practice as a nurse practitioner during the same time her injury occurred.

Just prior to the dry needling incident, the patient was found guilty of two misdemeanors:

- Driving while under the influence (this was her second incident in five-years).
- Assault against her husband.

These findings were communicated to the plaintiff attorney and the settlement amount was significantly decreased from the plaintiff's initial claims. The total incurred cost to defend and settle this case was greater than $72,000, which was significantly less than the original amount requested by the patient.

Risk Management Recommendations

For Treating Physical Therapists:

- ***Prior to dry needle therapy, consult with the patient's referring practitioner regarding precautions*** or contraindications and obtain a thorough and accurate history.
- ***Perform a thorough and accurate informed consent process,*** including risks and benefits of the treatment, as well as possible alternative therapies.
- ***Recognize patients' medical conditions,*** co-morbidities and any additional specific risk factors that may affect therapy.
- ***Document all patient-related discussions,*** clinical information, areas where the needle was inserted, response elicited, and patient's condition pre- and post-therapy. If the patient requires immediate medical care, implement the following measures:
  - Communicate urgent or critical patient care concerns to the referring practitioner in a timely manner.
  - Execute emergency responses to treat and transfer to a higher level of care any patient who has sustained a perforation of lungs or other hollow organ, or who has suffered secondary physiological effects or complications associated with dry needle therapy.

For Physical Therapy Business Owners:

- ***Provide clinical support and supervision f***or physical therapist assistants, aides and students in compliance with standards of practice for physical therapy.
- ***Know the current scope of practice parameters*** for physical therapists, physical therapy assistants, aides and students, and do not instruct them to provide services beyond their scope of practice.
- ***Perform at least annual performance reviews for each employee, including a review of errors, "near misses", document requirements compliance, existing skills and directly observed competencies.*** Provide physical therapy staff with coaching, mentoring, and clinical and system education as needed to ensure that patient safety requirements are satisfied.
- ***Ensure that clinical practices comply with standards endorsed by physical therapy professional associations,*** state practice acts and facility protocols.
- ***Review policies and procedures on a regular basis to ensure their effectiveness and alignment with actual practice.*** Federal and state regulations may require review of policies and procedures on an annual basis. Document dates of policy implementation, review and revision. Archive outdated or modified policies and procedures for later retrieval in case of litigation.
- ***Review policies and procedures with staff members upon hire and on a regular basis thereafter.*** Physical therapy staff should acknowledge in writing that they have read and understand the policies and procedures, and all records concerning staff education should be retained in personnel files.

Guide to Sample Risk Management Plan

Risk Management is an integral part of a healthcare professional's standard business practice. Risk Management activities include identifying and evaluating risks, followed by implementing the most advantageous methods of reducing or eliminating these risks – a good Risk Management Plan will help you perform these steps quickly and easily!

Visit **hpso.com/risktemplate** to access the Risk Management Plan created by HPSO and CNA. We encourage you to use this as a guide to develop your own Risk Management Plan to meet the specific needs of your healthcare practice.

CNA HPSO

*CNA HealthPro Physical Therapy Liability, 2001-2010, CNA Insurance Company, December 2011. To read the complete study along with risk management recommendations, visit www.hpso.com/ptclaimreport2011.

X-13809-0719 PT

Reminder: new AIM Rehabilitative Program effective November 1, 2019

Published: Nov 1, 2019

As we communicated in the October 2019 edition of *Provider News*, the AIM Rehabilitative program for our Commercial membership will relaunch on November 1. AIM Specialty Health® (AIM), a separate company, will begin to perform prior authorization review of physical, occupational and speech therapy services. Prior authorization requests may be submitted via the AIM ***ProviderPortal℠*** for dates of service on or after November 1, 2019. The OrthoNet program is no longer active in applicable markets.

Anthem is also transitioning vendors for review of outpatient physical, occupational and speech therapy rehabilitative services for our Medicare members to AIM Specialty Health. We have decided to delay the implementation of this transition. The AIM Rehabilitative program for Medicare members will now begin in April 2020. Prior authorization will not be required for the above-mentioned services for Medicare members through March 2020. *(Note: This delay does NOT apply to members in the states of Florida, New Jersey and New York for whom prior authorization will still be required.)* We will provide an update in an upcoming *Provider News* about the AIM Rehabilitative Program for Medicare members.

https://providernews.anthem.com/georgia/article/reminder-new-aim-rehabilitative-program-effective-november-1-2019-2

Featured In:
November 2019 GA Provider News

REMINDER: new AIM Rehabilitative Program effective November 1, 2019

Published: Nov 1, 2019

As previously communicated in the October 2019 edition of Anthem Blue Cross and Blue Shield (Anthem)'s *Provider News*, the AIM Rehabilitative program for Anthem's Commercial Membership relaunched November 1, 2019. AIM Specialty Health® (AIM), a separate company, will begin to perform prior authorization review of physical, occupational and speech therapy services. Requests may be submitted via the AIM ProviderPortal℠ for dates of service November 1 and after. The OrthoNet program is no longer active in applicable markets.

Anthem is also transitioning vendors for review of Rehabilitative Services for our *Medicare members to include outpatient physical therapy, occupational therapy, and speech-language pathology, to AIM Specialty Health. Anthem has decided to delay the implementation of this transition. The AIM Rehab program will now begin in April 2020. Pre-authorization will not be required for the above mentioned services through March 2020.

*This does not apply to members in the states of Florida, New Jersey and New York for whom prior authorization will still be required.

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https://providernews.anthem.com/kentucky/article/reminder-new-aim-rehabilitative-program-effective-november-1-2019

Featured In:
November 2019 Anthem Provider News - Kentucky

Reminder about AIM's new Rehabilitative Program effective November 1, 2019

Published: Nov 1, 2019

As previously communicated in the October 2019 edition of Empire's Provider News, the AIM Rehabilitative program for Empire BlueCross BlueShield's ("Empire") commercial membership relaunched on November 1st. AIM Specialty Health® (AIM), a separate company, will begin to perform prior authorization review of physical, occupational and speech therapy services. Requests may be submitted via the *AIM Provider Portal* for dates of service 11/1/19 and after. The OrthoNet program is no longer active in applicable markets.

Empire is also transitioning vendors for review of Rehabilitative Services for our *Medicare members to include out-patient PT, OT, and SLP, to AIM Specialty Health. Empire has decided to delay the implementation of this transition. The AIM Rehab program will now begin in April 2020. Pre-authorization will not be required for the above mentioned services through March 2020.

*This does not apply to members in the states of FL, NJ and NY for whom prior authorization will still be required.

Please be on the lookout for future updates on the AIM Rehabilitative Program for Medicare members.

https://providernews.empireblue.com/article/reminder-about-aims-new-rehabilitative-program-effective-november-1-2019

Featured In:
November 2019 Empire Provider News

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https://providernews.anthem.com/ohio/article/reminder-new-aim-rehabilitative-program-effective-november-1-2019

Featured In:
November 2019 Anthem Provider News - Ohio

PROVIDERUpdate

REGULATORY | NOVEMBER 5, 2019 | UPDATE 19-838 | 2 PAGES

Health Net®

HEDIS® Annual Medical Records Collection Begins December 1, 2019

Use Datafied™ to collect requested data at no cost

Health Net* is included in the efforts to collect data for the Healthcare Effectiveness Data and Information Set (HEDIS®) 2020 Clinical Effectiveness of Care measures. HEDIS is a standard set of nationally reported measures used to assess the quality of care given to members.

Randomly selected participating providers will be contacted for medical records starting December 1, 2019, to May 8, 2020. Based on a provision in their contract, participating providers must submit member data when requested for health care operations and quality review.

Datafied simplifies record collection

Datafied has been contracted to retrieve the requested medical records. They can also help copy records for high-volume provider sites. If a provider office chooses to use a different copy service vendor, it is at their own expense.

Your contact information will be confirmed by telephone before the HEDIS packet is sent. A list of members with the specific data needed will be in the packet.

Send records within five days

When contacted, providers are responsible for ensuring the records are released within five days.

- If unable to do so, contact Datafied with a time frame when they will be sent. Contact information is included in the packet.
- If records are not available, or the member was not your established patient during the requested time frame –
  - Complete a Certificate of No Record (CNR) included in the packet. Return the CNR to Datafied or
  - Contact Datafied right away so the request can be redirected.
- Datafied will continue to follow up with your office for requests that are not resolved.

Privacy notice

Datafied maintains the confidentiality of your patients' protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act of 1996

THIS UPDATE APPLIES TO **CALIFORNIA** PROVIDERS:

- ● Physicians
- ● Participating Physician Groups
- ○ Hospitals
- ○ Ancillary Providers

LINES OF BUSINESS:

- ● HMO/POS/HSP
- ● PPO
- ● EPO
- ● Medicare Advantage (HMO)
- ● Medi-Cal
  - ● Kern
  - ● Los Angeles
    - ○ Molina
  - ○ Riverside
  - ● Sacramento
  - ○ San Bernardino
  - ● San Diego
  - ● San Joaquin
  - ● Stanislaus
  - ● Tulare

PROVIDER SERVICES
provider_services@healthnet.com

EnhancedCare PPO (IFP)
1-844-463-8188
provider.healthnetcalifornia.com
EnhancedCare PPO (SBG)
1-844-463-8188
provider.healthnet.com
Health Net Employer Group HMO, POS, HSP, PPO, & EPO
1-800-641-7761
provider.healthnet.com
IFP – CommunityCare HMO, PPO, PureCare HSP, PureCare One EPO
1-888-926-2164
provider.healthnetcalifornia.com
Medicare (individual)
1-800-929-9224
provider.healthnetcalifornia.com
Medicare (employer group)
1-800-929-9224
provider.healthnet.com
Medi-Cal – 1-800-675-6110
provider.healthnet.com

PROVIDER COMMUNICATIONS
provider.communications@healthnet.com

(HIPAA) privacy regulations.[1] Records are only accessed by authorized persons to comply with these safeguards.[2]

Contact the HEDIS team

If you have specific concerns or questions related to the requested medical records or how or where to send the data, contact the Health Net HEDIS team at:

Phone	1-800-640-3545	• The phone number is for incoming messages only. • Calls will be returned within one business day.
Email	HEDIS@healthnet.com	• The email address is not secured. • **Do not** submit protected health information (PHI) data to this address.

Additional information

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by email at provider_services@healthnet.com within 60 days, by telephone or through the Health Net provider website as listed in the right-hand column on page1.

[1]Title 45 Code of Federal Regulations (CFR) §164.506 indicates that the routine authorization form you obtain from your patient is sufficient for disclosures to carry out health care operations. 45 CFR §164.501 defines health care operations to include quality assessment and improvement activities. Datafied follows HIPAA regulations and has procedures to protect the privacy of health information received.
[2]Providing medical records to Datafied follows all federal and state regulations to safeguard PHI and confidentiality.

Don't miss out on this upcoming **FREE WEBINAR** from a PTPN Preferred Vendor, whose products/services are available to you at exclusive discounts.

Register for this 45-minute session at the link below, or contact lmartinez@ptpn.com or 818-737-0237 to register. PTPN members only please!

Save a Life:

The Importance of Implementing an AED Program at Your Practice

from AED Superstore and PTPN

It is becoming the standard of care for PT practices to have an automated external defibrillator (AED) available should a patient or staff member fall victim to sudden cardiac arrest. The APTA recommends that all healthcare and wellness facilities providing PT services that are dependent upon a community emergency medical system have an AED available during first response CPR efforts. This webinar will provide:

- education on sudden cardiac arrest
- what an AED is and why it is the only treatment for sudden cardiac arrest
- a review of AED program management to assist with manufacturer guidelines and state laws pertaining to AED programs

Attendees will be confident in understanding that sudden cardiac arrest can happen to anyone at any time and how having an AED on site can save a life. Furthermore, they will learn about how to best ensure AEDs are kept ready to rescue and other components to managing a successful AED program.

Tuesday, November 19, 12PM Pacific/3PM Eastern
Register at https://bit.ly/2Nu27uQ

PTPN MarketingPro Minute

For PTPN Members Only September 2019

3 ways the internet can help you write better marketing copy

For anyone who isn't a trained marketer or writer, writing text for marketing purposes – ads, blog posts, websites, and so on – can be a daunting task.

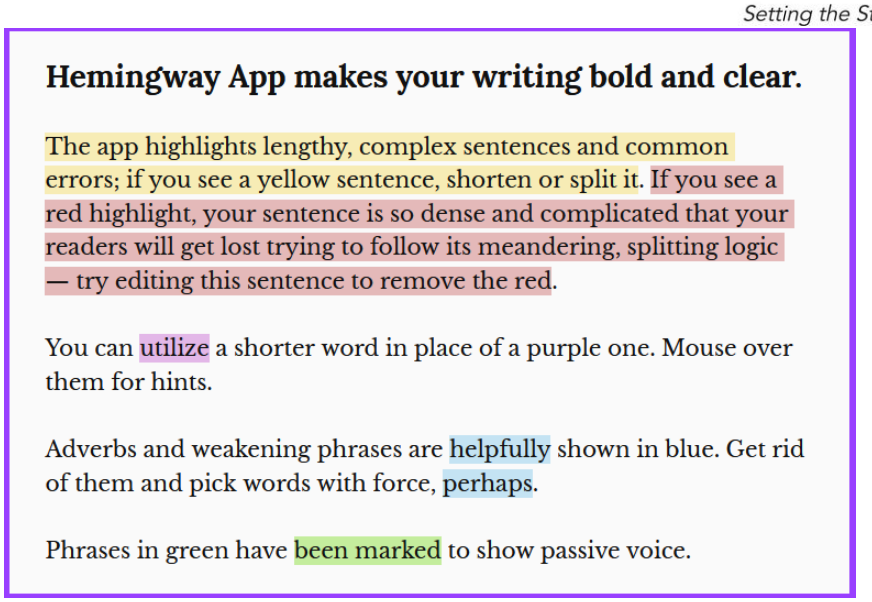
But the web is full of tools you can use to improve your marketing copy. "Whether you need an automated editor or help with organizing your files, there's an app for that," says Dominic Tortorice, a writer and editor with the digital marketing firm Brafton.

Here are three he recommends:

1. Hemingway Editor

The Hemingway Editor helps make your writing more concise and direct. This increases your chances of grabbing online readers' attention quickly and effectively. It analyzes your copy and points out elements that weaken the text, like passive voice, complicated phrasing and long, convoluted sentences and paragraphs. The editor isn't free, but it may be worth investing less than $20 to sharpen your copy.

Here's a look at what it does:



2. Grammarly

Grammarly is a free writing assistant that catches grammar and spelling errors. It's more powerful than the spellcheck functionality built in to most programs and apps. For example, you can tell it to analyze your writing based on your goals. "You can select between different audience, subject matter familiarity and tone options to ensure the writing suggestions you get are tailored to your specific needs and content objectives," Dominic says.

In addition, you can use it while you're writing directly on your website or social media channels. There's no need to write in Microsoft Word, for example, and use spellcheck there before copying and pasting into Facebook.

3. HubSpot Blog Ideas Generator

Great writing starts with great ideas, and we can all use some help in the brainstorming process. As Dominic points out, "Continually coming up with relevant ideas for blog posts can be taxing and take up valuable time."

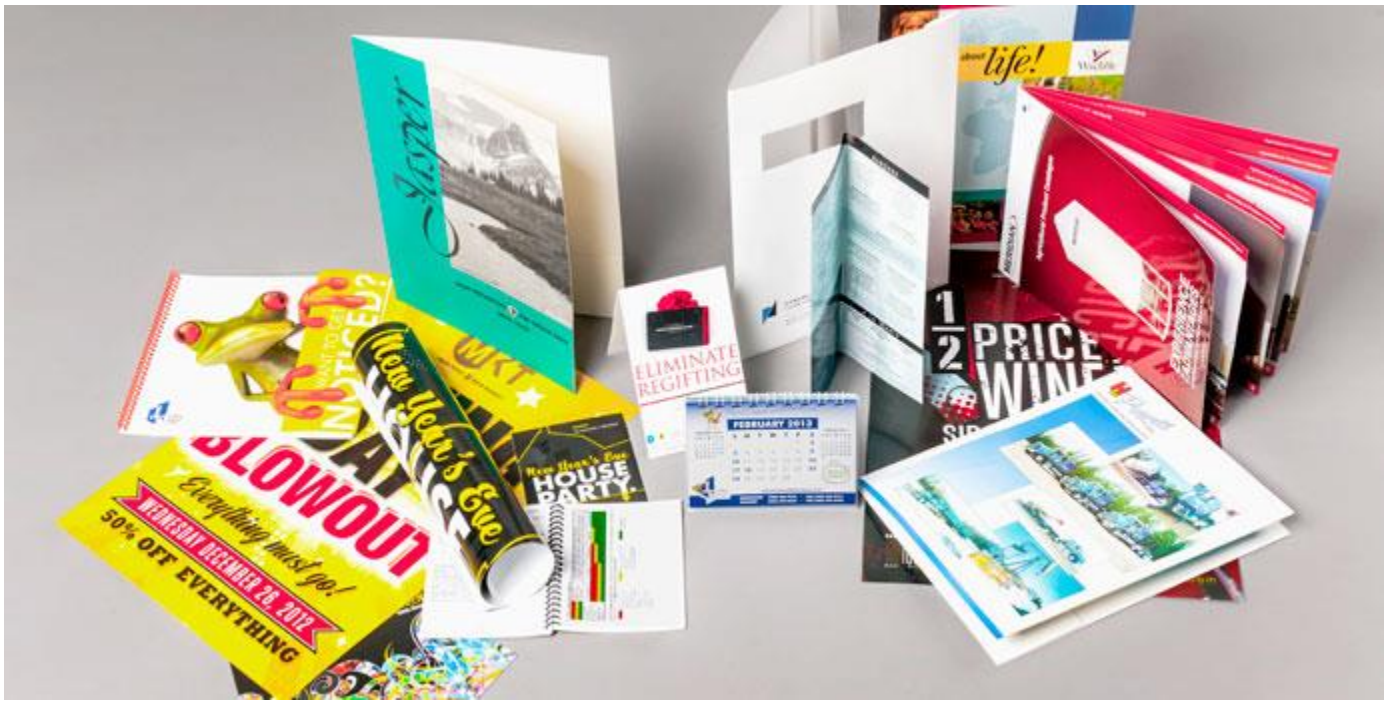
HubSpot's free Blog Ideas Generator can help with topic ideas and writing prompts to jumpstart your process. Here's how it works: Enter up to five different nouns and you'll get as many as 250 title ideas to get the ideas flowing. For example, here are a few of the titles resulting from entering the terms "physical therapy," "fitness" and "aging":

- Physical Therapy: Expectations vs. Reality
- The Next Big Thing in Fitness
- This Week's Top Stories in Aging
- Fitness Explained in Fewer than 140 Characters

To learn more about these tools, as well as two others Dominic recommends, take a look at his recent blog post.

PTPN MarketingPro Minute

For PTPN Members Only October 2019



Use print marketing to connect with millennials

There's no denying it: Our world is increasingly a digital one. So where should print advertising and marketing fit into promoting your practice?

According to the latest research, you should be prioritizing printed materials – particularly when it comes to marketing to millennials.

Millennials are usually defined as people born between 1981 and 1996. So right now, they're in the 23-39 age range. They're a prime target for a number of reasons:

- They're typically active and looking to stay that way, and they take a holistic view of their health. One study found that millennials are more likely than baby boomers to join wellness programs, for example.
- They're often willing to rely less on a primary care provider's instructions and orchestrate their own healthcare solutions, which means they may be more likely to come to you directly when they need help with fitness, flexibility, strength and so on.
- When a millennial becomes your patient or client, you're building a relationship that could last for decades.

But that means they need to know about you, and for that purpose, "print is an engagement goldmine," says Heather Fletcher, senior content editor for Target Marketing. "Print marketing — whether it's via direct mail, inserts or another means — works because the channel is more memorable, stirs the senses and creates trust," Heather says. "Trust creates engagement."

And for millennials specifically, print is a preference. Demographic expert Neil Howe, who coined the term “Millennial Generation,” reports that millennials lead other generations in reading and prefer print. He cites research findings that the majority of millennials prefer getting information from local business via physical mail rather than telemarketing or email, and that millennials are the most likely generation to read print marketing in the form of direct mail.

Why does print work for millennials? Here are a few reasons:

It’s memorable

Heather explains that print marketing has a significant advantage over more ephemeral touchpoints because it’s memorable. When marketers provide useful printed content, consumers will remember it and turn to the print marketing when they’re ready to make a decision and take action. “Memory generates emotion, which translates to positive brand associations,” she says.

It's tactile

“Print ads are genuine,” Heather says, citing a Bangor University study that found the “real” experience of physical media is more likely to become part of a consumer’s memory. “Touching printed materials while looking at them triggers spatial memory in a way that other channels don’t, leaving a footprint deeper in the brain.”

It’s a luxury

The sensory experience of printed media can feel like a luxury in our digital age. Millennial and marketing expert Ashley Leone explains it this way: “Maybe we like printed materials because we spend a majority of the day staring at a backlit screen and our poor retinas need a break. Maybe it’s because there’s something luxurious about being able to stare at a page for as long as you want without the fear of your device going to sleep mode. Either way, this preference spells out success for advertisers.”

Bonus tip: PTPN members can access free, customizable templates for printed marketing materials (brochures, newsletters, flyers, postcards and posters) on our Physiquality website. Log on at www.physiquality.com/clinic and click on “marketing material,” then “Physiquality.”