

Gateway Health PlanSM
Private Duty Nursing Billing Guidelines
Effective 4/1/04

- Submit all bills on HCFA 1500 form.
- Enter procedure code as authorized by Gateway's Special Needs/Case Management Department. Each code allowed will be entered on a separate line in the authorization record, applicable when multiple nursing services are being authorized.
- Claims must be billed on a calendar month basis. Weekly claims will no longer be accepted. All services incurred in a calendar month, must be billed on the same HCFA form. Claims cannot be itemized by date of service. Each authorized code must be identified on a separate line of the HCFA with the corresponding number of hours. Any hours billed that exceed the quantity authorized will be denied.
- Enter quantity as total number of hours, in whole hour increments, for services rendered during the calendar month for which you are billing. Any portion of an hour not billed in a full hour increment will be rounded down.
- **New Requests for Service:** The authorization will begin on the first date of service and extend through the last calendar day of the month. The claim **must** be billed using the **exact** date span as indicated in the authorization. For example, service begins on April 18. The authorization will reflect 4/18-4/30 with a specified number of approved hours. The claim must reflect 4/18-4/30 and the number of hours provided in the month. The authorization and claim for the subsequent dates of service for the following month(s) **must** use the start date of service as the first day of the calendar month and the end date as the last day of the calendar month.
- **Existing Authorizations:** The authorization will span the first day of the calendar month through the last calendar day of the month, regardless of the day(s) the services were rendered in that month. The claim **must** be billed using the dates of services as indicated in the authorization. For example, 4/1-4/30 has been approved. The claim must indicate these exact dates of service, even if services were not provided on April 1 or April 30.
- **Discontinuation of Services:** When services are discontinued within a calendar month, the authorization must use the start date and end date of the services within that calendar month. The claim **must** be billed using the exact dates of services as indicated in the authorization. For example, services are authorized to occur between 4/1 and 4/15 only. The claim must reflect this exact date span and should not extend through the end of the month.
- If an adjusted/corrected bill is submitted, the span date for the entire calendar month must be re-billed to allow for any adjustments to prior payments. The entire period must be billed so that Gateway may accurately identify duplicate billing.
- Gateway is the payer of last resort. If Gateway's records indicate the presence of other insurance, coordination of benefits guidelines apply. When there is a discrepancy in other insurance information, providers must supply either an explanation of benefits (EOB) or letter from the

employer verifying coverage is no longer effective. Attach primary carrier EOB's, covering all dates of services in the calendar month, to the HCFA. If the EOB's do not match all dates in the authorization for the calendar month, Gateway will be unable to coordinate benefits for any of the dates of services.

- EOB's are required for claims processing when a member has other insurance. When the primary has denied all private duty-nursing services, denial letters from primary/secondary payers will be evaluated to determine if Gateway will forego the EOB requirement. If accepted, the denial letter will be valid for the **balance of the calendar year**. If not accepted, the provider must continue submitting EOB's from the primary carrier. This process will operate on a calendar year basis. At the beginning of each year, providers must submit a new denial letter from the primary carrier. When benefits are exhausted for the benefit period under the primary insurance plan or whenever there is a change of coverage during a calendar year, the process for EOB's/denial letters will need to be re-assessed. Please see attached for Gateway's nursing letter exception process criteria.
- PLEASE NOTE: Letters already evaluated by Gateway under the existing process will be valid until a new letter is required in 2004 but will transition to the process noted in these billing guidelines for calendar year 2005.
- Gateway is not responsible for payment of any unauthorized hours of services incurred by the provider including the provision of 24 consecutive hours of care.
- Private nursing services or aides may not be billed while the member is in an in-patient setting.
- Billing guidelines apply to participating and non-participating home health agencies.
- Please direct all questions to Gateway's Provider Servicing department @ 1-800-392-1145.