



# GATEWAY Review

A PROVIDER NEWSLETTER PUBLISHED BY GATEWAY HEALTH PLAN®

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ISSUE 61



## According to the Centers for Disease Control, all toddlers who receive Medicaid should have blood lead level test drawn around the times of the first and second birthdays.

The code for this test is 83655. Gateway Health Plan® recognizes that there may be extenuating circumstances which make it difficult to obtain these test results. For example, the member may have had the test performed as part of a screening at a Women, Infants, and Children (WIC) appointment, rendering a repeat blood draw unnecessary. Also, a prescription for the laboratory test may be provided at the time of an EPSDT screening without the member ever reporting to the lab for the blood draw.

Lead screening is now a metric in the Gateway to Physician Excellence<sup>SM</sup> pay for performance program. Credit is given for this service based on a claim documented on the outpatient visit encounter form that the test was either performed or ordered.

In all such instances, Gateway Health Plan® encourages its providers to bill 83655 with a -90 modifier when blood lead level testing is either advised or ordered during an office visit, regardless if the test is actually drawn in the office at the time of the visit.



## BREAST PUMPS

Gateway Health Plan® has made arrangements with Edgepark Medical Supply to provide breast pumps to our PA Medicaid members. Prior authorization is not required from Gateway. Please contact Edgepark directly at 866-528-0343. Hours of operation are Monday thru Friday from 8:30am-8:00pm.



**Gateway Health Plan® utilizes a formulary for its PA Medicaid and PA & OH Medicare Assured<sup>SM</sup> members.**

The formulary is a list of FDA-approved medications reviewed and approved by our Pharmacy and Therapeutics (P&T) Committee and either the Department of Public Welfare (DPW) or CMS. The Pharmacy and Therapeutics Committee is comprised of actively participating network physicians and pharmacists who select products on the basis of their safety, efficacy, quality and cost to the plan.

Physicians are requested to prescribe medications included in the formulary whenever medically appropriate. Providers can contact provider/pharmacy services with any questions related to a member's prescription coverage limitations.

The Pharmacy and Therapeutics Committee meets on a regular basis to review and revise the formularies. Providers may request the addition of a medication to the formularies. Requests must include the drug name, rationale for inclusion on the formulary, role in therapy and formulary medications that may be replaced by the addition.

The committee will review requests. All requests should be forwarded in writing to:

**Gateway Health Plan®**  
Pharmacy Department  
US Steel Tower  
Floor 41  
600 Grant Street  
Pittsburgh, PA 15219

The formularies are accessible online at [www.gatewayhealthplan.com](http://www.gatewayhealthplan.com). They may be searched by drug name or drug class. Future updates to our Formulary will be available on a regular basis online. Additional hard copies of the Formulary may be printed directly from our Formulary website or requested as follows:

• **Physician Practices:**

- 1-800-392-1145 (PA Medicaid)
- 1-800-685-5205 (PA Medicare)
- 1-800-685-5205 (OH Medicare)

• **Pharmacy Network Providers:**

- 1-800-528-6738 (PA Medicaid)
- 1-800-685-5215 (PA Medicare)
- 1-888-447-4507 (OH Medicare)

*Questions about the formulary and its use can be directed to:*

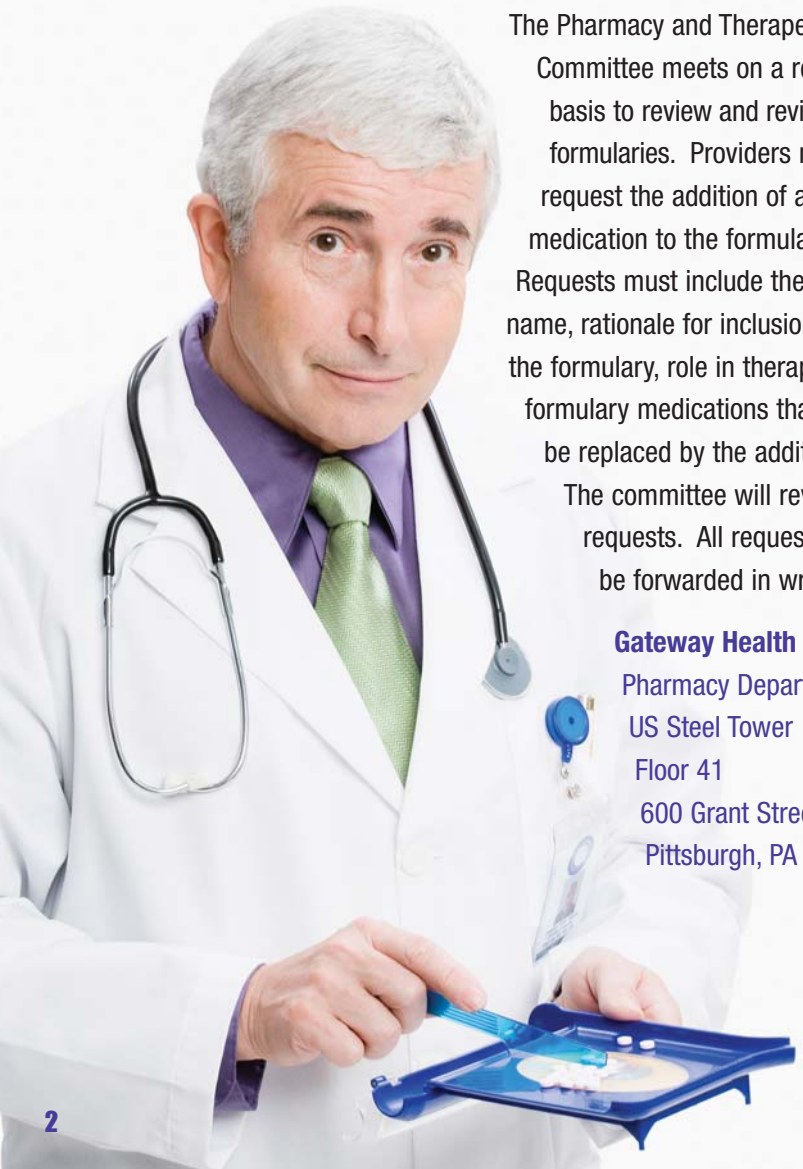
• **Pharmacy Service Center:**

- 1-800-528-6738 (PA Medicaid)
- 1-800-685-5215 (PA Medicare)
- 1-888-447-4507 (OH Medicare)

*Gateway Health Plan®'s Pharmacy Department can be reached directly by calling:*

• **Pharmacy Service Center:**

- 1-800-528-6738 (PA Medicaid)
- 1-800-685-5215 (PA Medicare)
- 1-888-447-4507 (OH Medicare)





## Office Manager Incentive Program Winners

Congratulations to the winners of the 4<sup>th</sup> Quarter 2007 and 1<sup>st</sup> Quarter 2008 Primary Care Office Manager Incentive Program! The winners are as follows:

- ★ Sewickley Valley Pediatric and Adolescent Medicine
- ★ East End Medical Associates
- ★ East Harbor Primary Care
- ★ Richard A. Mercurio, MD, Incorporated
- ★ Barry J. Snyder, M.D. & Associates, LLC
- ★ Community Care Center
- ★ West Penn Internal Medicine Associates
- ★ Monroeville Medical Associates
- ★ Tri-State Pediatric Associates, Inc. - Kasi
- ★ Mercy Health Center/IM
- ★ Butler Medical Associates-Evanko
- ★ Philip J. Reilly, M.D.

As a reminder, the criteria for participation includes the following:

1. Submission of claims electronically.
2. Submission of greater than or equal to the peer average of encounters per member per year.
3. Maintenance of a member transfer rate that is equal to or less than the peer average.
4. Submission of EPSDT forms and preventive health encounter forms.

The winners received a plaque to display in their office and a gift basket. The winners of the 2<sup>nd</sup> Quarter will be announced in the next issue of the *Gateway Review*.

## Good Luck!



### CLAIMS REMINDERS

- (1) If submitting paper claims please make sure all information is located in correct boxes before submitting. Offline submissions cause scanning and data entry errors that result in claim processing errors.
- (2) Please be aware that Gateway processes over 98% of claims within 30 days of receipt. Providers or their billing departments are encouraged to contact Gateway's Provider Services Department if payment has not been received within 45 days of the original billing date. It is not beneficial for providers to rebill claims on a weekly basis if payment has not been received within 30 days from the date of receipt. It is more appropriate and advantageous to review electronic acceptance/rejection reports for electronic claims and/or contact Gateway to inquire for a status of the electronic or paper claims rather than continue to resubmit multiple claims. The result will allow us to provide better turnaround time for all of the claims received.



### ACCESS STANDARDS WERE REVISED IN MAY 2008

Requirement	Standard
Wait time for an Emergent Appointment	Immediately seen or referred to an emergency facility
Wait time for Urgent Care Appointment	Within 24 hours
Wait time for Regular or Routine Appointments	Within 10 business days
Wait time for a Health Assessment/General Physical Examinations and First Examinations	Within 3 weeks of enrollment
After-hours Care Accessibility	Access to a practitioner 24 hrs/7 days a week
Waiting Time in the Waiting Room	No more than twenty (20) minutes or up to one (1) hour when the MD encounters an unanticipated urgent visit or is treating a member with a difficult need.



## UTILIZATION MANAGEMENT TIPS FOR PRECERTIFICATION

### Here are some tips that will help the Utilization Management Department better service your call when making requests for the *Medicare Assured*<sup>SM</sup> and Medicaid lines of business:

1. Have the member's name, Gateway Health Plan® Identification Number or Social Security Number when calling. You will be asked the member's address, phone number, and date of birth for verification purposes.
2. The Utilization Management Representative will need to know the date of service and the valid billing codes for the procedure or item you are requesting.
3. In order to complete the authorization process you will be asked to provide the name of the ordering physician and the name and/or provider number of the facility where the service will be performed.
4. Please have clinical information available when you call so that we can complete the request as timely as possible.
5. If the Utilization Management Representative needs further information to service your call, please verify the representative's name and phone number that you are to call with the necessary information or confirm the fax number and name of the person who is requesting the faxed information.
6. The lowest call volume times are in the mornings between 9AM and 11AM. The Utilization Management Department is accessible by voicemail 24 hours and we return voice mail within one business day.
7. When it is necessary for the Utilization Management (UM) Representative to transfer your call to the nurse line, you have the option of waiting for a call back from the nurse, or being transferred and put on hold for the next available nurse. While you are

on hold you can leave a message at any time. Cases routed to the nurse for a call back and voice messages are prioritized and calls returned the day of the request, or within one business day.

The UM Team that services the *Medicare Assured*<sup>SM</sup> line of business manages all types of requests including DME, therapy and chiropractic services.

The Utilization Management Department for the Medicaid line of business is comprised of the Red, Blue, Green and Gold teams. Providers are assigned to colored teams based on geographic regions. If you are unsure of your team assignment please ask the Utilization Management Representative to confirm this for you. Calling the correct team may avoid unnecessary wait times in the future. The Durable Medical Equipment/Therapy Team services all geographic regions for DME, therapies (PT, OT, ST, etc), and Chiropractor services.



## Utilization Management Criteria

The Gateway Utilization Management Criteria information is available to participating practitioners/providers via a telephone request to Gateway's Medical Director. The practitioner may also request criteria information over the telephone from the Utilization Care Management Nurse during the authorization request process, at orientation sessions and/or by written request to the Medical Management Department.

Information about how to request criteria is also included on all denial notices.

As a reminder, the Utilization Management telephone number for Pennsylvania Medicaid practitioners and providers is 1-800-392-1146 and for *Medicare Assured*<sup>SM</sup> practitioners and providers is 1-800-685-5207. Ohio *Medicare Assured*<sup>SM</sup> practitioners and providers may call 1-888-447-4375.



## THE DEADLINE IS APPROACHING - DO YOU HAVE EVERYTHING YOU NEED?

### *CME License Renewal Cycle*

At the end of this year, you will need to renew your license (Nov 1, 2007 – Oct 31, 2008). As you know, in order to do so, you must have fulfilled some CME requirements by that time. Those requirements are:

#### **M.D.**

- 100 total credit hours of CME in the two-year licensure cycle (Jan 1, 2007 – Dec 31, 2008)
- A minimum of 20 of the total credit hours in Category I
- 12 credit hours in the areas of patient safety and risk management

#### **D.O.**

- 100 credit hours of CME in the two-year cycle (Nov 1, 2007 – Oct 31, 2008)
- A minimum of 20 of the total credit hours in AOA Category I-A
- 12 credit hours in the areas of patient safety and risk management



## 2008 Practitioner and Provider Satisfaction Surveys

Gateway Health Plan® will again be conducting both the Medicaid and *Medicare Assured*<sup>SM</sup> Practitioner and Provider Satisfaction Surveys simultaneously this year. If you participate in both lines of business and are chosen in the random sample you will receive and need to complete only ONE survey. The survey will have a column for Medicaid responses, and a column for Medicare responses. This will alleviate having to complete two separate surveys.

If you participate in only Medicaid or only *Medicare Assured*<sup>SM</sup>, you will receive a survey and only need to complete the column for the product in which you participate.

If you have any questions regarding the survey process in 2008, please feel free to call Gateway's Provider Services Department at 1-800-392-1145 for Medicaid, or 1-800-685-5205 for *Medicare Assured*<sup>SM</sup>.



## NOMNC COMPLIANCE UPDATE

The Center for Medicare and Medicaid Services (CMS) released an updated template for the Notice of Medicare Non-Coverage (NOMNC) form via its website on November 14, 2007 with implementation by Medicare Advantage plans required in 90 days from release. At least two days prior to the end of care, CMS requires that Medicare Advantage Plan patients be informed of home health, skilled nursing or comprehensive outpatient rehabilitative facility services that are ending using the new NOMNC template form.

Gateway Health Plan *Medicare Assured*<sup>SM</sup> (Gateway) is responsible to monitor its participating providers' compliance with CMS requirements, including the requirement that every Medicare Advantage patient receive and sign a NOMNC at least two days prior to the end of the care. We are committed to collaborating with our participating Medicare providers in order to reach 100% compliance with CMS requirements. If you have any questions regarding the new NOMNC form or valid delivery of the NOMNC, please contact Rachel Wiehagen, UM Compliance Specialist, at 412-255-7137.



## AFFIRMATIVE STATEMENT ABOUT INCENTIVES

**Gateway's utilization management decisions are based only on the appropriateness of care and services and existence of coverage.**

Gateway does not specifically reward practitioners or other individuals for issuing denials of coverage or service. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

Gateway monitors for both over and under utilization of care to prevent inappropriate decision-making, identify causes and corrective action, and to indicate inadequate coordination of care or inappropriate use of services. Gateway is particularly concerned about underutilization and monitors utilization activities to assure members receive all appropriate and necessary care.



### QUALITY IMPROVEMENT/ UTILIZATION MANAGEMENT (QI/UM) PROGRAM AND WORK PLAN

Gateway's Quality Improvement/Utilization Management (QI/UM) Committee recently approved the 2008 QI/UM Programs and Work Plans that list activities planned for the year for each line of business.

The evaluations of the 2007 Programs have been finalized. If you would like a written summary of these documents, please call the QI Department at 412-255-1144.



# Medical Necessity Determinations

The authorization process for medical necessity determinations in Gateway's Medicaid line of business is accomplished through the application of the Pennsylvania Department of Public Welfare's definition of medical necessity. Satisfaction of any one of the following standards will result in authorization of the service:

- The service or benefit will, or is reasonably expected to, prevent onset of an illness, condition, or disability.
- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability.
- The service or benefit will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.

Medical necessity determinations must be made by qualified and trained providers.

The Utilization Care Management Nurse or Care Manager refers cases to the Gateway Medical Director and/or Physician Advisor for a medical necessity determination.



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) 1-888-447-4375

### 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

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