

TO: All Providers (Except Pharmacies, Hospitals, Hospital-based

SUBJECT: Billing for Services Provided to Garden State Health

EFFECTIVE: Immediately

PURPOSE: 1) To clarify the procedures to be used when billing for services provided to GSHP recipients; and
2) To identify and address common billing errors.

BACKGROUND: The Garden State Health Plan (GSHP), the State-operated Health Maintenance Organization (HMO), is expanding. Medicaid providers will be rendering services to more GSHP enrollees as a result of this expansion.

Providers can identify a GSHP recipient by one of two restrictive messages on their Medicaid Eligibility Identification (MEI) Card (FD-73/178)(REV.4/94) which states "HMO-CHECK GSHP ID CARD" or "Services Restricted", call HMO GSHP 1-800-525-0047. The GSHP recipient must present their GSHP "Gold ID Card" which lists the PCM of record for each GSHP recipient.

The GSHP Physician Case Manager (PCM) is responsible for coordinating all aspects of a recipient's health care and may refer the recipient to any provider who participates in the Medicaid program. Medicaid providers may then render any service that has been Prior Authorized by the PCM. The Medicaid provider will be reimbursed for all services provided to a GSHP recipient in an amount equivalent to that allowed in a fee-for-service environment.

ACTION: A Medicaid provider must obtain from the PCM a Prior

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I. DIRECTIONS FOR SUBMITTING GSHP MEMBER CLAIMS

There is a ten-digit Prior Authorization Number printed on the top right corner of each PA form. This Number is required for billing and MUST be included on the 1500 N.J. Medicaid claim form. Claims submitted for GSHP recipients which do not include the Prior Authorization Number will be denied. PA forms should not be attached to claim forms submitted to the Medicaid fiscal agent.

When submitting a claim, the ten-digit PA Number must be entered in FIELD #34, entitled "REMARKS". Providers must be sure to include the name and Medicaid Provider Number of the PCM on the 1500 N.J. claim form in FIELDS #19 and 19A, respectively. Claims which are submitted without either of these items will be denied.

II. COMMON BILLING ERRORS

1) Edit Code 410--Service Not Authorized by GSHP Case Manager

This Edit Code indicates that the GSHP PA Number is required, and is not on the claim form in the designated area. If the PA number is not entered in the proper field, is not legible, or crosses into another field, the claim will be denied.

2) Edit Code 231--Referring Provider # Required-GSHP

This Edit Code indicates that the PCM's Medicaid Provider Number is required, and is not entered in the proper field. This seven-digit number must be entered into FIELD #19A on the 1500 N.J. claim form. Claims will be denied if this FIELD is incorrect or incomplete.

III. OTHER BILLING ERRORS

1) Edit Codes 780, 781, 782, 783, 784

These five Edit Codes indicate that the PA number has been entered on the claim form, however, a problem exists with authorization, dates of service, procedures or units authorized. Providers should contact the GSHP for resolution.

IV. MISCELLANEOUS BILLING INFORMATION

1) Claims Submitted for Newborns

Newborns are not automatically enrolled in the GSHP on their date of birth. Claims for services to the newborn which fall on or before the last day of the calendar month in which the 60th day after birth occurs, do not require authorization from GSHP. These claims can be billed directly to Medicaid by using the Medicaid Eligibility Identification (MEI) number of the child's mother, the child's date of birth, the child's sex, and the child's name as it appears on the hospital records, on the claim form.

However, the newborn should be enrolled in the GSHP within 60 days of his/her date of birth. If the newborn is found ineligible for Medicaid, all claims for services will be denied.

2) Exempt Services

There are certain services that no longer require a Prior Authorization when the PCM or a member of the PCM group refers or prescribes the service. These services include durable medical equipment (DME) and medical supplies.

All anesthesia performed by an anesthesiologist, in support of a procedure by another practitioner, is deemed pre-approved, and requires no independent prior authorization.

When billing for these exempt services, it is absolutely necessary that the billing provider must enter the name and Provider Number of the prescribing provider (PCM or member of the PCM's group) in FIELDS #19 and 19A, respectively on the 1500 N.J. claim form. Claims will be denied without this information.

3) Laboratory Services

Laboratory services that are provided by an Independent Clinical Laboratory do not require Prior Authorization when ordered by the PCM or a member of the PCM's group. Laboratory services provided in any other setting (i.e., hospitals, physician offices), or ordered by a referral provider, require Prior Authorization.

For further information regarding this Newsletter, please contact the Division of Medical Assistance and Health Services, Garden State Health Plan at 1-800-525-0047.

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