GatewayHealthPlan.com

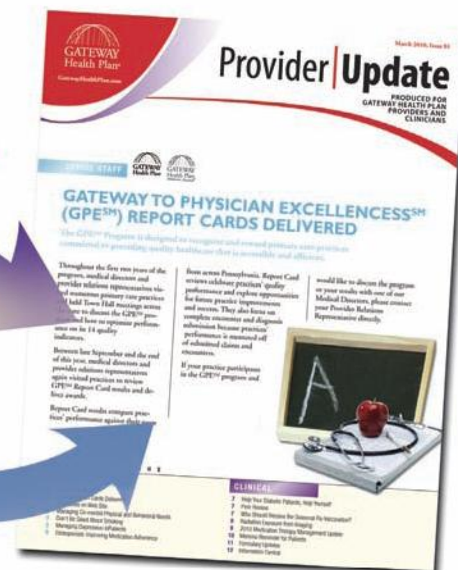
June 2010, Issue 01

Provider | Update

PRODUCED FOR GATEWAY HEALTH PLAN PROVIDERS AND CLINICIANS

OFFICE STAFF

2 IN 1



WELCOME TO THE NEW PROVIDER UPDATE!

We are continuing our efforts to minimize the amount of mail we send to our providers. This is why we consolidated the Gateway Review and Clinical Times newsletters into one newsletter.

While the name and appearance have changed, the new **Provider Update** delivers the same quality information and timely updates you need to help us deliver the best care for Gateway Health Plan® members.

Provider Update is organized to get you the information you need faster and easier. Content listed for "Office Staff" provides updates on Gateway processes and programs. Information relevant to physicians is categorized as "Clinical." The "Clinical" content pages can easily be detached and delivered directly to the physician(s) in your practice.

The logo icons indicate whether the information is related to Gateway's Medicaid or *Medicare Assured*® plans, or both.

We hope you enjoy this and future issues of **Provider Update**. If you would like to request a future article, give us a call at 1-800-392-1145 for Medicaid or 1-800-685-5205 for *Medicare Assured*®.

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OFFICE STAFF

IMPORTANT ANNOUNCEMENT REGARDING NEW CLAIMS MAILING ADDRESSES

Beginning September 5, 2010 all claims MUST be submitted to a new mailing address for processing as follows:

Medicaid	*Medicare Assured® HMO*
Mailing address for Medical Claims and Referral Forms	Mailing address for Medical and Behavioral Health Claim Forms:
Gateway Health Plan® P.O. Box 69360 Harrisburg, PA 17106-9360	Gateway Health Plan® P.O. Box 69359 Harrisburg, PA 17106-9359

If you have questions, please contact the Provider Services Department at 1-800-392-1145 for Medicaid or 1-800-685-5205 for *Medicare Assured®* Monday through Friday between 8:30am and 4:30pm or contact your provider relations representative.

Please alert billing staff to this important change. The new P.O. Boxes will not be in service until September 5, 2010, so please do not begin sending claims to the new addresses until then. Claims and referral forms sent to the Albany address after September 5, 2010 will be forwarded to the new address only through March 2011. ***Please be advised that submitting claims to the incorrect mailing address may result in a delay in claims processing or Gateway not receiving the claim at all.***

In August, Gateway will also be issuing new ID cards to all members with the new address information. The Gateway Medicaid and *Medicare Assured®* cards will be white with the red heart and bridge in the background. The Gateway Medicaid cards will no longer be green or yellow.

OFFICE STAFF

AFFIRMATIVE STATEMENT ABOUT INCENTIVES

Gateway's utilization management (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 underutilization 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.

OFFICE STAFF

COMPLETE DIAGNOSIS SUBMISSION IMPROVES QUALITY & CARE

Remember these important Dos and Don'ts of medical record documentation and coding:

DOCUMENTATION TIPS:

- DO fully assess all chronic conditions **at least** once a year to assure that the patient's conditions are being properly monitored.
- DO only document those conditions that were evaluated during each visit. The medical record for each visit must be able to stand on its own, so this requires the documentation of each visit to be complete.
- DO use terms within the medical record to denote that a condition was evaluated including phrases such as:
  - Stable on medications;
  - Condition worsening;
  - Medication adjusted;
  - Tests ordered and results reviewed;
  - Condition improving.
- DO use phrases that show the cause and effect which must be documented in the medical record. Cause and effect is documented when the specific disease is also followed by one of the following phrases:
  - Due to
  - Associated with
  - Secondary to
- DO remember the 4 "C's" in medical record documentation -- Clear, Concise, Consistent and Complete
- DO write legibly.
- DO sign and date each entry.
- DO code a condition *only* when it is certain.
- DO document all of the conditions present when the patient is a complex case. For example: COPD, CHF, Diabetes with Neuropathy & nephrosis. Complex patients require special attention when you are documenting and coding their medical record.
- DO document and code for all secondary or associated diagnoses when possible.
- DO remember that if it is NOT documented in the medical record, then it did NOT happen.
- DON'T enter a list of the medications that the member is taking in the medical record as proof that a condition was evaluated. A medication list does not mean that an evaluation occurred for the condition for which the medication is used.
- DON'T use the term "with" to support the cause and effect of a specific disease.
- DON'T code probable, suspected, ruled out or working diagnoses.

CODING TIPS:

- DO code the diagnosis to the highest level of specificity using the ICD-9-CM diagnosis coding system.
- DO code as many times as the patient receives treatment and care for a chronic condition.
- DO code every condition that exists at the time of the encounter when that condition results in or affects patient care, treatment or management and when the conditions are addressed in the medical record for that encounter or specified visit.
- DO remember ICD-9-CM Coding Guidelines may require multiple conditions to be combined into one code. For example: hypertensive heart disease with congestive heart failure: 402.91
- DO follow instructions to fully code all conditions when "code also," "code first" or "use additional code" are specified within the ICD-9-CM manual for a code. For example: Patient has dementia with multiple sclerosis.

  This requires two codes to be used:

  a. Multiple Sclerosis: 340

  b. Manifestation of Dementia: 294.10
- DON'T code conditions that were previously treated and no longer exist.

OFFICE STAFF

UTILIZATION MANAGEMENT TIPS FOR PRECERTIFICATION:

Please remember the following when calling the UM Department:

1. Have the member's name, Gateway ID Number or social security number ready. You will be asked the member's address, phone number and date of birth for verification.
2. The UM representative will need 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. For timely completion of your request, have clinical information available at the time of your call.
5. If the UM representative requests more information, please verify the representative's name and phone number that you can call with the necessary information. 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 UM Department is accessible by voicemail 24 hours and voice mail is returned within one business day.
7. When it is necessary for the UM representative to transfer your call to the nurse line you will be advised of the expected on-hold time. You have the option of holding for the nurse or requesting a call back. While you are on hold you can leave a message at any time. Cases routed to the nurse for a call back and voice messages are prioritized and returned the day of the request or within one business day.

OFFICE STAFF

WHAT IS A CORRECTED CLAIM?

When submitting corrected claims, please include all services that were previously billed on the original claim to ensure appropriate adjustments and payments are made. Gateway reprocesses corrected claims by retracting the original claim payment in its entirety and then processing the corrected claim. In addition, the claim must be clearly marked "corrected claim" and submitted for reprocessing within 120 days from the payment date of the original claim.

OFFICE STAFF

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

Gateway's QI/UM Committee recently approved the program and work plan that list activities for Medicaid and *Medicare Assured*® in 2010. The evaluations of the 2009 programs have been finalized. If you would like a written summary of these documents, please call the QI Department at 412-255-7162.

OFFICE STAFF

DIVA FAXES

As a Gateway Health Plan® provider, you have probably used DIVA to verify member eligibility or enter a referral. Effective May 3, 2010 Gateway added a line to the disclaimer on the verification fax that is generated through DIVA that states: *Please note that this information is being sent at the request of the provider.*

There is an increase in inquiries regarding the origin of DIVA faxes and we believe that this will help clarify. Please continue to use DIVA as usual.

Chlamydia SCREENINGS SHOULD OCCUR ANNUALLY for sexually active girls and/or other females who:

- Have new or multiple sex partners
- Are less than 25 years old
- Don't use barrier contraceptives consistently
- Have signs of a possible cervical infection
- Have previously had an STD

CHLAMYDIA BILLING CODE

87110 - Culture, chlamydia, any source
86631 - Chlamydia
86632 - Chlamydia, IgM

CLINICAL

CHLAMYDIA – GETTING YOUNGER PATIENTS TO TALK ABOUT THEIR SEXUAL HISTORY

Do you want to educate younger patients about chlamydia? Try posting information that appeals to them. The CDC has designed a brochure that is available for download on its website. It is a colorful, no nonsense approach to talking about chlamydia. The brochure can be printed directly or downloaded from the website: http://www.cdc.gov/STD/chlamydia/the-facts/default.htm#commprint. You can also order limited quantities of the brochure at no cost from the CDC.

The CDC website also features a new publication from the Academy for Educational Development. "Summary of a Review of the Literature: Programs to Promote Chlamydia Screening," examines the factors that influence how and why sexually active teens and young adults seek testing for chlamydia. The full publication is available at: http://www.cdc.gov/STD/HealthComm/ChlamydiaLitReview2008.pdf.

CLINICAL

PEER REVIEW INFORMATION

Gateway Health Plan® offers providers the opportunity for peer reviews whenever a decision is made to deny or reduce a service. The utilization management staff will phone the ordering or attending physician's office to provide information regarding the Gateway member and the details of the request and review decision. The office will also be given the name of the Gateway physician to contact to discuss medical necessity.

When returning a call to the Gateway physician, please have member information ready including the Gateway identification number and/or authorization number.

CLINICAL

FDA ISSUES NEW SAFETY REQUIREMENTS FOR HOW LONG-ACTING BETA AGONISTS (LABAS) ARE USED IN THE TREATMENT OF ASTHMA

The FDA is recommending changes to how inhaled Long-Acting Beta Agonists (LABAs) are used in the treatment of asthma. [1]

These changes are based on the FDA's analyses of studies showing an increased risk of severe exacerbation of asthma symptoms, leading to hospitalizations in pediatric and adult patients as well as death in some patients using LABAs for the treatment of asthma.[1]

LABAs are also indicated for the treatment of COPD and exercise-induced bronchospasm. However, the safety requirements issued by the FDA only apply to the treatment of asthma.

Available as a single ingredient product or in combination with a corticosteroid, examples of LABAs indicated for the treatment of asthma include, **Serevent Diskus** (salmeterol), **Foradil Aerolizer** (formoterol), **Advair Diskus** (salmeterol and fluticasone), and **Symbicort** (formoterol and budesonide).

Key points to remember about the use of LABAs in patients with asthma include:[1]

- LABAs should not be used as monotherapy in children or adults. Single ingredient LABAs should only be used in combination with an asthma controller medication.
- LABAs should only be used long-term in patients whose asthma cannot be adequately controlled on asthma controller medications (e.g. inhaled corticosteroids such as Flovent HFA or Asmanex, Singulair tablets)
- Pediatric and adolescent patients who require the addition of a LABA to an inhaled corticosteroid should use a combination product containing both an inhaled corticosteroid and a LABA (e.g. Advair), to ensure compliance with both medications.
- LABAs should be used for the shortest duration of time required to achieve control of asthma symptoms and discontinued, if possible, once asthma control is achieved. Patients should then be maintained on an asthma controller medication.
- The FDA recommendations only apply to the use of LABAs in the treatment of asthma. They do not recommend any change in the use of LABAs for COPD. There is no evidence to conclude that people with COPD who use a LABA are at any greater risk compared to people with COPD who do not use LABAs.

Gateway values the care that you provide for our members and is sensitive to the fact that maintaining long term control of asthma can be a challenge for both members and providers. We encourage you to take note of this drug safety announcement and conduct a comprehensive review of your patient's asthma treatment plan for medical appropriateness.

Reference:[1] New safety requirements for long-acting inhaled asthma medications called Long-Acting Beta-Agonists (LABAs), FDA Safety Announcement 02-18-2010

CLINICAL

PHARMACY FORMULARY UPDATES

The Gateway Health Plan® formulary is updated on a regular basis. The listed medication changes reflect the decisions made by Gateway's Pharmacy and Therapeutics Committee. Please review the changes and update your Gateway formulary book as necessary.

Please note that Gateway's formulary can be accessed online at www.GatewayHealthPlan.com. The website also provides additional information regarding prior authorization or step therapy requirements as applicable.

Additional copies of the formulary may be printed directly from our formulary website, or requested through Provider Services by calling 1-800-392-1145 for Medicaid members or 1-800-685-5201 for *Medicare Assured® HMO* members.

Medicaid Formulary Additions/Updates

Drug Name	Effective Date	Notes
Azor (amlodipine/olmesartan)	1/1/2010	QL ST
Suboxone (buprenorphine-naloxone)	4/1/2010	PA added
Subutex (buprenorphine)	4/1/2010	PA added

Medicare Assured® HMO Formulary Additions

Drug Name	Effective Date	Notes
Fanapt (iloperidone)	3/1/2010	QL
Invega Sustenna (paliperidone palmitate) 39mg, 78mg, 117 mg, 156 mg, 234 mg	3/1/2010	PA QL
Razadyne (galantamine HBr)	3/1/2010	GC PA QL
Voltaren Gel (diclofenac sodium)	3/1/2010	PA QL
Votrient (pazopanib)	3/1/2010	QL
Mozobil (plerixafor)	4/1/2010	PA QL

Medicare Assured® HMO Formulary Deletions

Brand Name Deletion (Generic added to formulary)	Effective Date
Prevacid capsules (lasoprazole)	5/1/2010
Risperdal M-Tabs 1 mg (risperidone ODT 1mg)	5/1/2010
Subutex tablets (buprenorphine)	5/1/2010
Trileptal Oral Suspension (oxcarbazepine)	5/1/2010
Valtrex tablets (valacyclovir)	5/1/2010
Mirapex tablets (pramipexole)	6/1/2010

Notes Key:
PA = Prior Authorization required
QL = Quantity Limit applies
ST = Step Therapy applies
SPN = Obtain through Specialty Pharmacy Network
GC = Generic covered

Please contact Gateway's Pharmacy Department with formulary questions or other pharmacy benefit concerns. For Medicaid members, call 1-800-528-6738. For *Medicare Assured® HMO* members, call 1-800-685-5215. You can also send a fax to 412-255-4544 or 888-245-2049 (Medicaid) or 888-447-4369 (Medicare), Attn: Pharmacy Department.

CLINICAL

GUIDELINES AND REVIEW STANDARDS ON GATEWAY'S WEBSITE

Throughout the year, Gateway reviews and revises its clinical guidelines and presents them to our Physician Advisory Workgroups for approval. To view these guidelines, go to www.GatewayHealthPlan.com, select a plan, click the provider link and click on the Quality Improvement links on the left-hand column. Clinical guidelines, medical record review standards and other helpful forms are listed. To request a hard copy of an item, call the Quality Improvement Department at 412-255-4541.

CLINICAL

THE SPECTRUM OF POSTPARTUM DEPRESSION

In order to better diagnose and treat postpartum depression, it may be useful to look at the disorder as a spectrum of symptoms.

The mildest form of postpartum depression (PPD) is often called the **baby blues. The baby blues affects** as many as 80% of new mothers. Symptoms include tearfulness, irritability and feeling overwhelmed and often subside by the time the infant is two weeks old.

A more severe form of PPD occurs in approximately 10-20% of women and onset can be delayed for up to one year after the birth. **It is important to continue screening the postpartum mother up to one year after the birth**. The symptoms are similar to those experienced with baby blues; however they are more intense, last longer and may involve negative feelings toward the baby, affecting the formation of the maternal-child bond. A combination of drug and talk therapy is often necessary to resolve the episode.

Postpartum anxiety is not talked about as often as PPD but is more common than depression in new mothers. The adjustment to a new life and responsibilities may invoke fears for the infant's safety. If thoughts are intrusive, repetitive and unpleasant, this may be an occurrence of **postpartum obsessive compulsive disorder** affecting 2% of new mothers. **Postpartum panic disorder** also affects approximately 2% of new mothers and is characterized by panic attacks which include heart palpitations, shortness of breath, dizziness and a fear of going "crazy."

Postpartum psychosis (PPP) is behind many of the tragic news stories that have warned us to take this disorder seriously. PPP affects only 0.1% of new mothers. It is characterized by rapid onset usually beginning 3-10 days after the baby is born. Symptoms range from mania and confusion to hallucinations and delusional thinking, often involving a plan to harm herself and/or the baby. Immediate hospitalization is necessary. There is a high correlation between bipolar disorder and PPP.

WHAT CAN YOU DO IN YOUR OFFICE TO BETTER IDENTIFY PPD?

The obstetrician, pediatrician and PCP all have frequent opportunities to screen new mothers for postpartum depression. Easy-to-use self reporting scales are a quick way to measure progress in the depressed postpartum patient. They can be administered at any office appointment and will not take up staff time as they are completed while the patient waits to see the doctor in the privacy of the exam room.

The Edinburgh Postpartum Depression Scale is a 10 question survey that is easily scored and can be repeated throughout the first year after delivery by the OB, PCP or pediatrician. Often the depressed patient does not readily identify any changes in her condition due to the gradual and subtle nature of recovery from depression and anxiety. These self assessments serve as a way to reassure the new mother if scores are improving or encourage the mother to discuss her situation with the doctor if scores remain the same or worsen. The scale is available for download on the American Academy of Pediatrics website, www.aap.org.

Gateway Health Plan® has a team of medical care managers who specialize in assisting our pregnant members with their complex, multi-faceted areas for concern. These care managers are trained nurses and social workers who help our members with community support and provide thorough follow-up attention throughout the pregnancy and postpartum period. To reach the MOM Matters® program at Gateway, call 800-642-3550 and choose option 2.

REFERENCES

Guidelines for Treating Postpartum Mood Disorders by Mary L. Obata, M.A.

Racial Differences in Reported Postpartum Depression. Howell E, Leventhal H, Mora P, Chassin MR; AcademyHealth. Meeting (2003 : Nashville, Tenn.). *Abstr AcademyHealth Meet.* 2003; 20: abstract no. 236.

Claudia M Klier[1] and Maria Muzik[21]
University Clinic of Child and Adolescent Neuropsychiatry, Währinger Gürtel 18-20, A-1090 Vienna, Austria2Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0118, USA

OFFICE STAFF

UM CRITERIA

Utilization Management (UM) criteria information is available to participating practitioners and providers via 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 or by written request to the Medical Management Department.

As a reminder, the UM telephone number for Medicaid providers is 1-800-392-1146. *Medicare Assured*® providers can call 1-800-685-5207.

OFFICE STAFF

HELP PREVENT TOOTH DECAY IN CHILDREN

Tooth decay remains one of the most common childhood diseases and is also one of the most preventable. Primary Care Physicians can help win the fight to prevent tooth decay by providing topical fluoride varnish in the office for their Gateway Medicaid patients under the age of five.

Effective April 1, 2010 Gateway will reimburse those PCPs properly certified for the application of topical fluoride varnish on a fee-for-service basis. Only those PCPs who have received a certificate for completing the on-line training module titled "Oral Health Risk Assessment" qualify for the fee-for-service reimbursement. (Refer to MA Bulletin 09-10-08, 31-10-08 for instructions on how to access the training module.) Qualified practitioners are able to provide 4 treatments per calendar year to patients on their PCP panel who are under 5 years of age.

In order to bill (D1206) and receive the $18.00 reimbursement PCPs must submit a copy of the training certificate to:

Gateway Health Plan®
U S Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219-2704
Attn: Provider Relations Department

OR

Fax to (412) 255-4504,
Attn: Provider Relations Department

At the top of the certificate, please include your 13-digit MA provider identification number and/or Gateway Individual Provider Number. PCPs will not be reimbursed for providing the topical fluoride varnish before we have a copy of the training certificate on file. Your practice will receive written notification confirming receipt of your certificate and a date when you may begin billing.

Please contact your provider relations representative directly with any questions.

OFFICE STAFF

TIMELINESS

There are two Gateway Health Plan® processing guidelines that contain the term "timely."

Timely Filing means the claims must be initially filed for processing within the specified day range.

- **Medicaid** timely filing timeframe is **180 days from date of service**
- ***Medicare Assured®*** timely filing timeframe is **365 days from date of service**

Timely Follow Up means the timeframe a written appeal or review request, or call must be made to question a previously processed claim.

- The timeframe is **120 days from date of initial processing** for both Medicaid and *Medicare Assured®* plans

The only exception to the timely follow up guideline for both Medicaid and *Medicare Assured®* is if Gateway is not the primary carrier. If the initial claim submission is denied with code D11 because primary carrier EOB (Explanation of Benefits) was not submitted; **the follow up timeframe is based on the process date from the EOB.**

- **Medicaid is 60 days** from process date on primary carriers EOB to resubmit for reconsideration
- ***Medicare Assured®* is 365 days** from process date on primary carriers EOB to resubmit for reconsideration

All claim processing inquiries should be directed to the Provider Services Department at: 1-800-392-1145 for Medicaid or 1-800-685-5205 for *Medicare Assured®*.

OFFICE STAFF

To ensure that your current Gateway Health Plan *Medicare Assured®* HMO patients do not lose their coverage, please remind them to renew their Medical Assistance benefits every year.

OFFICE STAFF

OFFICE MANAGER INCENTIVE PROGRAM WINNERS

Congratulations to the winners of the 1st Quarter 2010 Primary Care Office Manager Incentive Program! The winners are:

- Butler Pediatrics
- CHI-Ebandjieff/Park Hill
- East End Medical Associates
- Highlands Family Medicine
- Northeast Pediatrics LLC
- Washington Hospital Family Medicine

As a reminder, the criteria for participation include the following:

1. Submission of electronic claims
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 claims for EPSDT and preventive health encounters

The winners received a plaque and gift basket. The winners of the 2nd Quarter 2010 program will be announced in the next issue of Provider Update.

OFFICE STAFF

NOTICE TO PROVIDERS WHO PROVIDE SUBOXONE COUNSELING IN THEIR OFFICES

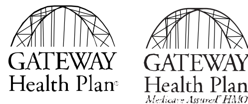
Please report these services by using diagnosis codes 304.0 or 304.7 and evaluation and management codes 99201-99215 or 99241-99245.

When these services are provided to members on a PCP's panel, they are covered under the monthly capitation. Because it may be difficult for our members to access these services, if a PCP renders these services to members who are not on their panel, a referral is required from the member's PCP. The rendering PCP will be reimbursed on a fee for service basis.

Specialists will be reimbursed the contracted rates for these services. A referral from the member's PCP is required.

As a reminder, payment from Gateway Health Plan® is considered payment in full and providers are not permitted to bill our members for any covered services.

OFFICE STAFF



2010 PRACTITIONER AND PROVIDER SATISFACTION SURVEYS

Gateway Health Plan® will again be conducting both the Medicaid and *Medicare Assured®* practitioner and provider satisfaction surveys this year. If you participate in both plans 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.

The survey results help us identify where we meet the needs of our network and where we need to improve. Your time to complete and return the survey is greatly appreciated.

If you have any questions about the 2010 survey, call your provider relations representative directly.

OFFICE STAFF

PHARMACY TOOLKIT FOR PROVIDERS

As a healthcare provider, staying on top of multiple health plan formulary polices and procedures can be a challenge. To support you in these efforts, we have put together this Pharmacy Toolkit for Providers that addresses common formulary issues. This is part of our commitment to provide you with the resources you need and the highest level of pharmacy service when caring for Gateway members.

PRIOR AUTHORIZATION AND STEP THERAPY CRITERIA

To view our prior authorization (PA) and step therapy (ST) criteria go to *www.GatewayHealthPlan.com*.

FOR MEDICAID:

1. Select Medicaid provider information.
2. Select Prior Authorization or Step Therapy Protocols (left side of page).
3. Click on the name of the drug to review criteria.

FOR MEDICARE ASSURED® HMO:

1. Select *Medicare Assured ® HMO* provider information.
2. Select Drug List (left side of page).
3. Select View Prior Authorization or Step Therapy information.

FORMULARY UPDATES FOR MEDICAID AND MEDICARE

Available **immediately** on our website at *www.GatewayHealthPlan.com*.

1. Under the For Providers tab, select either Medicaid or Medicare Assured®HMO provider information.
2. Select Drug List (left side of page).
3. Select Search Drug List (formulary).
4. Click on View Recent Updates or Year to Date Updates

Provided **quarterly** in our provider newsletter.

If your patient is impacted by a change to our formulary, you and your patient will be notified 30 days in advance for Medicaid and 60 days in advance for Medicare.

The Drug Formulary is available for download and printing directly from our website (see website instructions above) or you may request hard copy or electronic version of the formulary be sent to you by contacting Provider Services at 1-800-392-1145 (Medicaid) or 1-800-685-5201 (Medicare) Monday-Friday 8:30 a.m.-4:30 p.m.

REQUESTING A NON-FORMULARY DRUG OR PRIOR AUTHORIZATION

When a formulary medication is not medically appropriate for your patient, you must initiate a non-formulary request through our Pharmacy Services Department. Fax the completed form to 412-255-4544 or 1-888-245-2049 (Medicaid) or 1-888-447-4369 (Medicare) during normal business hours, or call 1-800-392-1147 during off-hours and weekends, with all of the information requested on the form.

To access a non-formulary request form go to *www.GatewayHealthPlan.com*.

1. Under the provider section, select either Medicaid or *Medicare Assured® HMO* provider information.
2. Select Forms (left side).
3. Under the Pharmacy Forms tab, select Non-formulary Drug Exception Form (Medicaid) or *Medicare Assured® HMO* Drug Exception Form (Medicare).

Requests for drugs that require prior authorization are processed by calling the Pharmacy Services Department at 1-800-528-6738 (Medicaid) or 1-800-685-5215 (Medicare) Monday-Friday 8:30 a.m.-4:30 p.m.

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

www.gatewayhealthplan.com

PROVIDER SERVICES
Medicaid 1-800-392-1145
Medicare 1-800-685-5205

MEDICAL MANAGEMENT
Medicaid 1-800-392-1146
Medicare 1-800-685-5207

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

NATIONAL IMAGING ASSOCIATES
Medicaid and Medicare 1-888-879-5922

OFFICE STAFF

HOW TO REQUEST A DRUG ADDITION TO THE FORMULARY

Providers may request the addition of a medication to the formulary. Requests must include the drug name, rationale for inclusion on the formulary, role in therapy and the formulary medications that may be replaced by the addition. The Pharmacy and Therapeutics Committee will review and take into consideration these requests. All requests should be forwarded in writing to:

Gateway Health Plan®
Pharmacy Department-P&T Committee
US Steel Tower-Floor 41
600 Grant Street
Pittsburgh, PA 15219

OFFICE STAFF

FAX NOTIFICATION

Gateway Health Plan® realizes that efficient communication is vital to maintain relationships with the provider community. We continuously look for ways to improve how we communicate, especially related to fulfilling the notification requirements for decisions surrounding medication exception requests.

As of October 2009, the Pharmacy Department has successfully implemented the use of Fax Press technology for decision notifications to providers for both Medicaid and Medicare. 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 on the patient chart for discussion at the next visit.

If you have questions or concerns about this notification process or receive a fax in error, please call the Pharmacy Services Department at 1-800-528-6738.

ICON KEY