



GATEWAY Review

A PROVIDER NEWSLETTER PUBLISHED BY GATEWAY HEALTH PLAN®

Visit us at our website @ www.gatewayhealthplan.com

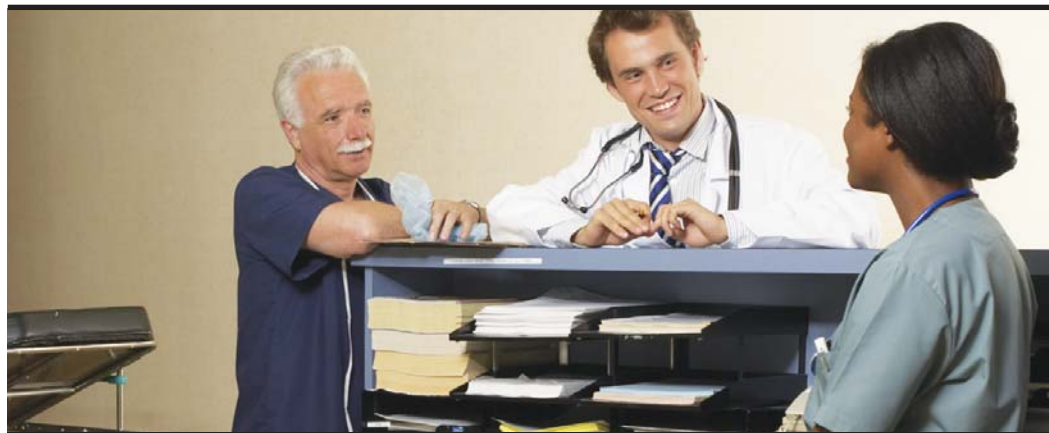
APRIL 2008

ISSUE 60



GATEWAY HEALTH PLAN® INTRODUCES NEW PAY FOR PERFORMANCE PROGRAM

At Gateway Health Plan®, we value the important role physicians play in serving our members. We believe that physician practices committed to providing quality healthcare that is accessible and efficient should be recognized and rewarded for their performance.



Therefore, working collaboratively with physician advisors, Gateway Health Plan® has designed and implemented an innovative pay for performance (P4P) program, **Gateway to Physician ExcellenceSM**. This program is aligned with the *Prescription for Pennsylvania* goals and the DPW's MCO P4P Program. **Gateway to Physician ExcellenceSM** supports Gateway's mission to deliver quality programs that positively impact the personal health of its members.

Gateway to Physician ExcellenceSM (GPESM) strives to:

- Improve the delivery of healthcare – including quality, access, and efficiency,
- Reduce racial and ethnic disparities,

- Improve the member experience, and
- Increase physician satisfaction.

Who is Eligible?

- High volume primary care physician practices (minimum of 200 members),
- Including Family Practice, Internal Medicine, and Pediatrics.
- These physicians touch approximately 76% of Gateway members.

Performance Measures

Gateway to Physician ExcellenceSM focuses on data driven measures to evaluate practice performance in the areas of Clinical Quality, Emergency Room Avoidance, and Encounter Data Submission.

CLINICAL QUALITY

Women's Health/ Preventive

Mammography Screening
Cervical Cancer Screening

Pediatric Care

EPSDT
• Adolescent
• Well Child (15 months)
• Well Child (3-6 years)
Lead Screening

Diabetes Management

• HbA1c Screening
• Retinal Exam
• Lipid Panel
• Medical Attention for Diabetic Nephropathy

Cardiovascular Care

Monitoring Lipid Levels

Asthma Management

Long Term Control Rx Use



GATEWAY HEALTH PLAN® (GATEWAY) IS PLANNING FOR IMPLEMENTATION OF THE NATIONAL PROVIDER IDENTIFIER (NPI) AS MANDATED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996.

By May 23, 2008 regulations require that all healthcare providers must use only the NPI as identification in HIPAA covered standard transactions and health plans and payers must be able to accept and use the NPI.

WHAT IS A NATIONAL PROVIDER IDENTIFIER (NPI)?

The NPI is a 10-digit unique numeric identifier for healthcare providers. The NPI replaces the proprietary provider numbers used to identify a provider to a health plan.

WHO IS REQUIRED TO OBTAIN A NPI?

All healthcare providers – individual and/or organizational – regardless of whether they conduct transactions electronically or on paper are eligible for NPIs. All healthcare providers who transmit electronic transactions must obtain an NPI to identify themselves in HIPAA standard transactions.

To complete an application visit <https://nppes.cms.hhs.gov> on the web.

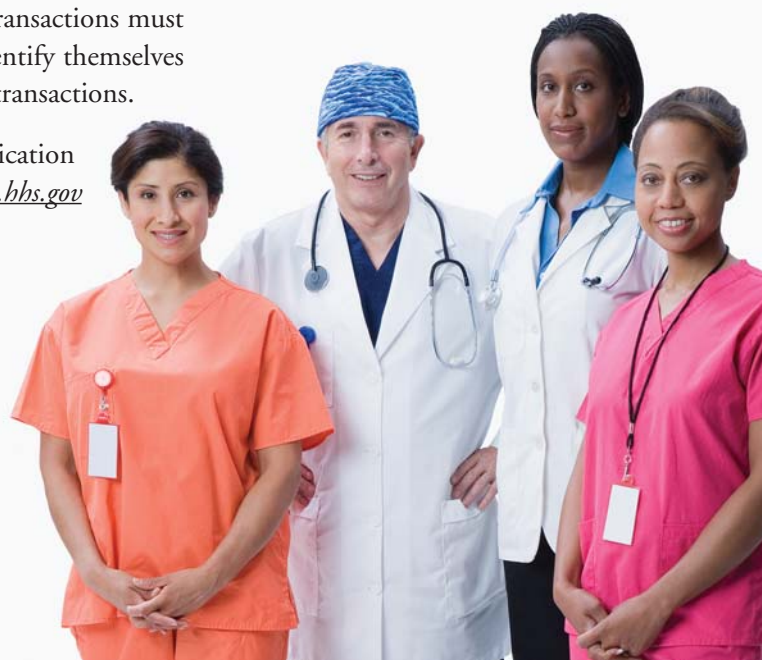
REGISTER YOUR NPI TODAY!

Every PA Medicaid provider MUST register and validate their NPI with both the Department of Public Welfare (DPW) and Gateway Health Plan® to ensure timely and accurate claims and encounter processing.

The link below provides instructions for registering NPI numbers with DPW (MA Bulletin 99-06-14).

<http://www.dpw.state.pa.us/PubsFormsReports/NewslettersBulletins/003673169.aspx?BulletinId=1536>

Please contact your Provider Relations Representative directly or Gateway's Provider Services Department at 1-800-392-1145 or 1-800-685-5205 for *Medicare Assured*™ should you have any questions or concerns.



RECREDEntIALING NEWS!

Gateway moved to a three (3) year recredentiaing cycle for all practitioners as a result of adherence to National Committee for Quality Assurance (NCQA) and Department of Public Welfare (DPW) standards. This new cycle has been implemented as of January 1, 2008. Subsequently, you will be afforded an extra year before being required to complete and submit your recredentiaing paperwork and credentials. The credentiaing department will notify all providers at least three (3) months in advance of their cycle due date for submission of all requested information and documentation, as it relates to continued participation approval. Should you have any questions, please feel free to contact Joyce Berry, Manager, Network Credentiaing at (412) 918-7825.



PROVIDER APPEALS

Gateway maintains an appeal process that allows all providers (Medicare or Medicaid alike) the opportunity to dispute denied claims or issues that have not been resolved through informal methods.

The provider appeal process does not require that you have the written consent to act on behalf of the patient, as the member grievance or reconsideration processes require. There are two levels of review that are available, and providers may elect to participate in the second level appeal review, either in person or by phone. Participating in the second level appeal is not a requirement. Further details on the provider appeal process can be found on our website.

INJECTABLE PROGRAM



“Gateway Health Plan® offers an enhanced injectable program. This program is available for all PA Medicaid members requiring treatment with injectable products. Products that may be available for processing through this program can be found in the Gateway Health Plan® Drug Formulary on-line at www.gatewayhealthplan.com with the notation “SPN” for Specialty Pharmacy Network. A subset of these medications may also require prior authorization, which will be notated in the formulary as “PA” for Prior Authorization Required. Questions about the process for obtaining injectable medications may be directed to the Pharmacy Department at 1-800-528-6738.”



NOMNC Compliance Reminders

In November 2007, the Center for Medicare and Medicaid Services (CMS) updated the Notice of Medicare Non-Coverage (NOMNC) template that skilled nursing facility, home health and comprehensive outpatient rehabilitative facility providers must deliver to Medicare Advantage patients at least two days prior to the end of care. The new template and provider instructions are available on the CMS website at www.cms.hhs.gov/MMCAG. You may also obtain copies from Gateway by calling 412-255-4537. Please insure that your agency is using the most up-to-date CMS forms!

Also, please be advised that signed NOMNC forms for Gateway Health Plan *Medicare Assured*SM members must be submitted to Gateway via mail or fax at 1-800-685-5231. If you have questions on the NOMNC delivery process, the CMS website can help at www.cms.hhs.gov/MMCAG.



EMERGENCY ROOM AVOIDANCE

- Measure ER services for members with Diabetes and Asthma, and
- Provide practices with data on “chronic” ER usage for targeted interventions.

ENCOUNTER DATA SUBMISSION

- Supports current and future performance assessments;
- Measurement not used in calculating final score or award; intended to provide feedback and encouragement for providers to submit encounters.

Scoring Methodology

Gateway uses a member-centric approach to assign the responsibility of treating patients to specific practices. If a member changes to a new assigned practice during the measurement period, then that member will be attributed to multiple practices. Physician practices are scored in relation to other practices.

All measures leverage encounter data (inpatient, outpatient, laboratory, and pharmacy). This eliminates the practice burden to self-report data through surveys or medical chart reviews.

Scorecard

Scores are measured, reported, and awarded at the practice level. Gateway will provide a scorecard to participating practices detailing:

- Practice eligible measures,
- Practice level numerator, denominator, and rate for each measure,
- Measure definitions and scoring methodology,
- Accessibility and availability factors, and
- Encounter submission rate.

Scorecards will be hand delivered to allow discussion of performance improvement opportunities.

Awards

Gateway to Physician ExcellenceSM is designed to recognize and reward practice quality. The financial award is a function of four factors – final practice performance across all measures, practice member volume, practice access and availability, and the annually established **Gateway to Physician ExcellenceSM** program budget. Annual award payments will be separate from physician base

payments. The awards for 2007 performance will be distributed late in 2008.

Recognition

In addition to financial awards, **Gateway to Physician ExcellenceSM** practice participation is noted in both the provider directory and the online Provider Lookup tool.

Physician Involvement

Gateway assures that the physician community is involved by engaging **GPESM** enrolled physicians, QI/UM Committee and Physician Portfolio Workgroup members in the ongoing program development. These physicians, representing the interest of a wide range of stakeholders, have provided clinical input throughout the program design process.

Want More Information?

In the spring of 2008 Representatives from Gateway Health Plan® will be meeting with eligible physician practices through on site and town hall meetings to describe the program in more detail. Look for future updates at www.gatewaywayhealthplan.com/gpe, upcoming newsletter articles and program education materials.



Gateway Health Plan® (Gateway) is now offering more options for its diabetic members with the addition of Accu-Chek blood glucose meters and supplies to its formulary. Accu-Chek has been available to both Gateway Medicaid and *Medicare AssuredSM* members since January 2007. Gateway will continue to cover LifeScan's One Touch products. The availability of Accu-Chek along with LifeScan products gives members the opportunity to select the type of glucometer that is most appropriate to accommodate their specific needs. Members will also be able to receive a free glucometer directly at their participating pharmacies with a prescription from their physicians, giving them easier access to their product of choice.



PATIENT AUTHORIZATION... HIPAA

Gateway takes its responsibility to safeguard our member and provider protected health information (PHI) very seriously.

According to HIPAA Privacy Rules (45 CFR 160, 164), healthcare providers may disclose PHI to health plans and other providers for the purposes of treatment, payment and operations without written authorization from the patient.

Health care operations include activities such as quality assurance, case management, and professional review.

If a request is received for another purpose, Gateway's position is to provide PHI in instances when the member has authorized or consented to the release of the information to the requesting party. If the member has not authorized or consented, Gateway will follow the parameters defined in 45 CFR 164.512 (Uses and disclosures for which an authorization or opportunity to agree or object is not required), to determine if the information can be provided. For example, Gateway is required to disclose PHI when required by the Secretary of the Department of Health and Human Services, for certain public health activities, or when required or compelled by legal process.

Gateway is proud to work with our providers and our members to provide a high quality health care program. We want you to know that we manage our members' health care needs and protected health information with utmost care.



ADVANCE DIRECTIVES

If an accident, injury or health problem caused one of your patients to be unable to communicate, would you know their wishes concerning resuscitation, types of care and extent of treatment. Would you be able to direct their care per their wishes?

Your patient medical records, which serve as a repository for patient-specific information, is the ideal place to document whether a patient has an advance directive and if they do, to house a copy.

As part of its medical record review of PCPs, Gateway Health Plan® (Gateway) assesses whether the office has asked our members ages 21 years and older if they have an advance directive or living will. Although beginning at age 21 may seem premature, it is this age group that is frequently injured, etc., and may not be able to verbalize their wishes after that occurrence. Some offices include a tab in their charts for Advance Directives. Others use a sticker on the outside cover that serves as a reminder to ask about this and to document whether the patient has an advance directive and if one is located in the medical record.

You can find a Living Will Declaration form as part of your Gateway Provider Manual. The form can also be located by going to our website, www.gatewayhealthplan.com, choosing Providers, then Plan, Forms and then #10. A form is also in the packet provided to Family Practice and Internal Medicine offices at the time of medical record review.

For additional information concerning advance directives, please call the Quality Improvement Department at 412-255-1144.





MEDICAL RECORD REVIEWS

A medical record review of PCP charts is performed every two years, utilizing standards approved by the QI/UM Committee.

For 2007, the overall Medicaid PCP score was 95.9%, with Family Practice offices scoring 94.9%, Internal Medicine scoring 94.5% and Pediatrics with a rate of 98.1%. For those Medicare offices, the overall score was 94.2%, with Family Practice offices scoring 94.1% and Internal Medicine scoring 94.8%

THE AREAS NOT MEETING A SCORE OF 85% FOR PCPS INCLUDED:

Medicaid and Medicare Family Medicine and Internal Medicine offices:

- Date of the last tetanus for adults (within ten years)
- Influenza and pneumovax immunizations given per Gateway and CDC recommendations
- Notation whether members 21 years of age and older have an advance directive.

Medicaid Pediatric offices:

- Use/non-use of tobacco, alcohol and drugs for members 14 years and older

TIPS FOR DOCUMENTATION:

- Utilize a preventive health flowchart and/or a history and physical form, kept in a specific place in the chart, to document all of the above information (Gateway's nurse reviewers have examples of forms with them at the time of review).
- Utilize a stamp or sticker to document above information



Gateway's Medical Record Review standards for PCPs and Specialists can be viewed by accessing Gateway's website, www.gatewayhealthplan.com (Providers, choose a plan, Clinical Guidelines, Medical Record Review Standards). Paper copies of these standards as well as preventive care flowcharts and history and physical forms can be obtained by calling the Quality Improvement Department at (412) 255-1144.



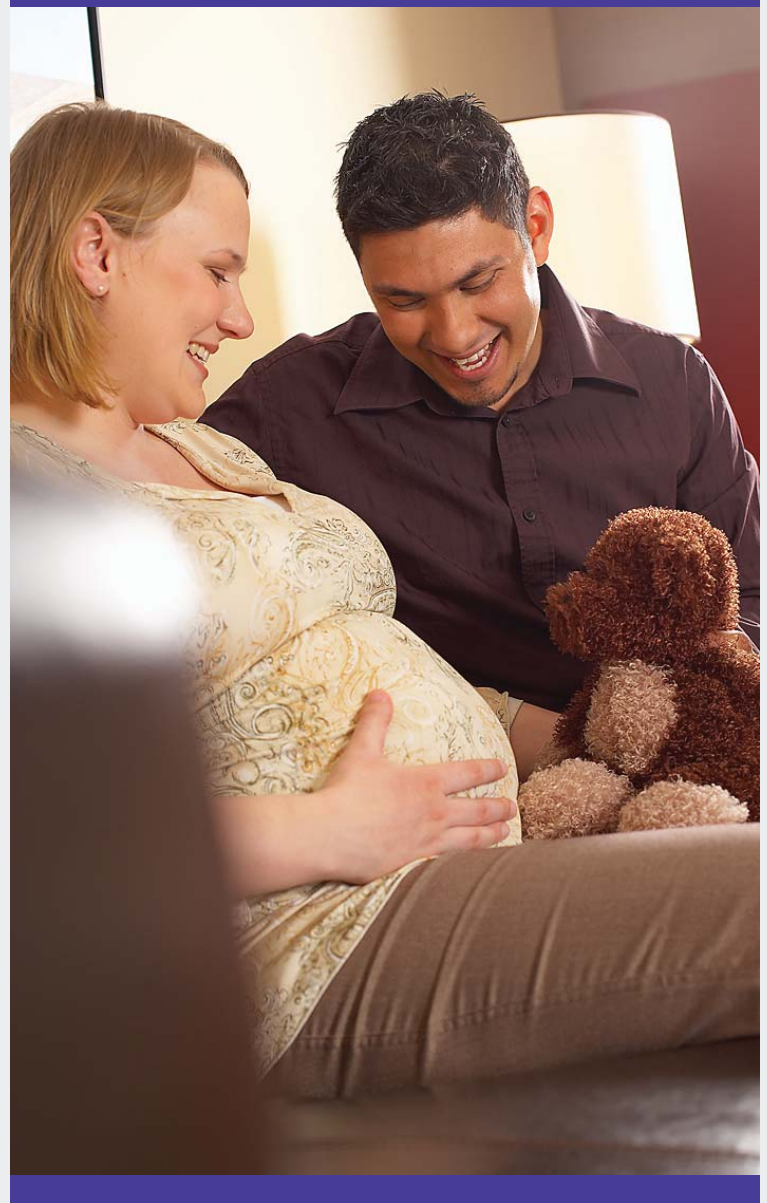
OBSTETRICAL NEEDS ASSESSMENT FORM

The first visit with an obstetrical patient is considered to be the intake visit, or if a patient becomes a Gateway member during the course of her pregnancy, her first visit as a Gateway member is considered to be her intake visit.

At the intake visit, an Obstetrical Needs Assessment Form, found in the Forms and Reference Materials Section of this Manual, must be completed.

The Obstetrical Needs Assessment Form should immediately be faxed to Gateway and then filed in the member's medical record. The Obstetrical Needs Assessment Form should be updated at the 28-32 week visits and also at the post-partum visit. These two updates should also be faxed to Gateway immediately following completion.

The purpose of the Obstetrical Needs Assessment Form is to help



identify risk factors before delivery. For that reason, the Obstetrical Needs Assessment Form must be faxed to Gateway's MOM MattersSM Department within 2-5 business days of the intake visit and at least 30 days prior to delivery.

As a reminder, it is critical that providers confirm eligibility when

completing and forwarding the Obstetrical Needs Assessment Form to Gateway. This will help to ensure that your form is sent to the correct health plan. In addition, please be sure that you are completing and submitting Gateway's Obstetrical Needs Assessment Form for Gateway members.



Please continue to use the appropriate B codes when billing for enteral nutrition that is administered through a feeding tube.

Medicare and Gateway *Medicare Assured*SM do not cover enterals that are administered orally. Gateway *Medicare Assured*SM requires the use

of the -B0 Modifier when billing for enterals that are being administered orally as this will allow you to coordinate coverage with Medicaid.



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

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) 1-888-447-4375

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

Medicare (Ohio) 1-888-447-4507

NATIONAL IMAGING ASSOCIATES

Medicaid and Medicare 1-888-879-5922

TABLE OF CONTENTS

ICON KEY

MEDICAID ONLY



MEDICAID & MEDICARE



MEDICARE ONLY



Cover:

- Gateway Health Plan® Introduces New Pay for Performance Program

Page 2:

- National Provider Identifier
- Recredentialing NEWS!

Page 3:

- Provider Appeals
- Injectable Program
- NOMNC Compliance Reminders

Page 4:

- *CONTINUATION OF* Gateway Health Plan® Introduces New Pay for Performance Program
- Accu-Check Products

Page 5:

- Patient Authorization...HIPAA
- Advance Directives

Page 6:

- Medical Record Reviews

Page 7:

- Obstetrical Needs Assessment Form
- Enteral Nutrition Billing