

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

Chapter XII FREQUENTLY ASKED QUESTIONS

Provider Enrollment and Related Questions

HOW CAN I BECOME A GATEWAY HEALTH PLAN MEDICARE ASSURED[®] NETWORK PROVIDER?

All Providers go through the credentialing process which begins by completing a Provider application. Providers may obtain an application package by contacting Provider Relations at 888-700-7370. All Providers must be approved to bill Medicare.

HOW DO I OBTAIN A MEDICARE NUMBER?

You must complete Form CMS 855b (for facilities and group practices) or CMS 855i (for physicians and non physician practitioners). These forms may be found at www.cms.hhs.gov. In the “Search Now” block enter the appropriate form number.

HOW DO I ENROLL WITH THE PENNSYLVANIA MEDICAL ASSISTANCE PROGRAM?

Since the Gateway Health Plan *Medicare Assured*[®] is a Plan for the dually eligible (i.e. Members have both Medicare and Medical Assistance), providers should also obtain a Medical Assistance PROMISE Number. You may visit DPW’s website at www.dpw.state.pa.us or call them at (717) 772-6456 24 hours per day, 7 days per week. To check the status of your application to be a Medical Assistance Provider call (717) 772-6140 Monday through Friday 8:30 – 12:00 or 1:00 – 5:00 pm.

WHAT IF I CANNOT ACCEPT ANY NEW REFERRALS OR OTHER CHANGES OCCUR THAT AFFECTS MY ABILITY TO SEE MEMBERS?

It is important that you tell your Provider Relations Representative any new information that affects referrals so Providers and Members will not be inconvenienced. Please be sure to notify us of phone number and address changes as well. CBHNP will need the information in written form via fax (717-671-6522) or mail. A “Provider Data Update Form” may be used and is available on the website. Temporary inability to accept referrals will not jeopardize network status.

WHO DO I NOTIFY WHEN A SITE MOVES OR A PRACTITIONER LEAVES/STARTS EMPLOYMENT?

This information should be reported to your Provider Relations Representative in writing using the “Provider Data Update Form.” Updated information prevents inconvenience for Members as well as Providers.

If you are structured as a group practice, each new practitioner must complete an Individual Application for Enrollment which is available on the website. If you are credentialed as an organization it is not necessary to complete the Individual Application for Enrollment for new hires however, you must let us know if you have a new prescribing practitioner. Failure to notify Gateway Health Plan *Medicare Assured*[®] through CBHNP of new prescribing psychiatrists may lead to problems when Members get prescriptions filled.

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

Clinical Operations and Authorization Questions

HOW DO I REQUEST AUTHORIZATION?

All services except psychiatric evaluation, medication management, and family, individual and, group therapies, which are outpatient services, require prior authorization through CBHNP.

Psychological Testing

Psychological testing should not be requested using the outpatient request forms. Psychological testing requests require prior authorization. The form is available on the Gateway Health Plan[®] website, CBHNP website or from a Provider Relations Representative. You must complete the form and fax it to CBHNP at 1-717-540-1146.

Neuropsychological Testing

Neuropsychological testing should not be requested using the outpatient request forms. Neuropsychological testing requests require prior authorization. A copy of this form will be available on the Gateway Health Plan[®] website, CBHNP website or from a Provider Relations Representative. You must complete the form and fax to CBHNP at 1-717-540-1146.

ECT

Requests for ECT should not be submitted on the OP Request form. These requests should be made by calling CBHNP at 1-866-755-7299 and request to speak with a Clinical Care Manager.

Current authorization request forms as well as instructions for completing the form can be found on the website. Inpatient hospitalization and partial hospitalization authorizations require a phone call to CBHNP. You will have access to a live person 24 hours per day, 7 days per week if you have questions or need to discuss a case.

HOW DO I KNOW WHO IS THE ASSIGNED CLINICAL CARE MANAGER?

Member Services Specialists can provide this information via phone inquires.

WHY DO MEMBER SERVICES STAFF ASK SO MANY QUESTIONS FOR EVERY CALL?

Our Member Services Specialists need to obtain as much information as possible from callers in order to determine how to handle each call. They are responsible for completing an initial assessment for each incoming call.

WHAT DO I DO IF A MEMBER WANTS TO GO TO A DIFFERENT PROVIDER?

As a Provider, you would be responsible for providing the Member with other provider options and/or referring the Member to Gateway Health Plan[®] if they require additional information or experience any problems with transferring providers.

WHAT IF I DO NOT AGREE WITH A PROVIDER PAYMENT DENIAL APPEAL?

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

If your payment denial appeal was denied due to administrative or procedural errors, you may request that Gateway Health Plan[®] through CBHNP reconsider the decision through a Second Level Review.

A provider may request a second level internal review. The provider must request the second level review in writing and within 30 days of the date of the first level internal review decision letter. All second level appeal requests must set forth the specific reason why the provider feels that the first level decision was in error.

A second level determination will be completed within 45 days of receiving the payment denial appeal. The provider may elect to participate in the review by telephone or in person to present information.

Providers requesting review of Provider Payment Denial Appeals will be instructed to send a letter to Gateway Health Plan[®] stating the following:

1. Plan Name (Gateway Health Plan *Medicare Assured*[®])
2. Member name
3. date(s) of service
4. type of service that was delivered
5. Reason for delay or failure to get authorization
6. Explanation of circumstances
7. Steps taken to correct and prevent future occurrences
8. Documentation of Members seen/dates services provided and billable amount(s)
9. Desired action from CBHNP
10. Documentation relevant to the request (i.e., Medical Record for review, fax confirmation page to show outpatient request was submitted, etc...)

Appropriate reasons for approval (reversal of the administrative denial decision) include but are not limited to:

- documentation of eligibility verification issues beyond the control of the Provider
- documentation of processing errors by CBHNP
- documentation of continued stay review issues beyond the control of the Provider
- unavoidable delays caused by another provider
- timely notification and resolution of the issue
- any other reason as decided by the review committee.

Reasons for upholding of an administrative denial include but are not limited to:

- failure in authorization management by the Provider
- submission of the request for review beyond the latter of 30 days of the initial notice or service delivery date
- failure to check eligibility prior to service delivery
- failure in claims or billing management by Provider
- this was a MNC denial when services have already been provided
- any other reason as decided by the review committee.

A decision will be made within 30 days of receipt of the documentation and a written decision will be mailed within 5 days of the decision. If the request is approved and the claim is in the Gateway Health Plan[®] claims processing system, CBHNP will contact Gateway Health Plan[®] to adjudicate the claim. The approval letter serves as authorization and you should retain it in your records.

Gateway Health Plan[®] will make a decision about your request and communicate that decision within 30 days of receipt of the appeal.

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

HOW WILL I KNOW ABOUT CHANGES IN AUTHORIZATION PROCESSES AND OTHER PROCEDURES AT CBHNP?

CBHNP will share this information with Providers through Provider News briefs and Provider Info's. Provider Info's should be regarded as supplements and clarifications to the Gateway Health Plan *Medicare Assured*[®] Provider Manual. All such communication can be found on the website and are available for download.

WHAT DO I DO IF A MEMBER NEEDS EMERGENCY SERVICES?

Gateway Health Plan *Medicare Assured*[®] expects the Provider to take immediate action to ensure the safety of the Member and others. Gateway Health Plan *Medicare Assured*[®] should be contacted for service authorization at 1-866-755-7299 after the situation is stabilized.

Incidents/behaviors should be considered emergencies when a Member is a direct threat to self and/or others and is in need of a higher level of care due to safety.

The Lead Clinician or Outpatient Therapist should be consulted first for an acute exacerbation of target behaviors that do not result in risk to self and/or others but still require immediate interventions for stabilization. This should be part of treatment plan and may include but not be limited to Lead Clinician's direct interventions in the home.

The Lead Clinician should contact the Member's assigned Clinical Care Manager within one business day to discuss the case. A team meeting may need to be convened to discuss any changes to current treatment interventions.

Claims and Eligibility Questions

HOW DO I SUBMIT A CLAIM FOR PAYMENT?

Claims must be submitted within 365 days of the date of service.

Depending on the service you provided, one of two (2) claim forms may be used. The CMS 1500 is used for ambulatory services or services billed with a procedure code. The UB-04 should be used for inpatient or other services that are billed with a procedure code (00124) (00126). Forms can be obtained at most office supply stores, as they are standard in the industry. Claims may be submitted to the following address:

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

WHEN WILL I GET PAID?

A minimum of ninety percent (90%) of all clean claims are paid within 30 days. All clean claims are paid within 45 days. A clean claim includes all of the information necessary to process your claim. Necessary information is listed in Chapter VI of the Gateway Health Plan *Medicare Assured*[®] Provider Manual.

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

WHAT IF I HAVE A QUESTION ABOUT MY CLAIM?

Call Gateway Health Plan *Medicare Assured*[®] Provider Services Department to check on a status of a claim. They are available Monday through Friday from 8:30 a.m. to 4:30 p.m. The phone number is 800-685-5205.