



GATEWAY Review

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PRIMARY CARE PRACTICE DASHBOARD: STREAMLINING CLINICAL COMMUNICATIONS AND PROMOTING QUALITY

Gateway's mission promotes quality, access and efficiency in the delivery of care to our members. We believe our unique Prospective Care Management (PCM®) approach helps reconnect members to doctors, reduce racial and ethnic disparities and improve member and practitioner experiences.

We strive to regularly provide practitioners with actionable data and our Medical Directors engage them in relevant clinical discussions to help move practice performance and close potential gaps in care. And though we are enthusiastic about these efforts, we recognize that in too large a dose, they can become burdensome. So with input from our network practitioners in primary care, here's what we have come up with.

Primary care physicians and their practice staff are challenged with handling and processing mountains of clinical mail from a myriad of sources. In response, we are making efforts to reduce the number of individual clinical mailings we send by consolidating that information into a compact, easily understandable **Primary Care Practice Dashboard Report**.

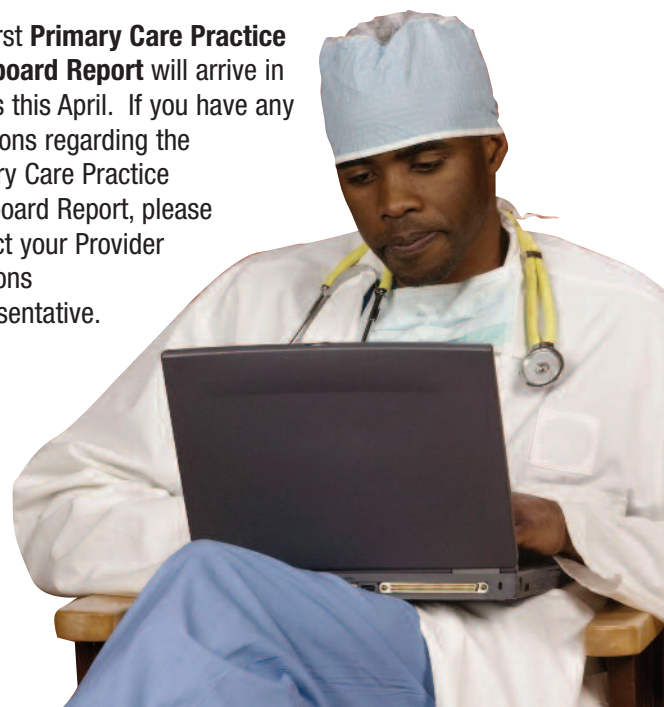
Primary Care Practice Dashboard Reports are delivered quarterly (January, April, July, October) and contain data on Gateway Health Plan® members in your practice who are due for or missing chronic care and preventive services. Data includes member contact information, self-disclosed racial and ethnic information, preventive care (e.g., EPSDTs, mammography, etc.) and chronic care (e.g., diabetic testing, gaps in pharmacy fills for hypertension and asthma controllers, etc.) services for which we have no "Medical" or "Physician Office" claim or encounter submission.

Information in the **Primary Care Practice Dashboard Report** is compiled from claims data. The dashboard highlights members for whom claims data does not show the presence of a recommended test or treatment. This doesn't necessarily mean that the test or treatment has not been done; it indicates that Gateway has not received a claim or encounter submission indicating the service was performed.

Information in the Dashboard is intended to be a practice tool that supports evidence-based care, not as a "report card." It does not, nor is it intended to, replace your professional clinical judgment as a patient's treating physician. It is not used to determine practice reimbursement and is not connected to the Gateway to Physician Excellence™ (GPE™) program. However, using this tool may promote care opportunities in your practice that, when addressed, may positively impact your performance on individual GPE™ indicators and associated annual payments.

While we provide this information to assist you, remember that our Care Management staff is simultaneously reaching out to members through our Prospective Care Management model of care. PCM® is designed to engage and help members follow preventive care and chronic care treatment recommendations and remain connected to their doctors.

The first **Primary Care Practice Dashboard Report** will arrive in offices this April. If you have any questions regarding the Primary Care Practice Dashboard Report, please contact your Provider Relations Representative.





MEDICAL RECORD REVIEWS

A medical record review of PCP charts is performed every two years, utilizing standards approved by the QI/UM Committee. For 2008, the overall PCP score for the 434 offices reviewed was 96.2%, with Family Medicine (FM) offices scoring 95.7%, Internal Medicine (IM) scoring 94.5% and Pediatrics with a rate of 98.5%. The areas not meeting a score of 85% for PCPs included:

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.

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.



2009 Gateway Provider Policy and Procedure Manual CD Coming Soon!

You may have already received or will soon receive a CD with our most current Gateway Health Plan® and Medicare Assured® Policy and Procedure Manuals. Your Gateway CD also includes electronic copies of important reference material as well as our QI Manuals. In addition to the CD, your practice will also receive Gateway at a Glance's for both our Gateway Medicaid and Medicare plans.





DISCUSS YOUR PATIENT'S WISHES ANNUALLY

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 serve as a repository for patient-specific information. Documenting whether a patient has an advance directive and if they do, housing a copy within the medical record are two important uses of that repository. 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. It is also important to address this issue every year in case the person has made changes to an existing document or decided that they need one.

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, this is the age group known for risky behaviors, often resulting in accidents, etc. They may not be able to verbalize their wishes at that time.

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, the plan, Forms and then #10. A form is also in the packet provided to FM and IM offices at the time of medical record review.

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



PROVIDER APPEALS

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

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



ATTENTION PRIMARY CARE PHYSICIANS

If not already performing HbA1c in your office, please contact your medical supplier to obtain the test. Gateway will reimburse all Primary Care Practices on a fee for service basis based on the practices contracted rates.

Please bill with the following codes:

	Procedure Code
Gateway Health Plan® Medicaid	83036
Gateway Health Plan Medicare Assured SM	83037



PRACTICE STANDARDS FOR CUSTOMER SERVICE

Fostering patient satisfaction encompasses more than the medical services provided. To understand the customer service message your practice is sending, consider the message your practice sends from the initial phone conversation to the waiting room experience, the visit and the coordination of follow-up care.

Have you established practice service standards for your office staff? Susan Baker, a practice management consultant suggests that physicians sit down with the entire office and define the practice's service standards.

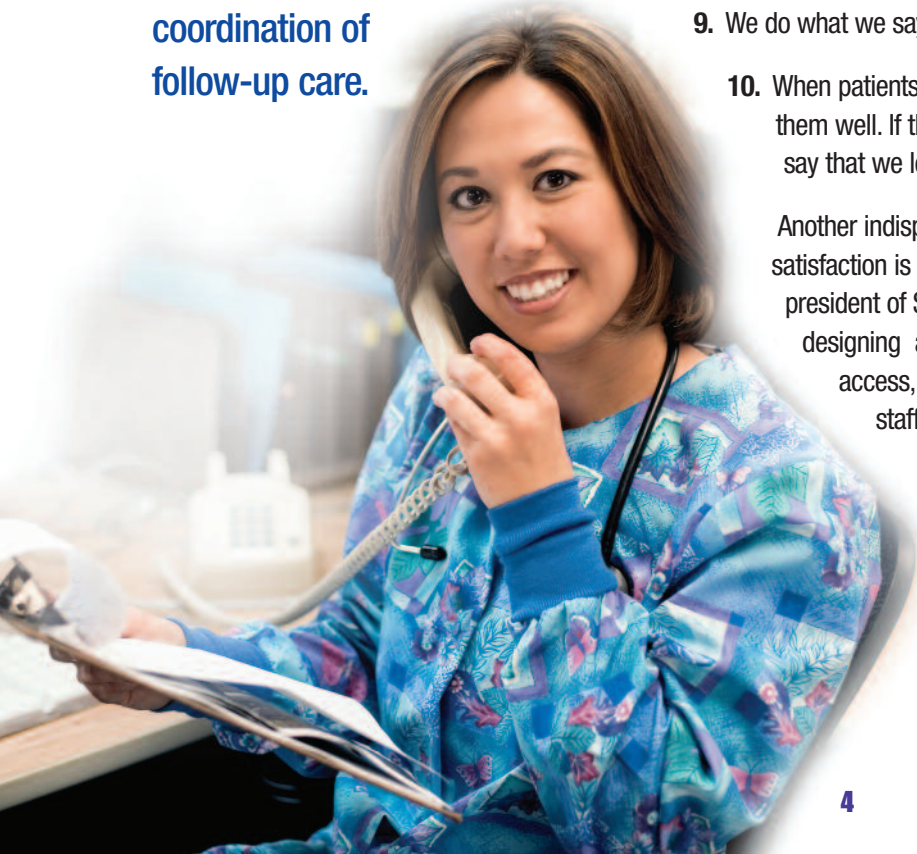
In her article "Improving Service and Increasing Patient Satisfaction", Susan Baker recommends the following standards for a physician practice. These standards were designed to improve interaction with patients and increase patient satisfaction.

1. We are the first to say hello when patients arrive.
2. We answer telephone calls in three rings with a consistent greeting.
3. We use the patient's name at least once during each conversation.
4. We take a moment to observe the patient's communication style and respond in a manner that will make the patient feel comfortable.
5. We explain to patients what is going to happen next.
6. We listen to patients without interrupting them.
7. We watch for verbal and nonverbal signs that indicate that the patient is not satisfied or is concerned about something. We are proactive in identifying and responding to problems.
8. We respect patient confidentiality at all times. We do not divulge who our patients are, even to members of our own families.
9. We do what we say we will do, when we say we will do it.
10. When patients are leaving, we say good-bye warmly and wish them well. If they have scheduled a follow-up appointment, we say that we look forward to seeing them again.¹

Another indispensable tool for evaluating customer service satisfaction is a patient satisfaction survey. Mary Shaub, the president of Shaub Medical Consultants in Philadelphia suggests designing a survey that captures such information as access, communication, and feedback on the doctor and staff performance.²

¹ Baker, Susan K. "Improving Service and Increasing Patient Satisfaction." *Family Practice Management* July/August 1998 <<http://www.aaafp.org/fpm/980700fm/keane.html>>.

² Shaub, Mary A. "Customer service for building your practice." *Physician's News Digest* November 2002 <<http://www.physiciansnews.com/business/1102shaubdv.html>>





TIMELY FILING



There are day limitations on initial claim filing and follow-up inquiries on processed claims for Medicaid and Medicare claim submissions. There is no appeal process for timely filing.

MEDICAID

- Initial Claim Filing / 180 days from date of service
- Follow Up Inquiries or Submissions / 120 days from process date of initial submission
- If Gateway is secondary payor; you have 60 days from process date on primary carrier EOB to make initial submission or submit corrected claim when initial was denied for primary EOB (D11)

MEDICARE

- Initial Claim Filing / 365 days from date of service
- Follow Up Inquiries or Submissions / 120 days from process date of initial submission
- If Gateway is secondary payor; you have 365 days from process date on primary carrier EOB to make initial submission or submit corrected claim when initial was denied for primary EOB (D11)



PATIENT AUTHORIZATION- HIPAA

by Bridget Morgan, BSBA, Compliance Specialist

Gateway Health Plan® takes great pride in protecting the privacy and security of member health information! Although member information must be made available to healthcare professionals to enable proper care, timely payment and reimbursement, Gateway employees follow strict guidelines to avoid disclosing more information than is needed.

Gateway takes its duty to disclose only the “minimum necessary amount of information” very seriously. Appropriate procedures are taken to disclose only the minimum amount of Protected Health Information (PHI) necessary according to the HIPAA Privacy Rules (45 CFR 160, 164.) By way of example, Gateway employees authenticate callers to determine if the caller is authorized or entitled to receive information.

In certain circumstances, HIPAA guidelines permit healthcare providers to use or give out member medical information without the need for written authorization from the member. One example is for public health activities, such as reporting disease outbreaks, and another 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).

There are other situations where Gateway cannot release information without the member’s authorization (consent).

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



SUBMITTING CLAIMS

Please do not “overstuff” envelopes or tape claims to the inside of the envelope as this causes the claims to be destroyed when opened. Please use the appropriate size envelope for the number of claims being submitted. Putting claims in an 8 1/2" by 11 1/2" envelope would prevent the information from being destroyed when opened and subsequently being returned or denied for illegible information.



2009 GATEWAY TO PHYSICIAN EXCELLENCESM PCP PAY-FOR-PERFORMANCE PROGRAM



As we embark on our second year of Gateway to Physician ExcellenceSM (GPESM) program, we wish to remind primary care physicians that we value the important role they 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.

This program supports Gateway's mission to deliver quality programs that positively impact the personal health of our members and supports the Governor's Prescription for Pennsylvania. It 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.

Thanks to you, the program was a success. It involved 313 primary care practices across Pennsylvania and over 1150 primary care physicians, providing care to 76% of Gateway's Medicaid membership. Gateway Medical Directors carried out 94 visits to Gateway to Physician ExcellenceSM practices and conducted seven regional Town Hall Meetings.

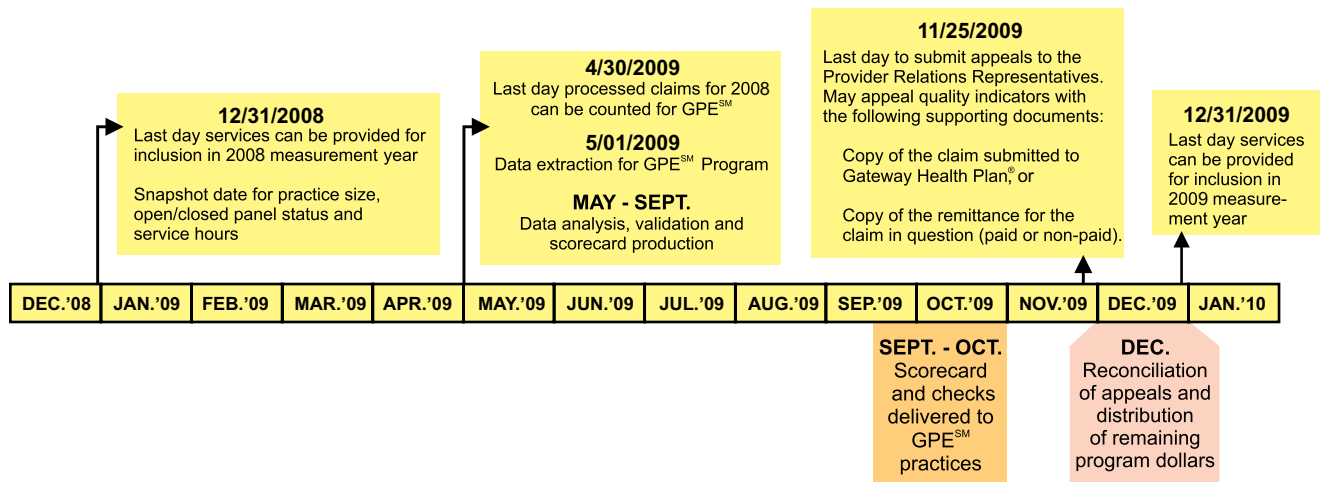
The program is designed to recognize and reward practice quality. In addition to financial awards, Gateway to Physician ExcellenceSM practice participation is noted in both the provider directory and the online provider search tool.

Based on our first year's experience, the 2009 program criteria and design will remain unchanged in order to establish a solid baseline for year to year comparison.

The timeline for the 2009 program is outlined below.

We are delighted with the interest in the program and look forward to engaging physician practices throughout 2009.

For more information or questions about the Gateway to Physician ExcellenceSM program, please visit our website at www.gatewayhealthplan.com/gpe or contact your Provider Relations Representative.





Generic Drug Substitution Required for Gateway Health Plan® Members



Physicians are requested to prescribe medications included in the formulary whenever medically appropriate. All drugs in the formulary are not necessarily covered by each patient's prescription drug coverage. Providers can contact Gateway's Pharmacy Department at 1-800-528-6738 with any questions related to a member's prescription coverage limitations.

Generic substitution is required when an equivalent generic drug is available. Generic drugs are subject to specific reimbursement levels, such as Maximum Allowable Cost (MAC) price reimbursements. Drugs that are available in generic form will appear in **bold** in the Gateway Health Plan® paper and on-line formulary. The **bold** font indicates that the generic drug product is on the formulary but the branded product is not. Requests for "Brand Necessary" medications will be considered a nonformulary medication request and will require authorization. The Gateway Health Plan® Request for Nonformulary Drug Coverage Form must be submitted with sufficient documentation to substantiate medical necessity of the Brand Name medication. Physicians are encouraged to prescribe generic medications whenever clinically appropriate.



OFFICE MANAGER INCENTIVE PROGRAM WINNERS

Congratulations to the winners of the 4th Quarter 2008 Primary Care Office Manager Incentive Program! The winners are as follows:

- Arshad Chughtai M.D.-Grp.
- Canonsburg Family Medicine Center
- Cornerstone Care/Ped. Assoc. of Washington
- Geisinger-Berwick Pediatrics
- Primary Health Network/New Castle
- Somerset Family Practice 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.

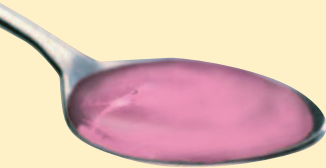
The winners received a plaque to display in their office and a gift basket. The winners of the 1st Quarter of 2009 will be announced in the next issue of the *Gateway Review*. Good Luck!



GATEWAY HEALTH PLAN® SPECIALTY PHARMACY PROGRAM



GATEWAY HEALTH PLAN® (GATEWAY) OFFERS A SPECIALTY PHARMACY PROGRAM FOR PROVIDERS TO OBTAIN SOME MEDICATIONS, INCLUDING INJECTABLE MEDICATIONS, FOR OUR PENNSYLVANIA MEDICAID MEMBERS. THIS PROGRAM ELIMINATES THE NEED FOR PROVIDERS TO PURCHASE AND STORE DRUGS IN THEIR OFFICES AND PREVENTS INCURRING ANY OUT-OF-POCKET EXPENSES.



On an on-going basis, Gateway identifies medications for inclusion

in the specialty pharmacy program utilizing an internal multi-disciplinary workgroup. This workgroup reviews clinical, safety, procedural and financial data related to new or existing products and makes recommendations for inclusion into the Specialty Pharmacy Program based upon these factors. Formulary medications already included in the Specialty Pharmacy Program are identified in the Gateway Health Plan® Medication Formulary with the notation "SPN". For a complete listing of formulary medications, please refer to the Gateway Health Plan® formulary book or the on-line formulary available at www.gatewayhealthplan.com.

The following is a listing of medications that will be added to the Specialty Pharmacy Program effective May 1, 2009. Please note that these medications may require prior authorization or the submission of a non-formulary exception request. *On May 1, 2009 these medications will no longer be reimbursed when provided in the physician office (POS 11).* Physicians who have earmarked supplies of these drugs for Gateway Health Plan® members should reduce their inventory in preparation for the conversion.

Drug Name	Description	JCode
Fusilev	Levoleucovorin calcium powder for solution	J0641
Doribax	Doripenem powder for solution	J1267
Emend	Fosaprepitant powder for solution	J1453
Privigen	Immune globulin (human) solution	J1459
DexFerrum	Iron dextran injection	J1750
InFeD	Iron dextran injection	
Iron Dextran Complex	Iron dextran injection	
Somatuline Depot	Lanreotide injection solution, extended-release	J1930
Keppra	Levetiracetam injection, solution, concentrate	J1953
Triesence	Triamcinolone acetonide injection, suspension, intravitreal	J3300
Alphanate	Antihemophilic factor VIII/Von Willebrand factor complex (human), per factor VIII	J7186
Treanda	Bendamustine powder for solution	J9033
Ixempra	Ixabepilone injection, powder for solution, concentrate	J9207
Torisel	Temsirolimus injection, solution, concentrate	J9330

If you have any questions or concerns about the process for requesting these medications or any other medications in the Specialty Pharmacy Program, please contact Gateway's Pharmacy Department at 1-800-528-6738 or our Provider Services Department at 1-800-392-1145.



DIABETES ON THE RISE

National trends undeniably show the rise in the prevalence of diabetes. Gateway Health Plan® (Gateway) is not immune and currently enrolls over 8000 Medicaid diabetic members. Governor Rendell's *Prescription for Pennsylvania* is committed to minimizing this growth throughout the state.

Disparities Exist Among Ethnic Groups

Among adults, diabetes increased disproportionately in the elderly and disparities exist among ethnic groups and minority populations¹. African Americans and Hispanics comprise Gateway's two most disparate groups.

Prescription for Pennsylvania

Gateway aligns its health care disparity initiatives with the *Prescription for Pennsylvania* in that all members will receive quality health care without regard to their gender, race, ethnicity, age, disability, mental status or language competency.

The HbA1c is the best single measurement available to clinicians to assess your overall diabetes control and the risk of complications of diabetes.

Studies have shown that, in general, every reduction in HbA1c level of 1% (e.g., from 8% to 7%) reduces the risk of developing microvascular complications by 35%.²

Gateway presents an opportunity for you to provide in office HbA1c tests for all Gateway diabetic patients.

A study published in *Clinical Diabetes* concluded that immediate feedback based on HbA1c results at the time of patient encounters resulted in a significant improvement of glycemic control at the 6-month follow-up and persisted for the 12-month study³. This test can be easily provided in your office, by a non-clinician. *This involves only a finger stick using a disposable kit.* Results are available in 5 minutes and are applicable to HEDIS.



In addition, all Primary Care Physician's will be paid a fee for performing this test in your office on ANY Gateway diabetic member. Please refer to page 3 for procedure codes.

What Gateway is Doing to Help our Diabetic Members

Gateway's Healthy Returns Diabetes Disease Management Program provides education and support to improve the diabetic members' quality of care, quality of life, and to reduce resource utilization. The primary approach provided by Health Management Corporation (HMC) entails education and supports interventions driven by a disease-specific health appraisal and assessment. In conjunction with the practitioner's plan of care, goals are set and progress monitored. The primary care practitioner and specialist are kept informed of the member's progress in the program by regular written reports.

All Gateway members with diabetes are automatically enrolled into the program and receive diabetic education through the mail and/or via the phone.

In addition to identification via claims data, members may self-refer, be referred by their practitioner, or are identified by Gateway care managers. The Program is offered to members of all ages. To initiate a referral to Healthy Returns Diabetes Program, call 1-866-366-9415.

¹ <http://www.omhrc.gov/templates/content.aspx?ID=2139>

² <http://www.ncoa.org/content.cfm?sectionID=109&detail=271>

³ *Clinical Diabetes* 24:6-8, 2006; © [American Diabetes Association](#)®, Inc., 2006; Clinical Use of Hemoglobin A_{1c} to Improve Diabetes Management; Alan M. Delamater, PhD, ABPP



Submitting Referrals

In order for a Referral to be entered properly into our system the following information must be present:

1. Correct and legible member name and identification number
2. Correct and legible provider name and matching Legacy identification number
3. Date referral being issued for

If the service requires a precertification, NIA or Adagio authorization, do not also submit a paper referral as these will only be returned to your office.



CMS COMPLIANCE ISSUE

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 Notice of Medicare Non-Coverage (NOMNC) CMS-10095-A Form Instructions, which are available on the CMS website at

www.cms.hhs.gov/BNI/09/MAEDNotices.asp#TopOfPage.

A NOMNC must be validly delivered at least two days prior to the end of care. The patient must be able to understand the purpose and contents of the notice in order to sign and must be able to understand that he/she may appeal the termination decision. 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.

CMS requires that notification for an institutionalized patient who is not competent be made to a representative acting on behalf of the patient.

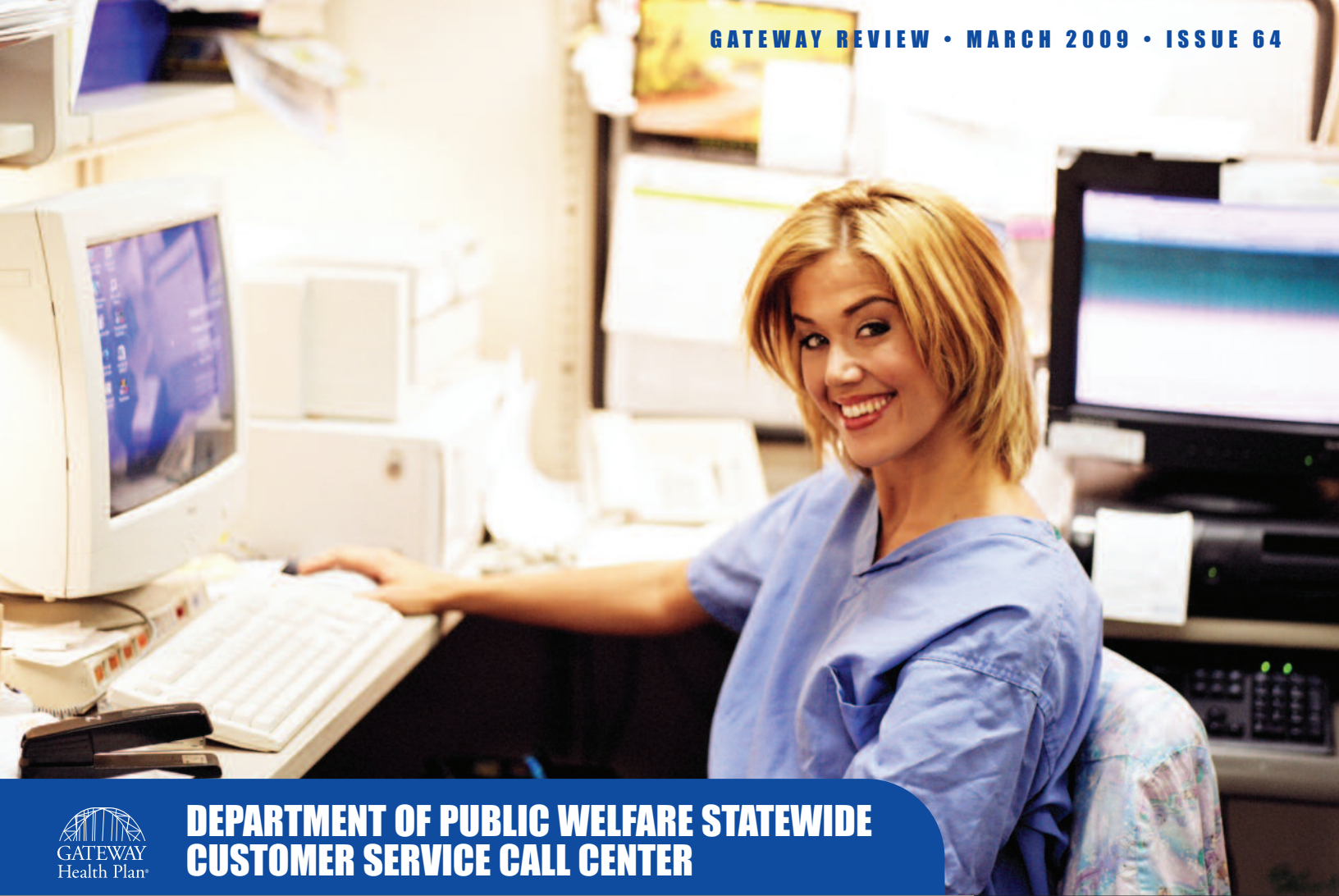
Notification to the representative may be problematic because that person may not be available to acknowledge receipt of the required notification.

Providers are required to develop procedures to use when the patient is incapable or incompetent, and the provider cannot obtain the signature of the patient's representative through direct personal

contact. If the provider is personally unable to deliver a NOMNC to a person acting on behalf of a patient, then the provider should telephone the representative to advise him or her when the patient's services are no longer covered. The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed the same date. When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of the receipt. When notices are returned by the post office with no indication of a refusal date, then the patient's liability starts on the second working day after the provider's mailing date.

Keep a copy of the notification in your records and FAX a copy of all signed NOMNC forms to 1-800-685-5231. Questions regarding valid NOMNC delivery to Gateway Health Plan Medicare AssuredSM members can be directed to Gateway's UM Compliance Specialist, Rachel Wiehagen, at 412-255-7137.





DEPARTMENT OF PUBLIC WELFARE STATEWIDE CUSTOMER SERVICE CALL CENTER

The Pennsylvania Department of Public Welfare has established a Statewide Customer Service Call Center where Medical Assistance Recipients can now call toll free to request general information or call to just report a simple address change.

The call center is an alternative to having recipients wait in long lines at county assistance offices. The Customer Service Call Center can be reached by simply calling: 1-877-395-8930 to:

- Request General Information
- Report a change of address or telephone number
- Name changes
- Add or Change a social security number
- Add or Remove a household member
- Change / Add information about your income
- Check on the status of their case application
- Request needed forms and documents
- Request Income Verification Letters

Upon calling, recipients should be prepared to verify the following information:

- Social Security number
- Date of Birth
- Current or previous address
- Case number

Please note that the call center is not however an alternative to any scheduled appointments with assigned case workers or for those with a previously scheduled training session.



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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