

# Provider | Update

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GATEWAY HEALTH PLAN  
PROVIDERS AND  
CLINICIANS



GatewayHealthPlan.com



## OFFICE STAFF

## GATEWAY TO PHYSICIAN EXCELLENCE<sup>SM</sup> (GPE<sup>SM</sup>) REPORT CARDS DELIVERED

The GPE<sup>SM</sup> Program is designed to recognize and reward primary care practices committed to providing quality healthcare that is accessible and efficient.

This is the third year for the GPE<sup>SM</sup> Program and once again report cards will be delivered between late September and the end of this year. Medical Directors and Provider Relations Representatives will visit select practices to review GPE<sup>SM</sup> Report Card results and deliver awards.

Report Card results compare practices performance against their peers from across Pennsylvania. Report Card reviews celebrate practices quality performance and explore opportunities for future practice improvements and success. They also focus on complete encounter and diagnosis submission

because practices performance is measured off of submitted claims and encounters.

If your practice participates in the GPE<sup>SM</sup> program and would like to discuss the program or your results with one of our Medical Directors, please contact your Provider Relations Representative directly.

Tip: A practice's GPE<sup>SM</sup> and other performance is linked to its submission of complete and accurate claims and encounter data. Incomplete or inaccurate submissions result in undercounting, suboptimal GPE<sup>SM</sup> performance and a picture of a

healthier population relative to peer practices. Here are some helpful tips:

- List as many diagnoses that exist for each visit,
- Make sure your office and/or billing service submits all claims and encounters,
- Submit claims and encounters even when Gateway is a secondary insurer.

By doing these things, you can maximize your practice's GPE<sup>SM</sup> quality performance and revenue while accurately reflecting the health of the Gateway members in your practice.



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# APPOINTMENT AND AFTER-HOURS SURVEY STUDY RESULTS

Every year, Gateway conducts two studies to assess compliance with appointment standards and after-hours accessibility. Many of our standards come from the Department of Public Welfare, the Department of Health, and NCQA. For a detailed listing of our accessibility standards, please visit [www.GatewayHealthPlan.com](http://www.GatewayHealthPlan.com). The Myers Group, an NCQA certified surveyor conducts Gateway's appointment and after-hours studies. The results of the 2009 surveys are listed below.

## 2009 Appointment Availability Survey Results

The Appointment Availability Survey was conducted October to November of 2009. The survey consists of six interviewer experience questions and appointment availability questions for several appointment types. The 2009 survey included both Medicaid and Medicare Assured® questions. The summary for our Medicare Assured® results include results from 2008 and 2007. This is the first year we have conducted the survey for our Medicaid plan. The survey population included PCPs, and high volume Specialists including cardiology, gastroenterology, neurology, obstetrics/gynecology, ophthalmology, orthopedic surgery, otolaryngology, podiatry, pulmonology, surgery and urology. The 2009 Practitioner Appointment Availability Survey was based on a sample of 1,200 PCPs and Specialists located in the Southwest, Lehigh Capital and Voluntary Regions.

The following is a summary of the appointment survey report. The summary rate is the proportion of all provider types that met the standard. The urgent, non-emergent care appointment availability was first attempted as a mystery shopper

question. The results of the mystery shopper question are presented in Question 7. Respondents were then notified of the interviewer's identity and were asked the remaining survey questions.

### MEDICARE ASSURED®

Question	Standard	Summary Rate		
		2009	2008	2007
Q7. Urgent, Non-emergent (Mystery Shopper)	Within 24 Hours (Same day or Next day)	46.9%	82.0%	41.7%
Q11. Urgent, Non-Emergent		84.1%	79.0%	88.9%
Q 9. Non-urgent, but in need of attention	Within 1 week	92.4%	90.5%	92.1%
Q 10. Routine or Preventive Care	Within 30 days	96.9%	95.1%	92.1%

### MEDICAID

Question	Standard	Summary Rate 2009
Q7. Urgent, Non-emergent (Mystery Shopper)	Within 24 Hours (Same day or Next day)	59.10%
Q11. Urgent, Non-Emergent		94.50%
Q10. Routine or Preventive Care (PCPs and Specialists excluding Orthopaedic Surgery and Otolaryngology)	10 business days	82.7%
Q10. Routine or Preventive Care (Orthopaedic Surgery and Otolaryngology)	15 business days	95.70%
Q12. General Physical (PCPs Only)	3 weeks	86.40%
Q13. Routine appointment for AIDS patient	1 week	59.30%
Q14. Routine appointment for patient on SSI	45 days	97.00%
Q15. Routine appointment during first trimester (PCPs & OB/GYNs who provide prenatal care)	10 business days	70.8%
Q16. Routine appointment during second trimester (PCPs & OB/GYNs who provide prenatal care)	5 business days	75.6%
Q17. Routine appointment during third trimester (PCPs & OB/GYNs who provide prenatal care)	4 business days	69.6%
Q18. Routine appointment for high risk patient (PCPs & OB/GYNs who provide prenatal care) Within 24 Hours	Within 24 Hours (Same day or Next day)	75.6%
Q19. Missed appointment	At least 3 attempts with at least one phone call	61.00%

## 2009 After Hours Survey Results

The after-hours survey is used to determine if practitioners are available to Gateway members at all times. The 2009 After-Hours Survey sample size was based on the number of completed surveys from the Appointment Availability Survey.

The survey consists of four sections, which are dependent on the type of after-hours service the interviewer reaches: a live person, a recording, an auto attendant or nothing.

The table below presents the results of the after-hours survey by initial response category.

When patients wait long periods of time to get an appointment, wait in the waiting room, or for test results, patient satisfaction goes down, no show rates increase, and patients become less likely to comply with doctors' orders. As a result, patient care suffers and healthcare professionals waste time with rework and redundancy.

### MEDICARE ASSURED®

Survey Question	Standard	2009 Rate	2008 Rate	2007 Rate
<b>Reached a Live Person</b>				
#B) Were you immediately placed on hold when calling in?	No	86.00%	78.20%	74.40%
#C) How long were you on hold?	1 Minute or Less	41.70%	94.70%	68.80%
#D) Is this the answering service for the office you called?	Yes	92.10%	100.00%	93.60%
#1) What would you tell a caller who states he/she is dealing with an emergency situation?	Hang-up and dial 911 or go to the nearest ER	16.40%	21.00%	22.20%
#2) If I wanted to have a doctor call me back tonight, do you have a way of reaching him/her or an on-call physician?	Yes, access to a practitioner 24 hrs/ 7 days a week	79.70%	86.30%	93.30%
<b>Reached a Recording</b>				
#3) If a recording is reached does it provide information similar to the following in the case of an emergency: Hang-up the phone and call 911 or go to the nearest ER Room?	Yes	54.00%	48.10%	44.70%
#4) Does the recording provide contact information for after-hours access for the physician?	Yes, access to a practitioner 24 hrs/ 7 days a week	75.40%	59.60%	73.60%
<b>Reached an Auto Attendant</b>				
#5) Does the auto attendant give emergency instructions?	Yes	90.90%	82.80%	75.40%
#7) If I wanted to have a doctor call me back tonight, do you have a way of reaching him/her or an on-call physician?	Yes, access to a practitioner 24 hrs/ 7 days a week	100.00%	100.00%	80.00%

### Tips for reducing wait time

There are several approaches to help reduce wait time for scheduling appointments. Here are a few recommended changes from the Institute of Healthcare Improvement Organization to consider:

1. Measure supply and demand over a long period of time in order to anticipate future highs and lows.
2. Reduce and eliminate backlog by first measuring the backlog, and then creating and using a deliberate backlog reduction plan.
3. Use alternatives to one-on-one visits.
4. Telephone consults.
5. Reduce future work (in many cases, eliminating the need for extra appointments) by doing as much for the patients while they are in the office for a given visit.

- a. Look for any patient who is also on the schedule for a future date and address future needs during the first visit.
- b. Use a preventive care checklist to anticipate patients' future needs and take care of them during today's visit whenever possible.

Visit [IHI.org](http://IHI.org) for more information on reducing wait times for appointments.

### MEDICAID

Question	Standard	2009 Rate
<b>Reached a Live Person</b>		
#B) Were you immediately placed on hold when calling in?	No	81.20%
#C) How long were you on hold?	1 Minute or Less	61.50%
#D) Is this the answering service for the office you called?	Yes	90.20%
#1) What would you tell a caller who states he/she is dealing with an emergency situation?	Hang-up and dial 911 or go to the nearest ER	7.30%
#2) If I wanted to have a doctor call me back tonight, do you have a way of reaching him/her or an on-call physician?	Yes, access to a practitioner 24 hrs/7 days a week	86.60%
<b>Reached a Recording</b>		
#3) If a recording is reached does it provide information similar to the following in the case of an emergency: Hang-up the phone and call 911 or go to the nearest ER Room?	Yes	64.00%
#4) Does the recording provide contact information for after-hours access for the physician?	Yes, access to a practitioner 24 hrs/7 days a week	82.40%
<b>Reached an Auto Attendant</b>		
#5) Does the auto attendant give emergency instructions?	Yes	84.10%
#7) If I wanted to have a doctor call me back tonight, do you have a way of reaching him/her or an on-call physician?	Yes, access to a practitioner 24 hrs/7 days a week	72.70%

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# 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. In addition to these applications practitioners are expected to complete a Gateway supplemental application.
- 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 admitting privileges in their practicing specialty at a Gateway participating hospital. Practitioners without admitting privileges must have written documentation of a formal coverage arrangement with another Gateway participating practitioner who holds active privileges at a Gateway participating hospital.
- Gateway standards require that all practitioners be board certified in their practicing specialty. The Gateway acceptable source of verification for MD and DO practitioner types is The American Board of Medical Specialties (ABMS), for DPM practitioner types The American Board of Podiatric Surgery (ABPS) or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine or (ABPOPPM) and for DMD and DDS practitioner types The American Board of Oral and Maxillofacial Surgery (ABOMS).
- Exceptions to board certification: Board certification is not required for chiropractors, practitioners

who began practicing prior to the availability of the boards, or practitioners that practice solely in rural counties. Additionally, practitioners completing their residency/fellowship within the past three years that intend to become board certified or practitioners completing board certification that requires additional completion time may be approved as exceptions. \*Please note that practitioners excepted from the board certification requirement must complete an adequate number of CME's to participate.

- CME's Required: Practitioners must maintain one hundred and fifty (150) CME credits over the previous three (3) years, of which 60 must be Category 1 credits. Podiatrists and Dentists must have evidence of a minimum of forty-five (45) continuing education credits over the previous three years.
- 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.





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WHAT'S IN A SIGNATURE?

The Centers for Medicare and Medicaid Services (CMS) requires that individuals who ordered or provided services be clearly identified in the patient's medical records. Each entry MUST be legible, include the practitioner's first and last name and include the practitioner's credentials (CRNP, P.A., D.O., M.D., etc). Signatures are required in medical records, operative reports, orders, and test findings to demonstrate that services have been accurately and fully documented, reviewed and authenticated. The practitioner's signature also indicates that the services were medically necessary and reasonable for payment consideration.

CMS prohibits the use of stamped signatures. Dictated notes must be signed and dated or indicate "electronic signature on file" in order to validate that the provider actually read and is attesting to the information documented in the medical record.

**ACCEPTABLE EXAMPLES:**  
*Illegible signature over typed/printed name*



*Illegible signature where the letterhead, addressograph or other information on the page indicates the identity of the signator. Example: An illegible signature appears on a prescription. The letterhead of the prescription lists 3 physicians' names. One of the names is circled.*

**NOT ACCEPTABLE EXAMPLES:**  
*Illegible signature NOT over a typed/printed name, NOT on letterhead and the documentation is NOT accompanied by a signature log or attestation statement.*



ENCOUNTERS STUDY BASED ON 2008 DATA YEAR

The use of encounter data is essential to Gateway's understanding of the population served, the development of effective health care programs, the management of health care resources and the determination of the level of illness of our population. Encounter data provides the basis for many key medical management and financial activities, as well as supplying the data required for studies.

The Primary Care Practitioner (PCP) is the key service provider for Gateway members. To correctly evaluate and report members' health services, encounter submission must be comprehensive and accurate. Especially for Medicaid where our reimbursement system is capitated, providers may not understand the importance of submitting encounter data because reimbursement is not linked to each individual encounter. Submitting encounter data, however, is addressed in all provider contracts. Submission of Encounters will directly impact provider reimbursement under Gateway's Medicaid PCP Pay 4 Performance (GPE<sup>SM</sup>) program; submission of encounters will directly impact provider reimbursement. This is the first year that Gateway had the information available to also assess the encounter rate for our Medicare members.

Gateway has taken two approaches to measuring and analyzing encounter submissions based on overall scores as well as evaluating the three PCP specialty types of Family Medicine (FM), Internal Medicine (IM), and Pediatrics (Ped).

• **Volume of encounters** – Based on administrative data alone to evaluate encounter submission rates for PCPs. Within each specialty type, the PCP Practice's rate of encounters per member is calculated and compared to the peer average for that specialty type. Low performers are then identified based on the peer average.

- **Medicaid** – There was a 9% increase in the number of practices that scored one standard deviation below their respective PCP Peer Group for average encounters/member.
- **Medicare** – 14.29% of the practices included in this study were more than one standard deviation below the respective PCP Peer Group for average encounters /member. 2007 was a baseline year therefore there is no comparison data.
- **Submission of encounters** – Based on dates of service extracted from Gateway members' medical records during medical record reviews. This information serves as a means to validate the rate of actual administrative encounter submissions for known visits to a PCP. Using this hybrid method allows Gateway to better understand and differentiate between low utilization vs. low submission.
- **Medicaid – 377 offices – compliance rate 85%**  
 All 3 practice types improved in the areas of 85-100% compliance and decreased in the category ≤60% compliance. The overall rate of 84.70%, as well as the Peds (84.74%) and IM (88.59%) showed statistically significant increases. There was a slight drop in FM scores (83.13%).
- **Medicare – 240 offices – compliance rate 95%**  
 The overall number of encounters submitted was 89.5%, which is a 1.9% increase over the previous year. The FM (88.9%) and IM (91.0%) scores were statistically significant increases as well.

Gateway is pleased with the improvement shown in the increasing number of Medicaid and Medicare encounters received. Your continued cooperation and support are needed for continued increases in the number of claims submitted.

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## IDENTIFYING CARE TRANSITIONS

Gateway Health Plan *Medicare Assured*® HMO SNP is a Medicare Special Needs Plan that insures dual eligible patients with Medicare and Medicaid/Medical Assistance. Since older and/or disabled patients moving between different health care settings are particularly vulnerable to receiving fragmented and unsafe care during poorly coordinated care transitions, the Centers for Medicare and Medicaid Services (CMS) requires special efforts from special needs plans to manage the care transition process. Care transitions occur when patients' healthcare needs change from one setting to any other setting, such as when a patient is admitted to a hospital, or is discharged from the hospital to a skilled nursing facility or home.

Some of the ways that *Medicare Assured*® facilitates safe care transitions are: identifying unplanned and planned care transitions between settings; establishing a single point of contact internally that is responsible for support throughout the care transition process; and increasing communication about the care transition process with the member, member's responsible party, care providers and the patient's PCP. In order to be successful in identifying and facilitating safe care transitions for members, *Medicare Assured*® must collaborate with its participating practitioners and providers who deliver patient care.

The prior authorization review and discharge planning processes are key components for the identification of unplanned and planned care transitions. Therefore,

timely provider notification of planned and unplanned transitions, such as an emergency hospital admission or transfer to a skilled nursing facility, is critically important. Although transitions should be identified as proactively as possible (with at least two business days advance notice recommended for elective admissions,) CMS requires *Medicare Assured*® to identify transitions to inpatient care within one business day of the transition.

As a reminder, the Utilization Management Department (UM) at Gateway Health Plan *Medicare Assured*® HMO SNP is committed to assuring prompt, efficient delivery of healthcare services and to monitor quality of care provided to its members. UM can be contacted between the hours of 8:30am and 4:30pm, Monday through Friday, at 1-800-685-5207. When calling before or after operating hours or on holidays, providers are asked to leave a voicemail message, and a UM Representative will return the call the next business day. Urgent requests or questions are directed to call 1-800-685-5209.

Gateway Health Plan *Medicare Assured*® HMO SNP looks forward to collaborating with its provider network to identify and coordinate safe care transitions for our vulnerable patient population. If you have suggestions for improving the care transition process or questions regarding the processes outlined above, please contact your Gateway Provider Relations Representative or the Gateway Health Plan® Provider Services Department at 1-800-685-5205.

## OFFICE STAFF



## REFERRING YOUR GATEWAY HEALTH PLAN MEDICARE ASSURED® HMO SNP 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*® HMO SNP Gateway At A Glance.

CLINICAL

# STOP THE DISPARITIES THAT OCCUR WITH ASTHMA!

According to government statistics, asthma is an increasing health concern in the United States. Some experts suggest this is due to a complicated number of factors, such as social practices, economic constraints, and environmental pollutants.

Prevalence among children between 1996 and 2006 increased on average of 5.3% per year. For children living in inner cities, the morbidity and mortality



rates are disproportionately higher for low-income and minority groups. The effects of asthma on children and adolescents include the following alarming statistics:

- In the American education system, an estimated 14 million missed school days occur annually, which directly link to asthma and asthmatic complications.
- Asthma is the third ranking cause for hospitalization and death for children and adolescents age 15 and younger.
- Government officials estimate the costs of the increases in associated deaths from this condition in children, as well as the cost for treatment, top out at greater than three billion dollars per year.

Clearly, asthma is not a condition for parents to take lightly. While there is no cure, children with Asthma can continue to lead active lives if they are appropriately managed. Managing this

complex and changing condition may require the expertise of a variety of medical professionals. Starting with their primary care providers is often the best place to begin.

Medications and eliminating certain environmental triggers are methods to help control asthma conditions. A Gateway Health Plan® Care Manager can help by providing information to your patients and collaborate with you to help implement your treatment plans. Ensuring the child has the proper treatment for asthmatic conditions is an important step in this process. You can refer a patient to a Care Manager in the "AIR" Gateway Asthma Program by calling; 1-800-642-3550, Option 3 or a fax referral form can also be downloaded from Gateway Health Plan® website at [www.GatewayHealthPlan.com](http://www.GatewayHealthPlan.com).

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.GatewayHealthPlan.com](http://www.GatewayHealthPlan.com).

Guidelines include:

- Adult with HIV
- Adult Preventive Care
- Asthma
- Cardiac Medical Management
- Child Preventive Care

- Diabetes 2010 ADA
- Hypertension
- Prenatal Care
- Lead Screening (Medicaid only)
- PCPs Treating Depression (Medicaid only)
- Bipolar Disorder (Medicare only)
- Schizophrenia (Medicare only)

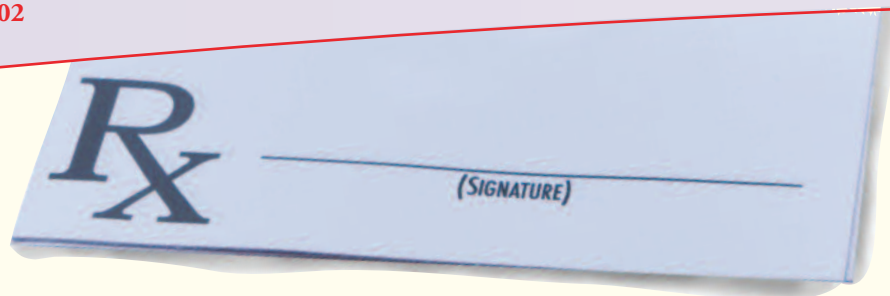
To view these guidelines, select a plan, click the provider link and at the bottom of the left-hand column,

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

## PHARMACY FORMULARY UPDATES

The Gateway Health Plan® (Gateway) 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](http://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 SNP members.

### Medicaid Formulary Quantity Limit Program Updates

Drug Name	Effective Date	Notes
Arixtra (fondaparinux) injection	6/1/2010	QL applies #10/month
Fragmin (dalteparin) injection	6/1/2010	QL applies #10/month
Lovenox (enoxaparin) injection	6/1/2010	QL applies #28/month
Roxicodone (oxycodone)	6/1/2010	QL applies #150/month

### Medicaid Formulary Deletions

Drug Name	Effective Date
Diovan (valsartan)	6/1/2010
Diovan HCT (valsartan/hydrochlorothiazide)	6/1/2010
Enablex (darifenacin)	6/1/2010
Exforge (amlodipine/valsartan)	6/1/2010
Exforge HCT (amlodipine/hydrochlorothiazide)	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  
 OTC=Over the Counter

### Medicaid Formulary Additions

Drug Name	Effective Date	Notes
Cozaar (losartan)	5/1/2010	GC, ST, QL
Hyzaar (losartan/hydrochlorothiazide)	5/1/2010	GC, ST, QL
Citranatal Assure	7/1/2010	GC
Citranatal DHA	7/1/2010	GC
Prenatal Plus DHA	7/1/2010	OTC
Duet DHA Complete	7/1/2010	GC
Citranatal 90 DHA	7/1/2010	GC

### Medicare Assured® HMO SNP Formulary Additions

Drug Name	Effective Date	Notes
Istodax (romidepsin)	5/1/2010	
Zyprexa Relprevv (olanzapine pamoate) injection	6/1/2010	PA, QL

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*® HMO SNP members or fax to 412-255-4544 or 888-245-2049 (Medicaid) or 888-447-4369 (Medicare), Attn: Pharmacy Department.

## Medicare Assured® HMO SNP Formulary Deletions

Brand Name Deletion (Generic added to formulary)	Effective Date
Acular and Acular LS (ketorolac tromethamine) ophthalmic solution	9/1/2010
Aldara (imiquimod) cream	9/1/2010
Alkeran (melphalan)	9/1/2010
Augmentin Suspension 250-62.5 (amoxicillin Tr/potassium clavulanate)	9/1/2010
Augmentin XR (amoxicillin Tr/potassium clavulanate) tablets	9/1/2010
Casodex (bicalutamide) tablets	9/1/2010
Catapress (clonidine) TTS patches	9/1/2010
Cellcept (mycophenolate mofetil) 250mg and 500mg	9/1/2010
Cytomel (liothyronine sodium) tablets	9/1/2010
Eloxatin (oxaliplatin)	9/1/2010
Golytely (PEG 3350)	9/1/2010
lopidine (apraclonidine) ophthalmic solution	9/1/2010
Ovide (malathion) lotion	9/1/2010
Plan B (levonorgestrel) tablets	9/1/2010
Prograf (tacrolimus)	9/1/2010
Pulmicort (budesonide) respules	9/1/2010
Tegretol XR (carbamazepine extended release)	9/1/2010
Urso (ursodiol)	9/1/2010
Vibramycin (doxycycline) suspension	9/1/2010
Vivactil (protriptyline)	9/1/2010
Zosyn (piperacillin/tazobactam) injection	9/1/2010

## CLINICAL

### GATEWAY LAUNCHES A POST-FRACTURE PROVIDER NOTIFICATION PROGRAM

In 2009, Gateway's Pharmacy Department conducted a retrospective review of Medicare Assured® HMO SNP female members over the age of 67 who suffered a fracture. The purpose of this review was to assess the frequency with which these members received a Bone Mineral Density (BMD) test and/or a drug to treat or prevent osteoporosis after the fracture. Due to the alarming low number of members who did not show evidence of a BMD screening or osteoporosis drug, a provider survey was conducted to solicit feedback as to the rationale for the absence of these services. **The results of our provider survey revealed that most primary care physicians (PCPs) were never aware their patient experienced a fracture.**

On a monthly basis, Gateway's Pharmacy Department reviews medical and pharmacy data to screen for Medicare Assured® HMO SNP female members over the age of 67 who sustained a fracture. **To enhance the care coordination between the member and their PCP, a post-fracture patient report is sent to the member's PCP when Gateway does not have evidence of a BMD screening or osteoporosis drug.**

We value the care that you provide for our members and recognize that you make clinical decisions based on the unique physical, medical, and mental needs of every member. **If you receive a post-fracture patient report, please consider the medical appropriateness of a BMD screening and/or drug to treat or prevent osteoporosis for your patient.**

Any questions or comments about the post-fracture patient report can be directed to Gateway's Pharmacy Department at [GatewayRx@GatewayHealthPlan.com](mailto:GatewayRx@GatewayHealthPlan.com).

## CLINICAL

### DRUG INTERACTION PROVIDER ALERT: OMEPRAZOLE (PRILOSEC) AND PLAVIX

Gateway Health Plan® is alerting our providers of the interaction between proton pump inhibitors (PPIs) and Plavix. Omeprazole (Prilosec) inhibits CYP2C19, the enzyme responsible for the conversion of Plavix into its active metabolite. A recent study found a reduction of about 45% in active metabolite levels and a similar reduction in the effect of platelets was found in people who received Plavix with omeprazole compared to those taking Plavix alone. All PPIs have some degree of involvement with the CYP2C19 pathway. It is unclear which agents have the least effect on the conversion of Plavix to its active metabolite. As a result, studies have found individuals taking both omeprazole and Plavix were more likely to have a coronary event.

A review of Gateway's internal data also supports these findings. On June 25th, Gateway sent letters to network providers regarding 766 members who were taking both omeprazole and Plavix. In light of the interaction, Gateway suggests providers evaluate the medical necessity of a PPI (possible continuation upon hospital discharge, etc) and/or consider the possible switch to a histamine-2-receptor antagonist (H2 blocker) (famotidine and ranitidine have been found to have the least interaction among the class with the CYP2C19 pathway). Gateway will continue to monitor and communicate any additional evidence that is published or available through the Food and Drug Administration (FDA).

#### REFERENCES:

- Public Health Advisory (11/17/2009). Updated safety information about a drug interaction between clopidogrel bisulfate (marketed as Plavix) and omeprazole (marketed as Prilosec and Prilosec OTC). Retrieved from the FDA Drug Safety website: <http://www.fda.gov/Drugs/DrugSafety/PublicHealthAdvisories/ucm190825.htm>
- Ho PM, Maddox TM, Wang L, et al. Risk of adverse outcomes associated with concomitant use of clopidogrel and proton pump inhibitors following acute coronary syndrome. JAMA. 2009;301:937-944. Accessed via: <http://jama.ama-assn.org/cgi/reprint/301/9/937>
- Gilard M, Arnaud B, Cornily JC, et al. Influence of omeprazole on the antiplatelet action of clopidogrel associated with aspirin: the randomized, double-blind OCLA (Omeprazole Clopidogrel Aspirin) study. J Am Coll Cardiol. 2008;51:256-260. Accessed via: <http://content.onlinejacc.org/cgi/reprint/51/3/256.pdf>
- Aubert RE, Epstein RS, Teagarden JR, et al. Abstract 3998: proton pump inhibitors effect on clopidogrel effectiveness: the Clopidogrel Medco Outcomes Study. Circulation. 2008;118:815A. Accessed via: [http://circ.ahajournals.org/cgi/content/meeting\\_abstract/118/18\\_MeetingAbstracts/5\\_815](http://circ.ahajournals.org/cgi/content/meeting_abstract/118/18_MeetingAbstracts/5_815)

## CLINICAL

# SMOKELESS TOBACCO – WHAT DO YOU NEED TO KNOW?

## TYPES OF SMOKELESS TOBACCO

**Snuff:** Available in dry or moist forms, snuff is finely ground or shredded tobacco leaves that are packaged in tins or teabag-like pouches. A pinch of snuff is placed between the lower lip and gum or cheek and gum. Users typically spit out the tobacco juices, but those who swallow the juices become more addicted. Dry forms of snuff can be sniffed into the nose; using snuff is also called *dipping*.

**Chew (chaw):** A wad of chewing tobacco is placed inside the cheek and held there, sometimes for hours, and users spit out the tobacco juices. Chew is made from loose tobacco leaves that are sweetened and packaged in pouches.

**Plug:** Chewing tobacco is pressed into a brick, usually with the help of molasses or another sweet syrup. Users cut off or bite off a piece of the plug and hold it between the cheek and gum, spitting out the tobacco juices.

**Twist:** Twist is flavored chew, braided and twisted into rope-like strands. It is held between the cheek and gum, and users spit out the tobacco juices.

**Snus:** Relatively new, snus (pronounced "snoos") is a smokeless, spitless tobacco product that originated in Sweden. Snus comes in a pouch that is placed between the upper lip and gum for about a half-hour before discarding.

**Dissolvable tobacco products:** Pieces of compressed powdered tobacco, similar to small hard candies, dissolve in the mouth and require no spitting of tobacco juices. Instead,

they melt like breath mints. Sometimes called "tobacco lozenges," these products are sold in shiny plastic cases and are not to be confused with the nicotine lozenges used for smoking cessation. Dissolvable tobacco products include:

- *Orbs:* similar to popular tiny breath mints
- *Sticks:* similar to toothpicks
- *Strips:* similar to mouthwash breath strips

## FACTS

### 1. Addiction

Dip and chewing tobacco contain more nicotine than commercially manufactured cigarettes. A typical dose of nicotine in snuff is 3.6mg, in chewing tobacco it's closer to 4.5 mg and in a commercially produced cigarette it's 1 to 2 mg. When used according to package directions, the nicotine in smokeless tobacco is easily absorbed through the lining of the mouth in quantities sufficient to cause addiction. Smokeless tobacco use can lead to nicotine addiction and dependence

### 2. Carcinogens & Cancer

Smokeless tobacco is known to contain 28 carcinogens, including very high levels of tobacco-specific nitrosamines (TSNAs). Other cancer-causing substances in smokeless tobacco include: formaldehyde, arsenic, cadmium and radioactive polonium-210.

People who use dip or chewing tobacco increase their risk of oral cancer by 50% compared to those who do not use these products; this includes cancer of the lip, tongue, cheek, roof and floor of the mouth, as well as cancer of the larynx and of the pancreas.

## Smokeless tobacco use in the US is higher among:

- Young white males
- People employed in blue collar, service, laborer jobs or who are unemployed
- People living in southern and north central states
- American Indians/ Alaska Natives

### 3. Gum Disease, Bone Loss, Leukoplakia and Tooth Decay

Smokeless tobacco creates an unhealthy environment in the mouth that leads to various problems:

- Permanent gum recession and bone loss where the tobacco rests
- Leukoplakia
- Tooth decay from the sugar used to enhance the flavor

### 4. Reproductive Health Problems.

Smokeless tobacco use during pregnancy increases the risks for preeclampsia, premature birth, and low birth weight. Smokeless tobacco use by men causes reduced sperm count and abnormal sperm cells.

## SOURCES:

<http://www.medscape.com/viewarticle/724317>

[http://www.cdc.gov/tobacco/data\\_statistics/fact\\_sheets/smokeless/smokeless\\_facts/](http://www.cdc.gov/tobacco/data_statistics/fact_sheets/smokeless/smokeless_facts/)

**5. Allure for Teenagers**

Adolescents who use smokeless tobacco are more likely to become cigarette smokers. But, why is it so appealing to many teens?

- New smokeless tobacco products give kids a way to use nicotine without it being obvious.
- Teens may view smokeless tobacco as relatively harmless compared with cigarettes.
- Adolescent girls may use smokeless tobacco to try to lose weight.
- New forms and flavors of smokeless tobacco appeal to youth tastes.
- Smokeless products are heavily promoted.
- Smokeless products are used by youth role models, including MLB players and rodeo stars.

**DOWNLOADABLE RESOURCES**

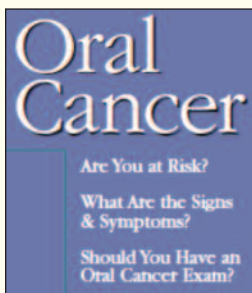
**Detecting Oral Cancer:**  
A Guide for Health Care Professionals



[http://www.killthecan.org/facts/files/detecting\\_oral\\_cancer.pdf](http://www.killthecan.org/facts/files/detecting_oral_cancer.pdf)

This color poster illustrates the steps to conduct an oral exam. It can be placed in a waiting or exam room to spark discussion.

**Oral Cancer: Are You At Risk?**



[http://www.killthecan.org/facts/files/oral\\_cancer\\_are\\_you\\_at\\_risk.pdf](http://www.killthecan.org/facts/files/oral_cancer_are_you_at_risk.pdf)

This brochure can be made available to patients to think about the risk factors that could impact their oral health.

# The Impact of Substance Use on Pregnant Women and Their Newborns

**Saturday, November 6, 2010**  
Henry Hood Center for Health Research  
Geisinger Health System, Danville, PA

**TOPICS RELATED TO:**

- Care of Women using Drugs during Pregnancy
- Neonatal Abstinence Syndrome Assessment and Management
- Continuity of Care after Birth and Newest Information about Buprenorphine during Pregnancy and with Newborns

**WITH EXPERT PRESENTERS FROM:**

Children's Hospital of Pittsburgh  
Gateway Health Plan®  
Geisinger Health System  
Lancaster General Women and Babies Hospital  
Magee-Womens Hospital of UPMC  
PA Department of Health  
PA Department of Welfare  
Penn State Children's Hospital  
Philadelphia Veterans Medical Center  
St. Christopher's Hospital for Children  
University of Pennsylvania  
Western Pennsylvania Hospital

**HIGHLIGHTS**

Keynote Address by:  
**Karol Kaltenebach, PhD**  
*Department of Pediatrics,  
Jefferson Medical College,  
Thomas Jefferson University*

Application for 6 CME credits for physicians, nurses, social workers, physician assistants has been submitted.

To register or for more information, contact:  
Sharon K. Hanley • Phone: 800-272-6692  
Email: [cme@geisinger.edu](mailto:cme@geisinger.edu)

This presentation is made possible through collaboration between:



**GEISINGER**  
HEALTH SYSTEM

**Don't be Trippin' — Stop Your Dippin'**



<http://dontdip.tamu.edu/signs.htm>

This website, managed by Texas A & M, provides resources that can be used with adolescents and young adults. It includes games like an online Jigsaw Puzzle where users must reconstruct a picture of an unsavory looking mouth of a smokeless tobacco user, and a Cash Calculator that challenges teens to think about how much money they "spit out" in comparison to other purchases they could make with that money.

**SMOKELESS TOBACCO IS A SIGNIFICANT HEALTH RISK AND IS NOT A SAFE SUBSTITUTE FOR SMOKING CIGARETTES!**

## CLINICAL

## BULLYING AND SPECIAL POPULATIONS

Bullying is an aggressive and intentional behavior involving an imbalance of power or strength between the bully, and the person being bullied. The behavior is repeated over time. Bullying can be physical, verbal, or non-verbal, either direct or indirect. Direct forms of bullying can include hitting, kicking, shoving, taunting, teasing, racial slurs, verbal sexual harassment, threatening, or obscene gestures. Indirect forms of bullying can include getting another person to assault someone, spreading rumors, or deliberately excluding someone from a group or activity. Overall, about 15-25% of students are bullied on a regular basis.

While any child can be the victim of bullying, children who are gay, lesbian, bisexual, or transgender (GLBT) can be the victims of bullying at a higher rate than the general population. According to the National Mental Health Association, GLBT youth hear anti-gay comments such as "homo," "faggot," and "sissy" about 26 times per day, or once every 14 minutes. A multi-state survey of GLBT students by the Gay, Lesbian, and Straight Education Network found 61% of GLBT youth reported verbal

harassment, 47% reported sexual harassment, 28% reported physical harassment, and 14% reported physical assault. GLBT youth are seen as the most at-risk population in middle and high schools. The GLBT youth is a risk for dropping out of school or running away, due to the amount of harassment they receive at school.

Children with special needs can also be the victims of bullying at a higher rate than the general population. According to the U.S. Department of Health & Human Services, children with the following special needs may be at more risk of being bullied:

- Children who have learning disabilities (LD)
- Children with Attention Deficit Hyperactivity Disorder (ADHD)
- Children with medical conditions that affect the child's appearance, perhaps requiring a wheelchair
- Children who are obese
- Children with hemiplegia (paralysis on one side of the child's body)
- Children who have diabetes and need to use insulin
- Children who stutter

Special needs children who need extra help in the classroom can be at higher risk of being bullied. Children who are alone at playtime and children with less than two good friends are also more at risk of being bullied. Special needs children who are boys are more at risk of being bullied than special needs children who are girls.

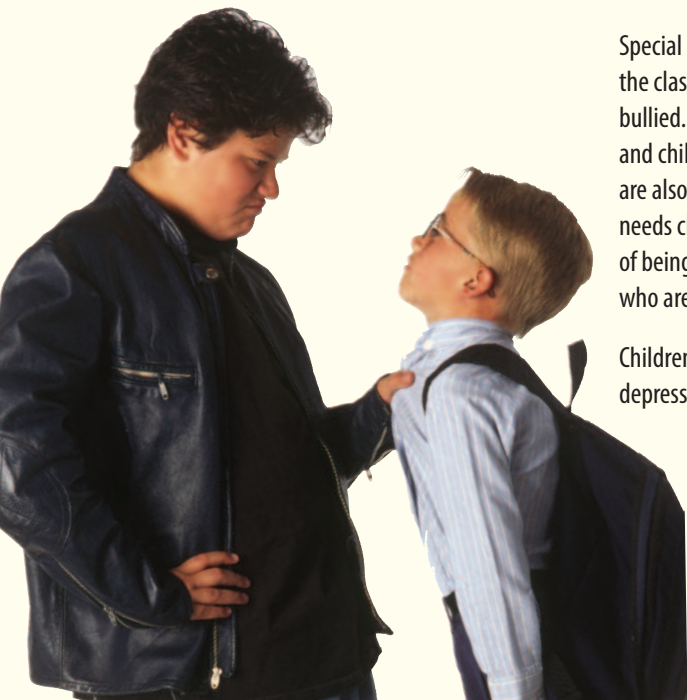
Children who are bullied can experience depression, anxiety, low self-esteem,

headaches, stomachaches, not wanting to go to school, low academic performance, problems sleeping, and in some instances the child might be thinking about suicide. Bullied children might isolate from others or may bully other children. The bullied child might come home with cuts and bruises, might "lose" belongings, or might have a change in behaviors, for example wetting the bed.

What can you do if you think your patient is being bullied?

- Be supportive of the child. Let the child know it is not their fault. Encourage the child not to fight back as this can make things worse.
- Teach the child ways to deal with a bully, which include ignoring the bully, having the child control their anger, having the child stay with a group of friends, and encouraging the child to tell their parent or guardian, or someone at school such as a teacher, counselor, or other adult when the child is being bullied.
- Encourage the child's parents to talk with the child's teacher about the bullying. If the teacher can not help, talk with the Principal.
- Bullied children can benefit from seeing a counselor, where the child can express their thoughts and feelings about being bullied. If the child is being bullied and you think counseling would help, consider calling the child's Behavioral Health MCO for additional information on supports. For GLBT youth living within Southwestern PA the Persad Center can be contacted for additional information at 412-441-9786.

If your patient's family needs more information, please let them know our Care Management Department can help. The family can call Gateway Health Plan's Care Management Department at 1-800-642-3550, option 1, and then option 2.





OFFICE STAFF

TIMELY FILING

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

MEDICAID

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

MEDICARE

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



OFFICE STAFF

MEMBER RIGHTS & RESPONSIBILITIES

All Gateway Health Plan® (Gateway) members enrolled in Gateway's Medicaid 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. Member Rights and Responsibilities can also be viewed on Gateway's website at [www.GatewayHealthPlan.com](http://www.GatewayHealthPlan.com) by clicking on For Members and Medicaid Members. The Medicaid Member Rights and Responsibilities can be accessed by clicking on Rights and Responsibilities at the bottom of the list on the left under the Member Rights section. Offices may also access these documents and print them out for posting.



OFFICE STAFF

PRIMARY CARE PRACTITIONER AVAILABILITY



On a semi-annual basis, Gateway Health Plan® monitors primary care practitioner availability to ensure members' access to an adequate network of primary care practitioners is provided. Gateway conducts the studies to meet National Committee for Quality Assurance (NCQA), PA Department of Public Welfare (DPW), and Department of Health (DOH) requirements. Gateway established the following availability standards:

**Geographical Availability:**

- For urban counties, 90% of Gateway members have a choice of two practitioners within 20-miles
- For rural counties, 90% of Gateway members have a choice of two practitioners within 45-miles

**Panel Capacity:**

- For all service areas, at least 80% of the PCP panels are open to Gateway members

In 2010, for Medicaid, Gateway met the geographical availability standard in all Counties except for Perry County. In Perry County, 78% of Pediatric members had access to a Pediatric PCP within 20 miles of their home. For *Medicare Assured® HMO SNP*, Gateway met the geographical availability standard in all Counties

Across the entire Medicaid and *Medicare Assured® HMO SNP* service area, 97% of Gateway's PCP offices are open to accepting Gateway members. Gateway met the 80% open panel standard in all counties except for Dauphin County, where 78% of the PCPs are open.

## OFFICE STAFF



# DEFICIT REDUCTION ACT (DRA): IMPLICATIONS FOR MEDICAL ASSISTANCE

The Deficit Reduction Act (“DRA”) was signed into law on February 8, 2006. This legislation is very broad in nature, and is designed to reduce the Federal deficit by targeting various areas of government spending. The DRA includes several provisions that address Federal payments to state Medicaid programs.

The Medicaid provision of the DRA applies to any entity that receives or makes payments of \$5 million dollars or more from the Medicaid agency of one or more states. As a managed care plan contracted with the Pennsylvania Department of Public Welfare, Gateway Health Plan® (“Gateway”) is subject to the DRA because it meets the \$5 million dollar threshold established by the act. Providers will need to determine for themselves individually if they are also subject to the DRA, based upon the amounts of the payments they receive and make from the Medicaid agency of one or more states. Under the DRA, one of the things that Gateway is required to do is to distribute to its network providers certain information about a law known as the False Claims Act.

There is both a Federal and Pennsylvania (state) version of the False Claims Act. The goal of each is to discourage the presentation of false or fraudulent claims for payment within the Medicaid program and to impose a penalty

when fraudulent claims are detected. For the most part, these laws are similar in the type of conduct that is prohibited as well as the type of penalties that are imposed. However, there are a few distinctions between the two.

Both laws prohibit a provider from knowingly submitting a false or fraudulent claim for payment or approval. The term “knowingly” means that the provider either knew that the claim was fraudulent or had reason to suspect the claim was false, but failed to act upon that suspicion. False or fraudulent claims include those for:

- Items or services that were not actually provided;
- Items or services that are medically unnecessary;
- Items or services for which the provider has already been reimbursed from any other source;
- Items or services that are duplicative of other items or services already provided;

- Charges that are not related to items or services supplied to the recipient;
- Charges that misrepresent the description of items or services provided, the dates of service, the identity of the recipient, the identity of the attending, prescribing or referring provider, or the identity of the actual provider;
- Charges that are higher than the provider’s usual and customary charge for the same item or service to the general public;
- Items or services dispensed, provided or rendered without the practitioner’s written consent (except in emergency situations);
- Charges for items or services dispensed, provided or rendered to an individual claiming to be a recipient of medical assistance without first making a reasonable attempt to verify that person’s eligibility (except in emergency situations);
- Charges for items or services that are supported by a falsified medical record;
- Items or services for which a provider conspired with another individual to have allowed or paid;
- Items or services that, in connection with, a provider receives any remuneration, kickback, rebate, or

bribe, directly or indirectly, in cash or in kind from any person;

- Charges for items or services dispensed, provided or rendered, or a referral to another provider for such items or services, that are not documented in the medical record in the prescribed manner, are of little benefit to the recipient, are below the accepted medical treatment standards, or are not medically necessary for the recipient.

Violations of the False Claims Acts carry significant penalties. Each violation of the Federal False Claims Act carries a civil penalty of not less than \$5,500 but not more than \$11,000. Most violations also impose an additional penalty consisting of treble damages, which is an amount equal to three times the amount determined to be sustained by the government as a result of the violation. For each violation of Pennsylvania’s False Claims Act, there is a maximum penalty of \$15,000 and seven years imprisonment, along with an exclusion from the Medical Assistance program for a period of five years from the date of conviction.

In order to protect individuals who come forward to employers, supervisors or authorities with information regarding possible violations of the False Claims Acts, both the Pennsylvania and Federal government have enacted “whistle-blower protections.”

These laws prohibit an employer from retaliating against an individual who makes a good faith report of actual or suspected instances of wrongdoing, or participates in an investigation of suspected wrongdoing. From a legal standpoint, “retaliation” includes more than the discharge of an employee. It includes such things as demotion, suspension, threats, harassment or discrimination against an individual with respect to compensation, terms or conditions of employment, location, or privileges of employment.

An employee who can successfully prove retaliation by an employer for good faith reporting or participation in an investigation of a False Claims Act violation is entitled to various remedies, including reinstatement of a position with the same seniority status and fringe benefits the employee would have had but for the discrimination, an amount equal to two times the back pay owed with interest, actual damages, compensation for special damages, litigation costs, attorneys’ fees or any combination of these remedies.

OFFICE STAFF



PATIENT SAFETY

In the office setting, clear and complete information in the medical record reduces the risk of a miscommunication that could result in patient harm. Set up practices and standards that support excellent medical record documentation.

- Have a designated place in each medical record where allergies are listed as well as the patient’s reaction to them (or NKA).
- The patient’s record should contain a past medical history as well as an up-to-date list of medications and chronic conditions. Having this information available when providing care reduces the risk that the patient will be prescribed a medication or treatment that is contraindicated.
- Include information from other physicians, hospitals, home care agencies, or skilled nursing facilities in the form of a filed correspondence or progress note to ensure safe coordination of care.
- The old adage is true - If you didn’t document it, it didn’t happen! Protect your patient and yourself.

Maintaining a complete and comprehensive medical record for each patient is a safe practice.



OFFICE STAFF

OFFICE MANAGER INCENTIVE PROGRAM WINNERS

Congratulations to the winners of the 2nd Quarter 2010 Primary Care Office Manager Incentive Program!

*The winners are:*

- D. Singh, M.D. and Associates
- Family Practice Center/PCP
- Handelsman Family Practice, LLC
- Pediatric Alliance, PC - Greentree Division
- Tri-State Pediatric Associates, Inc. – Kasi
- West Penn Internal Medicine Associates

As a reminder, the criteria for participation includes 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.





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

[www.GatewayHealthPlan.com](http://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



# YOUR ROLE IN THE MEMBER APPEAL PROCESS

Providers can play an active role in the member appeal process. When a member files an appeal, Gateway may ask you to forward supporting documentation for the denied service or item in question. Please refer to your Gateway contract for further information on your obligation to respond to requests for information or patient records for appeal purposes. We may also invite you to participate in an appeal hearing. Another type of appeal which may be filed by a member or provider is an Expedited Appeal. In this case, a physician must submit written certification that a member's life or health is in immediate danger if the requested service or item is not obtained. Depending on the member's insurance,

Gateway may only have 24 hours to have an appeal hearing and make a decision on an expedited appeal to be compliant with state and federal guidelines.

#### Acting on Behalf of Your Patient

Health care providers also have the right to act on behalf of their patients when Gateway has denied a prior authorization request for services. However, state and federal regulations require that the member appeal process be utilized if appealing the denial of a service that

has not yet been rendered. This may require a provider to have the member's written consent, depending upon the member's coverage (Medicaid or Medicare) or the service in question. More information about these processes can be found at [www.GatewayHealthPlan.com](http://www.GatewayHealthPlan.com) by choosing "Medicare provider" or "Medicaid provider", then "Appeals, Complaints, and Grievances". You may also contact Provider Services or your Provider Relations Representative for more information.

## ICON KEY

MEDICAID ONLY



MEDICAID & MEDICARE



MEDICARE ONLY

