



GATEWAY Review

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ISSUE 65



2 Great Benefits Keep Our Members *Moving*

Fitness Assured® and Transportation Benefits for Gateway Health Plan *Medicare Assured*™ Members.

Gateway is always working to make the quality of our member's lives better with benefits that can help them meet their health goals. This is why we are pleased to offer both a fitness and a transportation benefit to *Medicare Assured*® members.

***Fitness Assured*®**

Our members told us they wanted help getting fit, and we listened. *Fitness Assured*® is a valuable benefit offered to qualifying *Medicare Assured*® members ready to jump-start an active lifestyle.

Fitness Assured® is designed just for our Medicare members and provides free membership to various fitness centers in the community. The selected fitness centers that are part of the benefit have been determined to be accessible for members with disabilities. Members can use exercise equipment and take advantage of any services that are part of a standard fitness center membership.

If there is no participating fitness center within 15 miles of a member's home or a member is having difficulty getting to one of the participating fitness centers, an @Home Pak that contains fitness tools for home use is another option.

Getting started is simple. Members are encouraged to consult with their primary care physician before starting an exercise program. Next, the member can select a participating fitness center near their home and sign up for the club's membership program or explore the @Home Pak option through *Fitness Assured*® by calling Gateway Member Services.

Transportation

We realize that some members want to get to their medical appointments but it's the getting there that is the challenge. To help, we now offer non-emergency transportation services to *Medicare Assured*® members.

Members can receive 24 one-way (12 round-trip) non-emergency trips per calendar year. Locations must be plan-approved and within 50 miles of the member's home. If needed, the program allows for one additional person to accompany a member.

Non-emergency transportation includes visits to the doctor, dentist, vision or hearing specialist, behavioral health services, pharmacies and fitness centers.

With the addition of *Fitness Assured*® and transportation services, Gateway Health Plan *Medicare Assured*™ members continue to benefit from great programs from a health plan that understands their needs.

For more information on these benefits, visit www.gatewayhealthplan.com or ask your Provider Relations Representative for more details.





COMPLETE DIAGNOSIS SUBMISSION IMPROVES QUALITY AND CARE

Have you ever shot eight out of ten free throws in a row and had no one to witness your accomplishment? Ever make that incredible putt (alright, maybe it was just mini golf) and no one in your group was paying attention? That's what happens when a physician completes a thorough evaluation but doesn't document all of the

patient's diagnoses in the medical record – there is no witness to the thoroughness of your efforts. Big deal you say? Think again...

Proper charting is essential to managing patients, documenting quality and enhancing your effectiveness.

Are you aware that diagnoses codes are used to measure quality and identify care gaps (e.g., Primary Care Practice Portfolio Reports, Primary Care Practice Dashboards, HEDIS, etc.)? Diagnosis codes also impact quality-related revenue such as the Gateway to Physician ExcellenceSM program (which varies by practice). More than ever, Gateway Health Plan[®] needs you to care for your patients, our members, and to ensure that your medical records and claims are thorough and complete. The more thoroughly you document a patient's diagnoses, the better these measurements and data will be.

With accurate data from you, Gateway is able to proactively outreach to your Gateway patients and thus enhance the effectiveness of your practice. Gateway's outreach efforts help your

patients overcome barriers to care which is part of Gateway's Prospective Care Management model of care. Diagnosis codes on medical claims and pharmacy claims data enable our staff to identify members in need of services and then contact them to address care gaps and non-medical needs. We educate and empower patients to follow your instructions and learn about their condition in order to become better patients and healthier citizens. The more thoroughly you list patients' diagnoses, the better Gateway can outreach and enhance your efforts!

Paradigm shift? Yes. Help maximize quality measurements, quality-related revenue and Gateway's member outreach activities by thoroughly listing your patients' diagnoses in the patient's chart at every visit and when you submit a claim/encounter for every visit.





UM 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 practitioners and providers is 1-800-685-5207.



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.



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

Gateway's Quality Improvement/Utilization Management (QI/UM) Committee recently approved the 2009 QI/UM Programs and Work Plans that list activities planned for the year for each line of business. The evaluations of the 2008 Programs have been finalized. If you would like a written summary of these documents, please call the QI Department at 412-255-1144.



UTILIZATION MANAGEMENT TIPS FOR PRECERTIFICATION:



Here are some tips that will help the Utilization Management Department better service your call:

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.
2. The Utilization Management Representative will need to know the date of service and the valid billing codes for the diagnostic 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 or NPI 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 9 AM and 11 AM. The Utilization Management Department is accessible by voicemail 24 hours and we return voice mail within one business day.

When it is necessary for the UM Representative to transfer your call to the nurse line the Representative will advise you of the expected hold time for the nurse. You have the option of waiting for a call back from the nurse, or transferred and put on hold for the next available nurse. While you are on hold you can leave a voice message at any time. Cases routed to the nurse for a call back and voice messages are prioritized and calls are returned the day of the request, or within one business day.



FAX NOTIFICATION

Gateway Health Plan® realizes that effective and efficient communication is vital to maintain relationships with the provider community.

We continuously look for opportunities to enhance and improve the ways in which we communicate, especially when related to fulfilling the notification requirements for decisions surrounding Medication Exception Requests.

In December of 2008, the Pharmacy Department at Gateway began utilizing Fax Press technology to relay decisions to providers for our Pennsylvania Medicaid population. These faxes replace telephone calls and mailings as the primary method of notification to providers. Each notification consists of

a cover sheet along with the corresponding approval or denial letter that can easily be placed in the patient chart for discussion at the next visit if necessary.

Gateway is sensitive to the resources required to answer phone calls during normal office hours and feels that the elimination of telephonic notifications may free up time for offices to handle patient care related calls.

We have plans to expand the program in the near future to include decision notifications for Pennsylvania *Medicare Assured*®. We continue to investigate the value of this process for other types of notifications as well.

If you have questions or concerns about the new notification process or receive a fax in error, please call our Pharmacy Services Department at **1-800-528-6738** so that we may assist you.



ELECTRONIC DATA CLAIM SUBMISSION

If you are cleared to submit your claim electronically through Emdeon or Relay Health to Gateway Health Plan® for reimbursement; please remember that only the billing form itself (HCFA or UB04) is transmitted--attachments are not transmitted.

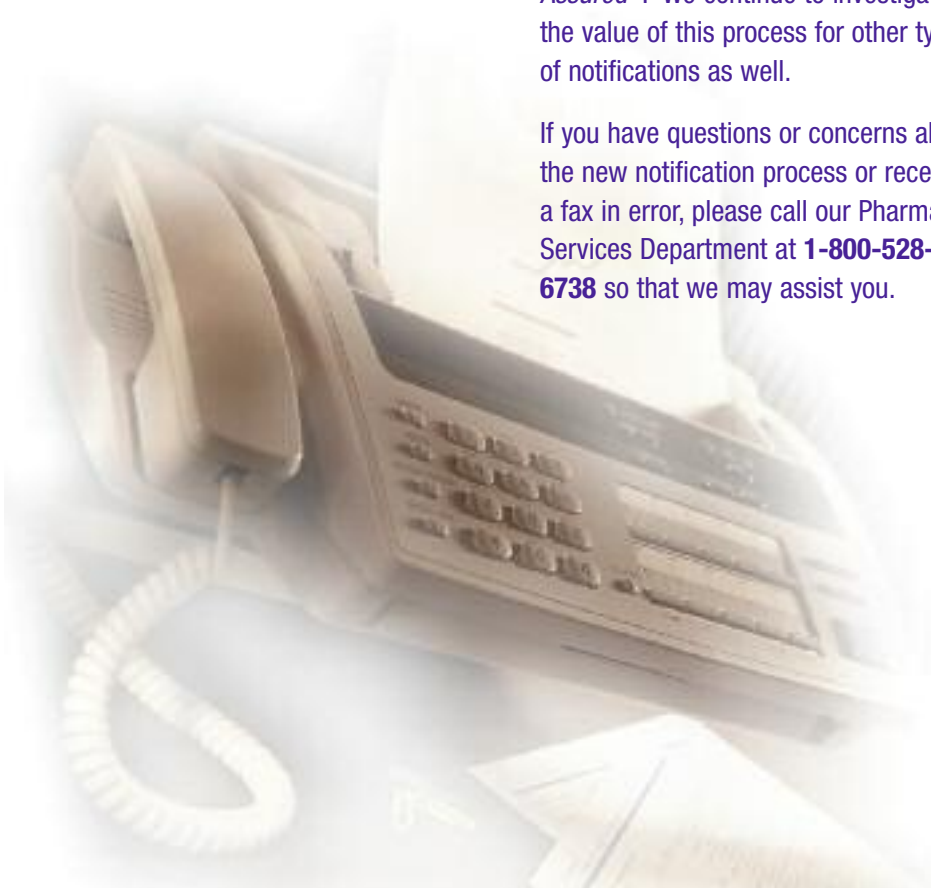
If the claim needs to be submitted with an Explanation of Benefits from another insurance carrier, medical records, referrals/authorizations or any other type of correspondence it must be submitted by paper to one of the following addresses for processing:

PA MEDICAID

Gateway Health Plan®
Claims Processing Department
POB 11-718
Albany NY 12211-0718

MEDICARE ASSURED®

Gateway Health Plan®
Claims Processing Department
POB 11-560
Albany NY 12211-0560





Gateway Health Plan *Medicare Assured*SM (Gateway) is required by the Center for Medicare and Medicaid Services (CMS) to monitor provider compliance with all relevant Medicare requirements. This includes assuring that all Gateway patients receiving home health, skilled nursing or comprehensive outpatient rehabilitative facility care receive and sign the Notice of Medicare Non-Coverage (NOMNC) at least two days prior to the end of the care.

Unfortunately, compliance auditing and monitoring of the NOMNC delivery process has shown that the CMS requirements are *not* being consistently met. Gateway is committed to collaborating with Medicare providers in order to attain 100% compliance with CMS requirements, so an exciting incentive program was introduced in a mailing to all participating home health, skilled nursing and comprehensive outpatient rehabilitation facilities in March 2009.

Effective with approved services ending after April 1, 2009, Gateway is offering a \$10 (ten dollars) incentive payment for each complete and accurate NOMNC (CMS-100095, exp date 8/31/2010) delivered to a *Medicare Assured*[®] member at least two days prior to the end of care. In order to be eligible for the incentive payment, the NOMNC must be submitted to Gateway by the end of the month following the last approved date of service.

Completed NOMNCs can be submitted to Gateway **by fax at 1-800-685-5231** or via US mail to:

Gateway Health Plan[®]
Attention: Utilization Management
600 Grant Street
US Steel Tower, Floor 41
Pittsburgh, PA 15219-2704

Blank NOMNC templates were distributed in the March mailing for your convenience. However, further information about the valid NOMNC form or delivery process may be obtained via the Medicare website at www.cms.hhs.gov.com. If you have questions, you may call Rachel Wiehagen, UM Compliance Specialist, at 412-255-7137.





OFFICE MANAGER INCENTIVE PROGRAM WINNERS

Congratulations to the winners of the 1st Quarter 2009 Primary Care Office Manager Incentive Program! The winners are as follows:



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 encounters.

The winners received a plaque to display in their office and a gift basket. The winners of the 2nd Quarter of 2009 will be announced in the next issue of the *Gateway Review*. Good Luck!



2009 PRACTITIONER AND PROVIDER SATISFACTION SURVEYS

Gateway Health Plan® will again be conducting both the Medicaid and *Medicare Assured*® 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*®, 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 2009, please feel free to call your Gateway Provider Relations Representative directly.



ELECTRONIC PRESCRIBING UPDATES

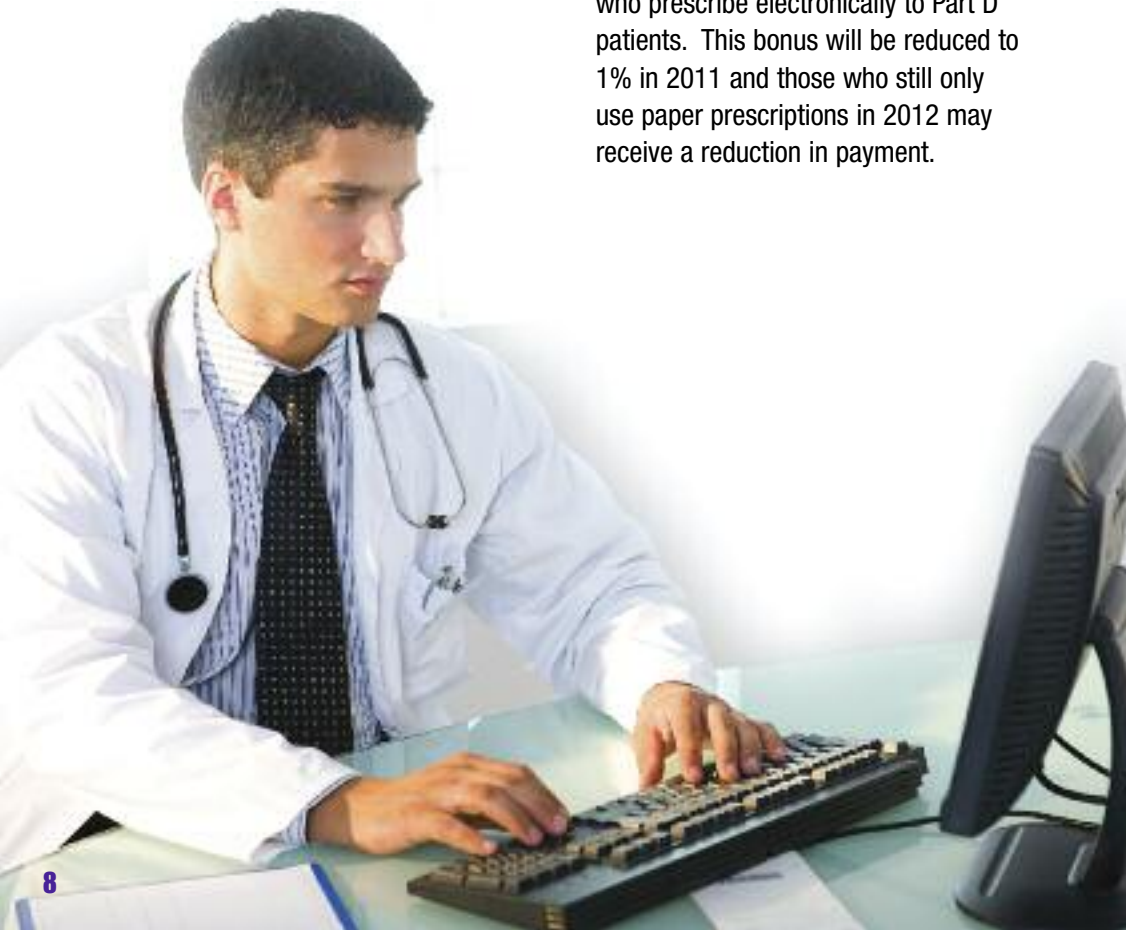
by Dino Conti, PharmD

GATEWAY HEALTH PLAN® HAS INCREASED THE FUNCTIONALITY OF ITS ELECTRONIC PRESCRIBING (E-PRESCRIBING) CAPABILITIES.

Physicians who are using e-prescribing via RxHub will now be able to view details of age and gender edits for applicable drugs on Gateway's formulary, and see which drugs require prior authorizations or are part of specific step therapies. Gateway has also added member medication fill history as a new feature. This functionality gives prescribers the ability to view other medications that a patient is using, thus decreasing the likelihood for drug interactions and therapeutic duplications.

An increasing number of physicians are recognizing that the enhancements in patient care and office staff efficiency that result from e-prescribing are worth the initial investment. This is evident by a 75% increase in the amount of Gateway electronic prescriptions since the inception of e-prescribing at Gateway in November 2007.

E-prescribing is also receiving attention at a national level. In an effort to speed the adoption of the service, beginning in 2009 the Department of Health and Human Services has agreed to pay a bonus of 2% to physicians who prescribe electronically to Part D patients. This bonus will be reduced to 1% in 2011 and those who still only use paper prescriptions in 2012 may receive a reduction in payment.



MEDICAL NECESSITY DETERMINATIONS

The authorization process for medical necessity determinations at Gateway is accomplished through the application of the 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 refer cases to the Gateway Medical Director and/or Physician Advisor for a medical necessity determination.



GATEWAY HEALTH PLAN® UTILIZES A FORMULARY FOR ITS PA MEDICAID AND PA & OH MEDICARE ASSURED® 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. They may be searched by drug name or drug class. Future updates to our Formulary will be available on a regular basis, both by provider publication and 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)
1-800-685-5201 (PA Medicare)
1-800-887-1898 (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)



Gateway is listening to you!

Over the past year, Gateway has made a number of changes based on your input. Here's a list of just a few of those changes:

AUTHORIZATIONS

- Except for a small number of procedures, prior authorization is no longer needed for Gateway Medicaid patients requiring outpatient surgical procedures rendered in either outpatient hospital or surgical center.

- Implemented use of McKesson InterQual Criteria for authorizing all services for both our Medicare and Medicaid plans.
- Utilization Management Department now accepts clinical information via voicemail for both our Medicaid and Medicare plans.
- When calling for an authorization, you now have the option to also reach someone in our Pharmacy Department, Provider Services, or *Medicare Assured*[®].

CREDENTIALING

- Accept Council for Affordable Quality Healthcare (CAQH) as well as the PA Standard application
- Moved from a 2 year to 3 year recredentialing cycle

HOSPITAL UPDATES

- Hospital Newsflashes now available on our website

PHARMACY INFORMATION AVAILABLE AT OUR WEBSITE

- Enhancements to Gateway's on-line formulary including user friendly filters such as therapeutic class and category, as well as generic and brand name.
 - Downloadable PDF formulary
 - Recent formulary updates

ELIGIBILITY VERIFICATION

- You can verify eligibility for all Gateway members through HDX.

NIA

- Implemented a new process to ensure authorizations are given to the appropriate rendering provider.

CLAIMS

- Added Relay Health as an additional claims clearinghouse vendor option

PAY FOR PERFORMANCE

- Implemented PA Medicaid PCP Pay for Performance program - Gateway to Physician ExcellenceSM

PROVIDER SERVICES

- Additional Provider Services Representatives available to answer your questions. On average, Provider Calls are now answered within 30 seconds or less.

MAILINGS

- Consolidated Medicaid and Medicare clinical mailings into a PCP Dashboard Report, mailed quarterly

Gateway is continuously looking for ways to improve and streamline processes to positively affect interactions between you and your Gateway patients.





HELPING PRACTICES GIVE GREAT CARE

Through Gateway's model of Prospective Care Management, we emphasize the importance of extensive member outreach, community involvement and physician practice engagement.

We support the efforts of physician practices in delivering the highest quality of care to members. Recent enhancements to our physician practice engagement initiatives include the Gateway to Physician ExcellenceSM PCP Pay-for-Performance Program, Primary Care Practice Dashboard Reports and educational trainings carried out by Gateway's Provider Relations department and medical directors.

These tips can help practices continue to deliver quality care:

Reporting

Primary care practices can take advantage of information provided in reports. These reports include:

- Primary Care Practice Dashboard Reports (quarterly)
- GPESM Report Cards (annual)
- Medicaid Provider Primary Care Practice Portfolio Reports (biannual)
- *Medicare Assured*[®] Primary Care Practice Portfolio Reports (annual).

These reports can be used to assess practice performance, plan future patient visits or perform outreach to patients in need of care. Although Gateway conducts reminder outreach to members, hearing directly from their doctor's office helps.

Prospective Care Management

Refer medically complex cases to Gateway's Care Management department. The referral phone numbers are:

- Medicaid — 800-642-3550
- *Medicare Assured*[®] — 800-685-5212



Coding and Claims Submission

- Always submit claims, even when Gateway is a secondary payer. This keeps us aware of the quality-related services provided.
- Bill EPSDTs. This not only demonstrates that this service has been performed, but also results in increased practice reimbursement.
- Code thoroughly and completely by listing all diagnoses. This way we are aware of a member's total health condition when conducting outreach.

Streamlining

- Schedule patients for annual physicals to review all of their needs.
- Schedule follow-up appointments before patients leave the office.
- Have a reminder system. Let patients know by mail or phone of an upcoming appointment to help minimize "no shows."
- Arrange for patients with chronic conditions to have blood work drawn a week before their next appointment. This allows the doctor to have more information at the time of the visit and reduces the amount of required follow-up communication.
- Make use of in-office testing (e.g., HbA1c), a reimbursed service by Gateway.



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

www.gatewayhealthplan.com

Important Phone Numbers

PROVIDER SERVICES

Medicaid 1-800-392-1145

Medicare 1-800-685-5205

MEDICAL MANAGEMENT

Medicaid 1-800-392-1146

Medicare (PA) 1-800-685-5207

Medicare (Ohio) 1-888-447-4375

MEMBER ELIGIBILITY/DIVA VERIFICATION LINE

Medicaid and Medicare 1-800-642-3515

EPSDT

Medicaid 1-800-642-3550, Option 4

PHARMACY

Medicaid 1-800-528-6738

Medicare 1-800-685-5215

Medicare (Ohio) 1-888-447-4507

NATIONAL IMAGING ASSOCIATES

Medicaid and Medicare 1-888-879-5922

TABLE OF CONTENTS

ICON KEY

MEDICAID ONLY



MEDICAID & MEDICARE



MEDICARE ONLY



Cover:

- Two Great Benefits Keep Our Members Moving Fitness Assured® and Transportation Benefits for Gateway Health Plan *Medicare Assured*SM Members.

Page 2:

- Complete Diagnosis Submission Improves Quality and Care

Page 3:

- UM Criteria
- Affirmative Statement about Incentives
- Quality Improvement/Utilization Management (QI/UM) Program and Work Plan

Page 4:

- Utilization Management Tips for Precertification:

Page 5:

- Fax Notification
- Electronic Data Claim Submission

Page 6:

- Gateway Health Plan *Medicare Assured*SM (Gateway) is required by the Center for Medicare and Medicaid Services (CMS) to monitor provider compliance with all relevant Medicare requirements.

Page 7:

- 2009 Practitioner and Provider Satisfaction Surveys
- Office Manager Incentive Program Winners

Page 8:

- Electronic Prescribing Updates
- Medical Necessity Determinations

Page 9:

- Formulary

Page 10:

- Gateway is listening to you!

Page 11:

- Helping Practices Give Great Care