2018 Provider Manual

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SECTION 1- CLIENT CONDITIONS OF PARTICIPATION

1.1 INDIVIDUALS ELIGIBLE FOR GATEWAY TO BETTER HEALTH BENEFITS

Gateway to Better Health benefits are available to individuals who are determined eligible by the local Family Support Division (FSD) office. Like any Medicaid or MO HealthNet program, Gateway to Better Health has its own eligibility determination criteria that *must* be met. Gateway to Better Health is subject to Day Specific Eligibility.

1.1.A DESCRIPTION OF ELIGIBILITY CATEGORIES

The following list includes descriptions and ME codes for all categories of Gateway to Better Health Assistance:

ME CODE	DESCRIPTION
91	Individuals who meet the Gateway to Better Health eligibility criteria for primary, specialty and urgent care.

1.2 GATEWAY TO BETTER HEALTH ID CARD

The St. Louis Regional Health Commission (RHC) issues a Gateway to Better Health ID card for each Gateway to Better Health eligible participant. For example, an eligible participant and his or her eligible spouse each receive their own card. Providers *must* use the card that corresponds to each individual to verify eligibility and determine any other pertinent information applicable to the participant.

An ID card does ***not*** show eligibility dates or guarantee that the participant is still enrolled in the program. Providers *must* verify the participant's eligibility status before rendering services as the ID card only contains the participant's identifying information. As stated on the card, *possession of this card does not guarantee eligibility for benefits*.

The FSD office issues an approval letter for each individual at the time of approval to be used in lieu of the ID card until the permanent ID card can be mailed and received by the participant. The card should normally be received within a few days of the caseworker's action.

If the participant needs a new card because their card has been lost or damaged they can get one by calling the Gateway to Better Health Call Center at 1-888-513-1417.

1.2.A ACCESS TO ELIGIBILITY INFORMATION

Providers must use the Member Identification Number on the participant's Gateway to Better Health ID card to access panel roster information via the Gateway to Better Health eligibility

website, www.stlgbh.com/providerportal. Eligibility information is updated on this site daily using the eligibility file that comes from MO HealthNet the night before.

SECTION 2-PROVIDER CONDITIONS OF PARTICIPATION

2.1 PROVIDER ELIGIBILITY

To receive Gateway to Better Health reimbursement, a provider of services *must* have entered into, and maintain, a valid participation agreement with the RHC and be enrolled into the Gateway to Better Health program with the State of Missouri MO HealthNet Division. This program is only open to a select number of providers.

2.2 RETENTION OF RECORDS

Gateway to Better Health providers *must* retain for 5 years, from the date of service, fiscal and medical records that coincide with and fully document services billed to the Gateway to Better Health program, and *must* furnish or make the records available for inspection or audit by the Department of Social Services, Missouri Medicaid Audit and Compliance Unit, Centers for Medicare and Medicaid Services, the RHC or their representatives upon request. Failure to furnish, reveal and retain adequate documentation for services billed to Gateway to Better Health may result in recovery of the payments for those services *not* adequately documented and may result in sanctions to the provider's participation in the Gateway to Better Health program. This policy continues to apply in the event of the provider's discontinuance as an actively participating Gateway to Better Health provider through change of ownership or any other circumstance.

2.2.A ADEQUATE DOCUMENTATION

All services provided *must* be adequately documented in the medical record. Documentation requirements for Gateway to Better Health are modeled after Missouri Medicaid (MO HealthNet) documentation requirements. The Missouri Code of State Regulations, 13 CSR 70-3.030, Section(2)(A) defines "adequate documentation" and "adequate medical records" as follows:

> Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.

Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnoses, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation *must* be made available at the same site at which the service was rendered.

2.3 NONDISCRIMINATION POLICY STATEMENT

Providers *must* comply with the 1964 Civil Rights Act, as amended; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975; the Omnibus Reconciliation Act of 1981 and the Americans with Disabilities Act of 1990 and all other applicable Federal and State Laws that prohibit discrimination in the delivery of services on the basis of race, color, national origin, age, sex, handicap/disability or religious beliefs. Further, all parties agree to comply with Title VII of the Civil Rights Act of 1964 which prohibits discrimination in employment on the basis of race, color, national origin, age, sex, handicap/disability, and religious beliefs.

2.4 OVERPAYMENTS

The MO HealthNet Division, CMS, or the RHC may conduct reviews of Gateway to Better Health claims. If during a review an overpayment is identified, recovery of that overpayment will be pursued. The provider is responsible for repayment of the identified overpayments.

2.5 POSTPAYMENT REVIEW

Services reimbursed through the Gateway to Better Health program are subject to postpayment reviews to monitor compliance with established policies and procedures. Non-compliance may result in monetary recoupments.

2.6 PARTICIPANT RIGHTS

General Rule. The provider *must* comply with any applicable Federal and State laws that pertain to participant rights and ensure that the provider's personnel take those rights into account when furnishing services to participants. Additionally, participants specifically have the right to:

- be treated with respect and dignity;
- have all personal and medical information kept confidential;
- have direction over the services provided, to the degree possible, within the service plan authorized;
- know the plan's established grievance procedure, how to make a complaint about the service and receive cooperation to reach a resolution, without fear of retribution; and
- receive service without regard to race, creed, color, age, sex or national origin.

2.7 PROVIDER RESPONSIBILITY TO COLLECT COPAY AMOUNTS

Providers of service *must* charge and collect the copay amount. Providers of service may *not* deny or reduce services to persons otherwise eligible for benefits solely on the basis of the participant's inability to pay the fee when charged. A participant's inability to pay a required amount, as due and charged when a service is delivered, shall in no way extinguish the participant's liability to pay the amount due.

As a basis for determining whether an individual is able to pay the charge, the provider is permitted to accept, in the absence of evidence to the contrary, the participant's statement of inability to pay at the time the charge is imposed.

The provider of service *must* keep a record of copay amounts collected and of the copay amount due but uncollected because the participant did *not* make payment when the service was rendered.

The copay amount is *not* to be shown as an amount received on the claim form submitted for payment. When determining the reimbursement amount, the copay amount is deducted from the maximum allowable amount, as applicable, before reimbursement is made.

2.8 APPOINTMENT WAIT TIMES

The RHC will monitor contract compliance, including requiring providers to self-report on a quarterly basis on appointment wait times, in order to evaluate capacity of the providers.

Based on similar guidance for MO HealthNet Managed Care health plans, the health providers shall have the capacity to ensure that the time elapsed between the request for appointments and the scheduled appointments do not exceed the following:

- Urgent care appointments for illness/injuries which require care immediately but do not constitute emergencies (e.g. high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services): appointments within twenty-four (24) hours.

- Routine care with symptoms (e.g. persistent rash, recurring high grade temperature, nonspecific pain, fever): appointments within one (1) week or five (5) business days whichever is earlier.

- Routine care without symptoms (e.g. well child exams, routine physical exams): appointments within thirty (30) calendar days.

- Gateway to Better Health Providers will be required to notify the RHC immediately if an Act of God or other unforeseen circumstance makes it impossible to continue to provide the contracted services.

SECTION 3-PROVIDER AND PARTICIPANT SERVICES

3.1 PROVIDER SERVICES

Gateway to Better Health has staff to assist providers with questions regarding claims filing, payment problems, participant eligibility verification, prior authorization status, etc. Assistance can be obtained by contacting the appropriate unit.

3.1.A GATEWAY TO BETTER HEALTH CALL CENTER

Gateway to Better Health provides a call center for use by providers and participants. The call center’s phone number is 1-888-513-1417. The responsibilities of the call center include:

- Providing inpatient hospitals and emergency departments with participant eligibility verification.
- Providing answers to participants about frequently asked and general knowledge questions with regard to eligibility, co-pays, and covered services.
- Ordering new member ID cards for participants who state that they have lost their Gateway to Better Health ID card.

3.1.B INTERNET

Gateway to Better Health maintains a provider portal which is updated on a daily basis. Providers must log on to the provider portal and enter the patient's Member ID number in the appropriate field in order to verify eligibility information on a patient *before* services are rendered. Panel roster information for the full clinic or organization is available on the provider portal as well. Providers may access this information at www.stlgbh.com/providerportal in accordance with the security level assigned to their user ID.

3.1.C CLAIMS INQUIRY AND APPEALS PROCESS

Providers may email gbhclaims@stlrhc.org for questions about claims submissions and denials. Please provide the following information in inquiry:

1) Check number
2) Check date
3) Patient ID (8-digit DCN), if inquiring about a specific claim
4) Reason for inquiry
5) Your contact information, including the name of the organization

A response will be provided within 10 business days of receipt. **Please do *not* submit medical records for claims inquires or appeals.**

3.2 PARTICIPANT SERVICES

Providers may direct participants to the Gateway to Better Health Call Center for questions regarding such things as Gateway to Better Health covered services and the location of participating providers in their area. For questions of eligibility for Gateway to Better Health or for information about other government assistance the Gateway to Better Health Call Center will likely forward the participant on to their local FSD office.

3.3 CHANGING PROVIDERS

Gateway to Better Health participants have the right to change providers while enrolled in the program. If the desired change is to simply receive services through another clinic in the same organization (from one Affinia Healthcare clinic to another Affinia Healthcare clinic for instance) then no reported change is necessary. If, however, the participant wants to completely switch provider organizations (from Affinia

Healthcare to Family Care or vice versa) then the participant must report this to FSD or fill out a Change of Provider form and fax it to the number on the form. Once reported, the change of providers will take effect on the first day of the following month.

SECTION 4-TIMELY FILING

4.1 TIME LIMIT FOR ORIGINAL CLAIM FILING

4.1.A GATEWAY TO BETTER HEALTH CLAIMS

Claims from participating providers who request Gateway to Better Health reimbursement *must* be filed by the provider and *must* be received by the state fiscal agent within 12 months from the date of service or within 45 days of the program termination date, whichever is earlier. The counting of the 12-month time limit begins with the date of service and ends with the date of receipt. Providers will enter their claims in their existent system; those claims will then be forwarded to Trizetto Provider Solutions (the program's clearinghouse) to be formatted and sent to the MO HealthNet Division and their fiscal agent.

4.2 TIME LIMIT FOR RESUBMISSION OF A CLAIM

Claims that originally were submitted and received within 12 months from the date of service and that were denied or returned to the provider *must* be resubmitted and received within 18 months of the date of service or within 45 days of the program termination date, whichever is earlier.

4.2.A CLAIMS FILED AND RETURNED TO PROVIDER

Some claims received by Trizetto Provider Solutions *cannot* be processed because additional data is required. These claims are *not* processed through the system but will show up on standard rejection reports provided by Trizetto Provider Solutions. Resubmit the claim only after the necessary information has been added.

4.3 CLAIMS NOT FILED WITHIN THE TIME LIMIT

In accordance with modeled MO HealthNet policy, claims that are *not* submitted in a timely manner as described in this section are denied. The RHC *may* make payment if a claim was denied due to state agency error or delay, as determined by the state agency. In order for payment to be made, the RHC *must* be informed of any claims denied due to MO HealthNet error or delay within 6 months from the date of the remittance advice on which the error occurred or 12 months from the date of service, whichever is longer, but no later than 45 days from the program termination date.

SECTION 5-PRIOR AUTHORIZATION

5.1 BASIS

Under the Gateway to Better Health Program, certain covered services require approval from Permedion prior to provision of the service as a condition of reimbursement. Prior authorization is used to promote the most effective and appropriate use of available services and to determine the medical necessity of the service.

5.2 PRIOR AUTHORIZATION GUIDELINES

Providers are required to seek prior authorization for certain specified services *before* delivery of the services (unless the provider seeks retroactive authorization).

The following general guidelines pertain to all prior authorized services:

- A Prior Authorization (PA) request *must* be completed in the referral system.
- Sufficient documentation *must* be included with the request to determine the medical necessity of the service.
- The health service *must* be ordered by a physician, nurse practitioner, dentist, or other appropriate health care provider.
- Do *not* request prior authorization for services to be provided to a person who has not applied for Gateway to Better Health.

5.3 PROCEDURE FOR OBTAINING PRIOR AUTHORIZATION

Complete the referral form in the Gateway to Better Health referral system (www.stlgbh.com/providerportal) indicating the CPT code of the procedure that you are requesting a referral for. The referral system will indicate whether or not that CPT code requires a prior authorization. If prior authorization is required, providers must upload documentation (X-Rays, consultation notes, diagnoses, etc) that supports the medical necessity for the procedure requested into the referral system. Permedion will then review the information provided and make an initial determination which will either approve or deny the request for the procedure. All denials will be routed to a physician to review.

If the Prior Authorization is approved, and once the service is rendered, the provider must enter the PA Approval Number on the claim form for reimbursement. Trizetto Provider Solutions, the program's clearinghouse, will validate that a number has been collected. If a correct PA Approval Number is on the claim, Trizetto Provider Solutions will forward the claim to the fiscal agent to be paid, assuming the participant is eligible on all other factors. **Providers are cautioned that an approved authorization approves only the medical necessity of the service and does *not* guarantee payment. Claim information *must* still be complete and correct, and the provider and the participant *must* both be**

eligible at the time the service is rendered. Providers are *not* reimbursed for participants who are ineligible for the program.

If you need assistance obtaining prior authorization, please email gbhissues@stlrhc.org.

SECTION 6-BILLING INSTRUCTIONS

6.1 ELECTRONIC CLAIM SUBMISSION

Providers must submit claims electronically to Trizetto Provider Solutions, the contracted clearinghouse for Gateway to Better Health. Trizetto Provider Solutions will submit the claims to MO HealthNet's fiscal agent.

6.2 ANSI 837 VERSION 5010

The ANSI 837 version 5010 will always be the claims format submitted for Gateway to Better Health claims.

6.3 TRIZETTO PROVIDER SOLUTIONS Call Center

The Trizetto Provider Solutions Call Center is available to answer questions about submitting claims for the Gateway to Better Health Program. To reach a customer service representative at the Trizetto Provider Solutions Call Center please dial 1-800-969-3666 and select option 4.

6.4 RESUBMISSION OF CLAIMS

Any line item on a claim that resulted in a zero payment can be resubmitted if it denied due to a correctable error. The error that caused the claim to deny *must* be corrected before resubmitting the claim. Trizetto Provider Solutions will report all zero payments within the reports on their website, specific to your organization's username and password. If you have not set up a username or password with Trizetto Provider Solutions, contact Trizetto Provider Solutions at 1-800-969-3666 and select option 4.

6.5 VOIDING CLAIMS

The claims adjudication system for Gateway to Better Health does not allow for a typical corrected claim (frequency type code "7"); to correct a claim, the old claim must be voided and a new claim must be submitted.

To void a Gateway to Better Health Claim one must submit a new claim with a frequency type code of "8" and the ICN of the original claim that you are attempting to void as follows:

On the ANSI 837P 5010

1. In the 2300 Loop, the CLM segment (claim information), CLM05-3 (claim frequency type code) must indicate the following qualifier code:
    - "8" – VOID (Void/Cancel of Prior Claim)

2. The 2300 Loop, the REF segment (Claim Information), must include the original claim number issued to the claim being corrected. The original claim number can be found on your electronic claims receipt confirmation reports or electronic remittance advisement. This is the ICN number.

Claim Frequency Code

1	**Indicates that the claim is an original claim**
8	**Indicates that the claim is a voided/canceled claim**

CLM*12345678*500*11:B:8*Y*A*Y*I*P~**
REF*F8*(Enter the Claim Original Reference Number)

In the above example, "11" (CLM05-1) indicates the place of service on a professional claim. "B" (CLM05-2) is the facility code qualifier and "8" (CLM05-3) is the Claim Frequency Code. This "8" indicates that the claim is being submitted to void the prior claim.

After the void has been submitted, wait at least two business days before submitting the new claim (frequency type code "1") to make sure that the void action hits before the adjudication of the new claim, otherwise the new claim will again deny as duplicate.

You must submit all of the lines from the original claim again, as you have voided the previous claim and therefore all paid lines will otherwise be recouped.