



GATEWAY AT A GLANCE

for Medicare Assured[®] HMO SNP Providers

GATEWAY HEALTH PLAN MEDICARE ASSURED[®] HMO SNP

**US Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219-2704**



YOUR PROVIDER NUMBERS:

Group Provider Number : _____

Individual Provider Numbers (used for billing) :

Practitioner : _____ **Provider Number :** _____

Practitioner : _____ **Provider Number :** _____

Practitioner : _____ **Provider Number :** _____

Frequently Asked Questions

What is Gateway Health Plan *Medicare Assured*[®] *HMO SNP*? Gateway Health Plan *Medicare Assured*[®] *HMO SNP* is a Special Needs Plan (SNP) for individuals who have Medicare Parts A and B, and Full or Qualified Medicare Beneficiary (QMB) Medicaid eligibility. These individuals are referred to as “dual-eligibles”.

As a SNP, Gateway is required by the Centers for Medicare and Medicaid Services (CMS) to administer a Model of Care Plan. The SNP Model of Care Plan is the architecture for care management policy, procedures, and operational systems.

Do Gateway Health Plan *Medicare Assured*[®] *HMO SNP* members have any out-of-pocket expense?

Gateway’s dual eligible *Medicare Assured*[®] *HMO SNP* members shall not be held liable for Medicare Parts A and B cost-sharing. Upon receipt of payment from Gateway Health Plan *Medicare Assured*[®] *HMO SNP* providers will bill the appropriate State source or accept Gateway’s payment as payment in full.

Do Gateway Health Plan *Medicare Assured*[®] *HMO SNP* members have to use “plan” providers?

Members of Gateway Health Plan *Medicare Assured*[®] *HMO SNP*, with a few exceptions, must use plan providers to get covered services. At the time of enrollment, members must choose a Primary Care Physician (PCP) to provide basic medical care and coordinate the covered services received outside of the PCP’s office.

Are referrals required for services outside of the PCP’s office? Services outside of the PCP’s office should be arranged or coordinated by the member’s PCP. PCPs are not required to use a specific Referral Form for submission to the specialist or Gateway. Certain types of covered services or supplies require prior-authorization. Prior-authorization is required for any services to a “non-plan” specialist. Refer to the Authorization Quick Reference Guide that is included for more information on which services require an authorization.

Self-Referred Services

Members may refer themselves for the following types of care:

- routine women’s health care
- pap smears
- pelvic exams
- mammograms
- flu shots
- pneumonia vaccinations
- specialists visits
- prostate screening
- colorectal screening
- bone mass measurements
- diabetes monitoring training
- vision exams
- hearing exams

Claims Submission Guidelines:

- Timely filing criteria for initial bills is 365 days from the date of service.
- Corrected claims or requests for review are considered if information is received within the 120-day follow-up period from the date of the remittance advice.
- Practitioners must bill within 365 days from the date of an Explanation of Benefits (EOB) from the primary carrier when Gateway is secondary.
- Correct/Current practitioner information, including NPI Number on electronic claims.
- Correct/Current member information, including Gateway Member ID Number, must be entered on all claims.
- Gateway accepts electronic claims through Emdeon and RelayHealth. To submit claims to Gateway, please refer to the following grid for Emdeon Payer IDs and RelayHealth CPIDs:

CPID	PAYER NAME	PAYER ID	CLAIM TYPE
2298	Gateway Health Plan <i>Medicare Assured</i> [®] <i>HMO SNP</i>	60550	Professional
2912	Gateway Health Plan <i>Medicare Assured</i> [®] <i>HMO SNP</i>	60550	Institutional

- All of a patient’s applicable diagnosis codes that support their Hierarchical Condition Category (HCC) must be reported at least once per year to CMS. CMS guidelines state that “Physicians should code all documented conditions that co-exist at the time of the encounter/visit, and require or affect patient care treatment or management.”

Gateway Health Plan Medicare Assured® HMO SNP Important Phone

Call to Inquire About:

Provider Services	Claims Inquiry/Supplies	1-800-685-5205	M-F 8:30am to 4:30pm
Utilization Management	Authorization	1-800-685-5207	M-F 8:30am-4:30pm Calls received during non-business hours are referred to 1-800-685-5209.
DIVA Member Eligibility Line	Member Eligibility	1-800-642-3515	24 hours a day, 7 days a week
Pharmacy	Requests for Non-Formulary Drugs and Prior Authorizations	1-800-685-5215 FAX: 1-888-447-4369	M-F 8:30am-4:30pm
Part D Prescriber Appeals	Expedited redetermination	1-800-213-7083	Voice mail box monitored 24 hours a day requests, status of 7 days a week redetermination requests
Case Management	Case Management	1-800-685-5212 Option 1	M-F 8:30am-4:30pm
Disease Management	Maternity Cardiac Asthma Healthy Returns Diabetes Program	1-800-685-5212 Option 2 Option 3 Option 3 1-866-366-9415	M-F 8:30am-4:30pm
Preventive Health	Preventive Health Services/Member Outreach	1-800-685-5212 Option 4 FAX: 1-888-225-2360	M-F 8:30am-4:30pm
Member Services	Member Complaints/Concerns/Inquiries	1-800-685-5209	8:00am – 8:00pm 7 days a week

Helpful Telephone Numbers:

National Imaging Associates, Inc. (NIA)	Authorizations for CT, MRI/MRA, Nuclear Cardiology, and PET Scans	1-888-879-5922
Community Behavioral Healthcare Network of Pennsylvania (CBHNP)	Authorizations for Behavioral Health Services	1-866-755-7299
Gateway Health Plan® Transportation Services	Schedule non-emergent transportation services within 3 business days advance notice	1-866-670-3063
Language Line Services	Providers qualified medical interpretation services	1-800-752-6096
TTY/TDD	Assistance with hearing impaired	1-800-654-5988, M-F 8:00am – 6:00pm

Mailing Address for Medical and Behavioral Health Claim Forms:

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

All Other Correspondence:

Gateway Health Plan®
US Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219-2704

Correspondence Type	Attention:
Claims Reviews	Claims Review Dept.
Provider Appeals	Appeals Department
Practice Change Information	Provider Relations

Visit us online at www.GatewayHealthPlan.com

Gateway Health Plan® offices will be closed to observe the following holidays: New Years Day, Martin Luther King Day, Good Friday, Memorial Day, Independence Day, Labor Day, Thanksgiving Day (and day immediately following), Christmas Eve Day, and Christmas Day. Operations will resume the following business day.

Gateway Health Plan *Medicare Assured*[®] HMO SNP AUTHORIZATION QUICK REFERENCE GUIDE

	Gateway AUTH	NIA AUTH	CBHNP AUTH	SCRIPT
AMBULANCE	X (Non emergent only)			
AMBULATORY SURGICAL SERVICES				
• If services provided in ambulatory surgery center	X			
• No auth required for lab services provided in an ASC lab				X
BONE DENSITOMETRY (Bone Mass Measurement)				X
CT SCANS		X		
CHIROPRACTIC SERVICES	X			
DME (Medical Supplies, Prosthetics, and Orthotics)				
• Items paid at \$500 and over \$500	X			
ELECTIVE ADMISSIONS (Medical and Behavioral Health)	X		X (BH Admissions)	
HOME HEALTH VISITS	X			
HOME INFUSION (*Gateway Pharmacy Authorization May Be Required)	X*			
INPATIENT ACUTE CARE (Including transplants and medical detox)	X			
INPATIENT PSYCHIATRIC OR MENTAL HEALTH CARE			X	
INPATIENT MEDICAL REHAB	X			
INPATIENT REHAB SUBSTANCE ABUSE CARE			X	
LONG TERM ACUTE CARE (LTAC) HOSPITAL	X			
MRI/MRA		X		
NON-PAR PROVIDERS	X		X (BH Services)	
NUCLEAR CARDIOLOGY		X		
OUTPATIENT HOSPITAL SHORT PROCEDURE (SPU) Services performed in a cardiac lab or GI lab do not require an authorization.	X			
OUTPATIENT PSYCHIATRIC PARTIAL HOSPITALIZATION			X	
OUTPATIENT PSYCH/NEUROPSYCH TESTING			X	
OUTPATIENT ECT TREATMENT			X	
OUTPATIENT THERAPY (Physical, Speech & Language, Occupational, Cardiac)	X			
PET SCANS		X		
SKILLED NURSING FACILITY (SNF) CARE	X			

- Authorizations are the responsibility of the ordering provider.
- Please contact Provider Services at 1-800-685-5205 for further explanation of what services require an authorization.
- NIA can be reached for authorization at 1-888-879-5922.
- CBHNP can be reached for authorization at 1-866-755-7299 .

Member Eligibility

- Newly enrolled members receive an Evidence of Coverage (EOC) and Gateway Health Plan *Medicare Assured*[®] *HMO SNP* Identification Card. The card itself does NOT guarantee that a person is currently enrolled in the Gateway Health Plan *Medicare Assured*[®] *HMO SNP* plan.
- Because of possible changes in a member's eligibility, each participating provider is responsible for verifying a member's eligibility with Gateway before providing services. This can be done by reviewing monthly panel reports or calling Gateway's telephonic eligibility system (DIVA), please dial 1-800-642-3515 and follow the prompts (also listed below).

To Verify Eligibility

Call 1-800-642-3515

PRESS 1 to verify eligibility

Member Identification Number?

The following sources may be used to verify eligibility:

PATIENTS FORM OF IDENTIFICATION

Social Security Number	PRESS 1, then #
Gateway Member Identification Number	2, then #
Medical Assistance Recipient Identification Number	3, then #
Health Insurance Claim Number (HIC)	4, then #

Verification of Date?

To verify eligibility for TODAY	PRESS 1
To verify eligibility on a specific date	2

Shortcuts

There is no need to listen to the entire menu. If you know the number, press it at anytime during the recorded message.

To speak with a Provider Services Representative during business hours, you may **PRESS 0**, then # at any time.

PRESS 9 to repeat the menu.

Additional Instructions:

Receive additional information about the patient/member	PRESS 1
Receive the patient's PCP name and telephone number	2
Fax information regarding the patient whose eligibility is being verified	3
Verify eligibility for another patient/member	4
Exit	5
Return to the previous menu	6



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Health Plan

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