



GATEWAY Review

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Visit us at our website @ www.gatewayhealthplan.com

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ISSUE 66



IMPORTANT H1N1 INFLUENZA UPDATE

Confirmed cases of the H1N1 influenza have already been reported in the Commonwealth of Pennsylvania. Our combined efforts are needed to ensure our most vulnerable citizens are protected. As a part of those efforts, Gateway is encouraging all health care providers to pre-register for the H1N1 Influenza program recently announced by The Pennsylvania Department of Health (DOH). The program gives selected providers the opportunity to receive a supply of H1N1 vaccine along with items such as needles, syringes, sharps containers, and alcohol swabs **free of charge**. The supply is to be administered to persons who fall within the 5 targeted groups listed below:

- Pregnant women
- People who live with or care for children younger than 6 months of age
- Health care and emergency services personnel
- Persons 6 months to 24 years of age
- Adults under 65 years with medical conditions

In order to participate in the program, providers must pre-register online with the Pennsylvania Statewide Immunization Information System (PA-SIIS) at <https://siis.health.state.pa.us/siis> and select the H1N1 Online Pre-Registration Request. For questions or assistance about registration in the PA-SIIS please contact the PA-SIIS Help Desk at 1-877-774-4748; all other questions regarding H1N1 influenza vaccination pre-registration should be directed to Dr. John Bart at 717-787-4366.



TELEPHONE TRIAGE SCRIPT

Using telephonic triage of patients with a respiratory illness instead of having them come into the office is one way to reduce spreading the influenza virus. Figuring out what telephone triage protocol to use may be a challenge. We recommend reading the article, “**Telephone Triage for Patients with Influenza**” written by Jonathan L. Temte, MD, PhD from the University of Wisconsin School of Medicine and Public Health, Madison, Wisconsin. In his article Dr. Temte offers primary care practices one successful approach to telephone triage for influenza.

This article is included with this issue of *The Gateway Review*.

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BILLING PROCEDURES – GATEWAY MEDICAID

Effective September 1, 2009 Gateway will reimburse providers \$10.00 for the administration of the H1N1 vaccine. Gateway will not reimburse for the vaccine and supplies since they will be provided free of charge. Providers must bill using HCPC code G9141-(Influenza A (H1N1) immunization admin (includes physician counseling for the patient/family)). For Gateway’s Medicaid plan the following codes are reimbursed for the **seasonal** flu vaccine regardless of whether you use your personal stock or obtain your flu vaccine supply from Vaccines for Children (VFC). The administration fee is included in the reimbursement for the vaccine.

- 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 fee-for-service for members ages 5 to 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 pay an administration fee for both doses.

BILLING PROCEDURES – MEDICARE ASSURED®

The seasonal flu vaccine is a covered benefit for our *Medicare Assured®* members. Please continue to bill valid HIPAA compliant CPT and HCPC codes (90655 thru 90658, 90660 and G00008) for the seasonal flu. For reimbursement of the H1N1 vaccine administration, providers must submit the following code:

- G9141-Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)

Providers will be reimbursed per their contracted rate for both the seasonal flu and H1N1 vaccines.

If you have any questions or concerns, please contact your Provider Relations Representative directly or Provider Services at 1-800-392-1145 for Medicaid or 1-800-685-5205 for *Medicare Assured®*.



COMPLIANCE REMINDER:

COMPLETED NOTICE OF MEDICARE NON-COVERAGE FORMS (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

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.



ANTIVIRAL MEDICATION UPDATE!

As of September 12, 2009, 99% of circulating influenza viruses in the United States were 2009 H1N1 influenza which were susceptible to both Tamiflu and Relenza.¹ Appropriate use of antivirals for the treatment and prophylaxis is a crucial component to pandemic influenza prevention and control. In response to the current H1N1 and seasonal influenza concerns, Gateway Health Plan® has added Tamiflu and Relenza to the Medicaid formulary and will continue to cover these medications for our *Medicare Assured*® population. The Center for Disease Control (CDC) continues to update their recommendations for the use of antivirals in the treatment and prevention of influenza. Please take the following recommendations into consideration when determining if Tamiflu or Relenza is appropriate for your patients:

- Persons presenting with suspected influenza and more severe symptoms such as evidence of lower respiratory tract infection or clinical deterioration should receive prompt empiric antiviral

therapy, regardless of previous health or age.

- People with more severe illness, such as those hospitalized with suspected or confirmed influenza.
- Early empiric treatment with Tamiflu or Relenza should be considered for persons with suspected or confirmed influenza who are at higher risk for complications including:
 - Children younger than 2 years old;
 - Persons aged 65 years or older;
 - Pregnant women;
 - Persons of any age with certain chronic medical or immunosuppressive conditions and,
 - Persons younger than 19 years of age who are receiving long-term aspirin therapy.
- Individuals with mild illness who are not in the above high risk groups do not necessarily require antiviral treatment.
- Treatment, when indicated, should be initiated as early as possible because

studies show that treatment initiated early (i.e., within 48 hours of illness onset) is more likely to provide benefit.

- Treatment should not wait for laboratory confirmation of influenza because laboratory testing can delay treatment and because a negative rapid test for influenza does not rule out influenza.
- Consideration for antiviral chemoprophylaxis should generally be reserved for persons at higher risk for influenza-related complications who have had contact with someone likely to have been infected with influenza. However, early treatment is an emphasized alternative to chemoprophylaxis after a suspected exposure. Household or close contacts (with risk factors for influenza complications) of confirmed or suspected cases can be counseled about the early signs and symptoms of influenza, and advised to immediately contact their health care provider for evaluation and possible early treatment if clinical signs or symptoms develop.

¹ Updated Interim Recommendations for the Use of Antiviral Medications in the Treatment and Prevention of Influenza for the 2009-2010 Season. www.cdc.gov/H1N1flu/recommendations.htm. Accessed September 29, 2009.



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!



PATIENT SAFETY THROUGH GOOD COMMUNICATION

Patient safety is an integral part of every health care practice and a critical responsibility of everyone who is involved in patient care. Safety encompasses the entire sphere of patient interaction and clear communication is a primary component of safe care.

How patients perceive their connection with their physician significantly affects patient satisfaction and enhances a patient's interest in improving their health. Patient satisfaction is influenced by a sense of partnership with their physician, and has a positive influence on adherence. Interaction based primarily on information sharing is negatively correlated with compliance.

According to the recent CAHPS (member satisfaction) survey, "How Well Doctors Communicate" is the area most highly associated with health care satisfaction. It is critical for the provider to listen carefully, to develop the trust necessary for open communication and to explain diagnoses and treatments in a way that is easily understood. Those behaviors associated with a positive outcome include empathy, courtesy/friendliness, attentiveness, encouragement of patient questions and laughter.

Another technique that has proven successful in enhancing communication and fostering positive behavioral changes is motivational interviewing.

This technique is useful in assessing a patient's readiness for change and in promoting movement from one stage to the next. (For further information about motivational interviewing go to: www.motivationalinterview.org.)

It is also important to use everyday language that is precise and addresses the patient's priorities. Include family members to enhance learning and elicit cooperation.

Improving communication with patients and their families will enhance patient satisfaction and increase your patient's investment in their own health care.



Referring Your Medicare Assured® Patient to a Specialist

Referrals are necessary in order to preserve the primary care practitioner's Gatekeeper relationship with the patient. Referrals allow the primary care practitioner to approve specialty services for members on their panel. **Referral Forms are not required for submission to the specialist or Gateway.** However, notification to the specialist is necessary, but can be made verbally or through a script given to the patient. Don't forget to document the referral in the patient's medical record including the number of visits or length of time of each referral.

Referrals must be made to an in-network Gateway specialist. Only under special circumstances can a primary care practitioner refer a member to an out-of-network provider. All out-of-network referrals require prior-authorization through Gateway's Utilization Management Department. Authorization is not required for emergency services or renal dialysis services (when the member is temporarily outside the plan's service area) provided by an out-of-network provider.

To determine which services require a referral or authorization, please refer to Gateway's Quick Reference Guide for Referrals and Authorizations in the Gateway Health Plan Medicare Assured® Gateway At A Glance.



APPLYING NATIONAL AND LOCAL COVERAGE DETERMINATIONS

Providers may not be certain how Gateway Health Plan *Medicare Assured*® uses the Medicare National Coverage Determinations (NCDs) and Local Carrier Coverage Determinations (LCDs), which are available on the Medicare website at www.cms.hhs.gov/mcd/search.asp.

Gateway Health Plan *Medicare Assured*® adheres to coverage decisions outlined in a NCD. If a certain procedure is determined to be non-covered, Gateway will not cover the procedure. *For example, Medicare has determined that bariatric surgery is a covered benefit, but an open adjustable gastric banding is non-covered. Likewise, Gateway does not cover an open adjustable gastric banding.*

Medicare Local Carriers issue LCDs based on geographic region, and Gateway follows the appropriate LCDs based on the member's geographic region. *For example, a LCD titled Botulinum Toxin Type A and B (L27476) states that the clinical efficacy of botulinum toxin in the treatment of chronic headaches and intractable headache has not been proven and is not medically necessary. Since it is not medically necessary, the treatment would not be covered by Medicare, nor is it covered by Gateway.*

Please note that some LCDs provide guidance on submitting medical records to carriers in order to obtain payment. Please note that instructions on how to obtain an authorization from Gateway for services that require prior authorization, or instructions for how to file a provider appeal with Gateway may be located in the Provider Manual, www.gatewayhealthplan.com or in a copy of your recent Gateway provider agreement.

It is important to note that Gateway Health Plan *Medicare Assured*® does cover additional benefits/services that are not covered under Medicare, such as eyeglasses and hearing aid benefits. These extra benefits are updated annually and are outlined in the member's annual Evidence of Coverage located in the Provider Manual and on www.gatewayhealthplan.com.



OPPORTUNITIES FOR PEER REVIEW DISCUSSION



Some providers are not aware of an opportunity for a physician or provider requesting authorization for services on behalf of a Gateway member to speak directly with a Gateway Health Plan® Medical Director.

If a Gateway Medical Director is not able to approve your authorization request as medically necessary services, Gateway staff will inform your office. Gateway staff will also provide information on how the requesting physician or provider may speak directly to the Medical Director for a peer-to-peer discussion regarding the patient's clinical needs. Gateway encourages physicians to take advantage of the opportunity to telephonically discuss potential denial decisions directly with the Gateway Medical Directors, as peer review discussions have led to the sharing of new information that could impact the authorization decision.



GATEWAY ADOPTS NEW URBAN/RURAL CREDENTIALING CRITERIA

A recent analysis of the Gateway provider network, as it relates to accessibility and other concerns was conducted. The outcome was presented to the June 2009 Quality Improvement Committee for approval and finalization. As a result, revisions to Gateway's credentialing criteria were implemented regarding urban and rural credentialing criteria. Some of you may be affected by the revisions while others may not be impacted. Please review the information below for Gateway's current board certification criteria, as well as urban/rural criteria. Should you have any questions, please contact your Provider Relations Representative.

Rural: A rural county is one that has **not** been designated as a metropolitan statistical area by the most recent Federal Census Bureau data available

Urban: An urban county is one that has been designated as a metropolitan statistical area by the most recent Federal Census Bureau data available

Recent Gateway Decisions for Podiatrists:

If you have been credentialed by Gateway previously under rural credentialing criteria and you have at least one office location in a designated urban county, to minimize any interruption in your participation with Gateway and your care of Gateway members, Gateway will “grandfather” you into a recredentialing status that will apply rural

county credentialing standards for three cycles in order to give you an opportunity to successfully complete certification with either of these Podiatric Boards, which are the ABPS and/or the ABOPMS. In 2011, Gateway will apply urban re-credentialing standards for your practice and will require verification that you have become board certified by those boards accepted by Gateway. During the interim period before urban criteria will be applied to your recredentialing, please be aware that the current CME requirement is 15 credits per year and that the grandfathered status regarding rural credentialing requirements will remain in effect providing you do not open an office in an adjacent urban county and you have no lapse in participation or credentialing with Gateway.

Recent Gateway Decisions for Primary Care or Specialist Practitioners:

If you have been credentialed by Gateway previously under rural credentialing criteria and you have at least one office location in a designated urban county, to avoid any interruption in your participation with Gateway and your care of Gateway members, Gateway will “grandfather” you into a recredentialing status that will apply rural county credentialing standards. Please be aware that the current CME requirement is 50 credits per year and that the grandfathered status regarding rural credentialing requirements will remain in effect providing you do not open an office in an adjacent urban county and you have no lapse in participation or credentialing with Gateway.

Gateway's Board Certification Criteria:

Practitioners must be Board Certified or Board Eligible with the intention of pursuing board certification in their particular practice of focus. All practitioners with board intentions must complete a board certification intent form which includes a date they are registered to take the exam. Practitioners who were Board Certified but are not Board Certified at the time of application or re-application are treated as non-certified practitioners.

Exceptions to the Board Certification standard for practitioners include:

- a. Practitioners who have completed a residency program and/or fellowship in their specialty and who began practice prior to the availability of boards; or
- b. Pennsylvania practitioners who practice solely in rural counties must meet the following criteria:
 - (1) Practitioner must have completed a residency program and/or fellowship in their practicing specialty. For practitioners whose practicing specialty does not require completion of a residency program and/or fellowship, verification of graduation from medical school is required. (Podiatrists who have not completed a residency





USING THE PCP DASHBOARD TO IMPROVE QUALITY

program must have completed at least one year of post-graduate training and must have graduated from an accredited school of podiatric medicine); and,

- (2) Have staff/clinical privileges at a Gateway participating facility in an appropriate department; and,
- (3) Maintain fifty (50) CME credits per year,
 - Podiatrists and Dentists must have evidence of fifteen (15) continuing education credits per year or at least thirty (30) over the previous two years.

A practitioner with multiple office sites will be identified as practicing in an urban county if any one office site is located in an urban county. If all office site locations are contained within rural counties, a practitioner will be identified as practicing in a rural county.

Rural practitioners who add a new urban office site must meet the board certification standards of a practitioner in an urban county at the time of their next recertification cycle.

Additionally, if updated Federal Census Bureau data is released, Gateway will complete an access study to determine the network impacts of applying new county designations.

THE PRIMARY CARE PHYSICIAN DASHBOARD WAS LAUNCHED IN APRIL 2009 IN ORDER TO PROVIDE PRACTICES WITH ACTIONABLE DEMOGRAPHIC AND CLINICAL INFORMATION ON CARE GAPS FOR GATEWAY HEALTH PLAN® MEMBERS.

Additionally, it was designed to consolidate multiple clinical mailings and reduce practices' paperwork. Two quarterly Dashboard reports have been distributed so far. Based on input we've received, here are some ideas about what practices can do with the information in the Dashboard.

Physicians and their staff can use the Dashboard report to:

- Outreach to members who are overdue for preventive services, regular appointments or first time appointments.
- Create reminders for practitioners at the next scheduled visit to:
 - order/conduct overdue clinical services.
 - address lack of adherence to prescribed antihypertensive medications or asthma

controller medications (based on Gateway's claims data indicating lack of fills for specific prescriptions).

- address annual monitoring of persistent medications (ACE/ ARB, digoxin, and diuretics - potassium and renal function; anticonvulsants – serum drug levels).
- Take advantage of Gateway's Care Management programs that members are enrolled in at Gateway such as "AIR" Gateway® for asthma, Healthy Returns for diabetes, MOM Matters® for high risk pregnancies and Help Your Heart for CHF and coronary disease.
- Consider addressing cultural and ethnic barriers that may be preventing your Gateway patients from following through on advice and treatment. The Dashboard contains self-disclosed primary language spoken as well as race information.

While the Dashboard is not connected with the Gateway to Physician ExcellenceSM (GPESM) program, using it as a tool to identify care opportunities may positively impact a practice's performance on individual GPESM indicators and associated annual payments.

We hope this new quarterly tool is helpful to your practice's continued pursuit of greater quality and helps to reduce the volume of mail you receive from us. A formal survey requesting feedback on the Dashboard will be sent along with the October report.





CREDENTIALING REMINDERS

- All practitioners in Pennsylvania have the option of completing the PA Standard Application or submitting a printed version of the pre-populated CAQH application to Gateway for review and consideration. The CAQH application is mandatory in Ohio.
- Gateway is committed to protecting the confidentiality of all provider information obtained by the Credentialing Department and to conducting credentialing/recredentialing in a non-discriminatory manner.
- Gateway standards require that all practitioners hold applicable staff/clinical privileges in their practicing specialty at a Gateway participating hospital. Primary care practitioners without staff/clinical privileges must have written documentation of a formal coverage arrangement with another Gateway participating practitioner who hold active privileges at a Gateway participating hospital.
- Practitioners who are called to active Military Duty may remain participating



through an established Gateway process. It is the responsibility of the practitioner or his/her office to notify Gateway in writing that the practitioner has been called to active duty, when the practitioner will be leaving and an approximate date of return. The letter should also include information regarding the practitioner who will be covering during the military leave. The Gateway Credentialing Department will not terminate the practitioner if he/she is called to active duty and have a formal coverage arrangement. The practitioner's office should notify Gateway of the practitioner's return, as soon as possible, but not to exceed 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 must 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. All information that is gathered during the ongoing monitoring process is made available for review and consideration by the Quality Improvement and Utilization Management Committee. Gateway affords 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 information varies substantially from the information submitted by the practitioner.
- Providers are notified in writing by Gateway's Credentialing Department of all credentialing/recredentialing decisions within 10 business 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.



COMPLAINTS, GRIEVANCES & APPEALS

Gateway provides a two-level review process that providers may use when medical services have already been rendered but a denial has occurred. Appeals should be submitted to Gateway in writing within ninety (90) days of a Gateway denial. Be sure to provide all supporting documentation for the Appeal Committee to review. The Appeal Committee, which is made up of two or more Gateway employees including one physician, will review the appeal and issue a written decision. If the decision is not overturned, a second level appeal may be requested. Providers are invited to participate in the second level appeal

review, but it is not required. This process is available for both Medicaid and Medicare claims.

Health care providers also have the right to act on behalf of their patients when Gateway has denied a prior authorization request for services. Please refer to your Provider Manual for further details.

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



OFFICE MANAGER INCENTIVE PROGRAM WINNERS

Congratulations to the winners of the 2nd 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 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 of 2009 will be announced in the next issue of the *Gateway Review*. Good Luck!



PROVIDER SERVICES DEPARTMENT – NEW HOURS OF OPERATIONS

Effective Monday, August 17, 2009 Gateway’s Provider Services phone lines will be closed between 12 pm and 1 pm, Monday through Friday.

In order to better service our providers, this change in operations coincides with our least busy time of the day and allows for complete staffing of the phones when you need us the most.

Provider Services is available to answer your claim inquiries, verify eligibility and handle supply requests. Just call 1-800-392-1145 for Gateway Health Plan® Medicaid or 1-800-685-5205 for Gateway Health Plan *Medicare Assured*®.

Gateway offices will be closed to observe the following holidays: New Years Day, Martin Luther King Day, Good Friday, Memorial Day, Independence Day, Labor Day, Thanksgiving (and the day immediately following), Christmas Eve and Christmas. Operations will resume the following business day.

Visit our website for additional information:
www.gatewayhealthplan.com.



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 Assured*®, or 1-888-447-4505 for Ohio *Medicare Assured*®.



What happens when a provider submits a claim with an eligibility print out from another carrier that indicates coverage has terminated:

When a claim is submitted with an eligibility print out, it will deny again with D11 (resubmit with EOB from primary carrier) until a Third Party Liability investigation is completed. When the investigation is completed, and the cancel date is confirmed, claims history will be reviewed. This review is completed on all previously denied claims, processed within the prior 120 days. These claims will then be reconsidered for possible payment.

What information is needed on a claim when a member has Other Insurance coverage?

The appropriate fields on the UB or HCFA form should be completed with the following:

- **Policyholder or subscriber name and date of birth**
- **Complete member ID# (with complete alpha prefix or suffix) or subscriber's Social Security Number**
- **Group number (if available)**
- **Complete name and address of Other Insurance carrier name**

Please remember to use the correct PO Box when submitting claims:

PA MEDICAID.....(PO Box 11-718)

PA *MEDICARE ASSURED*®.....(PO Box 11-560)

OH *MEDICARE ASSURED*®.....(PO Box 11-725)



HELP GATEWAY PREVENT IDENTITY THEFT

With today's economic conditions, Gateway's Special Investigation Unit is seeing an increase in potential identity theft cases. These cases typically involve either a Gateway Member allowing someone to use their ID card, or someone using a stolen ID card. If you have any concerns, just ask the patient if they mind answering a few questions to assist with the prevention of identity theft. If a person refuses, hangs up the phone, or leaves

without responding, you have probably just prevented identity theft. If the person agrees to participate, ask them to confirm their date of birth, address, and phone number. If a member cannot confirm this information, then identity theft may be occurring. If either of these situations occur, contact Gateway's Special Investigation Unit directly at (412) 255-4340 or (800) 685-5235. We will be more than happy to investigate the case further.



MEMBER RIGHTS & RESPONSIBILITIES

All Gateway Health Plan® (Gateway) members, whether enrolled in Gateway's 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 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. The Medicaid Member Rights and Responsibilities can be accessed by clicking at the bottom of the list on the right. *Medicare Assured*® members should click on Evidence of Coverage in the list and check the index for the page number. Offices may also access these documents and print them out for posting.



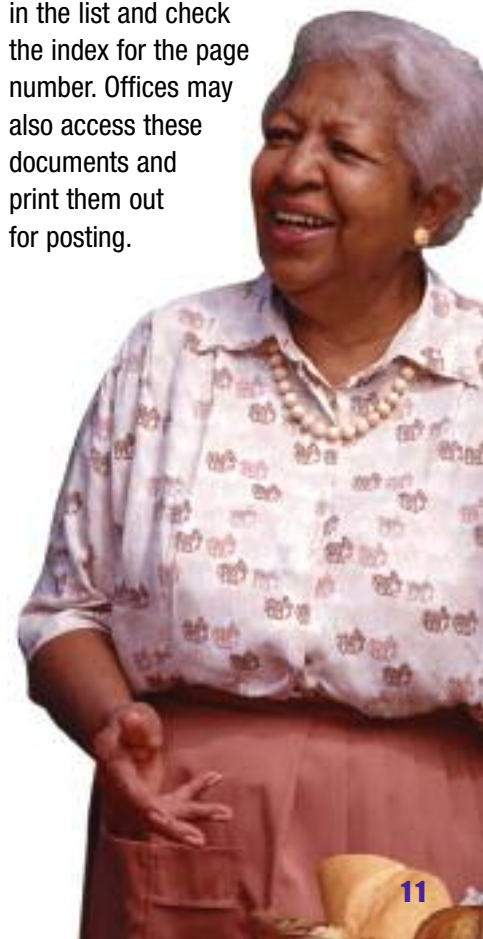
PRACTITIONER AVAILABILITY

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 NCQA, DPW, and DOH 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, 90% of Gateway members have a choice of two practitioners within 45-miles
- For urban areas, 90% of Gateway members have a choice of two practitioners within 20-miles
- For all service areas, at least 80% of the PCP panels are open to Gateway members.

In 2009, Gateway once again met the standard in all service areas for Open Panels. However, because of a re-classification of counties which lead to previously designated rural counties becoming urban, the following five (5) Medical Assistance counties fell below the required standards: Carbon (Internal Medicine), Luzerne (Internal Medicine, Pediatrics), Perry (Pediatrics), Pike (Internal Medicine, Family Medicine, Pediatrics), and Wyoming (Internal Medicine, Pediatrics). Additionally, the following two (2) counties in the Gateway *Medicare Assured*® service area now show less than required availability with this change: Lackawanna (Internal Medicine, Family Medicine) and Perry (Internal Medicine).





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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