



GATEWAY Review

A PROVIDER NEWSLETTER PUBLISHED BY GATEWAY HEALTH PLAN®

SEPTEMBER 2008

Visit us at our website @ www.gatewayhealthplan.com

ISSUE 62



Change to Outpatient Surgery Prior-Auth Requirement!

Gateway Health Plan® recognizes that medical practices are faced with tremendous challenges. At Gateway, we are committed to continuously look for opportunities to lessen the administrative burden on our network of participating physicians. With our mission to provide quality healthcare that is accessible and efficient and our commitment to our physicians in mind Gateway will implement the following changes to its Utilization Management (UM) Prior-Authorization requirement for Outpatient Surgical Procedures:

Gateway is very pleased to announce that Outpatient Surgical Procedures provided on or after October 1, 2008 for our Gateway PA Medicaid members will no longer require prior-authorization when rendered in either the Outpatient Hospital (POS 22) setting or Ambulatory Surgical Center (POS 24) within a hospital or freestanding!

Medical Necessity Reviews will only be required by calling Gateway's UM Department for the short list of surgical procedures (including any related procedures)

listed below. Please note **ALL** other prior-authorization requirements (inpatient stays, DME>\$500, SNF, etc.) remain in place including those requests that are managed by National Imaging Associates (NIA).

SURGERIES FOR REVIEW BY GATEWAY'S UM DEPARTMENT

- Bariatric Surgery/Stapling
- Hysterectomy
- Rhinoplasty
- Breast Reduction
- Panniculectomy
- TMJ Surgery
- Carpal Tunnel Surgery
- Removal of Breast Implant
- Varicose Vein

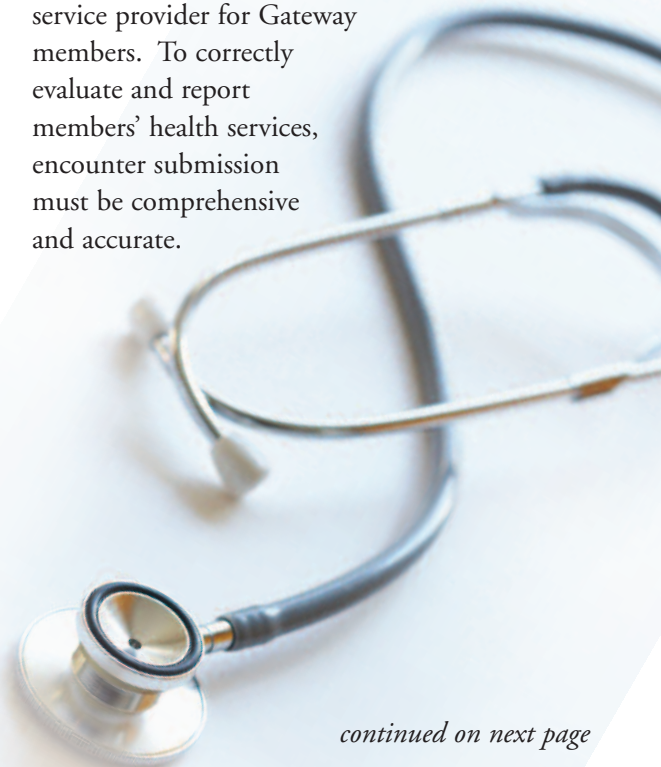
If you have any questions on which services require Prior-Authorization vs. a Referral please contact Gateway's Provider Services Department by calling 1-800-392-1145, Monday through Friday from 8:30 am to 4:30 pm.



ENCOUNTERS STUDY BASED ON 2007 DATA YEAR

The use of claims encounter data is essential to Gateway's understanding of the population served, the development of effective health care programs, the management of health care resources and the determination of the level of illness of our population. 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.



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ENCOUNTERS STUDY BASED ON 2007 DATA YEAR — continuation

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. Submission of Encounters will directly impact provider reimbursement under Gateway's Medicaid PCP Pay 4 Performance (GPESM) program. This is the first year that Gateway had the information available to also assess the encounter rate for our Medicare members.

Gateway has taken two approaches to measuring and analyzing encounter submissions based on overall scores as well as evaluating the three PCP specialty types of Family Medicine (FM), Internal Medicine (IM), and Pediatrics (Ped).



- **Volume of encounters** – Based on administrative data alone to evaluate encounter submission rates for PCPs. Within each specialty type, the PCP practice's rate of encounters per member is calculated and compared to the peer average for that specialty type. Low performers are then identified based on the peer average.
 - Medicaid – There was a 3% decrease in the number of practices that scored one standard deviation below their respective PCP Peer Group for average encounters/member.
 - Medicare – This was a baseline year.
- **Submission of claim encounters** – Based on dates of service extracted from Gateway members' medical records during medical record reviews. This information serves as a means to validate the rate of actual administrative encounter submissions for known visits to a PCP. Using this hybrid method allows Gateway to better understand and differentiate between low utilization vs. low submission.
 - Medicaid – 318 offices –compliance rate 85% All 3 practice types improved in the areas of 85-100% compliance and decreased in the category $\leq 60\%$ compliance. The overall rate of 82.68%, as well as the FM (83.3%) and IM (81.7%) showed statistically significant increases. There was a slight drop in Ped scores (81.29%).
 - Medicare – 70 offices –compliance rate 95% Considering that Gateway's Medicare program is "fee-for-service, it was unexpected that the overall number of submitted encounters was only 87.6 % of member visits recorded in member medical records.

Gateway is pleased with the improvement shown in the increasing number of Medicaid encounters received, but our numbers remain very low. It was surprising that offices were not submitting encounters for payment for their Medicare members. Your support is needed to increase the number of claims submitted.



CONFIDENTIALITY OF PATIENT INFORMATION

Gateway Health Plan® is committed to providing the highest level of protection and confidentiality of member's personal and medical information and practitioner's information.

Not only do employees of Gateway Health Plan® sign a form annually reminding them about laws and regulations that protect health information, they are also trained on laws protecting privacy such as HIPAA (Health Insurance Portability and Accountability Act) and ways to protect system security.

Gateway strongly believes that protecting member information is of key importance! Gateway has implemented many ways to protect PHI and other confidential information. One way is that Gateway provides specific training regarding, HIPAA, Compliance and Security when employees are first hired. Also, as on-going awareness practices, Gateway conducts annual Education Day training, holds refresher classes at departmental staff meetings through-out the year, and celebrates National Compliance & Ethics Week with the entire company.

With an increased focus in the industry with respect to ethics and integrity, Gateway also strongly encourages employees to become familiar with its Code of Conduct. Gateway expects all employees to work with honesty and integrity! To that end, Gateway aims to assure staff education and processes are in place to provide the utmost protection of member

and provider information.

Additionally, providers play an important role in protecting patient information as well. Providers can show they care by implementing simple processes for staff to follow, such as shredding unneeded documents containing PHI at the end of the day, establishing good password policies for employees to adhere by, and encrypting electronic files for additional safety.

Gateway Health Plan® takes its responsibility to protect patient information very seriously and encourages providers to do the same!



CME LICENSE RENEWAL CYCLE - CORRECTION TO JUNE NEWSLETTER

At the end of this year, you will need to renew your license (by December 31st for M.D. and October 31st for D.O.).



IMPORTANT INFORMATION ABOUT PRESENT ON ADMISSION (POA) INDICATOR REPORTING

Please Read This Information Carefully

The following information was taken from the CMS website: http://www.cms.hhs.gov/HospitalAcqCond/Downloads/poa_fact_sheet.pdf

Gateway is encouraging all providers to become familiar with these CMS requirements and to notify providers that your encounter data may be denied if the Present on Admission indicators are not completed correctly on your claims.

The Deficit Reduction Act of 2005 (DRA) requires a quality adjustment in Medicare Diagnosis Related Group (DRG) payment for certain hospital-acquired conditions. CMS has titled the program “Hospital-Acquired Conditions and Present on Admission Indicator Reporting” (HAC & POA). Inpatient Prospective Payment System (IPPS) hospitals are required by law to submit POA information on diagnoses for inpatient discharges on or after October 1, 2007.

The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any provider involved in the care and treatment of the patient may be used

to support the determination of whether a condition was present on admission. In the context of the official coding guidelines the term “provider” means a physician or any qualified health care practitioner who is legally accountable for establishing the patient’s diagnosis.

NOTE: Providers, their billing offices, third party billing agents, and anyone else involved in the transmission of this data must ensure that any resequencing of diagnosis codes prior to their transmission also includes a resequencing of the POA indicators.

Effective with discharge dates after June 30, 2008 the Department of Public Welfare will require POA indicators for Inpatient and Inpatient Crossover encounters. Editing will be done to determine if the POA indicator is being submitted for each diagnosis code and that the POA indicator is valid.

CODE	REASON FOR CODE
Y	Diagnosis was present at time of inpatient admission.
N	Diagnosis was not present at time of inpatient admission.
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
1	Exempt from POA reporting. This code is the equivalent code of a blank on the UB-04; however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the 00401/000410A1.

Paper Claims

On the UB-04, the POA indicator is the eighth digit of Field Locator (FL) 67, Principal Diagnosis, and the eighth digit of each of the Secondary Diagnosis fields, FL 67 A-Q. In other words, report the applicable POA indicator (Y, N, U or W) for the principal and any secondary diagnoses and include this as the eighth digit; leave this field blank if the diagnosis is exempt from POA reporting.

For More Information

The HAC POA web page at <http://www.cms.hhs.gov/HospitalAcqCond/> provides further information, including the links to the law, regulations, change requests (CRs), and educational resources including presentations, MLN articles, and fact sheets.

Electronic Claims

Using the 837I, submit the POA indicator in segment K3 in the 2300 loop, data element K301.

Example 1
POA indicators for an electronic claim with one principal and five secondary diagnoses should be coded as **POAYNUW1YZ**

POA — “POA” is always required first, followed by a single indicator for every diagnosis reported on the claim.

Y — The principal diagnosis is always the first indicator after “POA.” In this example, the principal diagnosis was present on admission.

N — The first secondary diagnosis was not present on admission, designated by “N.”

U — It was unknown if the second secondary diagnosis was present on admission, designated by “U.”

W — It is clinically undetermined if the third secondary diagnosis was present on admission, designated by “W.”

1 — The fourth secondary diagnosis was exempt from reporting for POA, designated by “1.”

Y — The fifth secondary diagnosis was present on admission, designated by “Y.”

Z — The last secondary diagnosis indicator is followed by the letter Z to indicate the end of the data element.

Example 2
POA indicator for an electronic claim with one principal diagnosis without any secondary diagnosis should be coded as **POAYZ**.

POA — “POA” is always required first, followed by a single indicator for every diagnosis reported on the claim.

Y — The principal diagnosis is always the first indicator after “POA.” In this example, the principal diagnosis was present on admission.

Z — The letter Z is used to indicate the end of the data element.

Failure to report a POA indicator on your claim records will result in failed encounter data reporting.



PRACTITIONER AVAILABILITY

On an annual basis, Gateway Health Plan® 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:

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

In 2008, Gateway once again met the standards in all of our service areas for both Geographic Availability and Open Panels.



CREDENTIALING REMINDERS

- Gateway's standards require that all practitioners hold 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 in the same specialty of the applicant who holds active privileges at a Gateway participating hospital.
- Gateway continues to follow a process for practitioners who are called to active Military Duty that allows them to remain participating. It is however, up to the practitioner or their office to notify Gateway that the practitioner has been called to active duty, when they will be leaving and an approximate date of return. 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 practitioner's 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 providers to include but not limited to Medicare/Medicaid Sanctions, Licensure Sanctions, Disciplinary Actions and Member Complaints. The ongoing monitoring allows Gateway to identify and act on pertinent 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. Gateway, however, will continue to afford practitioners a due process procedure for quality of care terminations.
- Gateway providers have the right, upon request, to be informed of the status of their credentialing/recredentialing applications.
- Gateway will notify providers of their right to review and correct erroneous information in the event that any information was submitted incorrectly on their application.
- Providers 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 provider in Gateway's provider network is within the sole discretion of Gateway.
- Gateway continues to be committed to protecting the confidentiality of all provider information obtained by the Credentialing Department and to conduct credentialing/recredentialing in a non-discriminatory manner.

CREDENTIALING NEWS!

All practitioners in Pennsylvania now have the option of completing the PA Standard Application or submitting the pre-populated CAQH application to Gateway for review and consideration. For further information, please contact Joyce Berry at 412-918-7825.

The CAQH application is mandatory in Ohio.





SUBMITTING NOTICES OF MEDICARE NON-COVERAGE (NOMNC) TO GATEWAY HEALTH PLAN®

Gateway Health Plan *Medicare Assured*™ requires completed Notice of Medicare Non-Coverage (NOMNC) forms to be faxed to Gateway at 1-800-685-5231. If your agency did not deliver a NOMNC to the patient, please provide Gateway with a documented explanation regarding why the NOMNC was not delivered.

You may have verbally provided the notice to an authorized representative and followed it with a written NOMNC sent via certified mail with return receipt, as the Center for Medicare and Medicaid Services (CMS) requires. In these instances, please provide a copy of your written documentation as evidence of a compliant NOMNC delivery.

Please note that NOMNCs are not necessary when care was authorized but never rendered. If your agency advises Gateway that care was not rendered to the patient, a NOMNC will not be required. Gateway will also void the authorization of services, and no claims will be paid.

If you have any questions regarding the NOMNC delivery and submission process, please call Rachel Wiehagen, UM Compliance Specialist, at 412-255-7137.



Complaints, Grievances and Appeals

Gateway provides a multi-level process to all providers to appeal for payment for services rendered.

You must submit your written request to Gateway within ninety (90) days of a Gateway denial. All documentation supporting the request should accompany your request. The Appeal Committee will review your request and issue a written decision within thirty (30) days of receiving the appeal. The Appeal Committee is made up of two or more Gateway employees including one physician. The Committee members will not have been involved in any prior review of the denied service. If you do not agree with the Committee's decision, you will have the opportunity to request a second review and to participate in that review if you wish.

As a health care provider, you also have the right to act on behalf of your patient if Gateway has decided not to pay for a service that you feel is needed. 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.

If you have questions regarding any of these processes, please contact Provider Services or your Provider Relations Representative.





PATIENT SAFETY

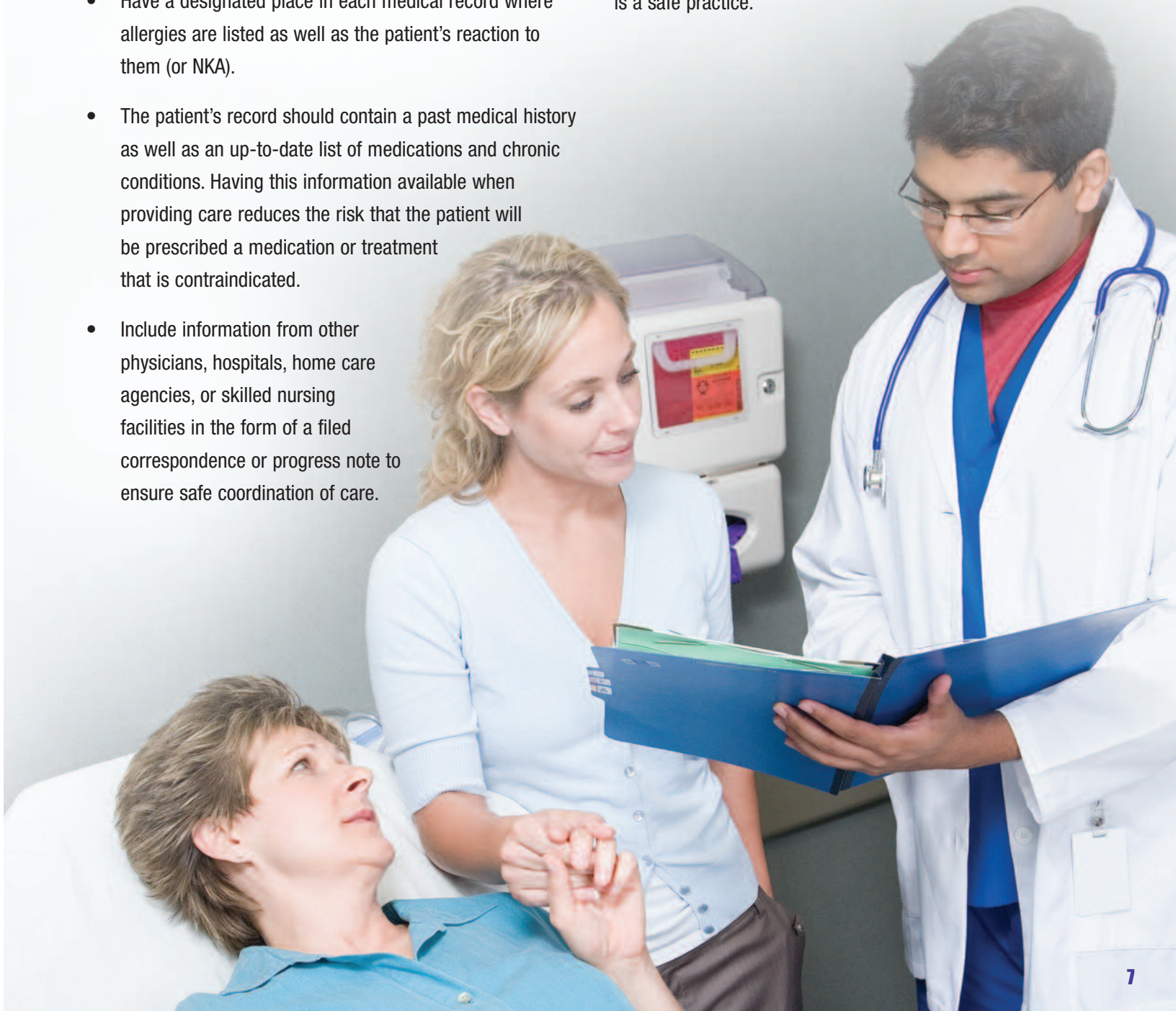
PATIENT SAFETY IS EVERYONE'S RESPONSIBILITY. WHAT CAN YOU DO?

In the office setting, clear and complete information in the medical record reduces the risk of a miscommunication that could result in patient harm. Set up practices and standards that support excellent medical record documentation.

- Have a designated place in each medical record where allergies are listed as well as the patient's reaction to them (or NKA).
- The patient's record should contain a past medical history as well as an up-to-date list of medications and chronic conditions. Having this information available when providing care reduces the risk that the patient will be prescribed a medication or treatment that is contraindicated.
- Include information from other physicians, hospitals, home care agencies, or skilled nursing facilities in the form of a filed correspondence or progress note to ensure safe coordination of care.

- The old adage is true - If you didn't document it, it didn't happen! Protect your patient and yourself.

Maintaining a complete and comprehensive medical record for each patient is a safe practice.



In Other Words...Bridging Literacy and Language Differences for Better Health Outcomes



By Helen Osborne, M.Ed., OTR/L, President of Health Literacy Consulting

Mr. R works as a day laborer for a landscaping company. He, along with others from a small Mexican village, comes to the U.S. each year for this work. Now Mr. R is at your clinic because of a sprained ankle. You check his vital signs and find he has a significantly elevated blood pressure level of 190/100. Mr. R. is surprised when you tell him this. Other than his ankle injury, he feels just fine.

Since Mr. R speaks only Spanish, you communicate with basic medical phrases you learned in his language. You explain about his blood pressure problem and tell him to take medication each day. Mr. R nods, smiles, and takes the prescription. But when he returns a month later for a follow-up visit, his blood pressure is unchanged. You explain again what he needs to do. Next appointment there still is no improvement – but there should have been.

Frustrated that Mr. R's condition is not improving, you ask an interpreter to meet with both of you. Through the interpreter you learn that Mr. R didn't take this medicine because he felt fine and saw no need for it. He said that when he feels sick, he'll take it.

Situations like this are all too common in the clinic where Jedan Phillips, MD, works. As both a family physician and clinical assistant professor at Stony Brook University School of Medicine in Long Island, Phillips sees many patients from outside the U.S. who speak no English whatsoever. He says that these patients come to the clinic with a sincere desire to get health problems taken care of but literacy or language problems may stand in the way.

Aldustus Jordan, EdD, agrees. He is associate dean at the Stony Brook University School of Medicine and also president of the board for the local literacy program, Literacy Suffolk. Jordan has been making connections between lit-

eracy, language, and health for many years. His interest not only is academic but also personal. Both of Jordan's grandfathers were illiterate and could neither read nor write.

Gini Booth helps make these connections happen. As executive director of Literacy Suffolk, she collaborates with Jordan and Phillips on many projects. The three of them recently discussed what all healthcare professionals can do to bridge literacy and language differences. What follows are their suggestions.

Appreciate your own language limitations

Phillips is realistic about his limited ability to speak Spanish. While he can ask basic medical questions such as "Do you have a headache?" he acknowledges that his fluency is more like that of an international traveler using only a guidebook. He lacks the sophisticated language skills and cultural context needed to fully communicate with Spanish-speaking patients. So when Phillips recognizes a problem, he knows it is time to bring in an interpreter.

Show genuine respect

Jordan says that patients who don't speak English often think of themselves as outsiders. Sadly, this feeling is reinforced when providers demonstrate an attitude that these people are either dumb or "less than." Jordan considers this attitude an abuse of professional power and sign of disrespect. It also can impact health outcomes. Jordan talks of patients who do not take prescriptions solely because of the disrespectful ways in which they were treated. "Patients are real people who appreciate what other people do for them," he says.

Simplify your message

Misunderstandings like the one with Mr. R can be due to differences in language, literacy, or both. To communicate better, Phillips assumes that each patient reads no higher than a 5th grade level. He simplifies all his messages and only adds complexity when a person shows obvious capacity and interest. Phillips says that patients at all literacy and language levels tell him how much they appreciate this approach, “Thank you so much for making this understandable.”

Limit the number of actionable items

Phillips gives patients only a few “actionable items” (tasks they need to do) at each visit. He has learned from many years of practice that the “batting average” of success increases this way. “If I give patients 6 items to do, they may do none of them. But if I give them only 3, patients may do 2 of them,” says Phillips. He has found that this approach produces very real benefits in terms of patients’ follow-through and health outcomes.

Teach students good communication skills

Regardless of discipline, Jordan believes that all healthcare training programs should address literacy and language in their curriculum. He recommends looking at these issues through both small and large “lenses.” He thinks of the small lens as how providers communicate on a personal level. An example is a doctor who “gets it” and realizes that communication problems are the fault of the provider, not the patient. The big lens is societal context. This looks at how limited language or literacy skills can affect patients’ access to timely and good healthcare.

Create “forgiving environments” in which to learn

Stony Brook University School of Medicine has a very active student-run clinic. Jordan says that this clinic offers an incredibly forgiving learning environment in which students can ask questions or admit they don’t understand. This helps students move beyond their comfort zones and learn to handle situations they first feared. Jordan says this includes learning the “warm fuzzy characteristics” of good communication that are modeled and nurtured.

If you want to change something, get involved

Phillips says we are at a crucial point in healthcare. Literacy and language differences are at the doorstep and healthcare professionals can no longer “push back” about dealing with them. Providers should not wait for someone else to act, says Phillips. “We are privileged as doctors and with that privilege comes responsibility.”

Booth, Jordan, and Phillips all speak with pride of their medical school and literacy program partnership. Booth says this partnership helps “everyone learn from everyone else.” Together, they consider literacy in a holistic way that affects all aspects of communication. Booth acknowledges that health literacy is the “crown jewel” of this partnership. So far, health literacy is the easiest for them to work with. Now their partnership is looking at issues of literacy and the law.



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MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights and Responsibilities are kept updated on Gateway's website at www.gatewayhealthplan.com. They can be accessed by choosing the Medicaid tab, then the Members tab and choosing Rights and Responsibilities on the right-hand side. They are also available on the Gateway website in the Provider Manual. To request a paper copy of this document, please call the Quality Improvement Department at 412-255-1144.



THIRD PARTY LIABILITY SUGGESTIONS FOR FILING CLAIMS

In order to help us complete our TPL claim process as expeditiously as possible, make sure the following information is complete:

- Policyholder or subscriber name
- Complete member ID# (with complete alpha prefix or suffix) or Social Security #
- Group number (if available)
- Primary carrier name
- Provider of service telephone number



What Gateway Health Plan® Does with Member Information

Gateway Health Plan® is committed to maintaining the privacy and security of Member health information!

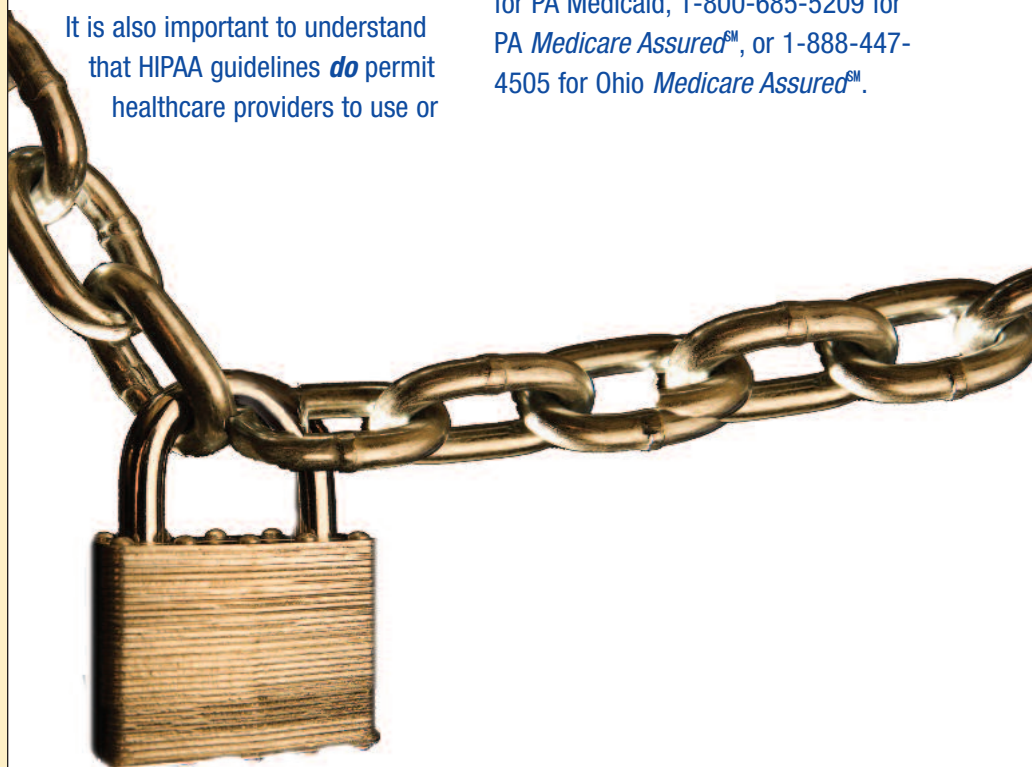
While Member information must be made available to healthcare professionals to enable proper care, timely payment and reimbursement, employees follow strict guidelines to avoid disclosing more Member information than is needed to perform treatment, payment and other Gateway operations.

Gateway seeks to assure that the appropriate procedures are taken to disclose only the minimum amount of Protected Health Information (PHI) necessary to accomplish a particular purpose as required under the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, specifically 45 CFR 160, 164.

It is also important to understand that HIPAA guidelines **do** permit healthcare providers to use or

give out member medical information in some instances without the need for written authorization from the Member. One example is for public health activities, such as reporting disease outbreaks. Another example permits Gateway to use or give medical information for government healthcare oversight activities (such as fraud investigations) or for judicial and administrative proceedings (such as a court order).

To learn more about how Gateway uses or discloses Member information, please visit us on-line at www.gatewayhealthplan.com to view the "Notice of Privacy Practices". To request a paper copy, please call Member Services at 1-800-392-1147 for PA Medicaid, 1-800-685-5209 for PA Medicare AssuredSM, or 1-888-447-4505 for Ohio Medicare AssuredSM.





CONGRATULATIONS TO THE WINNERS OF THE 2ND QUARTER 2008 PRIMARY CARE OFFICE MANAGER INCENTIVE PROGRAM! THE WINNERS ARE AS FOLLOWS:

- Vincent F. Petraglia, D.O., P.C.
- United Physicians, Inc.
- Children's Health Care West
- West View Family Health Associates
- Tri-State Pediatric Associates
- Norlanco Medical Associates

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 3rd Quarter will be announced in the next issue of the *Gateway Review*. Good Luck!



Referral Reminder

Gateway offers two ways for our participating PCP and Ob/Gyn practices to issue Referrals to a specialist or hospital for our members; DIVA (Digital Voice Assistant) and Paper Referrals.

DIVA is paperless, available 24 hours a day, 7 days a week and is fully automated. DIVA is used by PCP's and Ob/Gyn's to issue **REAL TIME** referrals as well as to verify member eligibility. Specialist and Hospitals can verify the existence of a referral and eligibility. If you would like more information or would like to schedule a demonstration please contact Provider Services at 1-800-392-1145 or your Provider Relations Representative.

Paper Referrals must be mailed within two days to avoid claim delays. Routine referrals allow 3 visits in 90 days, Allergy/Pain Management 9 visits in 90 days, Chemotherapy/Radiation Therapy/ Dialysis 90 visits in 90 days, Plain film X-Rays do not require a referral.

Mail Paper Referrals to:

Gateway Health Plan®
Claims Processing
P.O. Box 11-718
Albany, NY 12211-0718



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

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MEDICAID ONLY



MEDICAID & MEDICARE



MEDICARE ONLY



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