



GatewayHealthPlan.com

Provider | Update

PRODUCED FOR
GATEWAY HEALTH PLAN®
PROVIDERS AND
CLINICIANS

OFFICE STAFF



DIVA... YOUR DIGITAL VOICE ASSISTANT!

As part of our Going Green efforts here at Gateway Health Plan® we announced in the December 2010 Provider Update plans to discontinue printing and mailing the newsletter in 2011.

The newsletter will only be accessible on our website. We've received positive feedback to this news and suggestions from our providers and Gateway staff on other opportunities to help the environment and Go Green. To further reduce our impact on the environment, Gateway will discontinue printing and distributing paper Referral Forms and require providers to use DIVA – Gateway's Automated Telephone Referral System instead. This change will go into effect July 1, 2011 for our OB/GYN providers and October 1, 2011 for our Primary Care Physicians. Additional information on this change will be forthcoming. Training will be provided by your Provider Relations Representative who will share with you the many benefits of using DIVA.

If you are not a DIVA user already you don't have to wait until the implementation dates to begin. **Give it a try by calling 1-800-642-3515!**

We suggest for your initial try at entering a referral that you use the detailed Referral Entry instructions printed in the *Gateway At A Glance for Medicaid Providers* or you can view a DIVA video tutorial at www.GatewayHealthPlan.com.

You'll quickly find it only takes seconds to generate a DIVA referral versus the minutes it takes to manually write one. In addition, you can enter multiple referrals during the same call without having to hang up or re-enter your practice information. We're convinced that



you will find DIVA a faster and more economical alternative to paper.

Gateway understands that there may be instances when a provider is unable to use DIVA. A downloadable version of the PCP and OB/GYN Referral Form is available at www.GatewayHealthPlan.com. Each time a form is downloaded it is given a unique referral number. For claims payment purposes each referral you issue requires a NEW form to be downloaded and printed. Just print, complete and mail to the address on the form.

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2011 GATEWAY TO PHYSICIAN EXCELLENCE® (GPE®) PCP PAY-FOR-PERFORMANCE PROGRAM

The Gateway to Physician Excellence® (GPE®) program is now in its fourth year. Gateway values the important role providers play in serving members and believes that practices committed to providing quality healthcare that is accessible and efficient should be recognized and rewarded.

GPE® is part of Gateway's mission to deliver quality programs that positively impact member health. The program objectives:

- Improve the delivery of healthcare – including quality, access, and efficiency.
- Reduce racial and ethnic disparities.
- Improve the member experience.
- Increase physician satisfaction.

In 2010, the program involved 351 primary care practices across Pennsylvania, 1,266 primary care physicians which impacted 80 percent of Gateway's Medicaid membership. Additionally, Gateway's Medical Directors engaged 77 GPE® practices which provided care to 66,260 Gateway members.

In addition to financial awards, GPE® practice participation is noted in both the provider directory and the online provider search tool.

The program criteria and design will remain unchanged in 2011. The Department of Public Welfare is collaborating with its contracted Managed Care Organizations to develop a common pay-for-performance program in 2012. Gateway will provide an update upon final recommendations by DPW.

The timeline for the 2011 program is listed below.

12/31/2010

Last day services can be provided for inclusion in 2010 measurement year.

Snapshot date for practice size open/closed panel status and service hours.

4/29/2011

Last day processed claims for 2010 can be counted for GPE®

MAY – SEPT.

Data analysis, validation and scorecard production

11/23/2011

Last day to submit appeals to the Provider Relations Representatives. May appeal quality indicators with the following supporting documents:

Copy of the claim submitted to Gateway Health Plan®, or

Copy of the remittance for the claim in question (paid or non-paid).

| | | | | | | | | | | | | |
|--------|--------|--------|--------|--------|--------|--------|---------|--------|------------------------------------------------------------------|--------|--------|----------------------------------------------------------------------------------|
| DEC 10 | JAN 11 | FEB 11 | MAR 11 | APR 11 | MAY 11 | JUN 11 | JULY 11 | AUG 11 | SEP 11 | OCT 11 | NOV 11 | DEC 11 |
| | | | | | | | | | SEPT. – OCT. Scorecard and checks delivered to GPE® practices | | | DEC. Reconciliation of appeals and distribution of remaining program dollars. |

For more information or questions about the GPE® Program, please visit www.GatewayHealthPlan.com/gpe or contact your Provider Relations Representative.



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2011 GATEWAY PROVIDER POLICY AND PROCEDURE MANUAL COMING SOON!

You will soon receive notice via Fax/ E-mail that the 2011 Gateway Health Plan® and Gateway Health Plan Medicare Assured® HMO SNP Provider Policy and Procedure Manuals have been published to the GatewayHealthPlan.com website. Please reference these manuals and the Quality Improvement Manual for the most current information.

You will still receive our popular "Gateway at a Glance" in the mail in early Spring!



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HOW TO CODE THE ABSENCE OF CERTAIN BODY PARTS USING "V" CODES:

- V45.71 Acquired absence of breast and nipple
- V88.01 Acquired absence of both cervix and uterus (status post total hysterectomy)
- V88.02 Acquired absence of uterus with remaining cervical stump
- V88.03 Acquired absence of cervix with remaining uterus

PATIENT AUTHORIZATION-HIPAA

Gateway Health Plan® makes protecting the privacy and security of member health information a priority! Gateway understands that there are times when we need to share information with healthcare professionals to enable proper care, timely payment and reimbursement.

Understand that in some instances, HIPAA guidelines do permit healthcare providers to use or give out member medical information without the need for written authorization from the member. A few examples include:

- for public health activities, such as reporting disease outbreaks
- for government healthcare oversight activities, such as fraud investigations
- for judicial proceedings, such as court orders

When a request is received for another purpose, Gateway will provide PHI in situations when the member has given authorization or consent to release information to the requesting party. In the event the member does not give authorization or consent to release their information, Gateway will follow the parameters defined in 45 CFR 164.512 (Uses and disclosures for which an authorization or opportunity to agree or object is not required), to determine if the information can be provided.



To learn more about how Gateway uses or discloses member information or to view our "Notice of Privacy Practices," please visit us online at www.GatewayHealthPlan.com. To request a paper copy of Gateway's "Notice of Privacy Practices," please call Member Services at 1-800-392-1147 for Medicaid or 1-800-685-5209 for Medicare Assured®.

Gateway employees follow strict guidelines to avoid disclosing more information than is needed and restrict information to those who do not have the right to the information. This is why our employees ask for key information, such as a provider's tax ID number, prior to releasing medical information about our members.

Gateway takes great pride in protecting member information and looks forward to working with providers to manage our members' health care needs.

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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. All appeals should be in writing submitted to Gateway Health Plan® to the attention of the Appeals Department 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. You may also find this information on our website at: www.GatewayHealthPlan.com under the “For Providers” section.

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ADVANCE DIRECTIVES

If an accident, injury or health problem caused one of your patients to be unable to communicate, would you know their wishes concerning resuscitation, types of care and extent of treatment? Would you be able to direct their care per their wishes?

Your patient medical records, which serve as a repository for patient-specific information, is

the ideal place to document whether a patient has an advance directive and if they do, to house a copy.

As a participating provider within Gateway's network, you are responsible for determining if the member has executed an advance directive and for providing education when it is requested. You can also request a copy of a “Living Will” form from the Quality Improvement Department by calling 412-255-1144. There is no government mandated form. A copy of the “Living Will” form should be maintained in the medical record. Gateway's Medical Record Review Standards state that providers ask members age 21 and older whether they have executed advance directives and will document the response.

Although beginning at age 21 may seem premature, it is this age group that is frequently injured, etc., and may not be able to verbalize their wishes after that occurrence. Some offices include a tab in their charts for Advance Directives. Others use a sticker on the outside cover that serves as a reminder to ask about this and to document whether the patient has an advance directive and if one is located in the medical record. A form is also in the packet provided to provider offices at the time of medical record review.

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

MEDICATION THERAPY MANAGEMENT - UPDATE 2011: WORKING TOGETHER TO IMPROVE PATIENTS' DRUG THERAPY



**Medication related problems cost more than \$200 billion annually in the United States.¹
Another report estimated yearly prescription expenditures were equal to about \$250 billion.²**

Essentially, for every dollar spent on medications, another dollar is spent on problems these medications cause. It has also been shown that the more medications a person takes, the greater chance they have at suffering from an adverse event.^{3,4} Furthermore, studies have shown that when pharmacists provide medication therapy management (MTM) services, and are part of the clinical management of patients with chronic diseases and multiple medications, patient outcomes improve and unnecessary costs can be avoided.⁵ We can work together to help patients avoid these medication related problems and preventable hospital stays, and safely use their medications to optimize outcomes.

Medication Therapy Management (MTM) has been in effect since 2006 as a method for Medicare Part D Sponsors to help ensure medications are used appropriately and that they are safe and effective for patients identified as higher risk. Targeted patients include those with multiple chronic disease states and prescribed multiple Part D medications reaching a certain Part D drug spend. Patients will be notified via a welcome letter that they have qualified for the benefit. This will be done once a quarter. As providers, you will know that one of your patients has qualified because we will send you a letter requesting clinical data including, recent progress notes and lab results. This information helps us make

sure we have accurate information regarding your patient, which subsequently helps our clinical pharmacists provide more helpful recommendations regarding their drug therapy.

Changes for the 2011 program include switching to a new software tool developed by Medication Management Systems, Inc. (MMS). Additionally, Gateway clinical pharmacists will now be responsible for all medication reviews, including the initial comprehensive medication review (CMR), which previously had been conducted by clinicians associated with an outside vendor. These two changes are being done in hopes of streamlining the program and ultimately being able to offer our providers and members with an updated, reconciled medication list and appropriate, helpful recommendations to optimize patient's drug therapy.

When a patient qualifies for MTM, they are invited to call our new direct MTM line (1-800-877-2010) that will connect them directly to one of our clinical pharmacists to either go over their medications immediately or schedule an appointment for a later time more convenient to them. If we do not hear from them we will attempt to reach them telephonically. Based on the Centers for Medicare and Medicaid Services (CMS) requirements, all members who qualify are automatically enrolled, so whether we are able to contact them

or not, we are required to perform an initial CMR and quarterly follow up reviews. In order for our recommendations to you to be the most accurate and beneficial we do ask that you send the clinical data when requested (fax: 412-255-7165).

This program has the potential to improve patients' use of medications. The more that we are able to work together with their providers the more successful we will be, and ultimately the better outcomes our patients will see. We urge you to provide feedback when you receive the summaries of the MTM encounters by faxing back the note with your comments to 412-255-7165. If you have any questions, please contact us at our new MTM line: 1-800-887-2010 (phone) or email GatewayRx@GatewayHealthPlan.com.

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- 2.) Martin A, Lassman D, Whittle L, et al. Recession contributes to the slowest annual rate of increase in health spending in five decades. *Health Aff.* 2011;30(1):11-22.
- 3.) Field TS, Gurwitz J, Harrold LR, et al. Risk factors for adverse drug events among older adults in the ambulatory care setting. *J Am Geriatr Soc* 2004; 52 (8):1349-54;
- 4.) Viktil KK, Moger TA, Reikvam A. Polypharmacy as commonly defined is an indicator of limited value in the assessment of drug-related problems. *Br J Clin Pharmacol* 2007;63 (2): 187-95
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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 PPD is often called **The Baby Blues** and is very common, affecting as many as 80 percent of new mothers. The Baby Blues would most likely have disappeared on its own by the time the infant is 2 weeks old. Women may experience tearfulness, irritability and feel overwhelmed.

Postpartum Depression (PPD) occurs in approximately 10-20 percent of women and onset can be delayed for up to one year after the birth. ***This is why 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. They are adjusting to a new life which brings tremendous responsibility and 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 percent of new mothers.

Postpartum panic disorder also affects approximately 2 percent 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 is behind many of the tragic news stories that have warned us to take this disorder seriously. PPP affects only 0.1 percent 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. It should be mentioned that 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

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any office appointment and will not take up staff time as they are self-reporting surveys, easily 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 encourage the new mother if scores are improving or tweak treatment if scores remain the same or worsen.

Self assessment forms can be downloaded at <http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf>

Finally, 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 CM's are trained nurses and social workers, able to help the member/patient by linking the individual to community supports and providing thorough follow-up attention throughout the pregnancy and postpartum period. To reach the MOM Matters® program at Gateway Health Plan® call 800-642-3550 and choose option 2.

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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.

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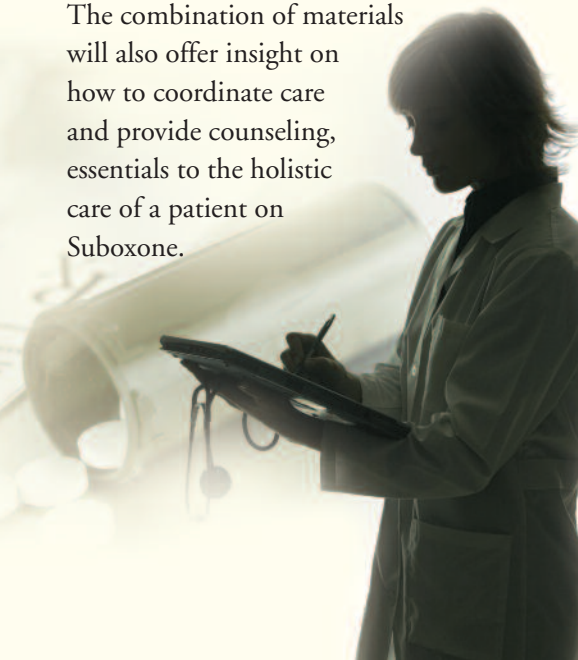
RESOURCES FOR PROVIDERS WHO PRESCRIBE SUBOXONE

It has been more than six years since the TIP 40: Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction was published as a guide to for the treatment of opioid dependency by healthcare providers. For the most part, the treatment protocols have remained the same with some variation. Since updated clinical guidelines have not been released since 2004, Gateway wanted to suggest free resources to our providers from the Addiction Technology

Transfer Center (ATTC) Network. This website (www.attcnetwork.org/index.asp) provides Training for Multidisciplinary Addiction Professionals through blending products, which can be found under the right hand column link NIDA/SAMHSA Blending Initiative, view blending products. These products may be suitable for you or anyone in your office staff who may have interactions with your patients utilizing Suboxone to provide them with a better understanding of the

medication and disease.

The combination of materials will also offer insight on how to coordinate care and provide counseling, essentials to the holistic care of a patient on Suboxone.



CLINICAL

BONE DENSITY TESTING

The current recommendation from the U.S. Preventive Services Task Force regarding bone density testing (BMD) is at least once for all women age 65 and older.

Guidelines from the National Osteoporosis Foundation include:

- All postmenopausal women under age 65 who have one or more additional risk factors for osteoporosis (in addition to being postmenopausal and female)
- All women age 65 and older regardless of additional risk factors
- Postmenopausal women who have sustained a fracture
- Women who are considering therapy for osteoporosis
- Women who have been on hormone replacement therapy for prolonged periods

Gateway Health Plan *Medicare Assured*® HMO SNP has made it more convenient for our providers to order a BMD test for our members by eliminating the need for a pre-authorization.



The new process only requires a script to be given to our member which can be taken to any participating provider to be completed.

In accordance with Gateway's effort to assure that all our members receive the best possible health care please consider BMD testing for all appropriate members.

CLINICAL

IMPORTANCE OF THE ANNUAL PHYSICAL

Many members seek out their Primary Care Physician only in times of illness or emergency. This care can feel fragmented at times due to the nature of the member visit. Gateway Health Plan *Medicare Assured*® HMO SNP encourages our members to call their physician and make an appointment to have a yearly

physical. This covered benefit allows the PCP office to get a more complete record of the member's overall health and to have the opportunity to see the member on a non-emergent basis.

As a health practitioner, you know that annual physicals are a great opportunity to obtain the member's family history, get a baseline on the member's ADL functioning and learn more information on past medical treatments without the pressure of needing to address an emergent medical issue. This time could also allow for education on diet and health related issues. It can also start the conversation on the importance of completing preventive health measures and vaccinations.

Gateway encourages members to bring a list of all their prescribed

medications, including over-the-counter drugs and any herbal medications to allow for a complete medication profile and any safety concerns can be addressed. Members should also provide a list of any specialists or alternative medicine providers involved in their care to facilitate any care coordination or more targeted education.

Lastly, the physical can greatly improve the member-physician relationship. Increased trust and communication can prove vital when the patient presents with a future medical crisis. A more complete patient care record can result in earlier detection of medical conditions and better outcomes for our shared members.



CLINICAL

CLARIFICATION ON HOW TO CODE AND BILL FOR PEDIATRIC OBESITY ASSESSMENTS

Data available to Gateway Health Plan® indicates that about 44 percent of its members between the ages of 2 and 21 do not have a body mass index (BMI) calculated or recorded during EPSDT screenings. We encourage all providers to incorporate the calculation of BMI into the medical record for all children and adolescents between these ages.

In November 2007, the Pennsylvania Department of Public Welfare published Medical Assistance (MA) bulletin 99-07-19, Childhood Nutrition and Weight Management Services (CNWMS) for Recipients Under 21 Years of Age. In February 2008, DPW issued a bulletin 99-08-01 to clarify the language in the Payment Limitations section of the original bulletin and to specify the types of CNWM providers for whom the limitations apply. The February 2008 bulletin applies to all physicians, certified registered nurse practitioners (CRNP), registered nurses, nutritionists, outpatient hospital clinics, independent medical surgical clinics, Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) enrolled in the MA Program.

The seven clarifications are as follows:

- Physicians, CRNPs, outpatient hospital clinics and independent medical surgical clinics may bill for a physical exam or complete EPSDT screen and an initial

assessment or re-assessment rendered to a child on the same day.

- Physicians, CRNPs, outpatient hospital clinics and independent medical surgical clinics may bill for an office visit or clinic visit and a CNWMS rendered to a child on the same day if the child is not being seen solely for a CNWMS.
- Physicians, CRNPs, outpatient hospital clinics and independent medical surgical clinics may bill for an initial assessment or re-assessment and individual, group, or family weight management counseling rendered to a child on the same day.
- An initial assessment is at least 30 minutes in duration, per assessment. Initial assessments are limited to three assessments per child per 365 consecutive day period.
- A re-assessment is at least 30 minutes in duration, per re-assessment. Re-assessments are limited to four re-assessments per child per 365 consecutive day period.
- Weight management counseling services are initially limited to a combined total of 24 15-minute

units of service or clinic visits, for individual, group, and family weight management counseling per child per 365 consecutive day period.

- FQHCs and RHCs may bill the MA Program for one medical visit per child per day for CNWMS.

The bulletins and fee schedule can be found by using the “Bulletin Search” engine at the bottom of the following DPW webpage: <http://services.dpw.state.pa.us/olddpw/bulletinsearch.aspx>.

CNWMS can be offered to any pediatric member with a body mass index (BMI) at or above the 85th percentile, or a BMI below the 85th percentile but which has rapidly increased over the past several months. If you have questions, please contact your Provider Relations Representative.



CLINICAL

GUIDELINES ONLINE

Gateway Health Plan® has developed clinical and preventive care guidelines based on current national guidelines. These guidelines can be viewed at www.Gateway-HealthPlan.com.

Guidelines include:

- Adult with HIV
- Adult Preventive Care
- Asthma
- Cardiac Medical Management
- Child Preventive Care
- COPD
- Diabetes 2010 ADA
- Hypertension
- Prenatal Care
- Lead Screening (Medicaid only)
- PCPs Treating Depression (Medicaid only)
- Bipolar Disorder (Medicare only)
- Schizophrenia (Medicare only)

To view these guidelines, select a plan, click the provider link and at the bottom of the left-hand column, choose Quality Improvement. Clinical Guidelines, as well as the Medical Record Review standards and Helpful Forms and Information are listed below. To request a hard copy of an item, call the Quality Improvement Department at (412) 255-1144.

CLINICAL

PEER REVIEW INFORMATION

Gateway Health Plan® offers providers the opportunity for a peer review 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 the review decision. You will also be given the name of the Gateway physician to contact to discuss the reason you determined the service to be medically necessary.

When returning a call to a physician at Gateway, please have the following information on hand to ensure a timely discussion with the appropriate physician:

- Name of the physician you were directed to speak with
- Member information including the Gateway identification number and/or authorization number.



**DO YOU ENCOUNTER
ROADBLOCKS WHEN TRYING
TO HAVE PATIENTS GET A FASTING LDL-C?**



IT DOESN'T HAVE TO BE THIS HARD...

**DIRECT LDL-C
NO FASTING REQUIRED**

CLINICAL

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. Gateway’s formulary is approved by the Department of Public Welfare (Medicaid) or the Centers for Medicare and Medicaid Services (*Medicare Assured*®). Please review the changes below 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, step therapy requirements, and quantity limits when 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 or 1-800-685-5201 for *Medicare Assured*®.

Gateway also supports a comprehensive e-prescribing program through RxHub. Providers who use e-prescribing will have access to the plan formulary right at the point of service. Electronic prescribing will enhance provider efficiency in handling prescriptions for initial coverage and refills, which will save on administrative time and effort.

Medicaid Formulary Additions

| Drug Name | Effective Date | Notes |
|-----------------------------------|----------------|--------|
| Dulera (mometasone/formoterol) | 1/1/2011 | QL |
| Januvia (sitagliptin) | 1/1/2011 | QL, ST |
| Janumet (sitagliptin/metformin) | 1/1/2011 | QL, ST |
| Symbicort (budesonide/formoterol) | 1/1/2011 | QL |

Medicaid Formulary Deletions

| Drug Name | Effective Date |
|----------------------------------------------------|----------------|
| Azor (amlodipine/olmesartan) | 2/1/2011 |
| Benicar, Benicar HCT (olmesartan, olmesartan/HCTZ) | 2/1/2011 |

Medicaid Utilization Management Formulary Changes

| Drug Name | Effective Date | Formulary Change |
|---------------------------|----------------|-------------------------------|
| Losartan and Losartan-HCT | 1/1/2011 | Step edit requirement removed |

Medicare Assured® Formulary Additions

| Drug Name | Effective Date | Notes |
|-----------------------------------|----------------|-------|
| Dulera (mometasone/formoterol) | 2/1/2011 | QL |
| Symbicort (budesonide/formoterol) | 2/1/2011 | QL |

Notes Key:

- PA = Prior Authorization required
- QL = Quantity Limit applies
- ST = Step Therapy applies
- SPN = Obtain through Specialty Pharmacy Network

Please contact Gateway’s Pharmacy Department with all formulary questions, and other pharmacy benefit concerns at 1-800-528-6738 for Medicaid members or 1-800-685-5215 for *Medicare Assured*® members. The Pharmacy Department fax number is 1-888-245-2049 (Medicaid) or 888-447-4369 (Medicare).

CLINICAL

DISEASE MANAGEMENT PROGRAMS

| Program | AIR Gateway® Asthma Program | Help Your Heart Program | Healthy Returns Diabetes Program | MOM Matters® Maternity Program ¹ |
|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Eligibility | Ages 2-56 with a diagnosis of asthma | Ages 21 and older with CAD, MI or HF | All age groups with Type 1 or Type 2 diabetes | All pregnant females |
| Contact for Referrals and Information | PA Medicaid 1-800-642-3550 Option 3 <i>Medicare Assured®HMO SNP</i> 1-800-685-5212 Option 3 | PA Medicaid and <i>Medicare Assured®HMO SNP</i> 1-866-366-9415 | PA Medicaid and <i>Medicare Assured®HMO SNP</i> 1-866-366-9415 | PA Medicaid 1-800-642-3550 Option 2 <i>Medicare Assured®HMO SNP</i> 1-800-685-5212 Option 2 |
| Description and Enrollment | <ul style="list-style-type: none"> Provides patient education and self empowerment for medication, diet and lab adherence, reductions in inpatient utilization and emergency room utilization and may delay or prevent the onset of disease specific complications. The programs support the physician's plan of care Members are identified through claims, provider or member self referral <p><i>Provider referrals are welcome</i></p> | | | <ul style="list-style-type: none"> Prenatal program offers care coordination to reduce low birth weight, pre-term deliveries and NICU admissions. ONAF submission helps to identify high risk women for proactive intervention |
| Coordination of Care | <ul style="list-style-type: none"> Care managers will assist you and your patients with coordination of care for specialist visits Enrollment notification is faxed to the provider upon member enrollment into the program Home health, behavioral health, DME and community referral needs are coordinated through the Gateway Care Manager | | | |
| Provider Benefits and Support | <ul style="list-style-type: none"> Management in the programs may decrease inpatient and emergency room utilization; increase appropriate lab testing and medication adherence and encourage adherence to obtain flu and pneumonia immunizations Care management provides education to assist your patient in understanding their condition, life style implications and encourages motivation to assume a proactive role in their health The maternity program has a proven record of decreasing the number of premature deliveries The Physician Dashboard identifies your patients enrolled in the disease management programs and highlights testing they may need to manage their condition | | | |
| Web-Based Education | www.GatewayHealthPlan.com | | | |

¹ MOM Matters® — Maternity Outreach and Management



OFFICE STAFF



GATEWAY HEALTH PLAN® 2010 PRACTITIONER AND PROVIDER SATISFACTION SURVEY RESULTS

Gateway conducted a Practitioner and Provider Satisfaction Survey from August to October of 2010. The population sampled included primary care practitioners with a panel size of 100 members or greater. The specialty care practitioners sample included high-volume specialists with at least five unique member visits and

paid claims with a date of service between 5/1/09 and 5/31/10. 100 percent of the hospital network and a remaining sample of ancillary providers were also surveyed.

Gateway will continue to strive toward meeting the needs of our practitioner and provider network. Action plans are developed to

improve those areas with deficiencies to assure ongoing improvement.

The below percentages are Summary Rate Scores based on the two most favorable response options. These results can also be found on www.GatewayHealthPlan.com under Provider News and Updates.

GATEWAY HEALTH PLAN® 2010 PRACTITIONER AND PROVIDER SATISFACTION SURVEY RESULTS

| Question | 2010 PCP | 2010 SCP | 2010 Hospital | 2010 Ancillary |
|-----------------------------------------------------------------------------------------------------------|----------|----------|---------------|----------------|
| CONTINUITY AND COORDINATION OF CARE | | | | |
| PCPs Only-Receipt of Appropriate Documentation received from Specialty Care Practitioners | 83.9% | N/A | N/A | N/A |
| PCPs Only-Receipt of Appropriate Documentation received from Hospitals | 87.3% | N/A | N/A | N/A |
| PCPs Only-Receipt of Appropriate Documentation received from Skilled Nursing Facilities | 70.2% | N/A | N/A | N/A |
| PCPs Only-Receipt of Appropriate Documentation received from Home Health Agencies | 95.3% | N/A | N/A | N/A |
| GATEWAY REPRESENTATIVE AND COMMUNICATION | | | | |
| Professionalism and Courtesy of your Gateway Provider Relations Representative | 95.5% | 90.9% | 80.0% | 88.5% |
| Timeliness of the Gateway Provider Relations Representative when responding to inquiries | 94.0% | 88.3% | 90.0% | 86.3% |
| Knowledge of the Provider Relations Representative regarding Gateway's Policies and Procedures | 96.1% | 90.6% | 85.0% | 85.7% |
| Your Overall Satisfaction with the Quality of Service from your Gateway Provider Relations Representative | 94.2% | 88.8% | 90.0% | 81.2% |
| Quality of Written Communications, Policy Bulletins, and Manuals | 96.2% | 89.5% | 94.4% | 84.8% |
| Do you find written clinical communications useful? | 92.1% | 93.3% | 73.3% | 93.4% |
| PROVIDER SERVICES AND CLAIMS | | | | |
| Consistency of Provider Services Representatives' Answers to Inquiries | 95.8% | 88.2% | 82.4% | 84.4% |
| The Knowledge of the Provider Services Representative regarding Gateway's Policies and Procedures | 95.8% | 87.9% | 83.3% | 84.6% |
| The Professionalism and Courtesy of the Provider Servicing Representative | 95.9% | 89.4% | 88.9% | 86.3% |
| Timeliness of Provider Servicing Staff when Responding to Inquiries | 95.2% | 85.9% | 77.8% | 83.9% |
| Your Satisfaction with Clean Claims being Processed Consistently | 90.7% | 86.8% | 73.3% | 79.4% |
| Your Satisfaction with Clean Claims being Paid in a Timely Manner | 92.0% | 90.3% | 85.7% | 81.5% |
| Your Overall Satisfaction with the Claims Review Process | 87.6% | 79.1% | 64.7% | 70.1% |
| UTILIZATION MANAGEMENT | | | | |
| Your Knowledge of which Services Require an Authorization | 94.8% | 86.0% | 100.0% | 80.7% |
| Timeliness of UM Staff when Responding to Inquiries | 90.1% | 89.1% | 78.6% | 86.2% |
| UM Staff's Clinical Knowledge | 94.0% | 89.7% | 92.3% | 89.3% |
| UM Staff's Consistency in the Authorization Process | 90.8% | 89.3% | 84.6% | 87.3% |
| Medical Appropriateness of Gateway's Physician Reviewer Decisions | 85.2% | 80.9% | 72.7% | 88.5% |
| Professionalism/Courtesy of the UM Staff Representative | 94.7% | 93.1% | 83.3% | 90.8% |
| Your Overall Satisfaction with the UM Process | 91.2% | 88.1% | 75.0% | 89.3% |
| Your Knowledge of which Services Require a Referral | 96.8% | 87.6% | 91.7% | 74.8% |
| The Ease of Use/Completion of the Paper Referral Form | 95.2% | 83.6% | N/A | N/A |

Continuation from page 13

| Question | 2010 PCP | 2010 SCP | 2010 Hospital | 2010 Ancillary |
|----------------------------------------------------------------------------------------------------------------------|----------|----------|---------------|----------------|
| PHARMACY AUTHORIZATION PROCESS, STAFF, AND DRUG FORMULARY | | | | |
| When Calling Gateway's Pharmacy Department, Pharmacy Staff's Professionalism and Courtesy | 89.7% | 93.1% | 100.0% | 90.0% |
| When Calling Gateway's Pharmacy Department, Pharmacy Staff's Consistency in Responses Regarding Formulary Procedures | 90.5% | 89.2% | 0.0% | 85.0% |
| When Calling Gateway's Pharmacy Department, Pharmacy Staff's Timeliness when Responding to Inquiries | 88.6% | 91.0% | 0.0% | 85.0% |
| Your Understanding of the Gateway Pharmacy Authorization Process | 92.8% | 85.0% | 0.0% | 85.7% |
| Your Overall Satisfaction with the Gateway Pharmacy Authorization Process | 85.6% | 86.6% | 100.0% | 90.0% |
| Ease of Using Gateway's Web-based and Smart Phone/Mobile Version of the Drug Formulary | 83.8% | 79.6% | 0.0% | 90.0% |
| Variety of Drugs Available on Gateway's Drug Formulary | 74.5% | 67.2% | 50.0% | 61.1% |
| DISEASE MANAGEMENT | | | | |
| Practice Benefits from the Asthma Disease Management Program | 83.0% | 54.5% | N/A | N/A |
| Practice Benefits from the Diabetes Disease Management Program | 87.2% | 76.9% | N/A | N/A |
| Practice Benefits from the Cardiac Disease Management Program | 82.5% | 86.4% | N/A | N/A |
| Practice Benefits from the MOM Matters SM High Risk Maternity Program | 81.4% | 87.0% | N/A | N/A |
| Practice Benefits from the Complex Case Management Program | 86.7% | 65.0% | N/A | N/A |
| EPSDT SERVICES | | | | |
| If you Conduct EPSDT Screens in your Office, Your Overall Satisfaction with the EPSDT Screening Program | 83.5% | N/A | N/A | N/A |
| ACCESSIBILITY | | | | |
| Routine Appointments Scheduled in less than 10 Business Days | 72.3% | 71.1% | N/A | N/A |
| Urgent Care Appointments Scheduled within 24 Hours | 98.1% | 74.6% | N/A | N/A |
| Wait Time in the Waiting Room no Longer than 30 Minutes | 95.5% | 88.5% | N/A | N/A |
| HOURS OF AVAILABILITY | | | | |
| Provider Relations Hours of Operation Meet Practice Needs | 95.3% | 95.9% | 88.9% | 86.9% |
| Provider Services Hours of Operation Meet Practice Needs | 92.4% | 97.0% | 94.4% | 93.8% |
| Utilization Management Hours of Operation Meet Practice Needs | 93.5% | 95.6% | 77.8% | 93.8% |
| Pharmacy Department Hours of Operation Meet Practice Needs | 92.5% | 96.4% | 100.0% | 89.5% |
| OVERALL SATISFACTION AND LOYALTY | | | | |
| Consistency Across all Departments at Gateway | 96.6% | 96.7% | 80.0% | 94.8% |
| Would you Recommend Gateway Health Plan [®] to other Physicians' Practices | 95.4% | 92.4% | N/A | N/A |
| Overall Satisfaction with Gateway Health Plan [®] | 93.8% | 86.2% | 87.5% | 83.2% |

GATEWAY HEALTH PLAN MEDICARE ASSURED[®] HMO SNP 2010 PRACTITIONER AND PROVIDER SATISFACTION SURVEY RESULTS

| Question | 2010 PCP | 2010 SCP | 2010 Hospital | 2010 Ancillary |
|-----------------------------------------------------------------------------------------------------------|----------|----------|---------------|----------------|
| CONTINUITY AND COORDINATION OF CARE | | | | |
| PCPs Only-Receipt of Appropriate Documentation received from Specialty Care Practitioners | 77.9% | N/A | N/A | N/A |
| PCPs Only-Receipt of Appropriate Documentation received from Hospitals | 83.8% | N/A | N/A | N/A |
| PCPs Only-Receipt of Appropriate Documentation received from Skilled Nursing Facilities | 64.8% | N/A | N/A | N/A |
| PCPs Only-Receipt of Appropriate Documentation received from Home Health Agencies | 97.4% | N/A | N/A | N/A |
| GATEWAY REPRESENTATIVE AND COMMUNICATION | | | | |
| Professionalism and Courtesy of your Gateway Provider Relations Representative | 96.4% | 92.0% | 88.9% | 89.8% |
| Timeliness of the Gateway Provider Relations Representative when responding to inquiries | 93.6% | 88.5% | 93.8% | 88.3% |
| Knowledge of the Provider Relations Representative regarding Gateway's Policies and Procedures | 94.6% | 90.1% | 88.2% | 85.8% |
| Your Overall Satisfaction with the Quality of Service from your Gateway Provider Relations Representative | 94.0% | 89.3% | 94.1% | 84.0% |
| Quality of Written Communications, Policy Bulletins, and Manuals | 96.6% | 89.4% | 93.8% | 86.5% |
| Do you find written clinical communications useful? | 88.8% | 93.2% | 84.6% | 95.7% |

>>> Continued on page 15

Continuation from page 14

| Question | 2010 PCP | 2010 SCP | 2010 Hospital | 2010 Ancillary |
|----------------------------------------------------------------------------------------------------------------------|-------------|-------------|------------------|-------------------|
| PROVIDER SERVICES AND CLAIMS | | | | |
| Consistency of Provider Services Representatives' Answers to Inquiries | 96.2% | 90.4% | 100.0% | 88.0% |
| The Knowledge of the Provider Services Representative regarding Gateway's Policies and Procedures | 96.4% | 88.5% | 93.8% | 85.1% |
| The Professionalism and Courtesy of the Provider Servicing Representative | 96.3% | 90.0% | 87.5% | 87.4% |
| Timeliness of Provider Servicing Staff when Responding to Inquiries | 96.5% | 86.1% | 88.2% | 86.3% |
| Your Satisfaction with Clean Claims being Processed Consistently | 92.7% | 89.0% | 100.0% | 82.1% |
| Your Satisfaction with Clean Claims being Paid in a Timely Manner | 92.7% | 90.1% | 100.0% | 83.1% |
| Your Overall Satisfaction with the Claims Review and/or Appeal Process | 85.1% | 78.8% | 66.7% | 74.8% |
| UTILIZATION MANAGEMENT | | | | |
| Your Knowledge of which Services Require an Authorization | 94.0% | 84.1% | 100.0% | 83.8% |
| Timeliness of UM Staff when Responding to Inquiries | 88.9% | 89.1% | 83.3% | 89.3% |
| UM Staff's Clinical Knowledge | 93.8% | 91.4% | 100.0% | 89.3% |
| UM Staff's Consistency in the Authorization Process | 88.2% | 90.8% | 81.8% | 87.0% |
| Medical Appropriateness of Gateway's Physician Reviewer Decisions | 80.7% | 80.5% | 77.8% | 89.2% |
| Professionalism/Courtesy of the UM Staff Representative | 93.7% | 92.4% | 80.0% | 94.0% |
| Your Overall Satisfaction with the UM Process | 89.4% | 88.1% | 80.0% | 91.4% |
| PHARMACY AUTHORIZATION PROCESS, STAFF, AND DRUG FORMULARY | | | | |
| When Calling Gateway's Pharmacy Department, Pharmacy Staff's Professionalism and Courtesy | 89.0% | 94.1% | 0.0% | 90.5% |
| When Calling Gateway's Pharmacy Department, Pharmacy Staff's Consistency in Responses Regarding Formulary Procedures | 89.6% | 87.1% | 0.0% | 85.0% |
| When Calling Gateway's Pharmacy Department, Pharmacy Staff's Timeliness when Responding to Inquiries | 87.4% | 91.2% | 0.0% | 86.4% |
| Your Understanding of the Gateway Pharmacy Authorization Process | 93.0% | 86.0% | 0.0% | 88.0% |
| Your Overall Satisfaction with the Gateway Pharmacy Authorization Process | 86.3% | 86.9% | 100.0% | 90.0% |
| Ease of Using Gateway's Web-based and Smart Phone/Mobile Version of the Drug Formulary | 86.0% | 85.7% | 0.0% | 90.0% |
| Variety of Drugs Available on Gateway's Drug Formulary | 71.3% | 68.0% | 50.0% | 64.7% |
| DISEASE MANAGEMENT | | | | |
| Practice Benefits from the Asthma Disease Management Program | 75.7% | 34.6% | N/A | N/A |
| Practice Benefits from the Diabetes Disease Management Program | 86.1% | 75.0% | N/A | N/A |
| Practice Benefits from the Cardiac Disease Management Program | 81.4% | 81.8% | N/A | N/A |
| Practice Benefits from the MOM Matters SM High Risk Maternity Program | 87.9% | 90.9% | N/A | N/A |
| Practice Benefits from the Complex Case Management Program | 84.5% | 72.2% | N/A | N/A |
| ACCESSIBILITY | | | | |
| Urgent Care Appointments Scheduled within 24 Hours | 98.9% | 75.7% | N/A | N/A |
| Wait Time in the Waiting Room no Longer than 30 Minutes | 95.5% | 91.0% | N/A | N/A |
| HOURS OF AVAILABILITY | | | | |
| Provider Relations Hours of Operation Meet Practice Needs | 95.4% | 95.6% | 86.7% | 90.4% |
| Provider Services Hours of Operation Meet Practice Needs | 91.3% | 96.7% | 93.8% | 94.3% |
| Utilization Management Hours of Operation Meet Practice Needs | 91.2% | 95.1% | 75.0% | 93.0% |
| Pharmacy Department Hours of Operation Meet Practice Needs | 89.3% | 93.9% | 0.0% | 88.9% |
| OVERALL SATISFACTION AND LOYALTY | | | | |
| Consistency Across all Departments at Gateway | 97.2% | 97.3% | 92.9% | 96.1% |
| Would you Recommend Gateway Health Plan [®] to other Physicians' Practices | 95.4% | 92.4% | N/A | N/A |
| Overall Satisfaction with Gateway Health Plan [®] | 94.1% | 87.0% | 93.8% | 86.0% |

OFFICE STAFF



MEDICAL RECORD REVIEWS

Primary Care Physician (PCP) offices with a panel size of 50 and more Medicaid and Medicare members combined, are reviewed every two years. Both Medicaid and Medicare members' records in an office are reviewed and evaluated on the same criteria, with one combined score for each office.

Beginning in the third quarter of 2010 a more comprehensive medical record tool was developed. Prior medical record standards allowed for less than optimal documentation of standards of care. For example, if the practitioner had a medication listing anywhere in the record the standard was met, however regulatory requirements state the medical record should have a specific page and/or area called a medication list.

Another example is the requirement for notation of allergies. If allergies were noted anywhere in the record

including the notation in a consult report the standard was met. NCQA, DPW, and CMS standards require the presence/absence of allergies be prominently displayed.

In 2010, the overall score for the 363 PCP offices reviewed was 95.3% for the first two quarters of the year.

Decrease in overall scoring was noted in the third and fourth quarter, the overall score for the PCP's offices at 83.1%, with the utilization of the revised medical record review tools. Specifically, the average Family Medicine (FM) score for the first two quarters was 95.6%, compared to the last two quarters at 81.9%. Internal Medicine (IM) scores for the first two quarters was 92.9%, compared to the last two quarters at 83.52%. Pediatrics (PD) scores for the first two quarters was 97.4% compared to the last two quarters at 83.9%. Five

PCP's did not meet the previous standards in the first two quarters.

Twenty-two PCPs did not meet the newly defined standards of 85% in the last two quarters. Comparisons to prior years are not trendable due to the implementation of the new record review tools.

Gateway's Medical Record Review standards for PCPs and Specialists can be viewed by accessing Gateway's website, www.GatewayHealthPlan.com (Providers, Medicaid or Medicare, Medicaid Quality Improvement or Medicare Quality Improvement). Paper copies of these standards can be obtained by calling the Quality Improvement Department at (412) 255-1144.



OFFICE STAFF



FREE CONTINUING EDUCATION CREDIT: Do Ask, Do Tell: A Practical Approach to Smoking Cessation

The CS2Day (Cease Smoking Today) Tobacco Cessation Training is a CE Webinar program being offered at no cost to educate clinicians and other health care professionals on how to become more involved in tobacco cessation counseling. The training promotes the ASK, ADVISE, REFER protocol—this is a simple, 3-minute intervention that can be conducted within the context of any interaction between a clinician and a patient.

Facts about the CS2Day Tobacco Cessation Training:

- Provided at no cost to you
- A 1- hour webinar presentation – a computer with sound is required to participate
- Participants MUST complete an “on-line” survey to receive CE units.
- ACPE, ACCME, and CNEP accredited, with CE units provided through Purdue University at no cost. CE Certificates will be mailed to participants in 4-6 weeks following each webinar.

Participants go to the following URL to “enter” the webinar room: <https://gomeet.itap.purdue.edu/r75452775/>. The room will “open” 15 minutes prior to the session start time; participants should arrive early

to allow for any trouble shooting (sound check, etc.). For tracking/CE purposes, participants should sign-in as a “guest” using their FULL NAME.

Scheduled webinar presentation dates and times that Gateway Health Plan® has reserved for healthcare providers:

- Wednesday, April 20, 2011 at 11:30 AM (EST)
- Thursday, June 9, 2011 at 12 PM (EST)
- Tuesday, August 9, 2011 at 10 AM (EST)
- Wednesday, October 12, 2011 at 11:30 AM (EST)
- Thursday, November 10, 2011 at 12 PM (EST)

Speaker: Francis M. Vitale M.A. University of Pittsburgh, School of Pharmacy

Learning Objectives:

1. Describe the role of the clinician in the tobacco cessation process, positioning them as the initiator of the quit attempt.
2. Briefly summarize how the clinician can ask about tobacco use and successfully advise patients to quit.

3. Explain the importance of clinicians referring patients to appropriate intensive interventions after initiating the cessation process.
4. Review the seven FDA approved medication for cessation.

Pre-registration & additional information:

Please notify Cami Douglas by email: cldougla@purdue.edu or phone at: (317) 613-2315 extension 637 to let her know in which session you will be participating and/or if you have any questions.

Faculty Disclosure: All faculty AND staff involved in the planning or presentation of continuing education activities sponsored/ provided by Purdue University College of Pharmacy are required to disclose to the audience any real or apparent commercial financial affiliations related to the content of the presentation or enduring material.

As a member of the planning committee and as program speaker,

Frank Vitale discloses that he is a Consultant for GlaxoSmithKline, Smoking Cessation Counseling. All additional planning committee members and Purdue University



College of Pharmacy staff have no relationships to disclose.

Disclosure of Unlabeled Use:

Faculty of this activity may include discussions of products or devices that are not currently labeled for use by the FDA. Faculty members will disclose to the audience any reference to an unlabeled or investigational use. Purdue University College of Pharmacy does not recommend the use of any agent outside of the labeled indications. Please refer to the official prescribing information for each product for discussion of approved indications, contraindications and warnings.

This opportunity is brought to you by Purdue University College of Pharmacy, in collaboration with a national consortium of the California Academy of Family Physicians, CME Enterprise, Healthcare Performance Consulting, Interstate Postgraduate Medical Association, Iowa Foundation

for Medical Care, Physicians Institute for Excellence in Medicine, University of Virginia School of Medicine, and the University of Wisconsin School of Medicine and Public Health. Funded through an unrestricted educational grant from Pfizer.

Pharmacist Accreditation Statement -

Purdue University College of Pharmacy is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. This program is a continuing education activity of Purdue University, an equal access/equal opportunity institution. Universal Activity Number (UAN): 0018-0000-11-004-L04-P, 1.0 contact hours (0.1 CEU) Release Date: 02/08/2011 Expiration Date: 02/08/2013

Physician Accreditation Statement -

Purdue University College of Pharmacy, an equal access/equal

opportunity institution, is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. **Credit Designation -** Purdue University College of Pharmacy designates this educational activity for a maximum of **1.0 AMA PRA Category 1 Credit(s)™**. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Purdue University Continuing Nursing Education (CNEP-09, 06/01/2011) is an approved provider of continuing nursing education by the Indiana State Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. This program has been approved for 1.0 contact hours.



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

MEMBER ELIGIBILITY/DIVA VERIFICATION LINE

Medicaid and Medicare 1-800-642-3515

PHARMACY

Medicaid 1-800-528-6738
Medicare 1-800-685-5215

NATIONAL IMAGING ASSOCIATES

Medicaid and Medicare 1-888-879-5922

MEDICAL MANAGEMENT

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

EPSDT

Medicaid 1-800-642-3550, Option 4

ICON KEY

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MEDICAID & MEDICARE



MEDICARE ONLY



MEDICARE ONLY

