



Provider News Brief

Gateway Health Plan Medicare Assured

November 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 Gateway Health Plan Medicare Assured. 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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NATIONAL PROVIDER IDENTIFIER (NPI)

Do you have your NPI number yet? The mandated compliance date for the NPI is May 23, 2007. All Individuals and Organizations who meet the definition of health care provider are eligible to obtain a National Provider Identifier, or NPI. If you are a HIPAA covered provider or if you are a health care provider/supplier who bills Medicare for your services, you need an NPI.

Gateway Health Plan requires NPI numbers for all providers who submit claims electronically, and strongly recommends that providers who submit paper claims also obtain an NPI.

Health care providers can apply for NPIs in one of three ways:

- For the most efficient application processing and the fastest receipt of NPIs, use the web-based application process. Simply log onto the National Plan and Provider Enumeration System (NPPES) and apply on line (see Related links inside CMS)
- Health care providers can agree to have an Electronic File Interchange (EFI) organization (EFIO) submit application data on their behalf (i.e., through a bulk enumeration process) if an EFIO requests their permission to do so
- Health care providers may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, ND, whereby staff at the NPI Enumerator will enter the application data into NPPES. The form will be available only upon request through the NPI Enumerator. Health care providers who wish to obtain a copy of this form must contact the NPI Enumerator in any of these ways:
 - Phone: 1-800-465-3203 or TTY 1-800-692-2326
 - E-mail: customerservice@npienumerator.com
 - Mail: NPI Enumerator

P.O. Box 6059

Fargo, ND 58108-6059

Regardless of how you obtain your NPI, it is important that you retain the notification document that NPPES sends to you that contains your NPI. You may need to share this notification with other health care partners. Even those providers who do not bill for services may need to disclose their NPIs to those providers who do (e.g. physicians who order lab tests or refer patients for diagnostic testing must be identified on the lab's or testing facility's claim).

REQUIRED MODIFIERS

Providers are not using modifiers when billing for *Medicare Assured* services. **Community Mental Health Centers** and **Provider Groups**, if someone other than the psychiatrist sees the Member, you must use the appropriate modifier with each procedure code to identify the individual who provided the service. A simple rule to determine if a modifier is required when billing, is that if Block 33 is an entity other than the individual practitioner or the tax ID number identified in Block 33 is a different ID number from the practitioner, then you must use a

modifier. If you are a licensed psychologist or Licensed Clinical Social Worker practicing in your own office, do not use a modifier. Modifiers are as follows:

- AH – Psychologist
- AJ - Licensed Clinical Social Worker
- SA - Certified Registered Nurse Practitioner (CRNP) or 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.

OUTPATIENT TREATMENT REGISTRATION (OTR) FORM

For Gateway's *Medicare Assured Plan*, we had to make several changes to the Outpatient Treatment Registration (OTR) forms. The revisions made to the forms were for Gateway processing purposes and do not include changes for providers. **Note:** Revised forms are dated 8/4/06. Older forms were processed until **September 30, 2006**. Any outdated forms received after September 30, 2006 will not be processed and will be returned to the provider. You can find the revised forms at www.gatewayhealthplan.com or www.cbhnp.org websites.

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 Registration Form within **ten (10)** calendar days from the date of the first session to register the services. Failure to submit the form within the ten calendar days will result in denial of all services provided before we receive the OTR form.

OTR REQUESTS

Effective with dates of service on or after **January 1, 2007**, Gateway's *Medicare Assured Plan* will no longer require outpatient services to be registered through CBHNP for par providers. You may provide any medically necessary outpatient mental health service or substance abuse service on the rate schedule and bill Gateway directly. However, services prior to January 1, 2007 must have a registration number in order for you to receive payment.

CBHNP will still pre-certify psychological and neuropsychological testing, partial hospitalization and outpatient ECT. The following codes will need authorized or pre-certified before delivering the service.

H0035 96101 96102 96103 96116 96118 96119 96120 90870

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 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 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.

Non-par Gateway *Medicare Assured* Providers will require all services to be authorized. If there is not an authorization for a non-par provider, Gateway will deny the claim.

OHIO EXPANSION

Gateway Health Plan *Medicare Assured* is on the move. We are pleased to announce that Gateway has been approved to begin marketing *Medicare Assured* in Mahoning, Stark, Summit and Trumbull counties of Ohio. This expansion will occur on January 1, 2007.

If you are a Pennsylvania provider and plan on seeing an Ohio Gateway Member, you must sign an Ohio agreement. For an Ohio agreement, please contact CBHNP, Network Development at 1-888-700-7370.

PENNSYLVANIA EXPANSION

Gateway Health Plan *Medicare Assured* is currently in 23 counties across Pennsylvania. We are pleased to announce that we will expand to **Mercer County** effective January 1, 2007. If you are not a network provider, please contact CBHNP, Network Development at 1-888-700-7370.

CONTINUED STAY REVIEWS

CBHNP conducts continued stay reviews (CSR) or concurrent reviews, for managed care members based on site of service. Continued stay reviews for IP and PHP must be done live by telephone with CBHNP Clinical Care Managers (CCM's). Please be prepared for reviews with current psychotropic medications and changes since the last review, updated diagnoses and GAF scores and current symptoms. CBHNP makes review decisions based solely on the medical information obtained at the time of the review determination.

The continued stay review is initiated on or before the last covered day to allow sufficient time for the concurrent review process to be completed, and provider notified of the determination prior to the end of the previously authorized period. **Reviews should occur on the last covered day by 4pm.**

The frequency of concurrent reviews is contingent upon the member's clinical condition and response to the prescribed plan of treatment or based on arrangements with specific facilities.

The CCM will collect relevant clinical information and evaluate the medical necessity of the request using MCAP or ASAM criteria as appropriate. The clinical information collected includes, but is not limited to:

- Diagnosis/co-morbidities
- Age
- Complications
- Progress of treatment
- Medical history
- Current medications
- Psychosocial situation
- Home environment/social situation, when applicable
- Treatment plan

Please have the above information available when you call!

If the CCM is able to authorize the request for service, the requesting practitioner/provider will be notified of the reference number telephonically or by return fax within designated timeframes. Confirmation of certification will include the number of extended days, units of service and the next anticipated review date.

Certification for services is based on the information available at the time it is issued (including information regarding the member's eligibility for coverage and/or the availability of benefits).

For those cases they are unable to authorize, the CCM must consult with a Physician Advisor/Medical Director for physician review. The Physician Reviewer will attempt to contact the treating provider to discuss the member's clinical condition prior to rendering a determination.

If additional information is needed to authorize or continue services, a request will be made as soon as the request for services is received.

ADMINISTRATIVE APPEALS

To date, CBHNP has processed 227 Administrative Appeals for Gateway's *Medicare Assured* Plan. Of the 227 appeals, approximately 67 are for inpatient services and 167 outpatient services. This is a high number of appeals. The majority of the appeals are due to the fact that providers were not aware that the patient had *Medicare Assured*. However, since July, most members are aware of their Medicare coverage and providers should be asking Members for their Gateway Health Plan *Medicare Assured* Card.

The March Newsletter contained information on Administrative Appeals. There is **no form** necessary to request an appeal. To request an appeal, you must send a letter with the following information:

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...)