



# GATEWAY Review

A PROVIDER NEWSLETTER PUBLISHED BY GATEWAY HEALTH PLAN

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ISSUE 58



## CMS REQUIRES LONGER PERIODS OF RECORD RETENTION AND AUDIT COOPERATION FROM MEDICARE ADVANTAGE PLANS AND CONTRACTED PROVIDERS

The Centers for Medicare and Medicaid Services (“CMS”) has revised several federal regulations that address record retention requirements and cooperation with audits conducted by federal regulatory bodies. The most recent versions of the affected regulations require Medicare Advantage plans and their contracted providers to retain medical records, financial records and source reports for a period of ten (10) years. These revisions represent a significant increase over the previous requirement that Medicare Advantage plans and network providers maintain records for a period of six

(6) years. As a result, Gateway providers will need to devote a much greater amount of office space to the storage of various types of records, or identify alternative mechanisms or remote sites for the storage of additional records. Financial reports and source records may be stored in the original paper format or preserved in micro media or electronic format. Providers must also maintain an office policy and procedure relating to the storage of various types of records.

CMS has also revised a federal regulation that requires both Medicare Advantage plans and network providers to cooperate with audits conducted by the Department of Health and Human Services (“HHS”), the Comptroller General or their designees for a period of ten (10)

years from the termination of provider’s network participation agreement with Gateway or from the completion of a then-pending audit, whichever is later. As is the case with record retention requirements, this revision represents a significant increase over the previous requirement that providers cooperate with audits conducted by federal regulatory bodies for a period of six (6) years. Providers must also comply with all final determinations rendered as a result of any such audit.

In the event that CMS later adopts a longer period of record retention or audit cooperation, providers will be expected to comply with those additional time periods. Gateway’s Provider Services Department is available to address any questions or concerns that providers might have regarding the most recent revisions to the Medicare Advantage regulations. Gateway’s Provider Services Department can be reached at 1-800-685-5205.





# ELECTRONIC PRESCRIBING

Electronic prescribing, or ePrescribing, is the use of electronic devices to write and send prescriptions, thereby eliminating the use of hard copy prescriptions.

Electronic prescribing software can provide physician support through a number of features such as:

- The storage of plan formularies
- Drug interactions messaging
- Assisting in the selection of the most appropriate drug
- Drug information resources
- Providing safety alerts
- Linking prescription information to lab data
- Screening for patient allergies
- Access to patient information such as medication dispensing history

One of the most significant advantages of ePrescribing is its propensity to reduce medication errors, increase compliance, and improve the overall care to patients. Electronic prescribing will also enhance the physician's efficiency in handling prescriptions for initial coverage and refills. Electronic prescribing additionally improves patient satisfaction by decreasing the time for prescription pickup at the pharmacy.

## Gateway Health Plan Formulary Website Application

The Gateway Health Plan<sup>SM</sup> website, located at [www.gatewayhealthplan.com](http://www.gatewayhealthplan.com), provides a number of resources to prescribers to assist in providing care to our members:



- *Updated online formulary:* Contains a searchable formulary that includes information concerning formulary edits such as prior authorizations and quantity limits.
- *Formulary/PDL PDA download:* From the PA Medicaid and PA and Ohio *Medicare Assured* sections, click on "Pharmacy" and then "PDA Formulary Download" for PA or "Preferred Drug List Formulary Download" for OH to download the formulary or PDL to a PDA.
- *Recent formulary updates:* Contains all formulary changes since the beginning of the calendar year.
- *Process for obtaining blood glucose meters:* Contains information on the coverage of LifeScan and Accu-Chek blood glucose meters and supplies.
- *Nonformulary drug coverage form:* Contains a downloadable nonformulary drug coverage form and the instructions by which to request a nonformulary medication.

If you have any recommendations to improve the ease of use of the current website, please fax your comments along with the ePrescribing survey included in this newsletter to the fax number listed on the survey.



## NOMNC COMPLIANCE UPDATE

On March 9, 2007, Gateway Health Plan<sup>SM</sup> *Medicare Assured* sent letters to participating skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitative facilities. Our letter outlined the shared responsibility that Gateway and its providers have to ensure that *Medicare Assured* members receive an accurate and appropriate Notice of Medicare Non-Coverage (NOMNC) from the provider at least two days prior to the end of that care. This is a federal regulation.

The Center for Medicare and Medicaid Services (CMS) regularly performs audits to determine compliance with the NOMNC process. In order to ensure compliance with CMS requirements, Gateway has begun to individually audit home health and skilled nursing providers, beginning with providers serving the highest volume of *Medicare Assured* members.

Gateway will share the results of the individual audits with each provider. We are hopeful that the audits will demonstrate provider compliance with the CMS regulations. Gateway looks forward to collaborating with you to attain this goal. If you would like more information on the NOMNC process, the CMS website can help at [www.cms.hhs.gov](http://www.cms.hhs.gov). Provider instructions for completing the NOMNC form can be found at [www.cms.hhs.gov/MMCAG/Downloads/NOMNCInstructions.pdf](http://www.cms.hhs.gov/MMCAG/Downloads/NOMNCInstructions.pdf).



## ENCOUNTERS STUDY

**The use of encounter data is essential to Gateway's understanding of the population served, the development of effective health care programs and in the management of health care resources.**

Encounter data provides the basis for many key medical management and financial activities, as well as supplying the data required for studies.

The Primary Care Practitioner (PCP) is the key service provider for Gateway members. To correctly evaluate and report members' health services, encounter submission must be comprehensive and accurate. Especially for Medicaid where our reimbursement system is capitated, providers may not understand the importance of submitting encounter data because reimbursement is not linked to each individual encounter. Submitting encounter data, however, is addressed in all provider contracts. More importantly, as Gateway moves toward a Pay for Performance program, submission of encounters will directly impact provider reimbursement

Gateway has taken two approaches to measuring and analyzing encounter submissions.

- Volume of encounters – This is based on claims data alone to evaluate encounter submission rates for PCPs overall and by type (Family Medicine, Internal Medicine, and Pediatrics). Those not submitting claims are identified by comparing their numbers to their peer rates. Of the 787 PCP Practices that met the criteria of having at least 50 members on their

monthly panel during the 2006 data year study period, there were 122 practices that scored below the respective PCP Peer Group Average Encounters/Member. This represents 15.5% of the practices included in the study, a 6% decrease from the 130 practices of the previous year. However, the Peer Average Encounters/Member increased for Family Medicine and Internal Medicine categories and is at the highest rate since the study began in 2001. There was a 0.07% decrease for the Pediatric offices, but their numbers surpass all previous years except for last year.

- Submission of encounters - Dates of service are extracted from Gateway members' medical records during medical record reviews (MRR) and compared to claims received for those members during that time frame. This comparison allows Gateway to better understand the extent of unreported encounters, and to differentiate between low utilization vs. low submission. Both the Family Medicine and Internal Medicine practices showed a statistically significant increase in the percentage of encounters submitted as compared to last year's study.

Gateway is pleased with the improvement shown in the increasing number of Medicaid encounters received, but our numbers remain very low. Your support is needed to increase the numbers of claims submitted.





## RX FOR QUALITY

### We at Gateway Health Plan<sup>SM</sup> appreciate your ongoing commitment to delivering quality healthcare to your patients/our members.

Our mission requires that we maintain a healthcare delivery system that ensures high quality medical care based upon:

- Quality
- Access
- Financial soundness

We accomplish this mission through the development and delivery of innovative programs that positively affect the health and well being of our members. Initiatives that enable the physician–patient relationship are keys to success.

The gap in quality for treatment of chronic conditions and prevention is well documented. Exacerbating this gap are challenges with access to care, as well as ethnic and racial disparities. Clinical care gaps for our members center on:

- Preventive services for women and children
- Management of diabetes, asthma and cardiac disease

These areas continue to be the focus, not just for our members, but throughout Pennsylvania and the United States. The commitment by the State of Pennsylvania is evident in *The Prescription for Pennsylvania*, a set of integrated, practical strategies for

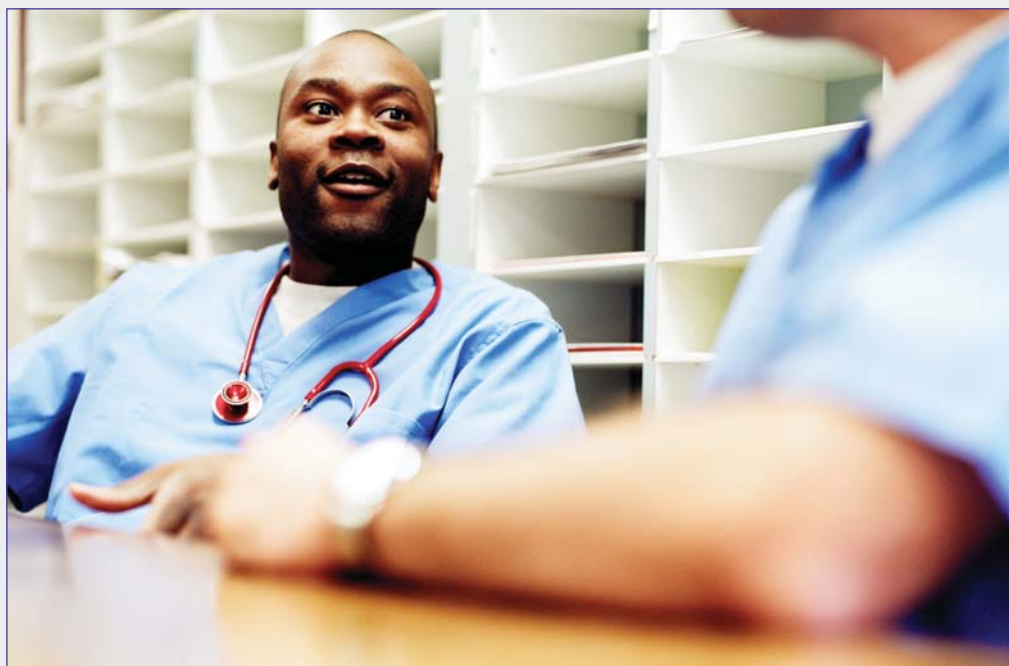
improving health care and containing costs. The core elements of the *Prescription* are affordability, accessibility and quality. Within this framework, the *Rx for Quality* has these key components:

Promote a payment system that:

- Rewards quality of care
- Encourages effective prevention and treatment of chronic conditions such as heart disease, diabetes and asthma
- Create a Pennsylvania where wellness is a shared and common goal

Your support and actions are critical to our shared success. For the remainder of 2007 and heading in to 2008, Gateway Health Plan<sup>SM</sup> is developing targeted approaches to “move the needle” on quality.

- For your practice, an outreach program to identify patients due for preventive health screenings and chronic care interventions. You can expect additional written information on this approach.
- To assure that your patients are fully involved in managing their conditions and receiving preventive screenings, member outreach programs. Applying Gateway’s unique Prospective Care Management (PCM<sup>SM</sup>) approach, we will facilitate delivery of these services and link members with community resources and government programs.
- In collaboration with physicians, an innovative new incentive program, *Gateway to Physician Excellence* that recognizes and rewards physicians who are committed to delivering quality care that is accessible and efficient ...more information will be forthcoming over the next few months.





# VACCINES FOR Children

**Gateway and Vaccines for Children both follow the Center for Disease Center (CDC) approved guidelines for Pediatrics, which includes high risk children and children the ages of 6-23 months.**

The administration of the flu injection is included in the reimbursement and will not be reimbursed separately.

The following flu codes are reimbursed by Gateway at \$14.65:

- 90655-Influenza virus vaccine, split virus, preservation free, 6-35 months dosage, for intramuscular or jet injection use.
- 90656-Influenza virus vaccine, split virus, preservation free, 3 years and above, for intramuscular or jet injection use.
- 90657-Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use.
- 90658-Influenza virus vaccine, split virus, 3 years of age or above, for intramuscular or jet injection use.
- 90659-Influenza virus vaccine, whole virus for intramuscular or jet injection use for children and adults.

The 90660 Nasal Flu vaccine is reimbursed at \$23.91 for members age 5-49. Providers should follow CDC recommendations for use of this vaccine.

Children under 9 years old should get two doses the first year they receive the flu vaccine. Gateway will now reimburse for both doses.

If you have any questions/concerns please contact Provider Services at 1-800-392-1145 or contact your Provider Relations Representative.





## GATEWAY HEALTH PLAN<sup>SM</sup> MEMBERS' RIGHTS AND RESPONSIBILITIES STATEMENT

### DIABETES MONITORING SYSTEMS

As part of our commitment to providing high quality treatment for our diabetic members, Gateway Health Plan<sup>SM</sup> offers LifeScan's OneTouch and Roche's Accu-Chek products as our blood glucose monitoring systems.

Gateway will provide members who do not have a One Touch or Accu-Chek with a meter directly from their pharmacy at no cost. OneTouch or Accu-Chek test strips are the only strips covered by the plan.

LifeScan and Roche Diagnostics provide the following choices of blood glucose monitoring products:

- OneTouch Ultra<sup>®</sup> Meter
- OneTouch Ultra Mini<sup>®</sup> Meter
- OneTouch Ultra2<sup>®</sup> Meter
- OneTouch UltraSmart<sup>®</sup> Meter
- Accu-Chek Advantage
- Accu-Chek Compact Plus
- Accu-Chek Active
- Accu-Chek Aviva
- Accu-Chek Complete

In order for a member to receive a new OneTouch or Accu-Chek meter, follow these steps:

1. Determine which meter that best meets the needs of your patient.
2. Write a prescription for the meter and the test strips.
3. Instruct the member to take the prescription to any participating pharmacy and they will provide the member with a meter at no cost.

Many of our diabetic members already have cardiac involvement as a result of their diabetes. Our hope is that with a choice, by better controlling the diabetes, they also may be able to stabilize their cardiac disease.

### MEMBER RIGHTS

As a Gateway Member, you have the right to:

1. Get information about Gateway Health Plan<sup>SM</sup> (Gateway), the services Gateway provides, doctors and other health care providers giving you care, and your rights and responsibilities as a Gateway member.
2. Be treated with respect and recognition of dignity and right for privacy when receiving health care.
3. Work with your doctor or other health care provider in making decisions about your health care including the right to refuse treatment and to express preferences about future treatment decisions.
4. Openly discuss without any limitations by Gateway appropriate or medically necessary treatment choices for your condition with a doctor or other health care provider, including treatment options, risks of treatments, alternative therapies, and consultations or tests that may be self administered, regardless of the cost or if it is a benefit.
5. Receive your medical and nursing care without regard to race, color, religion, sex, age, disability, national origin, or without regard to whether you have an advance directive.
6. Pick your own doctor from Gateway's network of doctors.
7. Refuse care from certain doctors.
8. File a complaint or grievance about Gateway or the care it provides.
9. Make recommendations regarding Gateway's members' rights and responsibilities policies.
10. Request a fair hearing from the Department of Public Welfare.
11. Prepare a Living Will and/or Advance Directive.
12. See, or have your medical record copied, within Federal and State laws, and to request that your medical record be changed or corrected within Federal laws.
13. Have your medical records kept private and confidential.

### MEMBER RESPONSIBILITIES

As a Gateway Member you have a responsibility to:

1. Give information to your doctor, other health care provider, or Gateway so they can provide care to you.
2. Follow the instructions and treatment plans that you agreed on with your doctor or other health care provider.
3. Provide consent to healthcare providers and Gateway to help them manage your care, to improve your health or for research.
4. Understand your health problems. As much as you can, take part in making a plan for treatment goals with your doctor or other health care providers.
5. See the doctor you picked on a regular basis.
6. Treat the people giving you medical care with the same respect and kindness you expect for yourself.



## WHAT GATEWAY DOES WITH MEMBER INFORMATION

**Gateway Health Plan<sup>SM</sup> protects personal medical and non-public information obtained from its members as required according to the HIPAA Privacy Rules (45 CFR 160, 164).**

Gateway seeks to assure that all employees follow strict guidelines to authenticate callers to determine if the caller is authorized or entitled to receive information, and educates staff to only disclose minimum necessary information.

It is important to note that HIPAA guidelines do permit healthcare providers to use or give out member medical information in some instances without the need for a written authorization from the member. These instances include:

- To state and federal agencies that have the legal right to receive such data,
- For public health activities (such as reporting disease outbreaks),
- For government healthcare oversight activities (such as fraud investigations),
- For judicial and administrative proceedings (such as in response to a court order),
- For law enforcement purposes (such as providing limited information to locate a missing person),
- For research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability),
- To avoid a serious and likely threat to health or safety,
- To contact members about new or changed benefits,
- To contact members for appointment reminders or for disease management programs and alternative treatments that may be of interest, and
- To create a collection of information that can no longer be traced back to the member.

Additionally, under HIPAA guidelines, Gateway may collect non-public information

regarding its members. This information is non-medical in nature and is collected from enrollment applications. Non-public information may also include data collected by the member or member's provider. Gateway does not give out non-public information, except if required or permitted by law. Gateway also does not give out non-public information to anyone unrelated to providing the member's care unless given permission to do so. Gateway protects member's non-public information by only providing data to those necessary to provide medical or health plan services to the member. Members also have the right to give or withhold permission for other uses or disclosures of this type of information, except as required by law.

Gateway members or providers interested in learning more about how Gateway uses or discloses information may visit [www.gateway-healthplan.com](http://www.gateway-healthplan.com) to view the "Notice of Privacy Practices" or may call Member Services at 1-800-392-1147 for PA Medicaid, 1-800-685-5209 for PA Medicare Assured, or 1-888-447-4505 for Ohio Medicare Assured for a paper copy.



### **MEMBER COMPLAINTS, GRIEVANCES & RECONSIDERATIONS: REPRESENTING YOUR PATIENT**

Earlier this year, Gateway Health Plan<sup>SM</sup> expanded its provider appeal process to two levels of review. As you know, this process exists to allow providers the opportunity to appeal for payment following a denial issued by Gateway. Did you know that providers are also permitted to act on behalf of their patients in the member complaint, grievance, and reconsideration processes? This is important to remember if you feel that Gateway has issued a denial for a service that you feel your patient needs. Please refer to your provider manual to learn how your patient can appoint you as his or her representative in order to appeal for coverage of services, items or medications that Gateway has denied. Questions regarding these processes can be directed to Provider Services or your Provider Relations Representative.



## PATIENT SAFETY THROUGH GOOD COMMUNICATION

Patient safety is an integral part of every health care practice and a critical responsibility of everyone who is involved in patient care. Safety encompasses the entire sphere of patient interaction and clear communication is a primary component of safe care.

How patients perceive their connection with their physician significantly affects patient satisfaction and enhances a patient's interest in improving their health. Patient satisfaction is influenced by a sense of partnership with their physician. Communication based upon a sense of partnership has a positive influence on adherence whereas interaction based primarily on information sharing is negatively correlated with compliance.

According to the recent CAHPS (member satisfaction) survey, "How Well Doctors Communicate" is the area most highly associated with health care satisfaction. It is critical for the provider to listen carefully, to develop the trust necessary for open communication and to explain diagnoses and treatments in a way that is easily understood.

Some physician behaviors encouraging positive interpersonal relationships include: empathy, courtesy/friendliness, attentiveness during history taking, encouragement of patient questions and laughter.

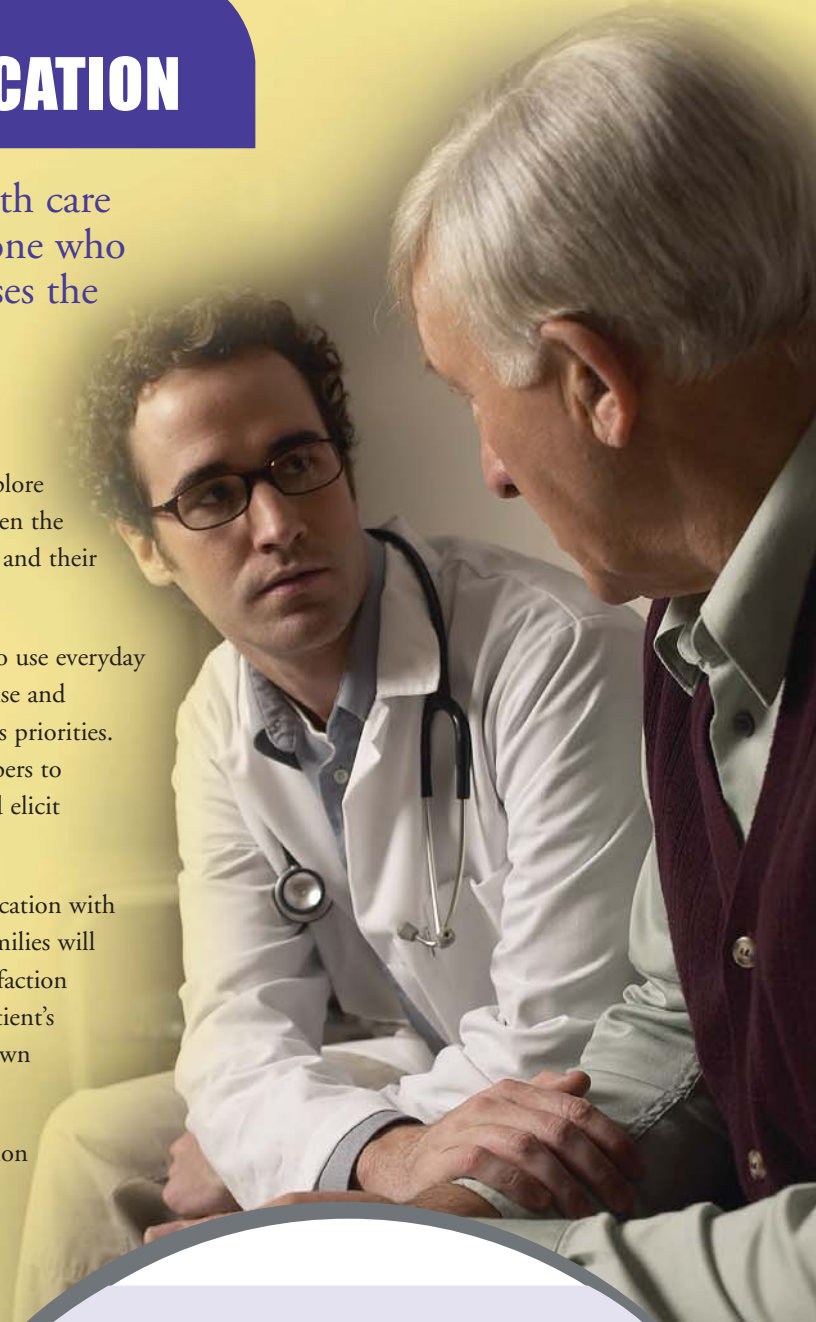
Another technique that has proven successful in enhancing communication and fostering positive behavioral changes is motivational interviewing. This technique is a method of interacting with patients to assess their readiness for change and to promote movement from one stage to the next. A main objective of motivational

interviewing is to explore the differences between the patient's desired goal and their health behaviors.

It is also important to use everyday language that is precise and addresses the patient's priorities. Include family members to enhance learning and elicit cooperation.

Improving communication with patients and their families will enhance patient satisfaction and increase your patient's investment in their own health care.

For further information about motivational interviewing go to: [www.motivationalinterview.org](http://www.motivationalinterview.org)



### THIRD PARTY LIABILITY

#### REMINDER! PLEASE REMEMBER TO INCLUDE THE FOLLOWING WHEN SUBMITTING THIRD PARTY LIABILITY INFORMATION TO GATEWAY:

- Complete policyholder name (if available)
- Complete member ID# including alpha prefix and or suffix (if available) OR policyholder Social Security #
  - Group number (if available)
  - Primary insurance carrier name



## Confidentiality of Patient Information

Have you ever heard of the phrase “Dumpster Diving?” This is when someone rummages through trash looking for papers with personal information on them.

Have you heard of situations where computer security has been breached or situations where emails or electronic records were sent to people who did not have a right to receive the information?

Think these situations can't happen to you or to your organization? Unfortunately health care providers have been the target of recent scams due in part to the large amount of personal and medical information contained in their records. It is increasingly important to stay alert to trends or quickly respond to potential security risks.

Gateway Health Plan<sup>SM</sup> believes it is essential to protect member information! There are many ways in which Gateway protects PHI and other confidential data. One very important way is that Gateway has every employee sign a form to remind them about laws and regulations that protect health information. Gateway trains all employees on laws protecting privacy like HIPAA (Health Insurance Portability and Accountability Act), PHI and Security. We remind our employees to protect information and report issues or concerns, and we also have guidelines and policies to keep PHI and important information safe.

As part of Gateway's on-going awareness campaign for our employees, we post materials on higher risk topics like identity theft, the importance of shredding documents with PHI on them, exercising caution when using the “reply to all” function in email communications, and suggestions for protecting computer passwords.

As a provider, it is important to take steps to keep patient information secure! You can protect PHI by shredding or using other forms of information destruction, and establishing good password policies for staff to follow. Don't overlook your electronic communications and potential areas for risk. Electronic files need protected as much as paper files. Consider the use of encryption or password protection on electronic files and review email protocols with office staff.

Gateway commits itself to practicing good, solid ways to secure member information and appreciates all providers who do the same!



## GATEWAY HEALTH PLAN<sup>SM</sup> SPECIAL NEEDS UNIT

The Special Needs Unit of Gateway Health Plan<sup>SM</sup> strives to deliver compassionate care management that will improve the health and well-being of our members. The Special Needs Unit (SNU) is comprised of case managers who are trained nurses and social workers that are available to help our members who are struggling with a variety of issues. A holistic evaluation is completed on each member referred to the SNU in order to identify what needs the member has and discover the strengths of that member.

Case managers are able to connect members to community resources, government programs and other agencies in their area. The case manager will assist in the navigation of health care system by making calls on the member's behalf to doctors, pharmacies and other providers. Case managers are committed to working in conjunction with providers and community agencies to help secure healthier futures for their clients. The Special Needs Unit is available Monday through Friday from 8:30 to 4:30 at 1-800-642-3550 for PA Medicaid, at 1-800-685-5212 for PA Medicare Assured, and at 1-888-447-4506 for Ohio Medicare Assured.



## CREDENTIALING REMINDERS:

**In order to minimize delays in processing practitioner applications, Gateway requests foreign boarded practitioners submit validation of attendance dates and completion from their highest level of training. Gateway requires work history, including beginning and ending month and year, be provided for a minimum of five (5) years of relevant work history for all new practitioner applicants.**

Gateway's standards require all practitioners have applicable staff/clinical privileges in their practicing specialty at a Gateway participating hospital. Practitioners without staff/clinical privileges in their practicing specialty must have written documentation of a formal coverage arrangement with another Gateway participating practitioner who has privileges at a Gateway participating hospital.

Gateway continues to follow a special process for practitioners called to active Military leave. It is however, up to the practitioner or their office to notify Gateway that the practitioner has been called to active duty and approximately when they will be leaving. The letter should also include the practitioner who will be covering during his/her leave. The Gateway Credentialing Department will not terminate the practitioner if they are called to active duty and have a formal coverage arrangement. The Practitioner's Office should notify Gateway of the practitioners return, as soon as possible, but not exceeding 14 days from the practitioners return to the office. The Gateway Credentialing Department will determine, based upon the length of time the practitioner was on active duty, if the practitioner will have to complete a recredentialing application.

Gateway's Credentialing Department conducts ongoing monitoring of Practitioners for Medicare/Medicaid Sanctions, Licensure Sanctions, and Member Complaints. The ongoing monitoring allows Gateway to identify and, when appropriate, act on important member quality and safety issues.

Gateway is committed to gathering and ensuring that all information is obtained and made available at credentialing and recredentialing for review and consideration by the Quality Improvement and Utilization Management Committee. Because of this and, to ensure

appropriate and timely member notification of terminated practitioners, Gateway continues to no longer accept non-quality of care appeals. Gateway however will continue to afford practitioners their Due Process Procedure for quality of care denials.

Gateway practitioners have the right upon request to be informed of the status of their Credentialing/Recredentialing. Gateway will notify practitioners of their right to review and correct erroneous information in the event that any information was submitted incorrectly on their application. Practitioners are notified by Gateway's Credentialing Department of all credentialing and recredentialing decisions within fourteen (14) days of the Quality Improvement and Utilization Management Committee's decision.

In accordance with Gateway's business practices, the inclusion of a practitioner in the Gateway Practitioner/Provider Network is within the sole discretion of Gateway.

Gateway continues to be committed to protecting the confidentiality of all practitioner information obtained by the Credentialing Department, and to conduct credentialing in a non-discriminatory manner.





## HOW FRAUD AND ABUSE CAN OCCUR IN EVALUATION AND MANAGEMENT CODING:

According to the May 2007 Comprehensive Error Rate Testing (CERT) audit results performed by CMS, Evaluation and Management (E/M) Services accounted for 10 of the top 20 services with the highest insufficient documentation paid claims error rates for Carriers/DMERCs/FIs.

These services included billing procedure codes for initial and subsequent hospital care, new and established patient office visits, initial and follow-up inpatient consultations, and critical care service codes.

Subsequently, a review of overpayment and underpayment coding errors identified E/M services having 12 out of the top 20 paid claim error rates that resulted in overpayments, and 8 out of the top 20 paid claims error rates resulting in underpayments.

Gateway's Special Investigation Unit continues to monitor the billing of E/M services to identify potential peer

outliers. As outliers are identified, audits are scheduled. Do not become the subject of one of these audits; follow proper documentation guidelines.

Providers can access the guidelines through the following URLs:

1995 Documentation Guidelines for Evaluation and Management Services  
<http://www.cms.hhs.gov/MLNProducts/downloads/1995dg.pdf>

1997 Documentation Guidelines for Evaluation and Management Services  
<http://www.cms.hhs.gov/MLNProducts/downloads/MASTER1.pdf>



## PRACTITIONER AVAILABILITY

On an annual basis, Gateway Health Plan<sup>SM</sup> monitors primary care practitioner availability to ensure Gateway provides its members access to an adequate network of primary care practitioners. Gateway conducts the study to meet both NCQA and DPW requirements. Gateway established standards for both geographical availability and percentage of open panels for primary care. Those standards for the availability of primary care practitioners are:

- o For rural areas, 95% of Gateway members have a choice of two practitioners within 45-miles
- o For urban areas, 95% of Gateway members have a choice of two practitioners within 20-miles
- o For all service areas, at least 80% of the PCP panels open to Gateway members.

In 2007, Gateway met the standards in all of our service areas for both Geographic Availability and Open Panels. This is an improvement from 2006, when the Erie County Pediatric Network, at 93%, did not meet the Geographic Availability standard.



US Steel Tower, Floor 41; 600 Grant Street; Pittsburgh, PA 15219

[www.gatewayhealthplan.com](http://www.gatewayhealthplan.com)

## Important Phone Numbers

### PROVIDER SERVICES

Medicaid 1-800-392-1145

Medicare 1-800-685-5205

### MEDICAL MANAGEMENT

Medicaid 1-800-392-1146

Medicare (PA) 1-800-685-5207

Medicare (Ohio) 1-800-447-4375

### MEMBER ELIGIBILITY/DIVA VERIFICATION LINE

Medicaid and Medicare 1-800-642-3515

### EPSDT

Medicaid 1-800-642-3550, Option 4

### PHARMACY

Medicaid 1-800-528-6738

Medicare 1-800-685-5215

### NATIONAL IMAGING ASSOCIATES

Medicaid and Medicare 1-888-879-5922

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### MEDICARE ONLY



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### Insert:

- Pharmacy Services Electronic Prescribing (ePrescribing) Questionnaire



# Pharmacy Services Electronic Prescribing (ePrescribing) Questionnaire

*Please take a few moments to complete this brief survey to help us better assess your needs as it relates to ePrescribing and our website.*

1. Are you familiar with electronic prescribing, its capabilities, and the benefits that it provides to your patients?

 YES NO

2. Do you currently use electronic prescribing, and if so, do you feel that it is valuable to your patients, office staff, and yourself?

 YES NO

3. If you currently use electronic prescribing, what intermediary (RxHub or SureScripts) do you currently use?

 RXHUB SURESCRIPTS

4. If you do not use electronic prescribing, would you be interested in learning more about it and the benefits that it can provide to you, your patients, and your office?

 YES NO

5. Additional Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please fax your response to Dino Conti at 412-255-6008.

If you have questions related to this questionnaire or ePrescribing, please feel free to contact Provider Services at 1-800-392-1145 for PA Medicaid or 1-800-685-5205 for *Medicare Assured*.

Thank you,

Pharmacy Department  
*Gateway Health Plan*<sup>SM</sup>

