



Quick Tips



Provider Services/Eligibility Verification

Provider Services is available Monday through Friday from 8:30am - 4:30 pm at **1-800-392-1145** for Medicaid or **1-800-685-5202** for *Medicare Assured*[®]. Provider Services is there to assist with questions regarding claims, eligibility or benefits. Verify eligibility by calling the DIVA Eligibility/Referral line at **1-800-642-3515** before rendering service. DIVA is available 24/7. PCPs can also use their Member Lists to verify eligibility.

Precertification

It is the ordering provider's responsibility to obtain authorization for services requiring precertification from Gateway's UM Department at **1-800-392-1146** Medicaid or **1-800-685-5207** for *Medicare Assured*[®]. Call National Imaging Associates at **1-888-879-5922** for authorizations for MRI/MRA, CT, Nuclear Cardiology, Bone Densitometry and PET scans.

Therapy Evaluations and Re-Evaluations

Providers must specifically request an auth for therapy initial evaluations or re-evaluation for PT, OT and ST. Initial evaluations and re-evaluations are authorized for a specific date of service. If the service is unable to be performed on that day, the provider must call UM to have the authorization updated to the correct date of service or the claim will deny. Initial evaluations and re-evaluations cannot be done on the same day that the member also received a therapy service.

Lab Services

Medicaid:

All laboratory-testing must be completed at the lab designated by the member's PCP. No referral is required when the member is referred to the designated lab noted on the member's Gateway ID card. Specialists must refer all laboratory testing to the lab designated by the member's primary care physician. If the member's designated lab is unknown the member must be referred back to the member's PCP to order the tests.

Medicare Assured[®]:

Diagnostic outpatient laboratory testing is covered with a script for all participating and non-participating facilities.

Referrals

Medicare Assured[®]:

Paper Referrals are not required. Referrals should be documented in the patient's medical record.

Referrals Continued:

Medicaid:

PCPs must issue a referral (DIVA or paper) for specialist consults and hospital services. Hospitals and specialists must obtain a valid referral prior to rendering services. Verify referrals using our DIVA system at 1-800-642-3515, Option 3. Print a DIVA fax confirmation for medical record documentation. Communicate in writing back to the PCP as to clinical findings and/or treatment plans. **(Please use paper referrals for Milton S. Hershey Medical Center and Geisinger Health System)**When referring to a facility and physician, issue the referral to the facility.

- All specialist referrals should be issued using the Gateway Group #.
- Diagnostic Testing, Fetal Non-stress Tests and Ultrasounds can be performed in the OB/GYN's office or at a hospital without an authorization or a referral.

Billing & Timely Filing

All services provided must be submitted following Gateway's timely filing guidelines, regardless of expected payment or coverage. EDI claims submitted without an NPI will be rejected. Paper claims can be submitted with both the NPI and the individual Gateway Provider ID#.

Medicaid:

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

Medicare Assured[®]:

- **365 days** from the date of service for initial claim submission
- **120 days** from the date of processing the initial claim to submit a claim review on any claim
- **365 days** from the date of claim processing by the primary carrier for coordination of benefit claims

Corrected and or Cancelled Claims

Corrected Claims:

- Must be submitted on paper CMS 1500 and must be stamped "Corrected Claim".
- Late charges must be submitted as corrected claims and must include all previously submitted charges as well as the new "late charges".

Overpaid/Cancelled Claims and Refunds

- Should **NOT** be submitted either via paper or electronic submission. No adjustments, reversals or retractions will be made when submitted to the claims office.
- Providers should send a refund request and check directly to the attention of the Finance Department at Gateway Health Plan[®]
- Refund requests can be sent via the Gateway Health Plan[®] Overpayment/Refund Form or a letter stating the reason for the refund.
- Letters must contain the following information:

Group/Provider Name	Group/Provider ID#
Member Name	Member ID#
Line of Business	Claim #
DOS	Amount of refund