

Gateway Health Plan *Medicare Assured*[®] Provider Manual 2010

Chapter VI CLAIMS HANDBOOK

This section provides an overview of the claims process for Gateway Health Plan *Medicare Assured*[®]. The Gateway Health Plan *Medicare Assured*[®] claims payment process is designed to ensure prompt and accurate payment for services provided to Members in the Gateway Health Plan *Medicare Assured*[®].

Completing & Submitting Claims Forms

Gateway Health Plan *Medicare Assured*[®] will accept the two existing claims forms, the UB-04 for inpatient or other services billed with a procedure code for inpatient (124) (126) (128) and the CMS-1500 for all services billed with a procedure code (outpatient mental health and D&A services).

Providers of inpatient services will use a UB-04 claim form. Providers of Ambulatory Services will use the CMS 1500 for billing. UB-04 claims forms will not be accepted for billing ambulatory MH services. **All invoices must be received within 365 days of the date of service to be considered for payment.**

Electronic Billing

Contact the Gateway Health Plan *Medicare Assured*[®] Provider Services Center for additional information about electronic claims submission. Gateway Health Plan *Medicare Assured*[®] accepts electronic claims through Emdeon and RelayHealth. To submit claims to Gateway Health Plan *Medicare Assured*[®] please note the Payer ID Number is 60550.

Gateway Health Plan *Medicare Assured*[®] can accept claims electronically through our association with Emdeon and RelayHealth. Gateway Health Plan[®] encourages practitioners to take advantage of our electronic claims processing capabilities. Submitting claims electronically offers the following benefits:

- Faster Claims Submission and Processing
- Reduced Paperwork
- Increased Claims Accuracy
- Time and Cost Savings

Gateway Health Plan[®] electronic claims through Emdeon and RelayHealth must be forwarded to Gateway Health Plan[®] in the HIPAA compliant format only.

Requirements for Submitting Claims to Gateway Health Plan[®] through Emdeon and RelayHealth

To submit claims to Gateway Health Plan *Medicare Assured*[®] please note the Payer ID Number is 60550. Gateway Health Plan[®] has a health plan specific edit through Emdeon and RelayHealth for electronic claims that differs from the standard electronic submission format criteria. The edits requires:

- A Gateway Health Plan *Medicare Assured*[®] assigned 8-digit Member identification number; the Member number field allows 8 or 12 digits to be entered. For providers who do not know the Member's Gateway Health Plan *Medicare Assured*[®] identification number it is acceptable to submit the Member's HIC Number on electronic claims.

In addition to edits that may be received from Emdeon and RelayHealth, Gateway Health Plan *Medicare Assured*[®] has a second level of edits that apply to procedure codes and diagnosis codes. Claims can be successfully transmitted to Emdeon or RelayHealth, but if the codes are not currently valid they will be

Gateway Health Plan *Medicare Assured*[®] Provider Manual 2010

rejected by Gateway Health Plan *Medicare Assured*[®]. Providers must be diligent in reviewing all acceptance/rejection reports to identify claims that may not have successfully been accepted by Emdeon, RelayHealth and Gateway Health Plan[®]. Edits applied when claims are received by Gateway Health Plan *Medicare Assured*[®] will appear on an EDI Report within the initial acceptance report or claims acknowledgement report. A claim can be rejected if it does not include current procedure and diagnosis codes. To ensure that claims have been accepted via EDI, practitioners should receive and review the following reports on a daily basis:

- Emdeon -- Provider Daily Statistics (RO22)
- Emdeon -- Daily Acceptance Report by Provider (RO26)
- Emdeon -- Unprocessed Claim Report (RO59)

- RelayHealth – Claims Acknowledgement Report (CPI 651.01)
- RelayHealth – Exclusion Claims Report (CPI 652.01)
- RelayHealth – Claims Status Report (CPA 425.02)

If you are not submitting claims electronically, please contact either your Gateway Health Plan *Medicare Assured*[®] Provider Relations Representative or an EDI vendor for information on how you can submit claims electronically. You may also call Emdeon directly at 1-877 469-3263 or RelayHealth at 1-800 545-2488 (phone numbers are current as of October 2008). Gateway Health Plan[®] will accept electronic claims for services that would be submitted on a standard CMS-1500 or a UB-04 Form. However, the following cannot be submitted as attachments along with electronic claims at this time:

- Claims with EOBs

Paper Claim Submission

Paper claims should be mailed to:

Gateway Health Plan[®]
Claims Processing Department
P.O. Box 11-560
Albany, NY 12211-0560

CMS 1500 Form and UB-04

Each claim form must indicate the Member's diagnosis using all applicable ICD-9-CM diagnosis codes and the procedures that you performed. Current procedure codes found with your agreement will be used for billing. Reimbursement will be based on the Gateway Health Plan *Medicare Assured*[®] rate schedule provided through the contracting process.

Billing Procedures

A "clean claim" as used in this section means a claim that has no defect, impropriety, lack of any required substantiating documentation, including the substantiating documentation needed to meet the requirements for encounter data, or particular circumstance requiring special treatment that prevents

Gateway Health Plan *Medicare Assured*[®] Provider Manual 2010

timely payment; and a claim that otherwise conforms to the clean claim requirement for equivalent claims under Medicare. In addition, a claim shall be considered "clean" if the appropriate authorization has been obtained in compliance with Gateway Health Plan *Medicare Assured*[®] Policy and Procedure Manual and the following elements of information are furnished on a standard UB-04 or CMS-1500 Form (or their replacement with CMS designations, as applicable) or an acceptable electronic format through a Gateway Health Plan[®]-contracted clearinghouse:

1. Patient name;
2. Patient medical plan identifier;
3. Date of service for each covered service;
4. Description of covered services rendered using valid coding and abbreviated description;
5. ICD-9 surgical diagnosis code (as applicable);
6. Name of practitioner/provider and plan identifier;
7. Provider tax identification number;
8. Valid CMS place of service code;
9. Billed charge amount for each covered service;
10. Primary carrier EOB when patient has other insurance;
11. All applicable ICD-9-CM diagnosis codes-inpatient claims include diagnoses at the time of discharge or in the case of emergency room claims, the presenting ICD-9-CM diagnosis code;
12. DRG code for inpatient hospital claims. (For informational purposes only)

Gateway Health Plan[®] processes behavioral health expenses upon receipt of a correctly completed CMS-1500 Form or UB-04. A description of each of the required fields for each form is identified later in this section. Paper claim forms must be submitted on original forms printed with red ink. A claim without valid, legible information in all mandatory categories is subject to rejection/denial. To ensure reimbursement to the correct payee, the Gateway Health Plan *Medicare Assured*[®] provider number must be included on every paper claim. For electronic claims submissions, Gateway Health Plan[®] will require providers to use their NPI number(s). Any claim billed on a CMS-1500 Form must include the individual practitioner name in box 31 on the form. Please note that it is extremely important to promptly notify CBHNP of any change that involves adding practitioners to any group practice, as failure to do so may result in a denial of service. All claims must have complete and accurate ICD-9-CM diagnosis codes for claims consideration. If the diagnosis code requires, but does not include the fourth or fifth digit classification, the claim will be denied. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. By signing a claim for services, the practitioner certifies that the services shown on the claim were medically indicated and necessary for the health of the patient and were personally furnished by the practitioner or an employee under the practitioner's direction. The practitioner certifies that the information contained in the claim is true, accurate and complete. Any questions concerning billing procedures or claim payments can be directed to Gateway Health Plan *Medicare Assured*[®] Provider Services Department at 1-800-685-5205.

Claim Payment Disagreements

All claims payments will include a Remittance Advice (RA). The RA provides you with a detailed explanation of the amount of each claim paid and the reason for any amount of the claim that was denied. If you have questions about a denial or disagree with a claim payment for any reason, contact Provider Services at 1-800-685-5205. A Gateway Health Plan *Medicare Assured*[®] Provider Services Representative can help to facilitate a review of the claim in question. Please be prepared to provide the authorization number, provider/facility name, the Member's name and ID number.

Gateway Health Plan *Medicare Assured*[®] Provider Manual 2010

If the claim is denied as a result of a Provider error that can be corrected, the Provider Services Representative will assist you to understand the required corrections so that you can re-submit the invoice.

If after reviewing the denial with the Gateway Health Plan[®] Provider Services Representative you continue to believe that a claim was denied in error, you have the right to request a formal review. Gateway Health Plan[®] will review any claim that a provider feels was denied or paid incorrectly. The request may be conveyed in writing or verbally through Gateway Health Plan[®]'s Provider Services Department if the inquiry relates to an administrative issue. Please forward hard copy information via mail to the Claims Review Department along with all of the appropriate documentation, i.e. the actual claim, medical records, and notations regarding telephone conversations, in order to expedite the review process. Initial claims that are not received within the timely filing limit will not qualify for review. All follow-up review requests must be received within 120 calendar days of the initial remittance advice.

Administrative Claims Review

Claims that need to be reviewed based upon administrative or processing issues are handled by a Provider Services Representative via a phone call to Gateway Health Plan[®]. For inquiries requiring documentation or received in the mail, Claims Review Representatives evaluate whether the documentation attached to the claim is sufficient to allow it to be reconsidered. Claims that qualify for adjustments will be reprocessed, and claim information will appear on subsequent remittance advices. Claims that do not qualify for re-processing will be forwarded to the Appeals Department for review. All review requests must be received within 120 days of the initial remittance advice.

Please refer to the Appeals and Grievances section of the manual for information on procedures for Appeals submitted by providers on behalf of a member.

Claims inquiries for administrative reviews should be mailed to:

Gateway Health Plan[®]
Attention: Claims Review Department
US Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219-2704.

Claim Re-submission

Resubmission of Corrected Claims

Corrected claims may be resubmitted when the Provider finds that they billed for an incorrect number of units. In cases where the resubmission serves to correct a claim that has already been paid, the claim must be clearly identified as a "resubmitted corrected claim" and resubmitted within 120 days of the remittance notice date relative to the original claim submission.

If no payment has been made for a claim because the claim was returned to you as incomplete or with a code error, the claim must be clearly identified as a "resubmitted corrected claim" and resubmitted within 120 days of the return date.

Resubmission for COB Request and Third Party Liability (TPL)

Gateway Health Plan *Medicare Assured*[®] Provider Manual 2010

When you receive a denial requesting Coordination of Benefits (COB) information, you should resubmit the claim with the primary carriers EOB's.

When submitting claims to Gateway Health Plan *Medicare Assured*[®] as a secondary payer, the EOB (Explanation of Benefits) from the primary insurer must be attached to the claim. **Claims with attached EOB must be submitted within 180 days of your notification of payment or denial by the other insurance company.**

Expectations for Gateway Health Plan *Medicare Assured*[®] Response to Claims Submission

Gateway Health Plan *Medicare Assured*[®] will pay all "clean" claims (claims that are accurate and complete) within forty-five (45) days. Our goal is to provide payment as quickly as possible and to pay most claims within thirty (30) days of receipt of a clean claim. **If you have not heard from Gateway Health Plan[®] within 30 days after you sent the claim in, please contact Provider Services at 1-800-685-5205 to inquire as to the status of the claim.** If Gateway Health Plan[®] indicates the claim was not received, Providers will be asked to resubmit the claim immediately. It is imperative that Providers closely monitor their claims submissions to identify potential issues quickly.

Checking on the Status of a Claim

You may check the status of a claim during normal business hours by calling Provider Services at 1-800-685-5205. To make an inquiry, you will need to provide the provider/facility name, Member's name and identification number, the procedure code(s) and the date(s) of service for which you are billing. **Again, if you have not heard from Gateway Health Plan *Medicare Assured*[®] on a claim within 30 days of the date you believe it was submitted, contact Gateway Health Plan[®] immediately as this may indicate that the claim was not received. If Gateway Health Plan[®] indicates the claim was not received, Providers will be asked to resubmit the claim immediately.**

Claims Appeals

Claims appeals are subject to the Member Reconsideration/Appeal process outlined in Chapter VIII. Members may request reconsideration of prior authorization denials or of claim payment denials. Providers may address claim payment denials via the Provider Appeal Process.

Gateway Health Plan *Medicare Assured*[®] Provider Manual 2010

CMS-1500 (08-05) Data Elements for Submission of Paper Claims Forms EDI requirements must be followed for Electronic claims submissions

Field #	Description	Requirements
1	Insurance Type	Required
1a	Insured Identification Number	Gateway Health Plan [®] Member Identification Number
2	Patient's Name	Required
3	Patient's Birth Date	Required
4	Insured's Name	Required
5	Patient's Address	Required
6	Patient Relationship to Insured	Required
7	Insured's Address	Required
8	Patient Status	Required
9	Other Insured's Name	Required, If Applicable
9a	Other Insured's Policy or Group Number	Required, If Applicable
9b	Other Insured's Date of Birth, Sex	Required, If Applicable
9c	Employer's Name or School Name	Required, If Applicable
9d	Insurance Plan Name or Program Name	Required, If Applicable
10	Is Patient Condition Related to: a. Employment b. Auto accident c. Other accident	Required, If Applicable
10d	Reserved for Local Use	Not Required
11	Insured's Policy Group or FECA Number	Required
11a	Insured's Date of Birth, Sex	Required, If Applicable
11b	Employer's Name or School Name	Required, If Applicable
11c	Insurance Plan Name or Program Name	Required, If Applicable
11d	Is There Another Health Benefit Plan?	Required, If Applicable
12	Patient or Authorized Person's Signature	Required
13	Insured's or Authorized Person's Signature	Required
14	Date of Current: Illness OR Injury OR Pregnancy	Required, If Applicable
15	If Patient has had Same or Similar Illness, Give First Date	Not Required
16	Dates Patient Unable to Work in Current Occupation	Required, If Applicable
17	Name of Referring Practitioner or Other Source	Required, If Applicable
17a, b	Identification Number of Referring Practitioner	Not Required
18	Hospitalization Dates Related to Current Services	Required, If Applicable
19	Reserved for Local Use	May be Required in Specific Circumstances (Consult CMS Criteria)
20	Outside Lab	Not Required
21	Diagnosis or Nature of Illness or Injury	Required
22	Medical Resubmission Code	Not Required
23	Prior Authorization Number	Not Required
24a	Date(s) of Service	Required
24b	Place of Service	Required
24c	EMG	Not Required
24d	Procedures, Services, or Supplies CPT/HCPCS/Modifier	Required
24e	Diagnosis Code Pointer	Required
24f	Charges	Required
24g	Days or Units	Required
24h	EPSDT Family Plan	Not Required
24i	ID Qualifier	Not Required
24j	Rendering Provider ID	Required, If Applicable

Gateway Health Plan *Medicare Assured*[®] Provider Manual 2010

Field #	Description	Requirements
25	Federal Tax Identification Number	Required
26	Patient Account Number	Not Required, but used as identifier on remit for claim processing
27	Accept Assignment	Not Required
28	Total Charge	Required
29	Amount Paid	Not Required
30	Balance Due	Not Required
31	Signature of Practitioner or Supplier including degrees or credentials	Gateway Health Plan <i>Medicare Assured</i> [®] Individual Practitioner Name and Date Required
32	Service Facility Location Information	Facility Name and Address where Services were Rendered Required
33	Billing Provider Info and Phone #	Gateway Health Plan <i>Medicare Assured</i> [®] Vendor (Payee) Name, Address, and Phone Number Required. NPI and Gateway Legacy Number should be entered.

Gateway Health Plan *Medicare Assured*[®] Provider Manual 2010

Hospital Services

Hospital claims are submitted to Gateway Health Plan *Medicare Assured*[®] on a UB-04. To assure that claims are processed for the correct Member, the Member's 8-digit Gateway Health Plan *Medicare Assured*[®] identification number must be used on all claims. To aid in the recording of payment, patient account numbers recorded on the claim form by the practitioner are indicated in the *Patient ID* field on the Gateway Health Plan[®] remittance advice.

UB-04 Data Elements for Submission of Paper Claims Forms EDI requirements must be followed for Electronic claims submissions

Field	Description	Requirements
1	Provider Name, Address, City, State, Zip, Telephone, Fax, Country Code	Required
2	Pay to Name, Address, City, State, Zip	Required If Different from Billing Provider in Field 1
3a	Patient Control Number	Required
3b	Medical Record Number	Not Required
4	Type of Bill	Required – If 4 Digits Submitted, the Lead 0 will be Ignored
5	Federal Tax Number	Required
6	Statement Covers Period	Required
7	Unlabeled Field	Not Used
8a	Patient Name	Required
9	Patient Address	Required
10	Birth date	Required
11	Patient Sex	Required
12	Admission Date	Required for Inpatient and Home Health
13	Admission Hour	Not Required
14	Type of Admission/Visit	Required, If Inpatient
15	Source of Admission	Required
16	Discharge Hour	Not Required
17	Patient Status	Required
18-28	Condition Codes	May be Required in Specific Circumstances (Consult CMS Criteria)
29	Accident State	Not Used
30	Unlabeled Field	Not Used
31-34	Occurrence Codes and Dates	May be Required in Specific Circumstances (Consult CMS Criteria)
35-36	Occurrence Span Codes and Dates	Required, If Inpatient
37	Unlabeled Field	Not Used
38	Responsible Party Name and Address	Not Required
39-41	Value Codes and Amounts	Required, If Inpatient
42	Revenue Codes	Required
43	Revenue Descriptions	Required
44	HCPCS/Rates/HIPPS Codes	Required, If Outpatient
45	Service Dates	Required, If Outpatient
46	Service Units	Required
47	Total Charges	Required
48	Non-covered Charges	Required, If Applicable
49	Unlabeled Field	Not Used
50	Payer Identification	Required
51	Health Plan ID	Not Required
52	Release of Information Certification Indicator	Required
53	Assignment of Benefits	Not Used
54	Prior Payments	Required, If Applicable
55	Estimated Amount Due from Patient	Not Required
56	National Provider ID	Required – NPI Number
57	Other Provider ID	Gateway Health Plan [®] Practitioner Identification Number should be entered on paper claims only- legacy number reported as secondary identifier to NPI on electronic claims
58	Insured's Name	Required, If Applicable

Gateway Health Plan *Medicare Assured*[®] Provider Manual 2010

Field	Description	Requirements
59	Patient Relationship to Insured	Required, If Applicable
60	Certificate-Social Security Number-Health Insurance Claim-Identification Number	Gateway Health Plan <i>Medicare Assured</i> [®] Member Identification Number Required
61	Insurance Group Name	Required, If Applicable
62	Insurance Group Number	Required, If Applicable
63	Treatment Authorization Code	Required, If Applicable
64	Document Control Number	Not Required
65	Employer Name	Required, If Applicable
66	Diagnosis and Procedure Code Qualifier	Required
67	Principal Diagnosis Code	Required (Coding for Present on Admission data required)
67A-67Q	Other Diagnosis Codes	Required (Coding for Present on Admission data required)
68	Unlabeled Field	Not Used
69	Admitting Diagnosis Code	Required
70A-70C	Patient Reason for Visit	Not Required
71	Prospective Payment System (PPS) Code	Required for DRG Code – If 4 Digits Submitted, the Lead 0 will be Ignored
72	External Cause of Injury Codes	Not Used
73	Unlabeled Field	Not Used
74	Principal Procedure Code and Date	Required, If Applicable
74A-74E	Other Procedure Codes and Date	Required, If Applicable
75	Unlabeled Field	Not Used
76	Attending Provider Name and Identifiers (Including NPI)	May be Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send
77	Operating Provider Name and Identifiers (Including NPI)	May be Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send
78-79	Other Provider Name and Identifiers (Including NPI)	May be Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send
80	Remarks	May be Required in Specific Circumstances (Consult CMS Criteria)
81	Code – Code Field	Optional (Consult CMS Criteria)