



# Provider News Brief

## Gateway Medicare Assured Plan

March 2006

*This news brief is produced at least twice per year. It is created to keep network providers informed of program information, federal and state requirements that impact the Gateway Medicare Assured Plan. This newsletter may be freely distributed throughout network provider agencies. Upon publication, a copy will be sent by US Mail to every network provider site. Additional copies are available on our web site (www.cbhnp.org). You will find the following information in this edition:*

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## OUTPATIENT SERVICES REGISTRATION

Initial outpatient individual, family and group therapy, psychiatric evaluations and medication management services do not require prior authorization; however, you (the provider) must complete and submit an Outpatient Treatment Request Form within ten (10) business days from the date of the first session to register the services. Providers have thirty (30) days from the date the authorization is received to have corrections made to the authorization, so review the authorizations carefully.

In order to assure proper payment, it is imperative that you register the proper service codes. For example, if you registered an individual therapy session (90806) but delivered a family session (90847), you will not be paid for the family session unless you request an authorization for the family session within five business days of the session. Services must be billed as authorized. Failure to do so will result in a denial of the claim. In addition, this is a Medicare Advantage plan and as such, services may only be authorized to the owner of a valid Medicare enrollment number. Medicare rules and regulations around service delivery apply.

**Authorizations are limited by the number of sessions and/or the authorization expiration date or calendar year. Please remember all authorizations for outpatient therapy are approved for 6 months from the start date on the request or December 31, whichever comes first, with a maximum of 24 one hour sessions. Medication management visits (90862) are approved for one year from the start date or December 31, whichever comes first, with a maximum of 18 visits per year.**

Reauthorization requests are needed when either the number of authorized sessions has been exhausted prior to the expiration date or the authorization expiration date has been reached. Authorizations cannot be extended. Providers may submit a reauthorization request up to two weeks prior to the requested authorization start date or up to ten (10) business days after the requested start date of the authorization.

If you find an error after thirty (30) days of receipt of the authorization, it must be addressed through an Administrative Appeal. The administrative appeal process is also addressed in this newsletter.

The Outpatient Treatment Request Form must be completed in full. It includes frequently used procedure codes but you may use any procedure code permitted under Medicare. If you are requesting an outpatient procedure with a CPT or HCPCS Code not listed on the request form, be sure to clearly indicate the code as well as the title, description and number of units.

When you submit a request for authorization, it will be returned with the authorization number listed on the bottom of the form. This authorization number is for all requested services unless otherwise noted. If the request for authorization cannot be processed, the problem will be listed on the request and returned to the provider.

Providers should not request authorization for a person who is not yet an eligible Member. It is the Provider's responsibility to verify eligibility. Eligibility should be verified prior to scheduling the first session. Members will have a *Medicare Assured Card*. Member eligibility can be checked by contacting the Gateway DIVA Member Eligibility Line at 1-800-642-3515. The line is available 24 hours per day, seven (7) days per week. Providers can use the Member's

Gateway *Medicare Assured* ID Number or the Member's Social Security number and should select the "Fax Option" in order to get a faxed copy of the eligibility.

Questions about your authorization should always be directed to the Member Services Line at **1-866-755-7299**. Forms and Instructions are available online at [www.cbhnp.org](http://www.cbhnp.org) or at the following link:

<http://www.gatewayhealthplan.com/Providers/documents/OutpatientInstructionsMA.pdf>

## ADMINISTRATIVE APPEAL PROCESS

An Administrative Denial is a request that was not approved because contractual or administrative requirements were not met. Administrative denials are NOT denied based on medical necessity.

Providers are expected to follow all prior authorization requirements as defined in the Provider Agreement, Provider Manual and Provider Infos. This policy is intended to apply to administrative denials and is not applicable to Medical Necessity denials. Providers have thirty (30) days from the date of the authorization to submit corrections for outpatient service authorizations. Thorough review of authorizations as well as good utilization management practices should eliminate the need for submission of an administrative appeal. If errors are identified after 30 days, Providers will be directed to the administrative appeal process.

Reversal of administrative denials should be regarded as an exception and will not be routinely approved without compelling evidence that the Provider did not follow protocol due to legitimate special circumstances as determined by CBHNP. CBHNP will evaluate all requests and take into consideration factors which caused the procedural error as well as remedies in place to prevent future occurrences.

All requests for review of an administrative denial *must be submitted in writing within 30 days of the receipt of the denial notification OR the date of service.*

1. Providers requesting review of an administrative denial should send a letter to:  
PROVIDER RELATIONS  
ADMINISTRATIVE DENIAL REVIEW  
5425 Jonestown Road  
Harrisburg, PA 17112
2. The Committee decision is final so providers are encouraged to include all relevant information however, the request **MUST** include the following information:
  1. Plan Name (*Gateway 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...)
3. A Committee consisting of the Director of Provider Relations, Director of Quality Improvement and Systems Integration and a Provider Relations Representative reviews and researches each request.

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.

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.

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 claims processing system, CBHNP will contact Gateway to adjudicate the claim. The approval letter serves as authorization and you should retain it in your records.

Questions about this process should be directed to CBHNP Provider Relations at 888-700-7370.

The decision of the review process is final.

## **CLAIMS**

Claims processing is handled by Gateway Health Plan. Claims must be submitted using the guidelines set forth below to assure proper payment. Claims should be mailed to:

Gateway Health Plan  
**Claims Processing Center**  
P.O. Box 11-560  
Albany, NY 12211-0560

## CLAIM SUBMISSION GUIDELINES

**Services must be billed as authorized. Gateway will deny claims for services that are not authorized or include different codes from the authorization request.**

- To be considered timely, claims must be submitted within 365 days from the date of service.
- Corrected claims are considered if information is received within the 120-day follow-up period from the date of the remittance advice (i.e. incorrect date of service, invalid diagnosis code).
- Practitioners must bill within 365 days from the date of an Explanation of Benefits (EOB) from the primary carrier when Gateway is secondary.
- Correct/Current practitioner information, including Gateway Provider ID Number must be entered on all claims. The format for the Gateway ID number and the Medicare number is 7 digits. Electronic claims allows for an alternate provider number such as the Medicare ID number. However, the Gateway ID Number is the preferred number.
- Correct/Current member information, including Gateway *Medicare Assured* Member ID Number, must be entered on all claims. The format for the Gateway *Medicare Assured* ID number is 8 digits. For electronic claims, Gateway will accept the Gateway member number or the member's HIC number in alpha-numeric format. Gateway prefers the Gateway *Medicare Assured* ID number to assure that Gateway processed the claim for the appropriate individual.

If you have questions about claims payment, contact the Gateway Provider Service Line at 1-800-685-5205. The Gateway Provider Service Representative will try to assist you. If the question is related to non-payment for lack of authorization, you may be directed to the Administrative Appeal process discussed above.

## PROVIDER INFORMATION

If you are a facility or group practice, when completing the CMS 1500, please enter the practitioner in Block 31 and your facility or group practice information in Block 33. If you are an independent practitioner, please enter your name in both Block 31 and Block 33

## REQUIRED MODIFIERS

When billing for services, a community mental health center must use modifiers with each procedure code to identify the individual who provided the service. Modifiers are as follows:

- AH – Psychologist
- AJ - Licensed Clinical Social Worker
- SA - Certified Registered Nurse Practitioner (CRNP)/Physician Assistant (PA)

No modifier is required for a psychiatrist.

If a master level clinician is providing the service "incident to" one of the providers listed above, please use the appropriate modifier for the supervising/attending practitioner.

## **“INCIDENT TO”**

Medicare pays for services and supplies that are furnished incident to a physician's or other practitioner's service. For persons enrolling in Gateway's Medicare Advantage Plan, the term physician also means a practitioner including a physician assistant, nurse practitioner, clinical nurse specialist and clinical psychologist.

To be covered incident-to the services of a physician, services must be:

- An integral, although incidental, part of the physician's professional service;
- Commonly rendered without charge or included in the physician's bill;
- Of a type that are commonly furnished in the physician's office or clinic;
- Furnished by the physician or by the auxiliary personnel under the direct supervision of the physician.

Direct supervision means that the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the service.

A physician assistant, nurse practitioner, clinical nurse specialist and clinical psychologist may provide behavioral health services without the direct supervision of the physician and have the services covered under Medicare. However, a physician assistant, nurse practitioner, clinical nurse specialist and clinical psychologist may opt to provide these services incident-to a physician.

## **ELECTRONIC CLAIMS**

Gateway accepts electronic claims through Emdeon (formerly WebMD). To submit claims to Gateway please note the Payer ID Number is 60550.

## **REPORTING NEW OR LOST CAPACITY**

Remember to notify CBHNP Provider Relations (888-700-7370 or 717-671-6500) when you need to temporarily halt new referrals or when you wish to take new referrals. **PLEASE BE ESPECIALLY VIGILANT IN LETTING US KNOW IF YOU HAVE A NON-ENGLISH SPEAKING PSYCHIATRIST OR THERAPISTS OR NEW PHYSICIAN TIME!**

## FEE SCHEDULE CHANGES

The following procedure codes were end-dated by Medicare effective January, 1, 2006 and replaced by new codes. We will add the new codes with the corresponding rates effective June 1, 2006.

<u>Old Code</u>	<u>New Code</u>	<u>Rate</u>
96100	96101	\$93.90
	96102	\$33.45
	96103	\$26.44
96115	96116	\$101.11
96117	96118	\$110.50
	96119	\$46.97
	96120	\$35.50
99301	99304	\$63.95
99302	99305	\$84.69
99303	99306	\$104.56
99311	99307	\$32.88
99312	99308	\$54.50
99313	99309	\$76.84
99321	99324	\$56.55
99322	99325	\$82.99
99323	99326	\$120.53
99331	99334	\$43.70
99332	99335	\$69.41
99333	99336	\$107.33

Also, the following codes were end-dated with no replacement codes:

99261	99271	99274
99262	99272	99275
99263	99273	

New procedure codes added by Medicare;

99310	\$96.16
99327	\$158.80
99328	\$196.68
99337	\$158.11