

*Gateway Health PlanSM Medicare Assured***December 2007**

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 PlanSM 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)

The mandated compliance date for the NPI was 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.

To ensure reimbursement to the correct payee, the Gateway Health PlanSM *Medicare Assured* provider number must be included on every claim. Currently, there is an interim NPI contingency period which will expire May 23, 2008. After the contingency period, Gateway Health PlanSM will require providers to use their NPI number(s).

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

Not all providers have submitted their NPI number to CBHNP for the Gateway Health PlanSM *Medicare Assured* Plan. Failure to do so can and will result in denial of payment to you.

If you have not sent us your NPI number, please do so as quickly as possible. You can fax your NPI Number to CBHNP, Network Development at 717-671-6522.

CONFIDENTIALITY

Gateway Health PlanSM *Medicare Assured* Providers will ensure that Member clinical information is kept secure and confidential, and that access will be limited to authorized persons only as identified by Member signed releases.

Providers are required to abide by all state and federal laws and regulations in regards to Member confidentiality, including HIPAA.

To guarantee Member confidentiality, Gateway Health PlanSM and CBHNP complies with federal and state regulations governing the release of client information (disclosure of confidential information) and record retention. Gateway Health PlanSM and CBHNP maintain strict policies concerning internal security, review processes, disposal of confidential documents and distribution of statistical information. Gateway Health PlanSM and CBHNP also require all Providers to adhere to strict confidentiality measures including:

- Password protection of on-line Member information.
- Written consent from Member/guardian is required before disclosure of any information, except as allowed by law, (e.g., emergency treatment, under court-order, etc.). Drug and Alcohol services require Member consent regardless of age.
- Members, 14 years and older, receiving mental health services shall control the release of their medical record. Any release of information forms needed shall be signed by the Member, when the Member is 14 years or older. Drug and Alcohol services require Member consent regardless of age.
- Members who are under the age of 14 years or who are incapacitated, except for Members in drug and alcohol treatment, may not sign their own release of information

forms. In these cases the parent or guardian shall sign the release of information forms.

- Members of any age receiving drug and alcohol services shall control the release of their medical records, in accordance with state and federal laws.
- Gateway Health PlanSM *Medicare Assured* Providers have the responsibility to make sure the release of information form is explained and understood by the Member/guardian prior to being signed.
- A copy of the signed release of information form will be filed in the Member's medical record and a signed copy given to the Member/guardian.
- Gateway Health PlanSM *Medicare Assured* Providers may release information when the Member's condition is life threatening and it is impossible to obtain the Member's/guardian's consent. All such occurrences must be thoroughly documented in the Member's record.
- Verbal disclosure about a Member can only be made if the Member/guardian has a signed release of information form specifying the information to be released.
- Any documents released or exchanged between Gateway Health PlanSM, CBHNP and a Gateway Health PlanSM *Medicare Assured* Provider must include a statement regarding the confidentiality of the information exchanged.
- Any Gateway Health PlanSM *Medicare Assured* Provider violating any of the confidentiality policies and procedures will be subject to disciplinary action.
- Release of information forms should be signed by the Member/guardian during the first session and retained in the Member's chart. If the Member/guardian refuses to allow the release of information, this must be clearly documented in the Member's chart.

Providers may use their own consent form to release information in accordance with the federal and state laws that govern confidentiality for mental health, e.g. Federal Regulations 42 CFR, part 2; Pennsylvania stature D&A Control Act & State Regulations, 28 PA Code Subsection 255.5, PA Code Title 55, Subsection 5100.33-39, 5200.41, 5210.56, 5221.52; Health Care Financing Administration, 42 CFR Chapter IV, 10-1-93.

Through contractual agreements, all practitioners and providers participating with Gateway Health PlanSM *Medicare Assured* have agreed to abide by all policies and procedures regarding member confidentiality. The performance goal for confidentiality is for practitioners to secure patient records from public access.

Under these policies, the practitioner or provider must meet the following:

1. Provide the highest level of protection and confidentiality of members' medical and personal information used for any purposes in accordance with federal and state laws or regulations including the following:
 - 42 USC 1296a(a)(7)
 - 42 CFR § 431,300
 - The Mental Health Procedures Act, 50 P.S. §§7111
 - Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164
2. Assure that member records, including information obtained for any purpose, are considered privileged information and, therefore, are protected by obligations of confidentiality.
3. Assure that a member's individually identifiable health information as defined by HIPAA, also known as Protected Health Information (PHI), necessary for treatment, payment or

healthcare operations (TPO) is released to Gateway Health PlanSM Medicare Assured without seeking the consent of a member. This information includes PHI used for claims payment, continuity and coordination of care, accreditation surveys, medical record audits, treatment, quality assessment and measurement, quality of care issues, and disease management. Gateway Health PlanSM Medicare Assured follows the requirements of HIPAA and limits its requests to the amount of PHI that is minimally necessary to meet the payment, treatments or operational function. All other requests for release of or access to PHI will be handled in accordance with federal and state regulations.

4. Environmental security of confidential information is conducted by all providers and practitioners treating Gateway Health PlanSM Medicare Assured members. This includes both internal and external monitoring of practice and provider sites. Provider and practitioner sites must comply with the Environmental Assessment standards that require that patient records be protected from public access.

OTR REQUESTS

Effective with dates of service on or after **January 1, 2007**, Gateway Health PlanSM Medicare Assured does not 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 Health PlanSM Medicare Assured directly.

CBHNP will still pre-certify psychological and neuropsychological testing, acute mental health 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 Health PlanSM website (www.gatewayhealthplan.com), CBHNP website (www.cbhnp.org) 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 PlanSM 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 outpatient 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 Health PlanSM *Medicare Assured* Providers will require all services to be authorized. If there is not an authorization for a non-par provider, Gateway Health PlanSM will deny the claim.

OHIO EXPANSION

Gateway Health PlanSM *Medicare Assured* is on the move again. Currently Gateway Health PlanSM *Medicare Assured* is in 4 counties in Ohio (in Mahoning, Stark, Summit and Trumbull counties). We are pleased to announce that Gateway Health PlanSM *Medicare Assured* has been approved to begin marketing the *Medicare Assured* Plan of Ohio in 8 additional counties. The new counties are Ashtabula, Columbiana, Cuyahoga, Geauga, Lake, Lorain, Medina and Portage counties. This expansion will occur on January 1, 2008.

If you are a Pennsylvania provider and plan on seeing an Ohio Gateway Health PlanSM *Medicare Assured* 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 PlanSM *Medicare Assured* is currently in 24 counties across Pennsylvania. We are pleased to announce that we will expand to **Lackawanna, Northumberland and Schuylkill counties** effective January 1, 2008. 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). If additional information is needed to authorize or continue services, you will be advised during the request for services.

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.

PROVIDER PAYMENT DENIAL APPEALS

Many providers received a mailing from CBHNP regarding the Provider Payment Denial Appeals. The effective date of the change is January 1, 2008.

Clinical Care Managers are not permitted to backdate any request for authorization. Such requests must be submitted through the provider payment denial appeal process. The process for appeal requests is outlined below.

Providers are expected to follow all prior authorization requirements as defined in the Provider Manual and Provider Infos. This policy is intended to apply to payment denials that resulted from administrative non-compliance and is not applicable to denials based on medical necessity decisions by CBHNP on behalf of Gateway Health PlanSM Medicare Assured. Payment denials are not denied based on medical necessity criteria unless a service has already been provided. For services not yet provided, the Gateway Health PlanSM reconsideration policy and procedure will apply.

Reversal of payment 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 that caused the procedural error as well as remedies in place to prevent future occurrences.

CBHNP will be responsible for all first and second level internal review appeals. The provider must initiate the formal Provider Payment Denials Appeal process through a written appeal request. All requests must go to:

Gateway Health PlanSM
Attention: Medicare Complaint Administrator
U.S. Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219-2704

Providers requesting review of a payment denial will be instructed to send a letter stating the following:

- Plan Name (Gateway Health PlanSM *Medicare Assured*)
- Member name
- Members Gateway Health PlanSM *Medicare Assured* ID Number
- Documentation of Members seen/dates services provided and billable amount(s)
- The service that was delivered
- Reason for the delay or failure to get authorization
- Explanation of circumstances
- Steps taken to correct and prevent future occurrences
- Desired action from CBHNP
- Documentation relevant to the request (i.e.... Eligibility slips verifying that Eligibility was checked and wrongly indicated enrollment status, fax confirmation page, etc...)
- ALL relevant information should be included with your appeal since the decision of the Committee is final.

Appropriate reasons for approval (reversal of the non-authorization decision) include but are not limited to:

1. Documentation of eligibility verification issues beyond the control of the provider
2. Documentation of processing errors by CBHNP or Gateway Health PlanSM
3. Documentation of continued stay review issues beyond the control of the provider
4. Unavoidable delays caused by another provider.
5. Timely notification and resolution of the issue.
6. Any other reason as decided by the review committee.

Reasons to uphold a non-authorization decision include but are not limited to:

1. Failure in authorization management by the provider.
2. Submission of the request for review beyond 90 days of the initial notice or service delivery date.
3. Failure to check eligibility prior to service delivery.
4. Failure in claims or billing management by provider.
5. This was a MNC denial when services have already been provided.
6. 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 but must also be mailed within 30 days of receipt of the appeal request. If the request is **approved** and the claim is in the Gateway Health PlanSM claims processing system, **CBHNP will contact Gateway Health PlanSM to adjudicate the claim.** The approval letter serves as authorization and you should retain it in your records.

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.

You should direct questions on this process to CBHNP Provider Relations at 888-700-7370.

All relevant information must be submitted with the appeal, as the decision of the Second Level Committee review is final.

MEDICAL RECORDS STANDARDS

The Quality Improvement Program provides guidelines for medical record documentation for Gateway Health PlanSM Medicare Assured Providers. These guidelines are consistent with the standards of national accrediting organizations. Gateway Health PlanSM Medicare Assured Medical Records standards for behavioral health providers are as follows:

Accessibility and Availability of Medical Records

Provider contracts include provisions to permit Gateway Health PlanSM and CBHNP Quality Improvement staff, and appropriate/required agencies access to the medical records of Gateway Health PlanSM Medicare Assured Members. Records may be reviewed to monitor quality, medical necessity, coordination of care, and continuing care planning.

Gateway Health PlanSM Medicare Assured Providers are contractually committed to maintaining medical record documentation of each encounter with Gateway Health PlanSM Medicare Assured Members.

Recordkeeping

Standards are established for organization, content, and readability of the Gateway Health PlanSM Medicare Assured Member's medical records. The Member medical record documentation may be either paper based or electronic. Documentation must be current, detailed, organized, comprehensive, and legible, promote effective care, and facilitate quality review. Providers must adhere to all applicable federal and state confidentiality regulations for treatment records. By provider contract, treatment records must be made available for review by CBHNP for quality improvement purposes. Data elements for Member medical records include:

- The Member's name and/or client number on each page of paper documentation and on every entry of electronic records.
- The Member's identifying information and demographics to include:
 - Name

- Age and Date of Birth (DOB)
- Address and County of residence
- Home, work telephone number and/or method of contact
- Employer or school
- Marital status
- Legal status
- Parent/Guardian Name (for children and non-adjudicated adolescents)
- Name and contact information of Primary Care Physician (PCP)
- All entries are dated; author of documentation is identified by name, title, credential and signature (paper) or key identifier (electronic).
- Written documentation is legible to someone other than writer or affiliated staff colleagues. Legibility is determined through review by CBHNP Staff.
- Allergies to include medication allergies and adverse reactions. Absence of allergies is noted as “no known allergies – NKA”.
- Risk factors/Risk assessments
- Past Medical History/Treatment History to include:
 - Significant Health Events – accidents, operations, hospitalizations
 - Developmental History (for children and adolescents)
 - History of past behavioral health interventions/treatment to include dates and duration of services and level of care
 - DSM-IV diagnoses for all axes I through V
- Medication Information to include medication name, frequency, dosage, effectiveness of treatment regime and any known side effects for:
 - Past medications for physical conditions
 - Past psychotropic medications
 - All current medications
 - Evidence that current medication has been consistently provided as prescribed and reevaluated as necessary; changes in medication, dosage and reason for change
- Past history and current use of alcohol/drugs to include kind, type, frequency and amount
- Consultations, Referrals and Specialists’ Reports to include laboratory results and review psychological evaluations, summaries and review as applicable
- Record of all emergency care, how directed and emergencies’ surveys
- Discharge summaries
- Individualized Treatment Plan to include:
 - Goals and objectives
 - Discharge criteria to move to lesser level of care
 - Therapeutic interventions/modalities
 - Client’s response to treatment/client progress towards goal achievement
 - Documentation of evidence and results of any behavioral health screening
 - Documentation of all treatment/interventions provided and results of treatment/interventions
 - Documentation of team Members involved in the multi-disciplinary team of Gateway Health PlanSM Medicare Assured Member needing specialty care
- Documentation of behavioral health and medical surgical integration to include:
 - Screening for behavioral health conditions which may be affecting physical health
 - Screening for physical health conditions which may be affecting behavioral health
 - Screening and referral to Gateway Health PlanSM Medicare Assured Primary Care physician when appropriate

- Documentation of Gateway Health PlanSM Medicare Assured Primary Care Physician referral to Gateway Health PlanSM Medicare Assured Provider.
- Quarterly summary of the Gateway Health PlanSM Medicare Assured Member's progress in behavioral health treatment, prepared by the Gateway Health PlanSM Medicare Assured Provider(s) for the Gateway Health PlanSM Medicare Assured Member's Primary Care Physician.
- Summary is prepared more frequently when clinically appropriate.
- Documentation that behavioral health professionals are included in the primary and specialty care service teams when a Gateway Health PlanSM Medicare Assured Member with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder.
- Documentation of GAF scores at initiation of treatment and delineated treatment intervals through episode of care/illness but at a minimum at termination of treatment for all Gateway Health PlanSM Medicare Assured Members.
- Documentation of reason for termination of treatment.
- Documentation of date(s) of family, therapy/intervention/visits for any Gateway Health PlanSM Medicare Assured Member under the age of 18.

RECORD RETENTION

Many providers received a letter from CBHNP providing an amendment to your contract with regards to Record Retention. In order to comply with revised federal regulations for Medicare Advantage organizations, CBHNP amended the following contract provisions of the existing provider services agreement or any amendment thereto, to be effective on December 15, 2007:

- Records, Reports and Inspections.

1. CBHNP Provider shall maintain financial reports and source records that include any revenues from, expenditures for, or other financial activity related to services rendered under this Agreement for the period required by law, at a minimum of **ten (10) years** or any longer period as may be required by CMS from time-to-time, following the termination or expiration of this Agreement or from the date of completion of any audit, whichever is later. Provider may keep such records in an original paper state or preserved on micro media or electronic format. Provider will develop and maintain written policies and procedures for the storing of these records.

CBHNP Provider further agrees to provide to Gateway Health PlanSM and CBHNP all medical, financial and administrative information and reports as may be necessary for (1) compliance by Gateway Health PlanSM with State and Federal law; (2) Gateway Health PlanSM Medicare Advantage Plan program management purposes; (3) Gateway Health PlanSM compliance with the reporting and quality assurance requirements of any contract between a government agency and Gateway Health PlanSM to provide healthcare services to a specified category of Members; and (4) such other legal purposes as determined by Gateway Health PlanSM from time-to-time.

Any and all references to a required financial report or source record retention of less than **ten (10) years** contained in provider's current participation agreement

or any amendment thereto are hereby omitted and replaced with the requirement herein.

4. CBHNP Providers agree to reasonably cooperate with and participate in such review and service programs related to the Gateway Health PlanSM Medicare Advantage Plan as may be established by Gateway Health PlanSM and CBHNP, including Utilization Review/Management, quality assurance programs, credentialing, sanctioning, external audit systems, and administrative and provider appeals, grievance and reconsideration procedures. CBHNP Provider further agrees to reasonably cooperate with HHS, the Comptroller General or their designees' inspection or evaluation of records for a period of **ten (10) years**, or for any longer period as may be required by CMS from time-to-time, from the termination of this Agreement or from the completion of a then-pending audit. CBHNP Provider acknowledges that CMS may inspect, evaluate and audit Gateway Health PlanSM, CBHNP and CBHNP Provider at any time if CMS determines that there is a reasonable possibility of fraud. CBHNP Provider will comply with all final determinations rendered through the above programs.

Any and all references to a required period of cooperation with an audit conducted by HHS, the Comptroller General or their designees of less than ten (10) years contained in provider's current participation agreement or any amendment thereto are hereby omitted and replaced with the requirement herein.

5. Medical Records. To the extent applicable to the provision of Covered Behavioral Health Services to Members, CBHNP Providers agree to maintain an appropriate and accurate medical and clinical record for each Member who has received Covered Behavioral Health Services, for a period of at least **ten (10) years** or any longer period as may be required by CMS from time-to-time, from the date of the last encounter, in accordance with State and Federal laws and regulations, and CBHNP standards and accepted medical and clinical practice. In the event CMS determines there is a need to retain records beyond the normal retention period, CBHNP Provider shall comply with written notice of such extended retention period.

Any and all references to a required medical record retention of less than ten (10) years contained in provider's current participation agreement or any amendment thereto are hereby omitted and replaced with the requirement herein.

If you did not receive your copy of the Amendment, please contact CBHNP, Network Development at 717-497-1141 or 717-497-1147.

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.

2008 MANUALS

The 2008 Gateway Health PlanSM *Medicare Assured* Provider Manual for Behavioral Health Care is now available online at www.cbhnp.org. There are separate manuals for Ohio providers and Pennsylvania providers.