



GATEWAY Review

A PROVIDER NEWSLETTER PUBLISHED BY GATEWAY HEALTH PLAN®

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DECEMBER 2008

ISSUE 63



GATEWAY TO PHYSICIAN EXCELLENCESM (GPESM) REPORT CARDS DELIVERED

The GPESM Program is designed to recognize and reward primary care practices committed to providing quality healthcare that is accessible and efficient.

Throughout this past year, Medical Directors and Provider Relations Representatives visited numerous primary care practices and held Town Hall meetings across the state to introduce the GPESM program and explain how to optimize performance on its 14 quality indicators.

Beginning in October and running through the end of 2008, Medical Directors and Provider Relations Representatives again visited practices. This time GPESM Report Card results were reviewed and awards delivered.

Report card reviews will celebrate practices' quality performance and solutions to areas of low performance that can be implemented for future success will be discussed. A particular focus will be on practices whose encounter submission per member fell below their peers. In those situations, practices' scores suffered from under-

reporting their quality activities.

If your practice participates in the GPESM program and would like to discuss the program or your results with one of our Medical Directors, please contact your Provider Relations Representative.



Overview of 2008 CAHPS[®] (Member Satisfaction) Survey

Gateway Health Plan[®] (Gateway) contracted The Myers Group, a NCQA certified vendor, for the 2008 CAHPS Member Satisfaction Survey. The process utilized was the NCQA defined methodology, which included attempting to contact the members by mail and then by phone. In 2008, both the Adult and Child members were included in the surveys.

Adult survey results revealed some decreases in the composite scores rating the "Health Plan", but these were not identified as significant compared to our 2007 scores. The composite summary scores for "Health Care received" also revealed decreases, not significant in comparison to the 2007 scores.

For all of the "Effectiveness of Care" measures, scores were higher than 2007. Once again, none of these increases were significant.

The Child survey is only done every other year. This year's results revealed a

decrease in the "Rating of the Health Plan" composite, which also showed a significant decrease from 2006. There were also decreases in two of the remaining composite questions which resulted in a significant difference from the 2006 scores.

Through the work of Gateway's CAHPS[®] task force, specialized work groups, individual department efforts and collaboration with delegates, Gateway will continue to improve the level of member satisfaction with the care received and with Gateway Health Plan[®].



FLU VACCINE

Gateway Health Plan® and Vaccines for Children (VFC) both follow the Center for Disease Center (CDC) approved guidelines for Pediatrics in the administration of the flu vaccine, which include high risk children and children the ages of 6-23 months. The administration fee is included in the reimbursement for the vaccine.

The following codes are reimbursed by Gateway Health Plan® for the flu vaccine 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 pay an administration fee for both doses.

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





WINNERS OF THE PRACTITIONER SATISFACTION SURVEY DRAWING

Congratulations to the winners of the 2008 Practitioner Satisfaction Survey Drawing.

The winners returned their surveys to the Myers Group, an independent survey vendor, by the date specified and qualified for the random drawing. All surveys were blinded, therefore Gateway received no specific results. Winners were chosen from both the Medicaid and *Medicare Assured*[®] provider network.

Medicaid

Phillip J. States, M.D.
The Family Care Associates of New Castle, P.C.
Chi-Ebandjieff/Park Hill
Paul D. Dalbey, DPM
Pediatric Ophthalmology and Strabismus, Inc.
Jacques L. Surer, Jr., D.O. PC

Medicare Assured[®]

Cove Surgical Assoc., LTD
Surgical Specialists of Lancaster, P.C.
Ankle and Foot Care, Inc.
Desai Medical Assoc., Inc.
Cocoa Family Medicine
Walter L. Aument Family Health Center/PCP

The winners received a Harry & David Gift Basket for their staff. Gateway appreciates your response to the survey and will work to improve our processes and policies to better serve your needs!

You can view the 2007 results of the Practitioner and Provider Satisfaction survey on the Gateway website at www.gatewayhealthplan.com. Results of the 2008 Practitioner and Provider Satisfaction will be available soon.



DIVA USAGE

Gateway's Digital Voice Assistant (DIVA) is our automated voice activated telephone eligibility and referral system; which is available 24 hours a day/7 days a week. DIVA may be used by Primary Care Practitioners and OB/GYNs to issue a referral in real time for your Pennsylvania Medicaid patients, and by specialty care practitioners and hospitals to verify and review a referral. DIVA is also

available to verify eligibility for both Pennsylvania Medicaid and *Medicare Assured*[®] members. To use the system simply call 1-800-642-3515 and follow the prompts or use the guide included in the Medicaid and *Medicare Assured*[®] Gateway At A Glance for providers. Practices are strongly encouraged to use the simple to use DIVA system!



Gateway Health Plan® is pleased to announce the addition of a second clearinghouse for electronic claims submissions through RelayHealth.



Providers interested in submitting claims through RelayHealth should call 1-800-545-2488. (Please note this phone number is correct as of Oct 2008).

The following CPID (Clearinghouse Process ID) and Payer ID numbers for submission of professional or institutional electronic claims for Gateway Health Plan® to RelayHealth are identified below.

CPID	PAYER NAME	PAYER ID	CLAIM TYPE
8472	Gateway Health Plan® - Medicaid PA	25169	Professional
4569	Gateway Health Plan® - Medicaid PA	25169	Institutional
2298	Gateway Health Plan® - PA Medicare Assured®	60550	Professional
2912	Gateway Health Plan® - PA Medicare Assured®	60550	Institutional
4741	Gateway Health Plan® - Medicare Assured® of Ohio, Inc.	91741	Professional
5905	Gateway Health Plan® - Medicare Assured® of Ohio, Inc.	91741	Institutional

To ensure that claims have been accepted via EDI, practitioners should receive and review the following reports from RelayHealth on a daily basis:

- Claims Acknowledgement Report (CPI 651.01)
- Exclusion Claim Report (CPI 652.01)
- Claims Status Reject Report (CPA 425.02)

Providers now have the option of using Relay Health or Emdeon for their EDI submissions.

Change to the Medicaid UM 800 line

In order to better service our providers, the UM department has made menu changes to the Medicaid 800 line effective October 1, 2008. These changes include options to reach someone in Pharmacy, Provider Services and Medicare Assured®.



AFFIRMATIVE STATEMENT ABOUT INCENTIVES

Gateway's UM 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 UM 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.



UTILIZATION MANAGEMENT CONTACT

Monday through Friday 8:30 AM to 4:30 PM (Voicemail during off hours. The call will be returned the next business day.) Please call 1-800-392-1146.

If the request is urgent and it is during non-business hours, do not leave a message, you will be directed to call another phone number. A Gateway staff person will answer your call and the urgency will be triaged.



GUIDELINES ON GATEWAY'S WEBSITE

Gateway Health Plan's® (Gateway) Clinical and Preventive Care Guidelines can be viewed by accessing Gateway's website, www.gatewayhealthplan.com. Those guidelines included are:

- ▶ Adult with HIV
- ▶ Adult Preventive Care
- ▶ Asthma
- ▶ Cardiac Medical Management
- ▶ Child Preventive Care
- ▶ Diabetes 2007 ADA
- ▶ Hypertension
- ▶ Lead Screening
- ▶ Prenatal Care
- ▶ PCPs Treating Depression

To view these guidelines, select Providers, choose the plan and Clinical Guidelines. Gateway's Medical Record Review standards for PCPs and Specialists are also located on this same screen. There is also a section called Helpful Forms and Other Information. You can request a hard copy of any of these items by calling the Quality Improvement Department at (412) 255-1144.



PROVIDER APPEALS

When taking advantage of Gateway's formal provider appeal process, to assure timely handling of your appeal, the Appeal Coordinators ask that you mail your written request to the following address:

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





HIGH VOLUME SPECIALIST MEDICAL RECORD REVIEWS

GATEWAY'S QUALITY IMPROVEMENT DEPARTMENT CONDUCTS A MEDICAL RECORD REVIEW OF HIGH VOLUME SPECIALISTS EVERY TWO YEARS.

The high volume specialties selected for medical record review this year were Cardiology, General Surgery, Gastroenterology, Ophthalmology, Otolaryngology and Obstetrics/Gynecology. The overall scores exceeded Gateway's standard of 85% with 97.8% for the general specialists and 95.7% for OB/Gyns. Both of these scores were lower than those in 2006.

Although the overall scores were good, of the 20 standards reviewed, some individual indicators did not meet the performance standard, also 85%. Ophthalmology and Otolaryngology did not meet the standard for the indicators for notation of use or non-use of tobacco, alcohol and drugs in members 14 years and older. The only other deficiency noted was for continuity and coordination of care by Ophthalmology, General Surgery and OB/Gyn practices. This is measured by documentation of a report or other communication to the Primary Care Physician of the specialist's findings.

Gateway would like to remind our physicians of the importance of documenting use or non-use of tobacco, alcohol and drugs in the medical record for those ages 14 and older. To assist with coordination of care between physicians, communication of findings should be sent to the member's PCP. Since our Medicaid members may self refer to an OB/Gyn office for routine services, a referral form may not be available to identify the PCP. Our Medicare members may also self-refer to specialists. Gateway member identification cards indicate the member's PCP so may be used to verify this information. Two forms are available to assist in the communication of findings to the PCP. They can be accessed on our website, www.gatewayhealthplan.com, by clicking on Providers, the plan and Clinical Guidelines. Both the Report of GYN Visit Back to PCP form and the Physician Communication Form can be found under Helpful Forms and Other Information. The Medical Record Standards are also available on this same screen. If assistance is needed in obtaining the name or address of the current PCP, contact Gateway's Provider Services Department at 1-800-392-1145.



NATIONAL IMAGING ASSOCIATES- RADIOLOGY AUTHORIZATIONS

Gateway delegates the service of authorizing the following radiology procedures to National Imaging Associates (NIA):

- MRI/MRA • CT Scans • Bone Densitometry • Nuclear Cardiology • PET Scans

To obtain authorizations for these services please contact NIA at 1-888-879-5922 Monday through Friday between the hours of 8:00 AM and 8:00 PM.

Gateway practitioners and providers can also receive up-to-the hour information on a member's authorization, including date called, date approved, exam category, valid billing codes and much more by visiting NIA's website, www.radmd.com. An account with a password will need to be established on the first visit, otherwise, receiving this information is as easy as logging in.





OFFICE MANAGER INCENTIVE PROGRAM WINNERS

Congratulations to the winners of the 3rd Quarter 2008 Primary Care Office Manager Incentive Program! The winners are as follows:

- Agustin Pediatrics
- Creighton Medical Center
- Hamilton Health Center Fam. Prac./Int. Med.
- Saltsburg Family Health Center
- Shadyside Family Health Center
- Twin Rose Primary Health Care

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 4th Quarter will be announced in the next issue of the Gateway Review. Good Luck!



Member Rights & Responsibilities

All Gateway Health Plan® (Gateway) members, whether with our Medicaid or Medicare Assured® plan, have certain “rights” concerning their care and treatment. They also have specific responsibilities as Gateway members.

Medicaid members can find their Member Rights and Responsibilities in their Member Handbook. Medicare Assured® members can find theirs in their Evidence of Coverage booklet. Both can be viewed on Gateway’s website at www.gatewayhealthplan.com by clicking on Current Members and their plan name. Medicaid members should then click on Rights and Responsibilities at the bottom of the list on the right. Medicare Assured® members should click on Evidence of Coverage in the list and look in the index for the page number. Offices may also access these documents and print them out for posting.



DELIVERING A VALID NOTICE OF MEDICARE NON-COVERAGE (NOMNC) TO AN AUTHORIZED REPRESENTATIVE

Do you represent a skilled nursing, home health or comprehensive outpatient rehabilitation facility (CORF) provider? If so, the following instructions are an excerpt of the CMS-10095 Instructions, which are available on the CMS website at <http://www.cms.hhs.gov/MMCAG/>.

A NOMNC must be validly delivered at least two days prior to the end of the needed care, which also means that the patient must be able to understand the purpose and contents of the notice in order to sign for receipt of it. The patient must be able to understand that he/she may appeal the termination decision, and valid delivery does not preclude the use of assistance devices, witnesses or interpreters during notice delivery. If the patient refuses to sign the notice, the notice is still valid as long as the provider documents that the notice was given, but the patient refused to sign.

Some providers experience difficulty with compliance when the patient is not competent to sign the NOMNC, or has authorized an individual to act on his/her behalf. CMS requires that procedures are developed to use when the patient is incompetent or incapable of receiving the

notice. Valid delivery to an authorized representative includes the following:

- Telephone the authorized representative to notify of the date that services are no longer covered.
- Explain the appeal rights, including the name and phone number of the QIO.
- The conversation date is considered the date of the notice receipt. However, it is important to confirm the telephone contact by written notice mailed on the same date.
- Place a dated copy of the notice in the patient's medical file and document the telephone call to include: name of person making the call, name of the patient's representative contacted, date and time of the call and the phone number called.
- When notices are refused or returned by the post office with no indication of a refusal date, the patient's liability starts on the second working day after the mailing date.

Keep a copy in your records and FAX a copy of all signed NOMNC forms to 1-800-685-5231. Failure to fax Gateway a copy of the signed NOMNC may result in your claim being denied. If you have questions regarding how to complete a NOMNC, call Gateway. If you are calling for a Pennsylvania Medicare Assured® member, please call 1-800-685-5207. If calling regarding an Ohio Medicare Assured® member, please dial 1-888-447-4375.



PCP Medication Fax Approval

In order to comply with requirements of the Health Choices Contract, and to increase coordination of care between physicians caring for Gateway members, we have begun to notify PCPs, via fax, of approvals of medications requested by other physicians. As of Monday, 12/15/08, we began notifying PCPs, via fax, of denials of medications requested by other physicians.

Our goals for the implementation of this process are two-fold. We wish to free up physician office staff from having to take telephone messages from Gateway, and we want to provide hard copy documentation that is member specific and can be placed on the patient chart.



REFERRAL REMINDER

When a PCP determines that a patient requires medical services or treatment outside of the PCP office a referral must be issued. Practices may complete a paper referral form or issue a referral through DIVA when a patient is directed to a specialty care practitioner and for services performed in a hospital setting. To determine which services require a referral or UM authorization, please refer to Gateway's Quick Reference Guide for Referral vs. Authorizations in the Gateway At A Glance for providers.



Change to UM Process for Voice Mail Messages

Based on feedback received from the provider community, as of 10/1/2008 nurses in the UM department are able to accept clinical information via voicemail. If you are calling a nurse in the department with an inpatient review or information related to a specific request, you may leave the clinical information on the voice mail of the nurse you are working with to obtain approval. The nurse will call you back if additional information is needed and you will be notified of the outcome of your request. This change applies to both Medicaid and Medicare Assured® lines of business.



ENVIRONMENTAL ASSESSMENT STANDARDS FOR GATEWAY OFFICE SITES

Gateway has established specific guidelines for evaluating both the external and internal aspects of a practitioner's office. This Environmental Assessment (EA) of the office is conducted as part of the initial credentialing process for all Primary Care Practitioners, Dental and high volume Behavioral Health office sites.

The standards reviewed address the following areas:

- Physical Accessibility
- Physical Appearance
- Adequacy of waiting and examining room space
- Availability of Appointments
- Adequacy of treatment record keeping

The following performance standards have been established:

- 80% compliance for site visit standards
- 80% compliance for medical record keeping standards

Any office found to have deficiencies will be required to develop an action plan and bring the office into compliance within 90 days. A Provider Relations Representative will re-review the office to assure ongoing compliance with the standards has been obtained. Gateway also reviews member complaints on a monthly basis to determine if there are issues with the practice site regarding EA standards. If deficiencies are noted the Provider Relations Representative will schedule another site visit to bring the office back into compliance. The same process is followed when a QI Nurse notifies Provider Relations of an office deficiency.

If you have any questions regarding the EA Standards or site visit process, please contact your Provider Relations Representative. A copy of Gateway's EA Standards is also available on Gateway's website at www.gatewayhealthplan.com.



In 2009 the following standards are relevant to all **Pennsylvania Medicaid primary care practitioners:**

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 thirty (30) minutes or up to one (1) hour when the MD encounters an unanticipated urgent visit or is treating a member with a difficult need.

In 2009 the following standards are relevant to all **Pennsylvania Medicaid specialty care practitioners:**

Requirement	Standard
Wait Time for Emergent Appointment	Immediately from the date of referral
Wait time for an Urgent Care Appointment	Within twenty-four (24) hours from the date of referral
Wait time for Asymptomatic Regular/Routine Appointment <i>except for the following specialties: Dermatology, Dentist, Orthopedic Surgery, Otolaryngology, Pediatric Allergy & Immunology, Pediatric Endocrinology, Pediatric Gastroenterology, Pediatric General Surgery, Pediatric Hematology, Pediatric Infectious Disease, Pediatric Nephrology, Pediatric Neurology, Pediatric Oncology, Pediatric Pulmonology, Pediatric Rehab Medicine, Pediatric Rheumatology, Pediatric Urology</i>	Within ten (10) business days from the date of referral
Wait time for Asymptomatic Regular/Routine Appointment <i>for the following specialties: Dermatology, Dentist, Orthopedic Surgery, Otolaryngology, Pediatric Allergy & Immunology, Pediatric Endocrinology, Pediatric Gastroenterology, Pediatric General Surgery, Pediatric Hematology, Pediatric Infectious Disease, Pediatric Nephrology, Pediatric Neurology, Pediatric Oncology, Pediatric Pulmonology, Pediatric Rehab Medicine, Pediatric Rheumatology, Pediatric Urology</i>	Within fifteen (15) business days from the date of referral
Waiting Time in the Waiting Room	No more than thirty (30) minutes or up to one (1) hour when the MD encounters an unanticipated urgent visit or is treating a member with a difficult need.

In 2007 & 2008, Gateway assessed compliance with the Primary Care Practitioner and Specialty Care Practitioner Accessibility Standards, which were in place at that time, via review of member complaints, results of the CAHPS Member Satisfaction Survey, and the *Provider Satisfaction Survey. Gateway has developed action plans to help improve these rates. Waiting times have increased to 30 minutes in 2009.

MEDICAID PRIMARY CARE PRACTITIONER RESULTS

Standard		2007 Rate	2008 Rate	Current Goal
Wait time for an Emergent Appointment	Immediately, and not inappropriately referred to the ER	54.0%*	39.3%	80%
Wait time for Urgent Appointment	Within 24 hours	91.0%*	57.6%	80%
Wait time for Routine Appointments	Within 10 business days	80.0%	79.2%	80%
Wait time for a Preventive Care	Within 3 weeks of Enrollment	Data not yet available	Data not yet available	80%
After-hours Accessibility	Access to a practitioner 24 hrs/7 days a week	66.7%	59.8%	80%
Waiting Time in the Waiting Room	No more than fifteen (15) minutes or up to one (1) hour when the MD encounters an unanticipated urgent visit or is treating a member with a difficult need.	48.6%*	57.2%	80%

MEDICAID SPECIALTY CARE PRACTITIONER RESULTS

Standard		2007 Rate	2008 Rate	Current Goal
Wait time for an Emergent Appointment	Immediately, and not inappropriately referred to the ER	65.1%	67.9%	80%
Wait time for Urgent Appointment	Within 24 hours	65.1%	67.9%	80%
Wait time for Routine Appointments	Within 10 business days	69.9%	71.2%	80%
Waiting Time in the Waiting Room	No more than fifteen (15) minutes or up to one (1) hour when the MD encounters an unanticipated urgent visit or is treating a member with a difficult need.	66.1%	71.5%	80%

If you would like additional information regarding this study or actions to be taken, please contact Gateway's Provider Services Department at 1-800-392-1145.



In 2009 the following standards are relevant to all *Medicare Assured*® primary care practitioners:

Requirement	Standard
Wait time for Urgent, but Non-Emergent Care Appointment	Within 24 hours
Wait time for Non-Urgent Care, but in need of Attention Appointments	Within 1 week
Wait time for a Routine or Preventive Care Appointment	Within 30 days
After Hours Care Accessibility	Access to a practitioner 24 hrs/7 days a week
Waiting Time in the Waiting Room	No more than thirty (30) minutes or up to one (1) hour when the MD encounters an unanticipated urgent visit or is treating a member with a difficult need.

In 2009 the following standards are relevant to all *Medicare Assured*® specialty care practitioners:

Requirement	Standard
Wait time for an Urgent, but Non-Emergent Care Appointment	Within twenty-four (24) hours from the date of referral
Wait time for a Non-Urgent, but in need of Attention Appointment	Within 1 week from the date of referral
Wait time for a Routine Care Appointment	Within 30 days from the date of referral
Waiting Time in the Waiting Room	No more than thirty (30) minutes or up to one (1) hour when the MD encounters an unanticipated urgent visit or is treating a member with a difficult need.

In 2007 & 2008, Gateway assessed compliance with the *Medicare Assured*® Primary Care Practitioner and Specialty Care Practitioner Accessibility Standards via review of member complaints and a Provider Appointment Availability and After Hours Survey. Waiting times have increased to 30 minutes in 2009.

MEDICARE ASSURED® PRIMARY CARE PRACTITIONER RESULTS

Standard		2007 Rate	2008 Rate	2009 Goal
Wait time for Urgent, but Non-Emergent Care Appointment (Secret Shopper)	Within 24 hours	61.1%	91.6%	92%-M
Wait time for Urgent, but Non-Emergent Care Appointment	Within 24 hours	92.2%	87.7%	92%-M
Wait time for Non-Urgent Care, but in need of Attention Appointments	Within 1 week	98.7%	97.6%	Maintain
Wait time for a Routine or Preventive Care Appointment	Within 30 days	94.4%	97.2%	Maintain
After Hours Care Accessibility	Access to a practitioner 24 hrs/7 days a week			
• After Hours Access to a practitioner when reached a live person		89.2%	82.6%	86.7%
• After Hours Access to a practitioner when reached a recording		78.9%	59.5%	80%
• After Hours Access to a practitioner when reached an Auto Attendant		83.3%	100%	Maintain
• No After Hours Access		7.9%	4.0%	0%

MEDICARE ASSURED® SPECIALTY CARE PRACTITIONER RESULTS

Standard		2007 Rate	2008 Rate	2009 Goal
Wait time for an Urgent, but Non-Emergent Care Appointment (Secret Shopper)	Within twenty-four (24) hours from the date of referral	31.3%	72.6%	80%
Wait time for an Urgent, but Non-Emergent Care Appointment	Within twenty-four (24) hours from the date of referral	85.1%	62.9%	80%
Wait time for a Non-Urgent, but in need of Attention Appointment	Within 1 week from the date of referral	85.5%	82.8%	86.9%
Wait time for a Routine Care Appointment	Within 30 days from the date of referral	89.8%	92.9%	Maintain

If you would like additional information regarding this study or actions to be taken, please contact Gateway's Provider Services Department at 1-800-685-5205.



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 & MEDICARE



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