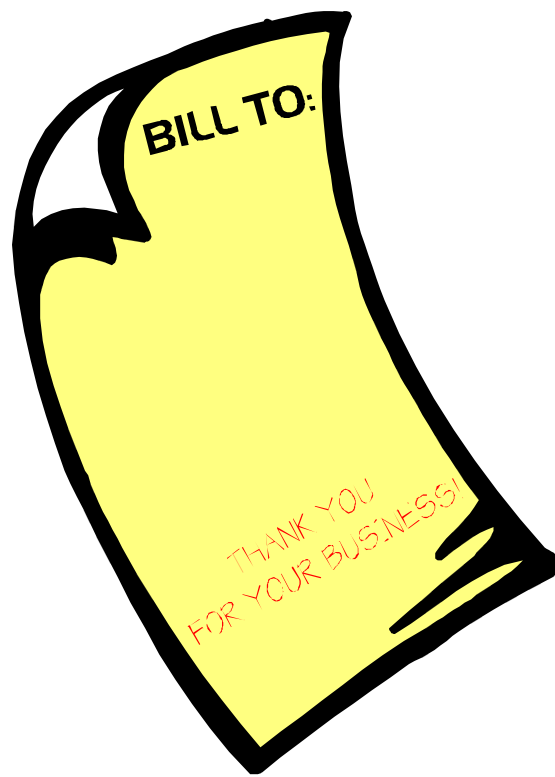


GATEWAY
HEALTH PLAN[®]
PENNSYLVANIA MEDICAID



PRIVATE DUTY SERVICES
PROVIDER BILLING HANDBOOK

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INTRODUCTION

GATEWAY HEALTH PLAN[®] MISSION STATEMENT

Gateway Health Plan[®] emphasizes the development and delivery of innovative programs to positively affect the personal health of its members. Gateway Health Plan[®] maintains a healthcare delivery system, which ensures the availability of high quality medical care for Gateway members based upon access, quality, and financial soundness.

Gateway Health Plan[®] is pleased to partner with you to provide private duty services to Gateway members age birth to twenty-one. Gateway has provided this handbook to you in an effort to ensure that our members are provided with high quality and appropriate care, and that your agency receives timely compensation. Please review the entire handbook and direct any questions to Gateway's Provider Services Department, 1-800-392-1145.

Private duty services are a covered benefit for all Gateway members age birth to twenty-one. All requests for private duty services are reviewed and approved by a Gateway Medical Director based on medical necessity. If private duty services are approved, a Medical Care Manager from Gateway's Special Needs Unit will be assigned to that member. Please contact Gateway's Special Needs Unit at 1-800-642-3550, Option 1 to speak to the Care Manager regarding authorized services.

GENERAL BILLING GUIDELINES

Submit all bills on CMS 1500 form. See Appendix for sample copy.

- Include the provider identification number in Box 33.
- Use only valid MA codes, CPT-4 codes, and modifiers or HCPCS codes.
- Use only valid diagnosis codes.
- Use place of service code “12.”
- Use procedure code provided by Gateway’s Special Needs Care Management Department. Each code allowed will be entered on a separate line in the authorization record, applicable when multiple nursing services are authorized.

CODE	PROCEDURE
S9123	RN-SHIFT (non-technology dependent)
S9124	LPN-SHIFT (non-technology dependent)
T1000 TD	RN – SHIFT (technology dependent)*
T1000 TE	LPN – SHIFT (technology dependent)*
S9122	HHA-SHIFT
T1019	Personal care services**

*dependent upon a Ventilator, BiPAP, or CPAP machine

**only for use by MA provider type other than 05

- Claims must be billed on a calendar month basis. All services incurred in a calendar month must be billed on the same CMS form. Each authorized code must be identified on a separate line of the CMS form with the corresponding quantity of total number of hours, in whole hour increments, provided. 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 4/18/08-4/30/08 with a specified number of hours. The claim must reflect 4/18/08-4/30/08 and the number of hours provided during that date span.

- 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, 4/1/08-4/30/08. The claim must indicate these exact dates of service, even if services were not provided on 4/1 or 4/30.
- 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 4/1/08-4/15/08 only. The claim must reflect this exact date span and should not extend through the end of the month.
- Multi-Child Rate/Single Caregiver: When more than one child in the same home are approved for private duty services and care will be provided by one professional, contact the Special Needs Care Manager to discuss billing.
- 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.
- SUBMIT ALL CLAIMS TO:
 Gateway Health Plan®
 Claims Processing Department
 P.O. Box 11-718
 Albany, NY 12211-0718

Timely Filing Guidelines

180 days from date of service for initial claim submission
90 days from date of processing to submit a provider appeal on any claim
60 days from date of primary EOB to submit claims for coordination of benefits

Contact Provider Services at 1-800-392-1145 and press Option 2 to research claims submitted for which you have not yet received payment within 45-60 days.

COORDINATION OF BENEFITS

Some Gateway recipients have other insurance coverage. Gateway, like the Pennsylvania Medical Assistance Program, is the payer of last resort on claims for services provided to members with other insurance coverage. Gateway does not deny or delay approval of otherwise covered treatment or services unless the probable existence of third party liability is identified in Gateway's records for the member at the time the claims are submitted.

Standard Method: Submission of an Explanation of Benefits (EOB) is the preferred billing method.

In order to receive payment for services provided to members with other insurance coverage, the practitioner must first bill the member's primary insurance carrier using the standard procedures required by the carrier. Upon receipt of the primary insurance carrier's EOB, the practitioner should submit a claim to Gateway. The practitioner must:

1. Follow all Gateway referral and authorization procedures.
2. File all claims within timely filing limits as required by the primary insurance carrier.
3. Submit a copy of the primary carrier's EOB with the claim to Gateway within 60 days of the date of the primary carrier's EOB.
4. Be aware that secondary coverage for covered fee-for-service items is provided according to a benefit-less-benefit calculation.
5. The amount billed to Gateway must match the amount billed to the primary carrier. Gateway will coordinate benefits; the provider should not attempt to do this prior to submitting claims.

Alternative Method: If the primary insurance carrier has denied all private duty 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 reassessed. Please seek assistance from Provider Servicing/1-800-392-1145 regarding this matter if needed.

New Cases: The medical review by the primary insurer must be completed within 60 days of the first date of service provision to qualify for review of an exception letter in place of an EOB

Existing Cases: The medical review by the primary insurer must be completed before March 31st of the calendar year to qualify for review of an exception letter in place of an EOB.

Gateway is considered the primary insurer when auto or casualty claims are involved. If the original bills received by Gateway include EOB's from the auto or casualty plan, Gateway will coordinate benefits. If the EOB from an auto or casualty plan is received after we have paid for services, we are unable to adjust our initial payment; our contract with the Department of Public Welfare (DPW) does not allow us to retrospectively adjust claims for auto or casualty accidents. If providers believe they are overpaid, reimbursements should be issued to DPW.

If a member indicates they no longer have primary coverage, but the State System indicates otherwise, the member must contact his or her caseworker to have the State System updated. If this is not possible, the practitioner may contact the primary carrier and request written verification of the coverage.

When Gateway receives a letter from the primary carrier indicating that the member no longer has coverage, Gateway will only use the letter to investigate the situation. If Gateway's investigation confirms that the member no longer has primary coverage, Gateway will request the State update the system. Once the State System has been updated, Gateway will go back 120 days and reprocess the coordination of benefits.

Note:

Denial reason from the primary insurance of no prior authorization does not qualify for review of an exception letter in place of an EOB.

The alternative method should only be used if the provider adheres to the specific timeframes required. Otherwise, the standard method should be used.

MEMBER ELIGIBILITY

Payment is contingent upon the member's eligibility on the date of service and authorization is not a guarantee of payment. Gateway Health Plan® will make no payment for any item or service furnished by a provider precluded from participation in Medicaid Services.

If you are unsure if a member is effective with Gateway please call 1-800-392-1145 and press Option 1.

DOCUMENTATION

The review process for continued approval of private duty services is ongoing. Please provide the following documentation to the Medical Care Manager assigned on any Gateway member that your agency is providing services to:

- Current Home Health Certification and Plan of care (Form CMS-485)
Submit signed document for current certification period every 60 days
- RN Supervisor visit notes and/or progress notes
Submit monthly or as often as completed
- Nursing/Home Health Aide notes
Submit upon request of the Gateway Medical Care Manager
- PA DPW Shift Care Report
Effective 10/1/08, the Department of Public Welfare (DPW) requires Physical Health Managed Care Organizations to report all down shifts for private duty nursing and home health aide services.

Your agency will receive a copy of the PA DPW shift care report each month which requires completion and submission back to Gateway. See detailed instructions in Appendix B.

In addition to the above documentation, Gateway also requires a Letter Of Medical Necessity (LOMN) for any request for private duty services. A new LOMN will need to be submitted each year or sooner if Gateway's Medical Director requests. Any requests to change the number of hours approved will require a new LOMN as well.

Please fax all information to the attention of the assigned Medical Care Manager in the Special Needs Unit. The Department fax # is 412-255-4264.

ADDITIONAL GUIDELINES

- 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, unless prior authorized.
- Private Duty Services may not be billed while the member is in an inpatient setting.
- The provider is permitted to staff the total number of hours authorized in that month as needed to meet the needs of the member's family. Hours are not to be "banked" to cover non-work related events or vacations. The total number of hours for the month cannot be exceeded and hours cannot be carried from one month to the next.
- The provider must deliver services according to the plan of care signed by the ordering physician and should be primarily delivering services to the member at his/her home and/or school.

Internet Email Security

The Health Insurance Portability and Accountability Act (HIPAA) includes security standards to address protecting health information that is sent electronically as well as mechanisms to encrypt and decrypt this information. The American Recovery and Reinvestment Act of 2009 (ARRA) and the Health Information Technology for Economic and Clinical Health Act (HITECH) contain several HIPAA regulations and the penalties are tougher than ever. Therefore, it's especially important to take additional precautions, such as using secure email, to reduce the likelihood of a breach.

If at all possible, emails to and from organizations should utilize internal corporate email servers instead of less secure or free email services. While some of these email providers offer encryption protection, it is not usually enabled by default. However, even when this option is selected, it only protects the email for part of the journey across the Internet.

To help protect email transmissions, Gateway Health Plan[®] has implemented a secure email messaging system for use with external entities. For those companies that have email systems that support end-to-end encryption, when a Gateway employee flags an email as 'secure', the work is all done behind the scenes. These emails are sent securely without the receiver needing to do anything different. They simply show up in a recipient's inbox like any other email.

If the recipient's email system can not receive secure email, the recipient receives an email notification containing a link to a secure portal where the recipient can log in and receive the email message.

IMPORTANT: If a secure email is sent and the recipient receives an email notification to visit the portal to retrieve the message, it is due to their email system. This is outside the control of Gateway Health Plan[®].

NOTE: The first time a recipient visits the portal to retrieve a message, they will need to make a password. The password must be at least six (6) long and contain two of the following:

- Both alpha and numeric characters
- Both upper and lower case characters, and/or
- At least one special character (e.g. #@!^%&)

If a user forgets his/her password, they can request that the password be emailed to them or re-set by following the instructions posted on the secure email portal. This process is handled by the secure email system, not by Gateway Health Plan[®].

Gateway has made the security of sensitive information a priority. Please take all reasonable precautions when transmitting provider, member, and health plan information via email

APPENDIX

A. CMS 1500 FORM

B. PA DPW SHIFT CARE REPORT INSTRUCTIONS