Gateway Health

Hospital Update

June 2013

SPECIAL EDITION

IN THIS EDITION:

Medicare Advantage Sequestration

Per the CMS Medicare FFS Provider e-News issued March 8, 2013 "The *Budget Control Act of 2011* requires, among other things, mandatory across-the-board reductions in Federal spending, also known as sequestration. As required by law, President Obama issued a sequestration order on March 1, 2013."[1] These budget reductions include a reduction of 2% in payment to providers under the Medicare program effective April 1, 2013. This includes Medicare FFS claims, which was implemented with dates of service or dates of discharge on or after April 1, 2013, and payments from CMS to Medicare Advantage plans like Gateway Health Plan *Medicare Assured*® which was also implemented April 1, 2013.

As a result, Gateway Health Plan *Medicare Assured*® is implementing this 2% reduction to physician, facility, and other healthcare professional payments for its Medicare Advantage plans, in accordance with the Medicare FFS processing logic. The payment adjustment will be a reduction on the total payment amount**,** after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments.

However, in order to avoid significant retroactive claims reprocessing, Gateway Health Plan® will apply this claims payment adjustment to all claims beginning with dates of service or dates of discharge on or after **May 1, 2013**. Claims that paid prior to the implementation of the payment

[1] www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-03-08-standalone.pdf

adjustment will be reprocessed accordingly.

The adjustment will be reported in the W.HOLD field ON EACH CLAIM LINE on the paper remittance. Manually adjudicated claims will also include a claim adjustment code of A42 – W.HOLD AMOUNT REFLECTS THE SEQUESTRATION 2% REDUCTION.

In the electronic remittance, the adjustment will be reported with CARC 223 code - Adjustment code for mandated Federal, State or local law/regulation that is not already covered by another code and is mandated before a new code can be created.

As a reminder, this adjustment does not apply to Gateway's Medicaid line of business.

Questions may be directed to Gateway's Provider Services Department by calling 1-800-685-5205, Monday through Friday between 8:30am and 4:30pm.

National Drug Code Reporting Requirements

Effective July 1, 2013 ALL outpatient drug claims must include the National Drug Code (NDC) number, quantity and unit of measure.

"The Affordable Care Act (ACA) requires manufacturers that participate in the drug rebate program to pay rebates for drugs dispensed to individuals enrolled with a Medicaid MCO if the MCO is responsible for coverage of such drugs. The ACA also requires all states to ensure that their MCOs report the necessary utilization data in order to bill manufacturers for rebates for covered outpatient drugs and to include utilization data reported by each Medicaid MCO when requesting quarterly rebates from manufacturers. Data that must be reported by each MCO includes physician-administered drugs and drugs dispensed to dual eligible children enrolled in an MCO even when Medicare is primary and the MCO pays the crossover-claim for the co-insurance and/or deductible[2]."

What is the impact of this change?
To facilitate this federal mandate and adhere to the Department of Public Welfare (DPW) encounter reporting requirements for all Medicaid MCOs, effective **July 1, 2013** all outpatient drug claims billed must include the **J code** and a valid **NDC (National Drug Code)**, **NDC quantity** and **NDC Unit of Measure (UOM).** This requirement will apply to paper claim forms CMS-1500 and UB-04 and EDI transactions 837P and 837I. Paper claims submitted without the required NDC, NDC quantity and NDC UOM will be denied on the provider's remittance with rejection code **D60- REJECTED-SUBMIT NDC CODE, NAME, DOSAGE, QUANTITY OR VERIFY QUANTITY**

[2] http://dpwintra.dpw.state.pa.us/HealthChoices/custom/post/sysnotice/2013/sys2013-007.asp

OF BILLED CODE. EDI claims without the required NDC, NDC quantity and NDC UOM will be rejected and returned to the provider's EDI clearinghouse

Paper Claim Requirements

CMS 1500 form:

- Include the NDC number in the shaded area of the service lines in field 24.
- When a claim is submitted with a HCPCS code requiring a NDC more than one time, each instance of the code must include the NDC.

UB 04 form:

- Field 42: Revenue Code
- Field 43: NDC 11 digit number, Unit of Measurement Qualifier, and Unit Quantity
- Field 44: HCPCS Code

EDI Requirements

- The loop is 2410
- The NDC code is sent in the LIN segment
- Pricing and drug quantity information is sent in the CTP segment
- Prescription number is sent in the REF segment

Reminders

- ✓ The NDC is found on the drug container (e.g., vial, bottle or tube).
- ✓ The NDC submitted to us must be the actual NDC on the package or container from which the medication was administered.
- ✓ ***Don't*** bill for one manufacturer's product and dispense another.
- ✓ ***Don't*** bill using invalid or obsolete NDCs.
- ✓ When submitting NDCs on claims, use the appropriate number with no hyphens or spaces between segments.

NEWBORN CLAIM FILING INSTRUCTIONS

Newborns

Newborns of Gateway mothers will be covered by Gateway for services rendered during the neonatal period. The Department of Public Welfare requires that the hospital submit the MA-112 Form for each newborn to the mother's assigned County Assistance Office. All charges for newborns that become enrolled in the plan, other than hospital bills covering the confinement for both mom and baby, are processed under the newborn name and newborn Gateway Identification Number.

Newborn Enrollment Information

- Baby is not automatically covered under mother for first 30 days-PA insurance law for commercial only.
- Mom has 30 days to enroll baby from DOB. If baby not enrolled in that time, claims will be denied D38 – BABY NOT ENROLLED IN PLAN; REFILE WITH BABY'S GATEWAY ID NUMBER
- Newborns will be effective on their DOB or the date the newborn was added to the member's grant.
- If baby dies on DOB, DPW will not enroll. Provider should be instructed to contact DPW directly to have an exception made to have the claims paid.

UM Authorizations

The number of authorizations on file for the newborn should match the hospital and bed types. All authorizations will be under the mother's number. (Example: delivery hospital-1 authorization, NICU, same hospital as delivery-2 authorizations NICU, transfer to another hosp-3 authorizations.)

- ✓ Per Diem – Mother and Baby processed under the mother's claim
- ✓ DRG – Mother's claim and Baby's claim will be processed separately.

Claim Submission

Newborn claims should be submitted under the baby's name and Gateway ID number and the providers have 180 days to file the claim.

- ✓ If providers submit claims using the mother's Gateway ID and the baby's name, the claims are suspended for 25 days to allow time for the newborn to be enrolled.
- ✓ If the baby is not enrolled, the claims will deny D38– BABY NOT ENROLLED IN PLAN; REFILE WITH BABY'S GATEWAY ID NUMBER

- If the baby is enrolled after claim have been submitted and denied D38, it is the provider's responsibility to contact Gateway within 180 days to follow-up.
- If the provider follows up within the specified timeframe of 180 days the baby's claims will be transferred from mother's file to the baby's file. The provider does not need to resubmit the claims.

REVISED MATERNITY OUTCOME AUTHORIZATION FORM

Please note that the Maternity Outcome Authorization Form has been revised for both our Medicaid and Medicare Assured® lines of business. Copies of the new forms can be found on our website at www.gatewayhealthplan.com under Forms and Reference Materials.


MaternityOutcomeAuth MedicaidRevised 6


MEDICARE ASSUREDMaternityOu

Additionally, the fax number for the submission of the completed forms back to Gateway Health℠ has also changed. Effective immediately, please fax all completed forms to **1-855-888-8252.**

FAX NUMBER CHANGES AND UPDATES

Effective immediately, Gateway's Provider Relations, Special Needs Unit and MOM Matters® Departments have new fax numbers!

Provider Relations: 1-855-451-6680

*Example of Correspondence sent to Provider Relations includes practice change information. The Practice Change Form can be found on our website at www.GatewayHealthPlan.com.

Special Needs Unit: 1-888-245-2071

*Authorization requests for Private Duty Nursing for special needs children should be faxed to this number.

MOM Matters®: 1-888-225-2360

*All OBNAF forms should be faxed to this number.

Submission of Maternity Outcome Authorization Forms: 1-855-888-8252

CORPORATE ADDRESS CHANGE

Effective April 1, 2013, Gateway has moved its corporate office in Pittsburgh to:

Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222

*****This move did NOT affect our claims processing offices. *****

Please continue to send all claim and referral forms for Gateway Medicaid to:

Gateway Health℠
P.O. Box 69360
Harrisburg, PA 17106-9360

Please continue to send *Medicare Assured*® medical and behavioral health claim forms to:

Gateway Health℠
P.O. Box 69359
Harrisburg, PA 17106-9359