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Quick Reference

**Important Phone Numbers for Gateway Medicaid**

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<thead>
<tr>
<th>Call to Inquire About:</th>
<th>Telephone Number</th>
<th>Hours of Operation</th>
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<tbody>
<tr>
<td>Care Management</td>
<td>1-800-392-1147</td>
<td>Monday-Friday 8:30 AM to 4:30 PM</td>
</tr>
<tr>
<td>Gateway Interactive Voice Response System (IVR) (Eligibility</td>
<td>1-800-642-3515 and</td>
<td>Twenty-four (24) hours a day/seven (7) days a week</td>
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<tr>
<td>Check/Generate and Review Referrals)</td>
<td>1-800-642-1147</td>
<td></td>
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<tr>
<td>Fraud and Abuse and Compliance Hotline</td>
<td>412-255-4340 or 1-800-685-5235</td>
<td>Twenty-four (24) hours a day/seven (7) days a week</td>
</tr>
<tr>
<td>Medical Management (Utilization Management)</td>
<td>1-800-392-1147</td>
<td>Monday-Friday 8:30 AM to 4:30 PM (Voicemail during off hours. The call will be returned the next business day.) Please do not leave multiple voicemail messages or call for the same authorization request on the same day.</td>
</tr>
<tr>
<td>Member Services</td>
<td>1-800-392-1147</td>
<td>Monday-Friday 8:00 AM to 8:00 PM</td>
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<tr>
<td>Pharmacy (Non-Formulary Requests and Prior Authorization)</td>
<td>1-800-392-1147</td>
<td>Monday-Friday 8:30 AM to 7:00 PM prescription drug cover</td>
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<tr>
<td>Practice Change Information</td>
<td>Fax: 1-855-451-6680</td>
<td>Twenty-four (24) hours a day, seven (7) days a week</td>
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<tr>
<td>Provider Services (Claims Inquiries and Eligibility Verification)</td>
<td>1-800-392-1147</td>
<td>Monday-Friday 7:00 AM to 5:00 PM</td>
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<tr>
<td>Regulatory Affairs (Provider and Member Appeals)</td>
<td>1-800-392-1147</td>
<td>Monday-Friday 8:30 AM to 4:30 PM</td>
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<tr>
<td>TTY/TDD (for all departments)</td>
<td>711 or 1-800-232-5460</td>
<td>Monday-Friday 8:00 AM to 5:00 PM</td>
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**Additional Helpful Telephone Numbers:**

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<td>Adagio Health (Authorization/Family Planning)</td>
<td>1-800-532-9465</td>
<td>Monday-Friday 8:00 AM to 6:00 PM</td>
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<td>Davis Vision – Provider Servicing</td>
<td>1-800-773-2847</td>
<td>Monday-Friday 8:00 AM to 6:00 PM</td>
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<td>Eligibility Verification System (EVS)</td>
<td>1-800-766-5EVS (5387)</td>
<td>Monday-Friday 8:30 AM to 3:30 PM</td>
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<tr>
<td>MA Provider Compliance Hotline (Fraud and Abuse Reporting)</td>
<td>1-866-379-8477</td>
<td>Monday-Friday 8:30 AM to 3:30 PM</td>
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<td>Call to Inquire About</td>
<td>Telephone Number</td>
<td>Hours of Operation</td>
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<tr>
<td>MA Provider Enrollment Applications</td>
<td>In-process (Inpatient and Outpatient Provider Only) 1-717-772-6140</td>
<td>Monday-Friday 8:30 AM to 3:30 PM</td>
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<td></td>
<td>Long Term Care Provider 1-717-772-2571</td>
<td>Monday-Friday 8:30 AM to 5:00 PM</td>
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<td>National Imaging Associates (NIA)</td>
<td>1-800-424-4890</td>
<td>Monday-Friday 8:00 AM to 8:00 PM</td>
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<tr>
<td>(Authorization for MRI/MRA, CT/CTA, CCTA, PET Scan, Nuclear Cardiology/MPI, Muga Scan, and Stress Echocardiography)</td>
<td>Or <a href="http://www.RadMD.com">www.RadMD.com</a></td>
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<tr>
<td>United Concordia Dental (Dental benefit provider)</td>
<td>1-866-568-5467</td>
<td>Monday-Friday 8:00 AM to 8:00 PM</td>
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**Important Addresses & Fax Numbers**

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<tr>
<td>Gateway Medicaid Claims and Referral Forms</td>
<td>Gateway HealthSM&lt;br&gt;Attention: Claims Processing Department&lt;br&gt;P.O. Box 830249&lt;br&gt;Birmingham, AL 35283-0249</td>
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<tr>
<td>Administrative Claims Reviews</td>
<td>Gateway HealthSM&lt;br&gt;Attention: Claims Department&lt;br&gt;Four Gateway Center&lt;br&gt;444 Liberty Avenue, Suite 2100&lt;br&gt;Pittsburgh, PA 15222-1222</td>
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<tr>
<td>Fax to 1-844-207-0334</td>
<td>Gateway HealthSM&lt;br&gt;Attention: Claims Department&lt;br&gt;Four Gateway Center&lt;br&gt;444 Liberty Avenue, Suite 2100&lt;br&gt;Pittsburgh, PA 15222-1222</td>
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<tr>
<td>Clinical Provider Appeals</td>
<td>Gateway HealthSM&lt;br&gt;Attention: Appeals &amp; Grievance&lt;br&gt;P.O. Box 22278&lt;br&gt;Pittsburgh, PA 15222-1222</td>
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<tr>
<td>Fax to 1-855-501-3904</td>
<td>Gateway HealthSM&lt;br&gt;Attention: Network Development Department&lt;br&gt;Four Gateway Center&lt;br&gt;444 Liberty Avenue, Suite 2100&lt;br&gt;Pittsburgh, PA 15222-1222</td>
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<tr>
<td>Initial Applications for Credentialing</td>
<td>Gateway HealthSM&lt;br&gt;Attention: Credentialing Department&lt;br&gt;Four Gateway Center&lt;br&gt;444 Liberty Avenue, Suite 2100&lt;br&gt;Pittsburgh, PA 15222-1222</td>
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<tr>
<td>Recredentialing Applications</td>
<td>Gateway HealthSM&lt;br&gt;Attention: Credentialing Department&lt;br&gt;Four Gateway Center&lt;br&gt;444 Liberty Avenue, Suite 2100&lt;br&gt;Pittsburgh, PA 15222-1222</td>
</tr>
<tr>
<td>Practice Change Information</td>
<td>Gateway HealthSM&lt;br&gt;Attention: Provider Information Management&lt;br&gt;Four Gateway Center&lt;br&gt;444 Liberty Avenue, Suite 2100&lt;br&gt;Pittsburgh, PA 15222-1222</td>
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<tr>
<td>Fax to 1-855-451-6680</td>
<td>United Concordia Dental Claims Processing Department&lt;br&gt;P.O. Box 69427&lt;br&gt;Harrisburg, PA 17106-9427</td>
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<tr>
<td>Dental Claims</td>
<td>Davis Vision&lt;br&gt;Attention: Vision Card Processing Unit&lt;br&gt;P.O. Box 1525&lt;br&gt;Latham, NY 12110</td>
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**Mental Health/Substance Abuse Contact Information**

Please note that these numbers are for members to call. Practices do not need to send a referral or authorize mental health/substance abuse services.

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<tr>
<th>County</th>
<th>Agency/ Area</th>
<th>Telephone Number</th>
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<tbody>
<tr>
<td>Adams</td>
<td>Community Care Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-866-738-9849, 1-717-771-9222</td>
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<tr>
<td>Allegheny</td>
<td>Community Care Behavioral Health Drug and Alcohol Services</td>
<td>1-800-553-7499, 1-412-350-3328</td>
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<tr>
<td>Armstrong</td>
<td>Beacon Health Options Drug &amp; Alcohol Services</td>
<td>1-877-688-5969, 1-724-354-2746</td>
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<tr>
<td>Beaver</td>
<td>Beacon Health Options Drug &amp; Alcohol Services</td>
<td>1-877-688-5970, 1-724-847-6220</td>
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<tr>
<td>Bedford</td>
<td>PerformCare Drug &amp; Alcohol Services</td>
<td>1-866-773-7891, 1-814-623-5009</td>
</tr>
<tr>
<td>Berks</td>
<td>Community Care Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-866-292-7886, 1-610-376-8669</td>
</tr>
<tr>
<td>Blair</td>
<td>Community Care Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-855-520-9715, 1-814-693-3023</td>
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<tr>
<td>Bradford</td>
<td>Community Care Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-866-878-6046, 1-570-265-1760</td>
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<tr>
<td>Bucks</td>
<td>Magellan Behavioral Health</td>
<td>1-877-769-9784</td>
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<tr>
<td>Butler</td>
<td>Beacon Health Options Drug &amp; Alcohol Services</td>
<td>1-877-688-5971, 1-724-284-5114</td>
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<tr>
<td>Cambria</td>
<td>Magellan Behavioral Health Drug and Alcohol Services</td>
<td>1-814-535-8531, 1-814-536-5388</td>
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<tr>
<td>Cameron</td>
<td>Community Care Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-866-878-6046, 1-814-642-9541</td>
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<td>Carbon</td>
<td>Community Care Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-866-473-5862, 1-570-421-3669</td>
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<td>Centre</td>
<td>Community Care Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-866-878-6046, 1-814-355-6744</td>
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<tr>
<td>Chester</td>
<td>Community Care Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-866-622-4228, 1-610-344-6620</td>
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<tr>
<td>Clarion</td>
<td>Community Care Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-866-878-6046, 1-814-226-1080</td>
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<tr>
<td>Clearfield</td>
<td>Community Care Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-866-878-6046, 1-814-371-9002</td>
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<tr>
<td>Clinton</td>
<td>Community Care Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-855-520-9787, 1-570-323-8543</td>
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<tr>
<td>Columbia</td>
<td>Community Care Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-866-878-6046, 1-570-275-5422</td>
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<tr>
<td>Crawford</td>
<td>Beacon Health Options Drug &amp; Alcohol Services</td>
<td>1-866-404-4561, 1-814-724-4100</td>
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<td>Cumberland</td>
<td>PerformCare Drug and Alcohol Services</td>
<td>1-888-722-8646, 1-717-240-6300</td>
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<tr>
<td>Dauphin</td>
<td>PerformCare Drug and Alcohol Services</td>
<td>1-888-722-8646, 1-717-635-2254</td>
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<td>Delaware</td>
<td>Magellan Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-877-769-9782, 1-610-713-2365</td>
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<td>Elk</td>
<td>Community Care Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-866-878-6046, 1-814-642-9541</td>
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<td>Erie</td>
<td>Community Care Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-855-224-1777, 1-814-451-6870</td>
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<td>Fayette</td>
<td>Beacon Health Options Drug &amp; Alcohol Services</td>
<td>1-877-688-5972, 1-724-438-3576</td>
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<td>Forest</td>
<td>Community Care Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-866-878-6046, 1-814-726-2100</td>
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<td>Franklin</td>
<td>PerformCare Drug &amp; Alcohol Services</td>
<td>1-866-773-7917, 1-717-263-1256</td>
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<td>Fulton</td>
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<td>Greene</td>
<td>Beacon Health Options Drug &amp; Alcohol Services</td>
<td>1-877-688-5973, 1-724-852-5276</td>
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<td>Huntingdon</td>
<td>Community Care Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-866-878-6046, 1-717-242-1446</td>
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<td>Indiana</td>
<td>Beacon Health Options Drug &amp; Alcohol Services</td>
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<td>Jefferson</td>
<td>Community Care Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-866-878-6046, 1-814-371-9002</td>
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<td>Juniata</td>
<td>Community Care Behavioral Health Drug &amp; Alcohol Services</td>
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<td>Lackawanna</td>
<td>Community Care Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-866-668-4696, 1-570-963-6820</td>
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<td>Lancaster</td>
<td>PerformCare Drug and Alcohol Services</td>
<td>1-888-722-8646, 1-717-299-8023</td>
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<td>Lawrence</td>
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<td>1-877-688-5975, 1-724-638-5580</td>
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<td>Lebanon</td>
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<td>1-888-722-8646, 1-717-274-0427</td>
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<td>Lehigh</td>
<td>Magellan Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-866-238-2311, 1-610-782-3555</td>
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<td>Luzerne</td>
<td>Community Care Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-866-668-4696, 1-570-826-8790</td>
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<td>Lycoming</td>
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<td>1-855-520-9787, 1-570-232-8543</td>
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<td>Mercer</td>
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<td>1-866-404-4561, 1-724-662-1550</td>
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<td>1-814-432-9744</td>
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<td>Warren</td>
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<td>1-866-878-6046</td>
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<td>Drug &amp; Alcohol Services</td>
<td>1-814-726-2100</td>
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<td>Beacon Health Options Drug &amp; Alcohol Services</td>
<td>1-877-688-5976</td>
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<td>1-570-253-6022</td>
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<td>1-866-542-0299</td>
</tr>
<tr>
<td></td>
<td>Drug &amp; Alcohol Services</td>
<td>1-717-771-9222</td>
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### Medication Assisted Treatment Providers

<table>
<thead>
<tr>
<th>County</th>
<th>Name</th>
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</tr>
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<tbody>
<tr>
<td>Allegheny</td>
<td>Gateway Rehabilitation Center</td>
<td>412-604-8900</td>
<td>311 Rouser Road, Moon Township PA 15108</td>
</tr>
<tr>
<td></td>
<td>West Penn Allegheny Health System</td>
<td>412-858-2000</td>
<td>30 Isabella Street, Pittsburgh, PA 15212</td>
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## Quick Reference

<table>
<thead>
<tr>
<th>County</th>
<th>Location</th>
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<tbody>
<tr>
<td>Berks</td>
<td>Reading Hospital and Health System</td>
<td>484-628-8827</td>
<td>6th Avenue and Spruce Street, West Reading, Pa 19611</td>
</tr>
<tr>
<td></td>
<td>New Directions Treatment Services</td>
<td>610-478-0646</td>
<td>20-22 North 6th Avenue, West Reading, PA 19611</td>
</tr>
<tr>
<td>Blair</td>
<td>Pyramid Healthcare, Inc.</td>
<td>814-940-0407</td>
<td>1896 Plank Road, PO Box 967, Duncansville, PA 16635</td>
</tr>
<tr>
<td>Bradford</td>
<td>CASA of Livingston County, Inc./Trinity</td>
<td>585-991-5012</td>
<td>100 Henry Street, Sayre, PA 18840</td>
</tr>
<tr>
<td>Bucks</td>
<td>Family Service Association of Bucks County</td>
<td>215-757-6919</td>
<td>4 Cornerstone Drive, Langhorne, PA 19047</td>
</tr>
<tr>
<td></td>
<td>Penn Foundation, Inc.</td>
<td>215-257-9999</td>
<td>807 Lawn Ave., Sellersville, PA 18960</td>
</tr>
<tr>
<td>Butler</td>
<td>Butler Memorial Hospital</td>
<td>724-284-4274</td>
<td>One Hospital Way, Butler PA 16001</td>
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<tr>
<td>Cambria</td>
<td>Alliance Medical Services-Johnstown</td>
<td>814-269-4700</td>
<td>1425 Scalp Ave., Suite 175, Johnstown, PA 15904</td>
</tr>
<tr>
<td>Centre</td>
<td>Crossroads Counseling, Inc.</td>
<td>570-323-7535</td>
<td>444 East College Avenue, Suite 460, State College, PA 16801</td>
</tr>
<tr>
<td>Clearfield</td>
<td>Clearfield-Jefferson Drug and Alcohol Commission</td>
<td>814-371-9002</td>
<td>135 Midway Drive, DuBois, PA 15801</td>
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<tr>
<td>Clinton</td>
<td>Crossroads Counseling, Inc.</td>
<td>570-323-7535</td>
<td>8 North Grove Street, Suite 4, Lock Haven, PA 17745</td>
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<tr>
<td>Dauphin</td>
<td>Pennsylvania Counseling Services - Allison Hill</td>
<td>717-230-1361</td>
<td>548 South 17th Street, Harrisburg, PA 17104</td>
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<tr>
<td></td>
<td>Hamilton Health Center</td>
<td>717-230-3910</td>
<td>110 S 17th Street, Harrisburg, PA 17104</td>
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<tr>
<td>Delaware</td>
<td>AIDS Care Group/Sharon Hill Medical</td>
<td>610-715-0127</td>
<td>2304 Edgemont Avenue, Chester, PA 19013</td>
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<td>Crozer-Chester Medical Center - Community Hospital</td>
<td>610-497-7459</td>
<td>2600 West 9th Street, Chester, PA 19013</td>
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<tr>
<td>Erie</td>
<td>Esper Treatment Center</td>
<td>814-459-0817</td>
<td>25 West 18th Street, Erie, PA 16501</td>
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<tr>
<td></td>
<td>Total Wellness Center, LLC</td>
<td>413-341-1787</td>
<td>1020 West Lackawanna Avenue, Scranton, PA 18504</td>
</tr>
<tr>
<td>Fayette</td>
<td>Highland Hospital</td>
<td>724-626-2356</td>
<td>401 East Murphy Avenue, Connellsville, PA 15601</td>
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<td>Jefferson</td>
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<tr>
<td>Lackawanna</td>
<td>The Wright Medical Group, PC</td>
<td>570-591-5146</td>
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<tr>
<td></td>
<td>Habit OPCO Dunmore Comprehensive Treatment Center</td>
<td>570-344-5327</td>
<td>118 Monahan Avenue, Dunmore, PA 18512</td>
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<tr>
<td>Lancaster</td>
<td>Lancaster General Hospital</td>
<td>717-544-4292</td>
<td>555 N. Duke Street, Lancaster, PA 17604</td>
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<tr>
<td></td>
<td>TW Ponessa &amp; Associates Counseling Services, Inc.</td>
<td>800-437-5405</td>
<td>410 North Prince Street, Lancaster, PA 17603</td>
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<tr>
<td>Lehight</td>
<td>Neighborhood Health Centers of Lehigh Valley</td>
<td>610-820-7605</td>
<td>333 West Union Street, Allentown, PA 18102</td>
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<tr>
<td></td>
<td>Treatment Trends, Inc.</td>
<td>610-432-7690</td>
<td>24 South Fifth St., P.O. Box 685, Allentown, PA 18105</td>
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<tr>
<td>Luzerne</td>
<td>Total Wellness Center, LLC</td>
<td>413-341-1787</td>
<td>189 E. Market Street, Wilkes-Barre, PA 18702</td>
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<tr>
<td></td>
<td>Pennsylvania Care LLC DBA Miners Medical</td>
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<td>43 Main Street, Ashley, PA 18706</td>
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<tr>
<td>Lycoming</td>
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<td>570-323-7535</td>
<td>501 East Third Street, Williamsport, PA 17701</td>
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<td>Total Wellness Center, LLC</td>
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<td>329 Pine Street, Williamsport, PA 17701</td>
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<td>Monroe</td>
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<td>570-839-7246</td>
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<tr>
<td>Montgomery</td>
<td>Resources for Human Development, Inc. Montgomery County Methadone Center</td>
<td>215-951-0300</td>
<td>316 DeKalb Street, Norristown, PA 19401</td>
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<tr>
<td>Montour</td>
<td>Community Health and Dental Care Inc.</td>
<td>610-326-9460</td>
<td>800 Heritage Drive, Pottstown, PA 19464</td>
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<tr>
<td>Northampton</td>
<td>Geisinger Clinic/GIM Danville</td>
<td>570-214-7021</td>
<td>100 North Academy Avenue, Danville, PA 17822</td>
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<tr>
<td>Northampton</td>
<td>Neighborhood Health Centers of Lehigh Valley</td>
<td>610-432-7690</td>
<td>24 South Fifth St., P.O. Box 685, Allentown, PA 18105</td>
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<td></td>
<td>New Directions Treatment Services</td>
<td>610-758-8011</td>
<td>2442 &amp; 2456 Brodhead Road, Bethlehem, PA 18020</td>
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<tr>
<td>Philadelphia</td>
<td>Pathways to Housing PA</td>
<td>215-390-1500</td>
<td>5201 Old York Road, Philadelphia, PA 19141</td>
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<td></td>
<td>Public Health Management Corporation</td>
<td>215-985-6886</td>
<td>1500 Market Street, Philadelphia, PA 19102</td>
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<tr>
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<td>Penn Presbyterian Medical Center</td>
<td>215-662-9758</td>
<td>5 N 39th Street, Philadelphia, PA 19104</td>
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<tr>
<td></td>
<td>Maternal Addiction Treatment, Education, and Research (MATER)</td>
<td>215-955-8419</td>
<td>1233 Locust Street, Philadelphia, PA 19107</td>
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<td></td>
<td>Temple University-Of the Commonwealth System of Higher Education</td>
<td>215-707-7547</td>
<td>3340 North Broad Street, Philadelphia, PA 19140</td>
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<tr>
<td>Schuylkill</td>
<td>Wedge Medical Center, Inc.</td>
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<tr>
<td>Washington</td>
<td>Crossroads Counseling, Inc.</td>
<td>570-323-7535</td>
<td>1873 Shumway Hill Road, Wellsboro, PA 16901</td>
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<tr>
<td>Washington</td>
<td>The CARE Center, Inc.</td>
<td>724-489-9100</td>
<td>75 East Maiden Street, Washington, PA 15301</td>
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<tr>
<td>Westmoreland</td>
<td>Mon Valley Health Services Inc.</td>
<td>724-489-9100</td>
<td>2 Eastgate Avenue, Monessen, PA 15062</td>
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<tr>
<td>York</td>
<td>Family First Health Corporation</td>
<td>717-801-4804</td>
<td>116 South George Street, York, PA 17401</td>
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<tr>
<td>York</td>
<td>Pennsylvania Counseling Services – York Psychiatric</td>
<td>717-315-0763</td>
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### Medication Assisted Treatment Providers Accessible Recovery

Warm handoff phone number for all locations: 724-591-5236 Ext. 101

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<tr>
<td>Allegheny</td>
<td>9400 McKnight Rd., Suite 103, Pittsburgh, PA 15237</td>
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<td>5601 Stanton Ave., Pittsburgh, PA 15206</td>
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<tr>
<td>Berks</td>
<td>401 Arch St., Suite 706, Philadelphia, PA 19102</td>
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<tr>
<td>Butler</td>
<td>220 South Main St., Holly Pointe Bldg., Suite C, Butler PA 16001</td>
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<td>301 Smith Drive, Unit 1, Cranberry Township, PA 16066</td>
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<td>Cambria</td>
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### Medication Assisted Treatment Providers Opioid Addiction Recovery Services (OARS)

Warm handoff phone number for all locations: 724-912-OARS (6277)

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Introduction

About This Manual
Gateway Health’s successes, measured by member and provider satisfaction and assessments by the Centers for Medicare and Medicaid Services (CMS), are dependent upon strong educational processes. Understanding Gateway policies and procedures is essential. The entire Gateway team is committed to providing accurate, up-to-date, comprehensive information to our member and provider populations through prompt and dedicated service. The Provider Manual is one way of sharing information regarding Gateway’s policies and procedures with participating practitioner offices, hospitals, and ancillary providers and is considered an extension of your contractual agreement with Gateway. This manual should be used as a general guideline by Gateway’s provider network. The manual is a reference, and is designed to be updated as needed. Please retain all updates with your manual.

This Manual and any updates are available in the Providers section of our website at www.GatewayHealthPlan.com under Medicaid Resources.

Corporate Overview
Gateway delivers access to high quality, affordable healthcare for its members. With more than twenty-five (25) years of service to the community, Gateway strongly believes that our commitment to members and the communities in which they live and work is what keeps so many “Good with Gateway”. We do not believe in just fulfilling members’ health insurance needs, but in assisting our members with other aspects of their daily lives that affect their health and well-being. Gateway understands that overall health is more than a factor of genetics and lifestyle – and where one lives should not dictate the quality of care they receive. Our large network provides access to top-notch physicians, hospitals and health services providers to ensure our members have access to the care they deserve. We take pride in knowing that our members will have the same access and quality standards as commercial members. Individuals are only as healthy as the communities in which they live so Gateway remains committed to the health of both.

Philosophy and Social Determinants of Health
Research shows that with the appropriate resources and support, people with chronic conditions can improve their overall health and well-being. In an effort to meet our members’ unique needs and to address the challenges and potential barriers faced by members in accessing medical and social support services, Gateway developed an enhanced healthcare management model called Prospective Care Management (PCM®). This model is a proactive holistic approach that addresses the Behavioral, Environmental, Economic, Medical, Social and Spiritual (BEEMSS™) issues a member faces that may present barriers to care. Using state of the art techniques, the PCM® model of care helps design a plan to ensure the member receives the individualized services needed. Some of our no-cost programs include smoking/tobacco cessation and help in managing chronic conditions, such as asthma, COPD, depression, diabetes, and heart disease. Additionally,
Gateway provides the Community Resource Connection which is a repository of resources and agencies to connect members with the services that they may need.

History
In 1992, Gateway, Inc. was established as an alternative to Pennsylvania’s Department of Human Services’ Medical Assistance Program. For the past twenty-seven (27) years, members have benefited from services such as disease management, health and wellness programs and preventive care. Today, Gateway is a top-ranked Managed Care Organization (MCO) that serves more than five hundred thousand (500,000) members.

Mission
Gateway’s mission is to improve the health and wellness of the individuals and communities we serve by providing access to integrated, superior healthcare.

Products
In addition to Gateway’s PA Medicaid product Gateway offers two Special Needs Plans (SNP), serving those with Medicare Parts A and B; among other qualifying factors. These plans are:

- **Gateway Health Medicare Assured Diamond™ (HMO SNP)** – A Dual Eligible Special Needs Plan, (D-SNP); serving those who have BOTH Medicare Parts A and B and who receive full assistance from the state.

- **Gateway Health Medicare Assured Ruby™ (HMO SNP)** – A Dual Eligible Special Needs Plan, (D-SNP); serving those who have BOTH Medicare Parts A and B and who receive specified levels of assistance from the state.

Gateway offers the following benefits to members enrolled in Gateway Health Medicare Assured℠:

- All the benefits of Original Medicare
- Prescription drug coverage
- Hearing, vision, and dental benefits (including dentures)*
- Health and wellness education, such as heart disease, diabetes, and smoking/tobacco cessation
- Bathroom safety products*
- A fitness program to help members stay active (including an @Home Pak for home-bound members)*
- Transportation*
- Meals benefits*
- Lifeline (Personal Response System)*

*Benefit coverage varies by product. Refer to the Evidence of Coverage booklet for each healthcare option located on our website at https://www.GatewayHealthPlan.com/medicare.
Gateway is dedicated to providing benefits to the Medicare and Medicaid populations to meet their medical and social needs. The specific needs of our membership have led to the development of wellness, education, and outreach programs at Gateway. These programs identify needs and provide effective case management for members with chronic conditions such as asthma, diabetes, cardiovascular disorders, chronic heart conditions, and HIV/AIDS.

**Continuing Quality Care**
Healthcare is an ever-changing field and Gateway strives to stay on top of its members’ needs. Gateway is committed to continually improving and providing high standards of quality in every aspect of service. This commitment is led by Gateway’s Quality Improvement/Utilization Management (QI/UM) Committee, made up of experts in a wide variety of medical fields. The QI/UM Committee evaluates Gateway’s ongoing efforts as well as new protocols and quality initiatives in order to improve service and care for members.

**Wellness & Disease Management**
Gateway is committed to improving the life of its membership and is working to find new ways to promote wellness, illness prevention and health education as demonstrated by the following:

- Preventive health care
  - Annual Flu Vaccinations (age eighteen (18) and older)
  - Annual Wellness Visit (age eighteen (18) and older)
  - Breast Cancer Screening (women ages fifty (50) to seventy-four (74) years)
  - Colorectal Cancer Screening (ages fifty (50) to seventy-five (75) years)
  - Diabetes tests as needed, such as HbA1C, dilated retinal eye exam, and microalbumin (for members with diabetes)
- Tobacco cessation education and benefits
- Pediatric and adult immunization reminders
- Gateway to Lifestyle Management™
  - Asthma Program
  - Cardiac Program
  - COPD Program
  - Diabetes Program
  - MOM Matters® Maternity Program
- Wellness Coaches
  - Registered Dietitian
  - Certified Diabetes Educator
  - Certified Rehab Counselor

**Healthcare Disparities**
Gateway understands that in order to help improve our members’ quality of life, we must take into account cultural and linguistic differences. For this reason, addressing disparities in health care is high on our leadership’s agenda. We believe a strong patient-provider
relationship is the key to reducing the gap in unequal health care access and health care outcomes due to cultural, language, and/or geographic barriers. One example of how we are working to close a quality gap can be seen in our diabetes disease management programs. In order to improve interventions at the point of care, Gateway pays for primary care practitioners (PCPs) to perform in-office HbA1c tests.

Test results can be available in as little as five (5) minutes. Gateway also has cross-cultural education programs in place to increase awareness of racial and ethnic disparities in health care among our employees, members and providers. A provider toolkit is available on our website at www.GatewayHealthPlan.com under the Provider section under Provider Resources. The toolkit includes facts about healthcare disparities from the Institute of Medicine, tips on how to better communicate with patients, tools to use to evaluate how well the practice is delivering quality care to culturally diverse populations, information about communication regulations and resources from the Title VI of the Civil Rights Act of 1964, facts about various cultures to enable the advocacy of high-quality, culturally competent services to multi-ethnic populations, web-based modules for physicians to practice responding to situations where culturally competent care is needed, and more.

**Community Involvement**

Gateway is an active partner in the community.

- Gateway participates in community events and sponsorships.
- Gateway provides assistance to community and social services agencies that serve high-risk, vulnerable populations.
- Gateway develops outreach programs for adults and children to educate about health, wellness, and safety issues at no cost to the community.
- Gateway carries out its Health Literacy Initiative with individuals and organizations in the communities we serve. The goal of this initiative is to help people better understand and navigate the healthcare system.

**Benefits of Gateway Health**

Gateway is a “win-win” situation for all involved.

Members receive improved access to primary medical care, health, and wellness programs. Providers receive timely payments, simplified administrative procedures, and dedicated provider servicing. Gateway fulfills its mission, and ensures the availability of high-quality medical care for the dual eligible population to positively affect the personal health of individuals.

**How Does Gateway Health Work?**

**Gateway Health Provider Network**

Gateway contracts directly with primary and specialty care practitioners, hospitals, and ancillary providers to provide care for our membership. Gateway’s provider network
includes more than one hundred thirty-five (135) hospitals, over twelve thousand two hundred (12,200) providers, and over two thousand (2,000) ancillary locations, a network of pharmacies, home healthcare agencies, and other related healthcare providers. Practitioners and other healthcare providers are chosen in such a manner that existing patterns of care, including patterns of hospital admissions, can be maintained. Participating practitioners treat patients in their offices as they do their non-Gateway patients, and agree not to discriminate in the treatment of or in the quality of services delivered to Gateway’s members on the basis of race, sex, age, religion, place of residence, or health status. Because of the cultural diversity of our membership, participating providers must be culturally sensitive to the needs of our members. Participation in Gateway in no way precludes participation in any other program with which the provider may be affiliated.

Gateway Provider Communications

NaviNet is a web-based solution for providers securely linking providers nationwide through a single website. This service is available at no cost to our participating providers. NaviNet is the preferred tool for inquiring about member information.

Gateway encourages our participating providers to access the NaviNet secure Provider Portal to utilize the self-service tools available, including:

- Secure Messaging and Document Exchange for direct and secure bi-directional communication and submission of documentation;
- Claims search including remittance advice data search option that displays all claims that have been paid to a specific check number;
- Batch claims search which allows the user to view all claims for a specific provider office; and
- Authorization requests.

Gateway Provider Relations Role

Gateway uses dedicated, highly trained Provider Account Liaisons (PALs), Lead Provider Relations Representatives or Federally Qualified Health Center (FQHC)/Rural Health Center (RHC) Contracting and Servicing Consultant. We are keenly aware that it is essential that our providers and their staff have a solid understanding of the member’s needs, our contract requirements, protocols, and Federal and/or State regulations in order to provide exceptional access and quality health care to our members.

PALs and FQHC/RHC Contracting and Servicing give initial orientation training to providers and their office staff within thirty (30) calendar days of successfully gaining approval to participate in our network. During that training the Provider Manual is reviewed. The training familiarizes new providers and their staff with Gateway’s policies and procedures.
Each participating primary care practice, specialty care practice and hospital is assigned a Provider Account Liaison or FQHC/RHC Contracting and Servicing Consultant who is responsible for ongoing education. As a follow-up to the initial orientation each assigned Provider Account Liaison and FQHC/RHC Contracting and Servicing Consultant regularly contacts providers and their staff to ensure full understanding of the responsibilities outlined in the Provider Agreements and Manual.

**Primary Care Practitioner’s Role**
The definition of a PCP is a specific practitioner, practitioner group, or a certified registered nurse practitioner (CRNP) operating under the scope of his/her licensure, who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating, and monitoring other medical care and rehabilitative services and maintaining continuity of care on behalf of a member. The PCP is responsible for the coordination of a member’s healthcare needs including access to services provided by hospitals, specialty care practitioners, ancillary services, and other healthcare services.

To ensure continuity and coordination of care, when a member obtains care outside of the primary care practice, a report should be forwarded by the rendering provider to the member’s designated PCP. By focusing all of a member’s medical decisions through the PCP, members are given comprehensive and high quality care in a cost-effective manner.

*One of Gateway’s goals is to work together with a dedicated group of practitioners to make a positive impact on the health of our membership and truly make a difference.*

**Department of Human Services Master Provider Index Number**
All network practitioners must have a Department of Human Services (DHS) issued identification number. The Office of Medical Assistance Programs (OMAP) may be contacted to obtain a Master Provider Index (MPI) Number at 717-772-6140 from 8:00 AM to 12:00 PM, or leave a message at any time at 717-772-6456. Information about DHS’ Office of Medical Assistance (MA) Programs may also be found on the Internet at www.dhs.pa.gov.

**Revalidation of Medical Assistance (MA) Providers**
Section 6401 (a) of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (together known as the Affordable Care Act or ACA) and the implementing regulation at 42 C.F.R. § 455.414 require states to revalidate the enrollment of participating providers every five years.

Per our HealthChoices Agreement (HCA) we are required to ensure that all providers operating within the PH-MCO’s network who provide services to recipients must be enrolled in the Commonwealth’s MA program and possess an active PROMISe Provider ID for each location in which they provide services to our members. Furthermore, we
are required by the HCA to reconcile monthly our provider file against DHS’ provider file to ensure all service locations are enrolled with MA.

If a provider does not have a valid PROMISe ID and service location (together forming the 13 digit MAID) they will not be setup in our systems and will not be in our directory for members to choose. Additionally, on January 1, 2018, the additional Ordering, Referring, and Prescribing (ORP) requirements go into effect which will also prevent payment for providers at service locations that do not have a valid MAID for that location.

Beginning in July 2019, Gateway Health will require the Claim Service Facility (2310C) information to be reported on a claim when:

1) the Claim Place of Service (2300 CLM05-1) equals 21, 22, 23, 24, 31, or 32, AND the Service Line Date of Service is greater than/equal to 07/01/2019.

2) the Claim Service Facility NPI (2310C NM109) equals the Billing Provider NPI (2010A NM109) and the Service Line Date of Service is greater than/equal to 07/01/2019 on all Professional Claims.

Claims received on or after 7/1/2019 with a Date of Service on or after 7/1/2019 will be rejected if the above requirements are not met.

As a reminder, Gateway Health Plan requires providers to submit a rendering provider on their claim when the Billing Provider is a group only provider. Billing Providers who can be identified as an Individual Provider or who are registered with the Department of Human Services (DHS) as Home Health, Hospice, Clinic, Pharmacy (when billing medical supplies), DME, Transportation, Laboratory, X-Ray Clinic, Renal Dialysis, Birthing Center or Vendor/Environmental Investigation are not required to submit a rendering provider at this time.

EDI Technical Guidance for Submitting a Rendering Provider:

Professional and Dental:
Rendering Header Loop 2310B Rendering Detail Loop 2420A

Institutional claims:
Rendering Header Loop 2310D Rendering Detail Loop 2420C

Unsure of your enrollment status with DHS?
Instructions for providers who have applied for enrollment and want to check the status:

- First, check the status of the portal enrollment application to verify the application has been approved or has been pended in the event FFS has reached out for additional information.
- Second, if the provider already has an existing enrollment, check ePEAP to determine if the new service location address has been added.
Contracts/No Gag Clause
Gateway allows open practitioner-patient communication regarding appropriate treatment alternatives without penalizing practitioners for discussing medically necessary or appropriate care for the patient. All of Gateway’s contracts with practitioners and providers include an affirmative statement indicating that the practitioner can freely communicate with patients regarding the treatment options available to them, including medication treatment options regardless of benefit coverage limitations. There is no language in Gateway’s contracts that prohibits open clinical dialogue between practitioner and patient.

Gateway Value-Based Programs
GHP continues its efforts to improve quality, enhance the member experience, and reduce the overall cost of health care by providing Value-Based programs to both primary care physicians (PCP) and Specialty Care Physicians (SCP).

Gateway’s Value-Based Program offers the potential for significant outcomes based reimbursement by rewarding providers for managing their Gateway member population toward high value, both quality and efficiency, outcomes of care. Gateway continues its work to improve the health of its members by encouraging care coordination across all aspects of care delivery and aligning value-based goals and objectives. Gateway’s current Value-Based Programs are Advanced Patient Centered Medical Home (APCMH), Shared Savings, and Bundled Payments or Episodes of Care.

Advanced Patient Centered Medical Home (APCMH)
The APCMH program was started in late 2017 and offers providers a first step into the Value Based world. The APCMH model of care includes key components such as: whole person focus on behavioral health and physical health, comprehensive focus on wellness as well as acute and chronic conditions, increased access to care, improved quality of care, team based approach to care management/coordination, and use of electronic health records (EHR) and health information technology to track and improve care.

The responsibilities of the Provider participating in the APCMH program are:
1. Will be a high-volume Medicaid practice already participating in the MCO provider pay for performance program or a defined set of practices willing to share care management resources.
2. Will accept all new patients or be open for face-to-face visits at least 45 hours per week.
3. Will have already received a payment in the Medicaid or Medicare electronic health record meaningful use program.
4. Will join a health information exchange organization in order to share health related data.
5. Will deploy a community-based care management team as described below:
The PCMH must deploy a community-based care management (CBCM) team that consists of licensed professionals such as nurses, pharmacists or social workers and unlicensed professionals such as peer recovery specialists, peer specialists, community health workers or medical assistants. The CBCM team’s activities can replicate but not duplicate already existing and CBCM reimbursed care management services. The care management team will work within their local community to accept individuals with complex care needs from local emergency departments, physical and behavioral health hospitals, specialty providers, and MCO. Through actively engaging patients and taking into account their preferences and personal health goals, the CBCM team will develop care plans that help individuals with complex chronic conditions to stay engaged in comprehensive treatment regimens that include, but are not limited to physical health, substance use disorder and mental health treatments. The CBCM team will also connect individuals as needed to community resources and social support services through “warm hand off” referrals for assistance with problems such as food insecurity and housing instability.

1. Will collect and report annual quality data and outcomes pertinent to their patient population as defined by the current MCO provider pay for performance program, the Integrated Care Program, and additional population specific measures defined by the Department.
2. Will conduct internal clinical quality data reviews on a quarterly basis, report results and discuss improvement strategies with the MCO.
3. Will measure patient satisfaction using a validated low literacy appropriate tool to assess individual and family/caregiver experience.
4. Will include as part of the health care team patient advocates or family members to support the patients’ health goals and advise practices.
5. Will see 75% of patients within seven (7) days of discharge from the hospital with an ambulatory sensitive condition.
6. Will participate in a PCMH learning network.
7. Will complete a Social Determinants of Health assessment using a Nationally recognized tool and submit ICD-10 diagnostic codes for all patients.
8. Will educate and disclose to patients through low-literacy appropriate material the practice is a PCMH that has a community-based care management team available to help patients manage complex care needs.

All of these items will be reviewed by your Provider Account Liaison (PAL) when they come to your office for their quarterly visit.

**Shared Savings Program**

Gateway offers a Shared Savings Program that will reward improved performance, reward quality, reward patient centered care, and share in lowered cost savings. This next step in the value based process focuses on patient care while lowering costs and improving quality. The requirements to participate in the program are as follows:
• 1,000 Eligible Members as of October 1\textsuperscript{st} in the year prior to the effective date of January 1\textsuperscript{st}.
• Providers that drop below 1,000 members in the Program Year will still be eligible to continue for the duration of that Program Year.
• Reporting, Performance Assessments, and any Value-Based Reimbursements are based upon claims submitted by Provider during the program year.
• Providers must be contracted for the program no later than March 31\textsuperscript{st} of the Program Year.
• Any Provider contracted for the program after March 31\textsuperscript{st} will automatically roll to the next January 1\textsuperscript{st} for their effective date.
• Additions to any Provider practice must be made by and notification to Gateway Health must be made by June 1\textsuperscript{st} of the Program Year.
• All additions made after June 1\textsuperscript{st} will be rolled into the next Program Year with no exception.

**Bundled Payments / Episodes of Care**
Like other value based options, Bundled Payments focuses on quality care while lowering costs. Instead of paying separately for hospital, physician, and other services, Gateway bundles the payment based on particular condition, reason for hospital stay, or care over a period of time. A provider organization can keep the money it saves through reduced spending on some components of care included in the bundle.

**Quality Improvement**

**Purpose of the Quality Improvement/Utilization Management Program**
The purpose of the Quality Improvement/Utilization Management (QI/UM) Program is to ensure that members have access to and receive safe, appropriate, timely, and equitable quality medical and behavioral health care services. The QI Program monitors and evaluates the quality and appropriateness of care provided by Gateway's provider network, and the effectiveness and efficiency of systems and processes that support the health care delivery system. Utilizing quality improvement methodologies and industry-accepted quality measurement tools, Gateway evaluates its performance outcomes to:

- Identify opportunities to improve the provision and delivery of health care and health plan services.
- Identify opportunities to improve member and provider satisfaction with care delivery and services.
- Achieve optimum member health outcomes.

The QI Program centers on these key areas: (a) preventive health care, (b) prevalent chronic health care conditions, (c) service indicators, (d) quality of clinical care, (e) safety of clinical care, (f) quality of service, and (g) members’ experience. The Program strives to improve members’ adherence to preventive care guidelines, to disease management strategies, and to therapies that are essential to the successful management of certain chronic conditions. The Program also strives to improve patient safety through:
• Educating members and providers in regards to safe practices.
• The assessment and identification of opportunities to improve patient safety throughout the provider network.
• The communication to members and providers of safety activities and provisions that may be in place throughout the network.

To ensure that all these efforts impact all members equitably, the Program endeavors to continually identify opportunities to impact racial and ethnic disparities and language barriers in health care.

In addition, the QI Department maintains a catalog of policies and procedures that guide the execution of the QI Program. QI Policies and Procedures are reviewed and updated annually to reflect changes in requirements, government regulations, and the needs of the membership and provider network.

**Goal of the Quality Improvement/Utilization Management Program**

The goal of the QI/UM program is to ensure the provision and delivery of high quality medical and behavioral health care, pharmaceutical, and other covered health care services and quality health plan services. Additional goals for the QI Program are to serve members with complex health needs and to serve a diverse membership. The QI/UM program focuses on monitoring and evaluating the quality and appropriateness of care provided by the Gateway provider network, and the effectiveness and efficiency of systems and processes that support the health care delivery system. Gateway focuses on assessing its performance outcomes utilizing quality improvement concepts and appropriately recognized quality measurement tools and reports such as qualitative, quantitative and, root/cause barrier analyses. Assessing performance outcomes helps identify opportunities for improvement in the provision and delivery of health care and health plan services, patient safety, satisfaction with care and services, and achieving optimum member health outcomes.

Of specific importance, the QI/UM program focuses on three key areas:
• Preventive health care.
• Prevalent chronic health care conditions.
• Service indicators.

The Program strives to:
• Improve members’ compliance with preventive care guidelines, disease management strategies, and therapies that are essential to the successful management of certain chronic conditions.
• Identify opportunities to impact disparities and language barriers in healthcare.
• Improve patient safety by providing member and practitioner education about safe practices, and communicating safety actions or provisions in place throughout the practitioner/provider network. The program allows for the assessment and identification of opportunities which will improve patient safety.
By considering population demographics and health risks, utilization of healthcare resources, and financial analysis, Gateway ensures that the major population groups are represented in QI/UM activities and health management programs chosen for assessment and monitoring. This information, along with high-volume/high-cost medical and pharmaceutical/drug reports, health risk assessment data, disease management and care management data, satisfaction survey information, and other utilization reports, is used to identify members with special needs and/or chronic conditions and to develop programs and services to assist in managing their condition.

**Objective of the Quality Improvement/Utilization Management Program**

The objectives of the QI/UM program are consistent with Gateway’s mission, as well as its commitment to the effective use of healthcare resources, and continuous quality improvement in order to positively affect the personal health of its members. An annual QI/UM work plan is developed to ensure that the current needs of the population are being evaluated, changes are noted, programs implemented to address the needs of members, and to ensure continuous quality improvement. The QI/UM program is assessed on an annual basis to determine the status of all activities and identify opportunities that meet the QI/UM program objectives.

Objectives are as follows:

Implementation of a QI/UM work plan that identifies and tracks completion of planned activities for each year:

- Assuring processes are in place using Total Quality Management (TQM) values to assess, monitor, and implement actions when opportunities are identified
  - Regarding the utilization of healthcare resources, quality of care, and access to services.
- Developing and updating guidelines from assessment of the member population to address key healthcare needs. These guidelines are built on scientific evidence and recommendations from expert and professional organizations and associations.
- Conducting studies to measure the quality of care provided, including established guideline studies which evaluate improvements made, observed barriers, and opportunities.
- Developing actions to address quality of care opportunities,
- Evaluating the utilization and quality performance of Gateway practitioners and vendors to assure Gateway standards are met, identify opportunities, and best practices.
- Identifying barriers, opportunities, and interventions (as needed).
- Conducting satisfaction surveys to determine member and provider satisfaction with Gateway services, programs, organizational policies, and the provision of healthcare. Results are reviewed to identify barriers and opportunities. Interventions are developed and implemented following an analysis of results in an effort to increase member satisfaction and to improve the quality of care and services provided.
Scope of the Quality Improvement/Utilization Management Program

Implementation and evaluation of the QI/UM program is embedded into Gateway’s daily operations. The QI/UM program leverages internal information, systems, practitioners, and community resources to monitor and evaluate use of healthcare services, continuous improvement, and to assure implementation of positive change. The responsibility of implementing the QI/UM Program is a Gateway Health corporate responsibility, not only that of the Quality Improvement and Utilization Management Departments.

Implementation and evaluation of the QI/UM Program is embedded into the Gateway Health daily operations. The scope of the QI/UM Program focuses on the following areas:

- **Quality of Clinical Care**
  The QI/UM Program focuses on delivering to members clinical services that are safe, appropriate, and meet professional standards. This is ensured through the monitoring of key indicators including, but not limited to, HEDIS measures, Preventive and Clinical Practice Guideline studies, and Quality of Care issues such as Preventable Serious Adverse Events (PSAE), Never Events, and Critical Incidents. Initiatives are designed and implemented to address any indicators that have not achieved or are negatively deviating from goals.

- **Quality of Service**
  The QI/UM Program focuses on delivering to members’ customer service that is professional and meaningful. This is ensured through the monitoring of key indicators including, but not limited to, the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) Member Satisfaction Survey, Member Complaints, Appeals and Grievances, and Member and Provider Call Center Statistics. Initiatives are designed and implemented to address any indicators that have not achieved or are negatively deviating from goals.

- **Safety of Clinical Care**
  The QI/UM Program works to improve patient safety by monitoring for member and practitioner education regarding safe practices, by assessing and identifying opportunities to improve patient safety throughout the practitioner/provider network, and by ensuring that members and practitioners have been informed about safety activities and provisions which may be in place throughout the network.

- **Member Experience**
  The QI/UM Program focuses on creating and maintaining a positive member experience by monitoring experience through the annual CAHPS survey, Care Management satisfaction survey, and the trending of member inquiries, complaints, appeals and grievances to identify areas of opportunity. Experience is also monitored through the quality and availability of provider services. This is ensured through the monitoring of network PCP and specialist availability and accessibility, the conduct of medical record reviews, including documentation...
standards, the assessment of continuity and coordination of care, and the conduction of an annual Member and Provider Satisfaction Survey.

Furthermore, the QI/UM Program utilizes appropriate internal resources, race/ethnicity data, information systems, practitioner data, and community resources. These data and resources are used to monitor and evaluate utilization of health care patterns, the continuous improvement process, and to ensure implementation of positive change. The scope of the program includes:

- Enrollment.
- Members’ rights and responsibilities.
- Network accessibility and availability, including those related to special needs.
- Healthcare disparities.
- Network credentialing/recredentialing.
- Medical record standards.
- Member, provider, and employee education.
- Member and provider services.
- Claims administration.
- Fair, impartial, and consistent utilization review.
- Evaluating the healthcare needs of members.
- Preventive health, disease management, and care management services, including complex case management.
- Clinical outcomes.
- Oversight of delegated activities.
- Patient safety.
- Continuous quality improvement using total quality management principles.

To request a copy of the Quality Improvement Program, Work Plan, or Annual Evaluation, please contact Gateway’s Provider Services Department at 1-800-392-1147.

**Quality Improvement Manual**

The Quality Improvement Manual is designed as a resource to assist practitioners in caring for Gateway members. The manual consists of guidelines that are developed using evidence-based clinical guidelines from recognized sources or through involvement of board-certified practitioners from appropriate specialties when the guidelines are not from recognized sources. The guidelines are evaluated on an ongoing basis and are developed based on the prevalent diseases or conditions of Gateway members, as well as applicable regulatory/accrediting body requirements. The use of guidelines permits Gateway to measure the impact of the guidelines on outcomes of care and may reduce inter-practitioner variation in diagnosis and treatment.

Clinical guidelines are not meant to replace individual practitioner judgment based upon direct patient contact. The manual consists of an introductory page, along with the following guidelines: Asthma, ADHD, COPD, Cardiac, Childhood Obesity, Cystic Fibrosis, Diabetes, Depression, HIV, Hypertension, Palliative Care, Prescribing Opioids for
Chronic Pain, Schizophrenia (Children and Adolescents), Sickle Cell Disease, Substance Abuse, Adult Preventive Care, Child Preventive Care, Routine and High Risk Prenatal Care, and Preventive Dental Care. To facilitate distribution of the most current version of these guidelines, they have been added to Gateway’s website at www.GatewayHealthPlan.com. Medical record review procedure guidelines are also provided. A paper copy of the Quality Improvement Manual and individual guidelines are available upon request. For a paper copy, please contact Provider Services at 1-800-392-1147.

**Medical Record Requests**

From time to time, Gateway will submit an ad-hoc request for medical records. It is imperative that providers in our participating network respond to these requests within fifteen (15) days at no cost, with the exception of Quality of Care cases which require a response within three (3) business days, as dictated per contractual obligations to Gateway. These requests are made to comply with regulatory requirements, requests, audits, or for operational purposes (e.g. to investigate quality of care issues, complaints/grievances, or Serious Adverse Event cases).

In addition to providing Gateway with medical records upon request, providers are required to transfer member medical records, or copies of records, to newly designated PCPs, specialists, or treatment facilities within fifteen (15) business days from receipt of the request from DHS, its agent, the member, or the member’s new treating practitioner without charging the member.

Gateway regularly conducts a review of our providers’ medical records to assure compliance with criteria as specified in the Medical Record Review Standards. The standards, which incorporate a core set of critical factors, were developed and approved by Gateway’s QI/UM Committee, and adhere to regulatory requirements as prescribed by NCQA. These standards can be provided upon request or via Gateway Health’s website at: [http://www.GatewayHealthPlan.com](http://www.GatewayHealthPlan.com)

**Potential Preventable Serious Adverse Events/Hospital Acquired Conditions and Never Events**

Potential Preventable Serious Adverse Events, Hospital Acquired Conditions and Never Events are identified by several internal and external mechanisms such as, but not limited to: case management review, credentialing/recredentialing activities, claims payment retrospective review, utilization management case review, complaint and grievance review, fraud and abuse investigations, practitioner/providers, delegates, and State and/or federal agencies.

Once a potential event has been identified an extensive review is conducted by the Quality Improvement and Medical Management Departments at Gateway Health. The
process includes a medical record review and possible telephonic or mail communication with the practitioner/provider. Once it has been determined if an actual event has been discovered, Gateway Health will notify the practitioner/provider by mail that payment denial or retraction will occur. Should you have any question, please contact Gateway Health’s Provider Services Department at 1-800-392-1147.

**Patient Safety**

Patient safety is the responsibility of every healthcare professional. Healthcare errors can occur at any point in the healthcare delivery system and can be costly in terms of human life, function, and healthcare dollars. There is also a price in terms of lost trust and dissatisfaction experienced by both patients and healthcare practitioners.

There are ways practitioners can develop a patient safety culture in their practice. Clear communication is key to safe care. Working in collaboration with members of the multidisciplinary care team, hospitals, other patient care facilities and including the patient as an important member of his care team are critical. Examples of safe practices include providing instructions to patients in terms they can easily understand, writing legibly when documenting orders or prescribing, and avoiding abbreviations that can be misinterpreted. Read all communications from specialists and send documentation to other providers, as necessary, to assure continuity and coordination of care. When calling orders over the telephone, have the person on the other end repeat the information back to you.

Collaborate with hospitals and support their safety culture. Bring patient safety issues to the committees you attend. Report errors to your practice or facility’s risk management department. Offer to participate in multidisciplinary work groups dedicated to error reduction. Ask Gateway’s QI department how you can support compliance with our safety initiatives.

Gateway also works to assure patient safety by monitoring and addressing quality of care issues identified through pharmacy utilization data, continuity, and coordination of care standards, sentinel/adverse event data, Disease Management Program follow-up, and member complaints.

If you would like to learn more about patient safety visit these web sites:

Institute of Medicine report: *To Err is Human-Building a Safer Health Care System*
https://www.nap.edu/catalog/9728/to-err-is-human-building-a-safer-health-system

The Joint Commission National Patient Safety Goals
https://www.jointcommission.org/
National Patient Safety Foundation  
http://www.npsf.org/

The Leapfrog Group for Patient Safety  
http://www.leapfroggroup.org/

Agency for Healthcare Research and Quality  
https://www.ahrq.gov/

### Reportable Conditions

Gateway practitioners are contractually required to follow Gateway QI programs, including, but not limited to, reporting certain diseases, infections, or conditions in accordance with Pa. Code § 27.21a. Gateway’s Reportable Conditions Policy, QI-050-MD-PA, has been established to detail this requirement, and the methods by which practitioners will be notified of its necessity.

To request additional information or to obtain a copy of the Reportable Conditions Policy, please contact Gateway’s Provider Services Department at 1-800-392-1147. The regulations, which include the complete list of reportable conditions, can be found via the Pennsylvania Code website at www.pacode.com.

### Living Will Declaration

**Advance Directives**

The Omnibus Budget Reconciliation Act (OBRA) of 1990 included substantive new law that has come to be known as the Patient Self-Determination Act and which largely became effective on December 1, 1991.

The Patient Self-Determination Act applies to hospitals, nursing facilities, providers of home healthcare or personal care services, hospice programs, and health maintenance organizations that receive Medicare or Medicaid funds. The primary purpose of the act is to assure that the beneficiaries of such care are made aware of advance directives and are given the opportunity to execute them if they so desire. It is also to prevent discrimination in care if the member chooses not to execute advance directives.

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. While there is no specific governmentally mandated form, member outreach or advance directive forms are made available through Gateway’s Member Handbook and Member Newsletter, or by visiting Gateway’s website at www.GatewayHealthPlan.com. 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 twenty-one (21) and older whether they have executed advance directives and will document the response.

Providers will receive educational material regarding member’s rights to advance directives upon entering the Gateway practitioner network.

**Member Outreach**

Gateway’s Member Outreach Navigators help members better understand their healthcare benefits and to appropriately access services within a managed healthcare plan. Gateway practitioners can request assistance to provide additional education to members who need further explanation on such issues as obtaining referrals for specialty care and utilizing the emergency room appropriately.

Practitioners can refer members for additional education regarding adhering to their treatment plan, of keeping scheduled appointments, understanding their benefits and resources available by completing a Member Outreach Form, which can be found in the Forms and Reference Material Section of this Manual. A Gateway representative will contact the member and follow-up with the practitioner at the practitioner’s request.

For more information or to request member outreach, please call Gateway’s Case Management Department at 1-800-392-1147. You can also fax the Member Outreach Form to the fax number listed on the Form.

**Provider Engagement Team (PET)**

Gateway’s Provider Engagement Team is a dedicated team of clinical quality improvement professionals who partner with our providers to improve the overall outcomes of our members. The PET provides information regarding best practices in quality improvement programs, information regarding performance compared to national benchmarks and peers, as well as assistance with achieving incentive goals for our Gateway to Practitioner Excellence (GPE®) pay-for-performance program. Our PET is a strategic partner with our providers in achieving their quality goals.
Member

The Enrollment Process

Enrollment in Gateway’s health plan is offered to medical assistance recipients within Gateway’s service area. Gateway serves medical assistance recipients as an option in the HealthChoices mandatory program.

The Department of Human Services (DHS) employs a Pennsylvania Enrollment Services Contractor. An Enrollment Specialist explains the benefits offered by Gateway and other PH-MCO’s and helps the recipient choose a PH-MCO that meets their needs. Potential members are encouraged to select a primary care practitioner from a list of participating practitioners. The Pennsylvania Enrollment Services Contractor electronically submits all applications to DHS to validate. DHS then electronically notifies the Pennsylvania Enrollment Services Contractor and Gateway that a recipient will be enrolled in Gateway.

MA recipients approved by DHS are added to Gateway’s information system, with the effective date assigned by DHS. It typically takes two (2) to six (6) weeks from the time a recipient calls the Pennsylvania Enrollment Services until they are enrolled with the PH-MCO. Newly enrolled members receive a new Member Handbook and a Gateway Identification Card. (see sample Gateway ID Card below)

Medical Assistance (MA) ACCESS Cards

DHS issues a Pennsylvania ACCESS card to all eligible medical assistance recipients, including those recipients that choose to join Gateway. All Gateway members will have both a DHS ACCESS card and a Gateway identification card. If a patient presents an ACCESS card, the member’s eligibility can be verified through DHS’ Eligibility Verification System (EVS). Practitioners must participate with the MA program in order to use the EVS.
To access DHS’ EVS, call 1-800-766-5EVS (5387). Please have your thirteen digit Master Provider Index (MPI) Number and the member’s State ID (also known as Recipient Number) from the member’s ACCESS card available when you call. Since important information is provided throughout the verification process, please listen to the entire message. If the recipient is covered by a managed care plan, such as Gateway, their eligibility with the plan is indicated immediately following the member’s demographic information (name, date of birth, etc.).

The Point of Service (POS) swipe-box provided DHS confirms all of the information provided through the EVS phone system, and provides printed verification for your records.

The following information is available from the EVS 1-800 number/POS device/PC Software:

<table>
<thead>
<tr>
<th>Managed Care Information</th>
<th>If the recipient is enrolled in a MCO, EVS will provide the name and telephone number of the MCO as well as the recipient’s PCP name, telephone number, TPL, and benefit package information and category of assistance. The system will inform you if the recipient has managed care coverage extending beyond the period of his/her MA coverage.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient Restriction Information</td>
<td>If the recipient has been restricted to certain practitioners, EVS alerts the practitioner to whom the recipient is restricted.</td>
</tr>
<tr>
<td>ACCESS Card Information</td>
<td>When an invalid card number is entered, EVS will indicate so by returning a message that the recipient is not eligible.</td>
</tr>
</tbody>
</table>

**Determining Eligibility through Gateway**

Because of frequent eligibility changes in a member’s eligibility, each participating practitioner is responsible to verify a member’s eligibility with Gateway before providing services. Verifying a member’s eligibility along with the applicable referral or authorization will assure proper reimbursement for services. To verify a member’s eligibility, the following methods are available to all practitioners:

1. Gateway Identification Card - The card itself does not guarantee that a person is currently enrolled in Gateway. Members are only issued an ID card once upon enrollment unless the member changes their PCP or requests a new card. Members are not required to return their identification cards when they are no longer eligible for Gateway.

2. Gateway Interactive Voice Response System (IVR), which is available twenty-four (24) hours a day, seven (7) days a week at 1-800-642-3515. Practitioners can also call 1-800-392-1147 and Press 2 for provider to access the following service prompts:
Press 1, RX Pharmacy Services
Press 2, IVR (Referrals & Eligibility)
Press 3, Provider Services
Press 4, Utilization Management
Press 5, Special Needs Unit
Press 6, Credentialing

NOTE: To proceed with the call, providers must Press 1 to enter the 10-digit NPI or Press 2 to enter the 9 digit tax identification number.

Providers follow a few simple steps once connected, which are listed below:

Press 1  If you are calling regarding retail or specialty pharmacy questions you will be connected to RX Pharmacy Services.

Press 2  If you are calling to verify eligibility or to issue/confirm a referral you will be connected to Gateway’s 24/7 IVR. Participating providers also have the capability to verify eligibility and confirm a referral via NaviNet.

Press 3  If you are calling regarding claims, to verify benefits, or authorization on file questions you will be connected to Provider Service. Participating providers have the capability to check claim status and to verify benefits via NaviNet.

Press 4  If you are calling regarding authorization requests you will be connected to UM. Participating providers have the capability to submit certain authorization requests electronically via NaviNet.

Press 5  If you are calling regarding care management you will be connected to the Special Needs Unit (SNU).

Press 6  If you are calling regarding credentialing status.

ACCESS Cards
- Showing a medical assistance ACCESS card does not indicate membership in Gateway.
- Use the swipe-box or call EVS at 1-800-766-5EVS (5387) to verify a patient’s eligibility before providing services.
Gateway Health℠ Verification of Eligibility

Disclaimer: The eligibility information provided through this automated information system represents updates processed as of the last business day. Eligibility information is provided to Gateway Health℠ and is subject to change. Please note that this information is being sent at the request of the provider.

CONFIDENTIAL INFORMATION: The documents accompanying this tele copier transmission contain information that is confidential and/or privileged. The information is intended only for the use of the individual or entity named on the cover sheet. If you are not the intended recipient, you are hereby notified that the documents should be returned to the sender immediately and that any disclosure, copying or distribution or tacking of action in reliance upon the contents of this transmission is strictly prohibited. In this regard, if this transmission has been received in error, please notify the sender by telephone immediately to arrange for the return of the original documents at no cost to the unintended recipient.

Eligibility Information

Entered ID Number: 12345678
Member Name: Doe, John
Member Gender: Male
Birthday: 12-02-1994
Member Address1: 123 Main Street
Member City: Anywhere, PA 12345
Member Telephone: 0000000000
PCP Code: 7654321
PCP Name: Pediatric Practice
PCP Telephone: 1234567891
PCP Address1: 111 Center Street
PCP City: Somewhere, PA 54321
PCP Zipcode: 54321
Plan Enroll Date: 01-01-2011
Benefit Plan: 400
Elig. for Benefits? Yes
Date of Service: 05-06-2011
Member Region Description: Allegheny County
Lab Code: 2345678
Lab Name: Lab Provider
TPL: TPL Address1: TPL City: TPL Enrollment Date: TPL Contract Num:

For additional information call: 1-800-392-1147
Primary Care Practitioner’s Role in Determining Eligibility
PCPs verify eligibility by consulting their panel listing in order to confirm that the member is a part of the practitioner’s panel. The panel list is distributed on or about the first of every month. The PCP should check the panel list each time a member is seen in the office. If a member’s name is on the panel list, the member is eligible with Gateway for that month.

If members insist they are effective, but do not appear on the panel list, the practitioner should call Gateway Provider Services at 1-800-392-1147 Option two (2) for help in determining eligibility.

Addition of Newborns
When a member selects Gateway, the member’s effective date is usually the first or the fifteenth of the month. However, when the member is a newborn, the member may be added at any time during the month. Because newborn information is reported to Gateway retroactively, newborns will show up as a retrospective addition to the primary care practitioner’s next monthly panel listing. Newborns will be effective on their date of birth or the date the newborn was added to the member’s grant.

Member Benefit
Gateway members are eligible for all of the benefits covered under the Pennsylvania DHS Medicaid program. Members obtain most of their healthcare services either directly from or upon referral by their PCP, except for services available on a self-referral basis. PCP is responsible for the coordination of a member’s healthcare needs and access to services provided by hospitals, specialty care practitioners, ancillary providers, and other healthcare providers as needed.

Benefits and Special Services
Gateway members that are age twenty-one or older may have copayments and applicable service limits. Service limits do not apply for members under twenty-one (21) or if member is pregnant. Copayments do not apply to members under twenty-one (21) or any member who is pregnant (through the post-partum period beginning on the last day of the pregnancy and extending through the end of the month in which the sixty (60) day period following termination of the pregnancy ends) or in a nursing home. Members cannot be denied a service if they are unable to pay their copayment.

The provider is required to submit in field 29 of the CMS-1500 form and field 54 of the UB-04 form the patient responsibility amount. Gateway’s system automatically deducts the copayment from the provider's reimbursement and reflects this on the provider's remittance advice. Gateway tracks the applicable copayments on each claim and through a retrospective analysis will identify members that reach the thresholds and issue member reimbursements as necessary. Please contact Gateway’s Provider Services Department at 1-800-392-1147 with any questions regarding services not listed.
Below is an excerpt from the Gateway Health Member Handbook which describes some of the services that are covered by Gateway at no cost to members:

- Visits to your PCP.
- Visits to the doctor while you are pregnant.
- Yearly physical examination.
- Well child care, including regular check-ups and shots.
- Non-emergency dental care, if eligible for non-emergency dental care under medical assistance.
- Topical fluoride varnish treatments for members under the age of sixteen (16).
- Braces for teeth for members under age twenty-one (21), if medically necessary.
- Eye exams.
- Contraceptives (birth control), insulin, insulin syringes, vitamins, and certain over-the-counter medicines when prescribed by a doctor.
- Drugs for members under age twenty-one (21) when prescribed by a doctor.
- Orthopedic shoes and hearing aids for members under age twenty-one (21), if medically necessary.
- Emergency care twenty-four (24) hours a day, seven (7) days a week.
- Twenty-four (24) hour toll-free member telephone service for non-emergency and urgent needs, through Member Service.
- Surgery and anesthesia, if medically necessary.
- EPSDT expanded services for members under age twenty-one (21).
- Extended home nursing services for members under age twenty-one (21), if medically necessary.
- Nursing facility care (limited to thirty (30) days), if medically necessary.
- Home health care visits, if medically necessary and ordered by your doctor.
- Molded shoes, if medically necessary.
- Any other medical services for members under age twenty-one (21) determined to be medically necessary.
- Laboratory Services.
- Tobacco Cessation Counseling.

Some of the services that are covered by Gateway that may require members to pay a co-payment include:
### MEDICAL ASSISTANCE

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>COPAY*/LIMITS</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand Name RX</td>
<td>$3.00</td>
<td>Applicable to age twenty-one (21) and older</td>
</tr>
<tr>
<td>Generic Drug RX</td>
<td>$1.00</td>
<td>Applicable to age twenty-one (21) and older</td>
</tr>
<tr>
<td>Inpatient Hospital (General or Rehab)</td>
<td>$3/per day, up to $21/per admission</td>
<td>Applicable to age twenty-one (21) and older</td>
</tr>
<tr>
<td>Surgical Procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any Setting</td>
<td>$3/per covered service</td>
<td>Applicable to age twenty-one (21) and older</td>
</tr>
<tr>
<td>Office Visits (Not applicable to PCPs, OBs, GYNs and OB/GYNs)</td>
<td>$2/per visit</td>
<td>Applicable to age twenty-one (21) and older</td>
</tr>
<tr>
<td>Radiology Services</td>
<td>$1/per covered service</td>
<td>Applicable to age twenty-one (21) and older and hospital or physician office</td>
</tr>
<tr>
<td>Chiropractor Outpatient Visits</td>
<td>$2/per visit</td>
<td>Applicable to age twenty-one (21) and older</td>
</tr>
<tr>
<td>Podiatrist Outpatient Visits</td>
<td>$2/per visit</td>
<td>Applicable to age twenty-one (21) and older</td>
</tr>
<tr>
<td>Vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gateway covers all medically necessary vision services for children. Children may go to a participating provider.</td>
<td>Applicable to members under twenty-one (21) years of age</td>
<td></td>
</tr>
<tr>
<td>Children are covered for the following each calendar year:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two pairs of standard frames and eyeglass lenses, or Two pairs of standard contact lenses, or One pair of standard frames and eyeglass lenses and one set of standard contact lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Members under the age of 21 are given a $20 allowance for non-standard frames and eyeglass lenses. Members will be required to pay for any amount over $20.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>Gateway covers some vision services for adults. Members must go to a participating provider.</td>
<td>Applicable to age twenty-one (21) and older</td>
</tr>
<tr>
<td>Children are covered for the following each calendar year:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two medically necessary eye exams. Members are given a $100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td>Age Range</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Vision</td>
<td>Credit for each calendar year to be used toward standard frames, eyeglass lenses and contact lenses combined. If medically necessary, members age 21 and older who are diagnosed with Aphakia are covered for the following each calendar year: Two pairs of standard frames and eyeglass lenses, or Two pairs of standard contact lenses, or One pair of standard frames and eyeglass lenses and one set of standard contact lenses.</td>
<td>Applicable to members under twenty-one (21) years of age.</td>
</tr>
<tr>
<td>Dental</td>
<td>Gateway covers all medically necessary vision services for children. Children may go to a participating provider.</td>
<td>Applicable to age twenty-one (21) and older</td>
</tr>
<tr>
<td>Dental</td>
<td>Two exams, and two cleanings (one every six months) X-rays. Limited lifetime benefits for: One partial upper denture or one full upper denture; and One partial lower denture or one full lower denture. Benefit Limit Exception (BLE) is required for the below services: Crowns and related services; Root canals and other endodontic service; Root canals and other endodontic services; Periodontal services.</td>
<td>Applicable to age twenty-one (21) and older</td>
</tr>
<tr>
<td>Tobacco Cessation</td>
<td>70 visits per calendar year</td>
<td>Applicable to age twenty-one (21) and older</td>
</tr>
<tr>
<td>Home Health Care including Nursing, Aide, and Therapy Services</td>
<td>28 days unlimited/15 days per month thereafter</td>
<td>Applicable to age twenty-one (21) and older</td>
</tr>
</tbody>
</table>
*Copayments do not apply to:

- Services or items provided to a terminally ill individual who is receiving hospice care.
- Services provided to individuals of any age eligible under Titles IV-B and IV-E Foster Care and Adoption Assistance.
- Services provided in emergency situations.
- Family planning services and supplies.
- Home health agency services
- Renal dialysis services.
- Blood and blood products.
- Oxygen.
- Rental of Durable Medical Equipment.
- Outpatient services when the MA Fee is under $2.00.
- Medical exams requested by the department.
- More than one of a series of a specific allergy test provided in a twenty-four (24) hour period.
- Targeted case management services.
- Members under twenty-one (21) or any member who is pregnant (through the post-partum period beginning on the last day of the pregnancy and extending through the end of the month in which the sixty (60) day period following termination of the pregnancy ends) or in a nursing home.
- Members covered under the MA adult benefit category do not have a copayment for the following kinds of drugs:
  - Drugs, including immunizations that you get in the doctor’s office.
  - Anti-hypertensive agents.
  - Anti-diabetic agents.
  - Anti-convulsants.
  - Cardiovascular preparations.
  - Anti-psychotic agents, except those that are also schedule C-IV antianxiety agents.
  - Anti-neoplastic agents.
  - Anti-glaucoma drugs.
  - Anti-Parkinson drugs.
  - Drugs used only to treat HIV/AIDS.
  - Naloxone.
  - Smoking cessation products.

The pharmacy will inform the member of any applicable copay for a prescription.

Members cannot be denied a service or drug if they cannot pay the co-payment. If a member cannot afford to pay, the provider may bill later for co-payments not paid at the time of service.
Members’ Rights and Responsibilities
All Gateway members have the following rights and responsibilities.

Member Rights

As a Gateway Member, you have the right to:

1. To be treated with respect, recognizing your dignity and need for privacy, by Gateway Health staff and network providers.
2. To get information in a way that you can easily understand and find help when you need it.
3. To get information that you can easily understand about Gateway Health, its services, and the doctors and other providers that treat you.
4. To pick the network health care providers that you want to treat you.
5. To get emergency services when you need them from any provider without Gateway Health approval.
6. To get information that you can easily understand and talk to your providers about your treatment options, without any interference from Gateway Health.
7. To make all decisions about your health care, including the right to refuse treatment, and to express preferences about future treatment decisions. If you cannot make treatment decisions by yourself, you have the right to have someone else help you make decisions or make decisions for you.
8. To talk with providers in confidence and to have your health care information and records kept confidential.
9. To see and get a copy of your medical records and to ask for changes or corrections to your records.
10. To ask for a second opinion.
11. To file a grievance if you disagree with Gateway Health’s decision that a service is not medically necessary for you.
12. To file a complaint if you are unhappy about the care or treatment you have received.
13. To ask for a DHS Fair Hearing.
14. To be free from any form of restraint or seclusion used to force you to do something, to discipline you, to make it easier for the provider, or to punish you.
15. To get information about services that Gateway Health or a provider does not cover because of moral or religious objections and about how to get those services.
16. To exercise your rights without it negatively affecting the way DHS, Gateway Health, and network providers treat you.

Member Responsibilities

As a Gateway Member you have a responsibility to:

1. Provide, to the extent you can, information needed by your providers.
2. Follow instructions and guidelines given by your providers.
3. Give consent to the health plan, your providers and their respective designees for the purpose of providing patient care management, outcomes, improvement and research. For these purposes, members will remain anonymous to the greatest extent possible.


5. Work with your providers to create and carry out your treatment plans.

6. Tell your providers what you want and need.

7. Learn about Gateway Health coverage, including all covered and non-covered benefits and limits.

8. Use only network providers unless Gateway Health approves an out-of-network provider.

9. Get a referral from your PCP to see a specialist.

10. Respect other patients, provider staff, and provider workers.

11. Make a good-faith effort to pay your co-payments.

12. Report fraud and abuse to the DHS Fraud and Abuse Reporting Hotline.
Benefit Limits

Exception for Service Limits

Members and practitioners may request an exception for services above the service limits by calling Gateway’s UM department at 1-800-392-1147 and press 2 for Provider and press 4 for Utilization Management. All exception requests are reviewed for medical necessity and can be granted if:

- The member has a serious chronic illness or other serious health condition and denial of the exception will jeopardize the life of the member; or
- The member has a serious chronic illness or other serious health condition and denial of the exception would result in the serious deterioration of the member’s health; or
- The exception is a cost-effective alternative to the Medical Assistance Program; or
- Granting the exception is necessary in order to comply with Federal law.

Any exception request received prior to the service being rendered will get a response within twenty-one (21) days of the date Gateway received the request. Prospective urgent exception requests will be responded to within twenty-four (24) hours of the date and time Gateway received the request. Requests received after the service has been rendered will be responded to within thirty (30) days of the date that Gateway received the request.

A retrospective request for an exception must be submitted no later than sixty (60) days from the date Gateway rejects the claim because the service is over the benefit limit. Retrospective exception requests made after sixty (60) days from the claim rejection date will be denied.

Both the recipient and the provider will receive written notice of the approval or denial of the exception request. For prospective exception requests, if the provider or recipient is not notified of the decision within twenty-one (21) days of the date the request is received, the exception will be automatically granted.

Gateway denials of requests for exception are subject to the right of appeal by the provider or recipient.

A provider may not hold a Gateway member liable for payment for services rendered in excess of the limits established unless the following conditions are met:

- The provider has requested an exception to the limit and Gateway denied the request.
- The provider informed the member before the service was rendered that the recipient is liable for payment if the exception is not granted.

Benefit Limits
Prescription Drug Coverage

Gateway provides coverage for outpatient prescription drugs when the drug labeler participates in the Federal Drug Rebate Program and the medication is included on the Gateway formulary. The formulary is a listing of medications that have been approved by Gateway’s Pharmacy and Therapeutics (P&T) Committee for use by Gateway members after a review of clinical evidence, effectiveness, safety, and cost of the pharmaceuticals. Prescribers are requested to prescribe medications included in the formulary whenever possible.

Gateway’s formulary is updated on a regular basis and can be accessed online at www.GatewayHealthPlan.com. Medication additions or deletions reflect the decisions made by Gateway’s P&T Committee. If a formulary deletion affects one of your patients, Gateway will provide you with notification thirty (30) days prior to the change. Additional copies of the formulary may be printed directly from our website or requested through Provider Services by calling 1-800-392-1147.

Prescribers may request the addition of a medication to the formulary. Requests must include the drug name, rationale for inclusion on the formulary, role in therapy and formulary medications that may be replaced by the addition. The committee will review requests. All requests should be forwarded in writing to:

Gateway Health℠
Attn: Pharmacy Department
Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222

Some medications, although listed on the formulary, may require prior authorization or step therapy to be covered. All prior authorization and step therapy criteria can be found on Gateway’s website. Gateway allows access to all non-formulary drugs, other than drugs excluded by DHS’ Fee-for-Service program, through the exception process based on medical necessity. If use of a formulary medication is not medically advisable for a member, you must initiate a Request for Drug Exception. The exceptions process allows for a twenty-four hour turnaround when reviewing requests for non-formulary, prior authorization, and step therapy medications. If a member’s prescription for medication is not filled when a prescription is presented to the pharmacist due to a prior authorization requirement, the pharmacist may authorize up to a five (5) day supply for new medications or a fifteen (15) day supply for an on-going medication (the pharmacist must contact Gateway to obtain a manual override for a fifteen (15) day supply).

Prescription medications are reimbursed when at least one of the following is met:

- The medication is prescribed for an FDA approved indication(s).

Benefit Limits
• Prescribed for indications, dosages, and formulations that are part of nationally developed standards.
• Prescribed for indications, dosages, and formulations that have been shown to demonstrate both efficacy and safety based on pertinent clinical evidence, expert opinion, and relevant findings from applicable governmental agencies, medical associations, national commissions, peer-reviewed journals, and authoritative compendia.

Any other prescription is considered experimental and therefore not covered unless specific authorization has been given by Gateway for an individual member based on a demonstration of medical necessity.

Select over-the-counter (OTC) pharmaceuticals are a covered benefit for all members. Members must have a written prescription for each OTC pharmaceutical/vitamin.

All prescriptions must be filled by a participating pharmacy in order to be covered by Gateway. Gateway utilizes the CVS Caremark National Network which consists of over 68,000 participating pharmacies nationwide. The member may utilize any CVS Caremark participating pharmacy and the claims should be billed to Gateway via the CVS Caremark Network.

A list of participating pharmacies can be obtained by contacting Gateway’s Member Service Department at 1-800-392-1147 or by searching Find a Pharmacy located on the upper banner of our webpage, at www.GatewayHealthPlan.com.

Copayments are applicable for prescriptions for members age twenty-one or older who are not pregnant (excluding the post-partum period beginning on the last day of the pregnancy and extending through the end of the month in which the sixty (60) day period following termination of the pregnancy ends) or in a nursing home. Please refer to the Member Benefit Packages and Copayments section of this manual for additional information regarding copayments.

**Specialty Pharmacy Medications**

Gateway contracts with specialty pharmacies who are equipped to supply specialty medications to meet the unique needs of our members. Specialty drugs are prescription medications that require special handling, administration, and monitoring. These drugs are used to treat complex, chronic, and often costly conditions. Gateway requires most specialty medications to be authorized and dispensed through a specialty pharmacy network. Prescribers can call the Pharmacy Services Department to confirm whether a pharmacy is contracted with Gateway as a specialty pharmacy provider. A list of participating specialty pharmacies is available by accessing the “Specialty Pharmacy” tab on the Gateway website at: https://www.gatewayhealthplan.com/provider/pharmacy-tools.
Prescribers can also search for a specialty pharmacy by location using the “Find a Pharmacy” button at the top of the Gateway Health Plan® website. Specialty pharmacies are identified under “Pharmacy Type.”

Medications that may only be dispensed by a participating specialty pharmacy are noted in the Gateway formulary book by the SPN notation.

The Specialty Pharmacy Drug List below highlights all of the specialty medications that are available through the specialty pharmacy network. Please refer to the Formulary Drug List to see which medications are included on the formulary or have additional requirements or limits on coverage such as prior authorization, step therapy, or quantity limits.

**Specialty Pharmacy Drug List:**

The Specialty Pharmacy Drug List can be found on Gateway’s website under Provider tab, Pharmacy Tools section and by selecting the link under Specialty Pharmacy. Once the prescriber sends a prescription to the specialty pharmacy, the pharmacy will outreach to the member to coordinate delivery of the medication and services needed.

If you have additional questions about obtaining a specialty medication please call Pharmacy Services at 1-800-392-1147.

**Drugs Covered Under the Pharmacy Benefit**

Prescription drugs are “covered drugs” under the pharmacy benefit at participating retail pharmacies or specialty pharmacies, as applicable, when they are:

- Approved by the Federal Food and Drug Administration (FDA).
- Distributed by a manufacturer that entered into a Federal Drug Rebate Program agreement with CMS.
- Listed in the Formulary. Drugs not included in the Formulary are available through the exceptions process described above.
- Prescribed by a licensed Prescriber within the scope of the prescriber’s practice.
- Dispensed or administered in an outpatient setting.
- Authorized by Gateway, if needed.
- Not otherwise excluded.

The limit is an amount normally prescribed by the practitioner, but must not exceed a thirty-four (34) day supply. A ninety (90) day supply is available for select generic maintenance medications. This list is available by accessing the “ninety (90) Day Generic Medication Supply” tab on the Gateway website at: [https://www.gatewayhealthplan.com/provider/pharmacy-tools](https://www.gatewayhealthplan.com/provider/pharmacy-tools).

Most prescriptions can be refilled up to twelve months from the original prescription date as authorized by the prescriber.

**Benefit Limits**

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Exclusions

- Drugs and other items prescribed for obesity or appetite control.
- Over the counter drugs in the form of troches, lozenges, throat tablets, cough drops, chewing gum, mouthwashes, and similar items.
- Pharmaceutical services provided to a hospitalized person.
- Drugs and devices classified as experimental by the FDA or whose use is classified as experimental by the FDA.
- Drugs and devices not approved by the FDA or whose use is not approved by the FDA.
- Placebos.
- Prescription and over the counter soaps, cleansing agents, dentifrices, mouthwashes, douche solutions, diluents, ear wax removal agents, deodorants, liniments, antiseptics, irrigants, emollients, and other personal care items.
- Durable Medical Equipment (DME) items (with the exception of preferred diabetic supplies, syringes, lancets, spacers, and condoms).
- Items prescribed or ordered by a physician who has been barred or suspended from participating in the MA program.
- Prescriptions or orders filled by a pharmacy other than the one to which a recipient has been restricted.
- DESI drugs and identical, similar, or related products or combinations of these products.
- FDA approved pharmaceutical products whose indicated use is not to treat or manage a medical condition, illness, or disorder.
- Prescription and over-the-counter pharmaceutical products distributed by a company that has not entered into a national rebate agreement with the federal government.
- Fertility promoting agents.
- Erectile dysfunction drugs unless used for an FDA approved indication other than for the treatment of sexual, or erectile dysfunction.
- Agents prescribed for cosmetic purposes or approved by the FDA for cosmetic purposes only.

Drug Recalls and Drug Safety Monitoring

Gateway is dedicated to providing our prescriber with access to the most up-to-date medication safety information. Drug recall and drug safety updates can occur on a daily basis due to newly published research or to the FDA’s Adverse Event Reporting Program. In order to provide the latest information, Gateway has posted links to the FDA website displaying the latest recalls and drug safety alerts.
Coverage Arrangements

All participating practitioners must assure twenty-four (24) hour, seven (7) day-a-week coverage for members. Coverage arrangements should be made with another Gateway participating practitioner or practitioners who have otherwise been approved by Gateway. Also, all participating practitioners must assure that the hours of operation for Medicaid patients are no less than what the practice offers to commercial members. When a participating PCP has arranged, on a permanent basis, cross coverage arrangements with another participating PCP, the PCP should contact their Provider Account Liaison to set up a Provider Association between the two practitioners. All encounters must be billed under the name of the rendering practitioner, not the member’s assigned PCP. Any services paid per the member’s assigned PCP contract will be paid directly to the participating covering PCP.

Covering practitioners, whether participating or not, must adhere to all of Gateway’s administrative requirements. Additionally, covering practitioners must agree not to bill the member for any covered services. The covering practitioner should report all calls and services provided to the member’s PCP. To request approval of a non-participating covering practitioner, the participating practitioner must submit a request to Gateway’s Medical Director with a signed On-Call Practitioner Coverage Agreement. All encounters must be billed under the name of the rendering practitioner, accompanied by a copy of the Coverage Agreement. Reimbursements will be paid directly to the covering practitioner. Participating practitioners will be held responsible for the actions of their non-participating coverage practitioners.

PCPs agree that, in their absence, timely scheduling of appointments for members shall be maintained.
Laboratory Services

Gateway members are required to have all of their outpatient laboratory work completed through the appropriate contracted lab. Failure to do so could result in non-payment of services. At the time of the initial orientation, the PCP is required to select a designated laboratory based on the office’s location and the lab used most frequently.

Gateway requires participating practitioners to utilize the member’s specific designated laboratory, based on their PCPs selection, for any and all studies required for Gateway members. The designated laboratory is listed on the member’s Gateway ID Card and on Gateway’s on-line Provider Directory located at www.GatewayHealthPlan.com. Go to PA Medicaid, then: Find a Provider, utilize the Eligibility and Benefits feature on NaviNet, or contact Provider Services at 1-800-392-1147.

Note: Genetic testing requires prior authorization.

Primary Care and OB/GYN Practitioner

All outpatient laboratory testing should be ordered with a prescription according to the PCPs designated laboratory. Specialists and OB/GYN practitioners can order laboratory testing directly, but must send the member to the member’s PCPs designated laboratory listed on the member’s Gateway ID Card with an order for the lab procedure to be performed. Practitioners are encouraged to perform venipuncture in their office and arrange for the specimens to be picked up by the laboratory provider.

Participating PCPs and OB/GYN practitioners who do not perform venipuncture in their office should send members to the appropriate designated laboratory.

Specialty Care Practitioner

Certain Specialists are permitted to perform lab work in their offices as part of the authorized office visit.

Preadmission Laboratory Testing

Gateway strongly recommends that preadmission laboratory testing be completed by the practitioner through the member’s designated laboratory. When this occurs, no referral is needed. The PCP must issue a Gateway referral to the specific Gateway participating hospital’s outpatient laboratory.

STAT Laboratory

STAT laboratory services must only be utilized in urgent cases. If a lab other than the member’s designated lab is to be used, a referral form is required. Every effort should be made to direct the member to his/her designated lab.
Blood Lead Screening

The Pennsylvania EPSDT Periodicity Schedule requires that all children under age seven receive a minimum of two blood lead screenings as part of EPSDT well child screenings, regardless of the individual child’s risk factors. The tests for lead screening should be conducted during the nine month screening and the second test for lead should be conducted during the twenty-four month screening. Please refer to the Pennsylvania EPSDT Periodicity Schedule for further testing clarification.

The PCP can use either their designated laboratory or Kirby Health Center Laboratory to process blood lead samples. If you choose to send blood lead samples to Kirby Health Center, you must use the sample Lead Analysis ID Form. The form is only for Gateway members, and when completing the form please verify the member’s eligibility. All demographic information, including the practitioner name, member name, member address, member date of birth, Gateway member identification number, and the date of service must be completed for the sample to be processed.

A supply kit of Gateway Lead ID Forms, postage-paid mailers, instructions, capillectors or filter papers for sample collection, and supply reorder forms may be requested through Kirby Health Center Laboratory by calling 1-888-841-6699. When ordering a supply kit, please identify yourself as a participating Gateway practitioner.

Members with a venous lead draw showing an Elevated Blood Lead Level of ≥5 µg/dL, are eligible for an Environmental Lead Investigation (ELI).

Children should be referred for an Environmental Lead Investigation

A provider should submit an order to an enrolled ELI provider for a comprehensive environmental lead investigation for a Gateway member under twenty-one years of age with a venous blood lead screening result of at least 5 µg/dL to assess for environmental influences of lead contamination. The order for a comprehensive environmental lead investigation must include a primary diagnosis code of toxic effect of lead and its components.

Gateway Health will cover ELI for members under twenty-one years of age who are enrolled on Gateway Health Pennsylvania Medicaid within the following parameters:

- Services must be provided by a participating Gateway Health ELI provider.
- Member must have a venous BLL result of at least 5 µg/dL based on venous draw
- Limited to one ELI per household.
- A provider order is required. No prior authorization from Gateway Health is needed.

Questions regarding Gateway’s EPSDT program can be directed to EPSDT Coordinator at EPSDTinfo@GatewayHealthPlan.com.
Unusual Circumstances

Should circumstances arise where it is impossible to follow the laboratory procedures outlined above, please contact Gateway’s Utilization Management Department at 1-800-392-1147 and press two for provider and press four for UM for assistance.
Primary Care Practitioner

Each member in a family has the freedom to choose any PCP, and a member may change to another PCP should a satisfactory patient-practitioner relationship not develop. A PCP agrees to accept a minimum number of Gateway members, as specified by their practitioner agreement, to their patient panel at each authorized office location without regard to the health status or healthcare needs of such members and without regard to their status as a new or existing patient to that practice or location. The PCP must maintain at least twenty weekly appointment hours per marketed location.

The PCP, after meeting their contract minimum may, upon ninety days prior written notice to Gateway, state in writing that they do not wish to accept additional members. The written request excludes members already assigned to the PCPs practice, including applications in process.

Through Gateway’s model of Prospective Care Management (PCM®), we emphasize the importance of extensive member outreach, community involvement and physician practice engagement. We support the efforts of physician practices in delivering the highest quality of care to members.

Gateway to Practitioner Excellence GPE® Program

The GPE® Pay-for-Performance and Improvement Program recognizes and rewards excellent practices for improving the health of Gateway members. Practice resources are provided such as a CPT II code reference guide, HEDIS definitions, and Dashboard Reports.

GPE® Program Objectives:
- Improve member experience.
- Increase physician satisfaction.
- Supports Patient-Centered Medical Home.
- Supports accurate and complete coding.
- Incentivize quality care.

Who is eligible?
- Primary care physician practices.
- Obstetrical Care Providers.
- Dentists (Medicaid).

Performance Measures

GPE® focuses on data driven measures to evaluate practice performance in the areas of:
- Adolescent Well-Care Visits
• Annual Dental Visit (ages 6 months – 20 years)
• Controlling High Blood Pressure.
• Diabetes Care - HbA1c Poorly Control >9%.
• Ambulatory Care – Emergency Department Visits.
• Medication Management for People with Asthma.
• Obstetrical Care: Timeliness of Prenatal Care, Frequency of Ongoing Prenatal Care: >81 Percent of Expected Number of Prenatal Visits, and Postpartum Care.
• Plan All Cause Readmission.
• Well Child Visits in the First fifteen (15) Months of Life.
• Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.

For a complete listing of the measures and program details, please visit our website at www.GatewayHealthPlan.com or contact your Clinical Transformation Consultant.

**Scorecards and PCP Dashboard Reports**

Scorecards and their associated payments are distributed quarterly and annually.

**Scorecards**
The GPE® scorecard provides a summary of the services and payments the practitioner received for that quarter, broken down by measure.

**Dashboard Reports**
The dashboard report provides primary care practices with member specific care gaps on GPE® measures as well as multiple other non-GPE® quality measures. The purpose of the dashboard report is to provide supplemental information for care and clinical opportunities for the physician practice.

**Practitioner/Staff Education and Communication**
Gateway assures that GPE® practitioners and their staff are well informed of the program. Various approaches engage PCPs and Obstetrical Care Providers throughout the year that may include Physician Advisory Workgroups and practice visits by Provider Relations, Medical Directors, operational leads, Provider Engagement, and/or Provider Management. Webinars are also made available throughout the year. Dentists are educated through Gateway’s dental benefit provider. In addition, Gateway’s website and newsletter articles provide education on the GPE® Program.

**Encounters**
PCPs are required to report to Gateway all services they provide for Gateway members by submitting complete and accurate claims regardless of expected reimbursement.

**Accurate Submission of Encounter/Claim Data**
Claim/Encounter data provides the basis for many key medical management and
financial activities at Gateway:

✓ Quality of care assessments and studies.
✓ Access and availability of service evaluation.
✓ Program identification and evaluation.
✓ Utilization pattern evaluation.
✓ Operational policy development and evaluation.
✓ Financial analysis and projection.

To effectively and efficiently manage member’s health services, encounter submissions must be comprehensive and accurately coded. All Gateway providers are contractually required to submit encounters for all member visits. Underreporting of encounters can negatively impact all stakeholders.

For PCPs, encounter data is essential as many of Gateway’s quality indicators are based on this information. Gateway evaluates PCP encounter data in two ways. The rate of submitted encounters per member for individual PCP practices is measured and compared to a peer average based on specialty (Family Practice, Pediatric, and Internal Medicine). Additionally, Gateway extracts dates of service during on-site medical record review and compares the visit dates to encounters submitted to the health plan. This rate is also compared to peer averages.

The expected rate of submission for encounters is 100%. Gateway provides support and education to practices as indicated by their encounter submission rates.

DHS uses the Chronic Illness & Disability Payment System (CDPS) model to assign a risk score to each Medicaid recipient who meets certain eligibility criteria. Accurate and complete reporting of diagnosis codes on encounters is essential to the CDPS model. Physicians must establish the diagnosis in the medical record and coders must use the ICD-10-CM coding rules to record each diagnosis. Chronic illnesses should be evaluated on a complete physical exam each year. Reporting complete conditions present in the member will help to assure that DHS has complete data when determining the member’s risk score.

If you would like to learn more about the importance of complete and accurate coding visit these web sites:

Official Coding Guidelines on CDC Website: http://www.cdc.gov/nchs/icd/icd10cm.htm

Coding Clinic for ICD-10-CM available through the American Hospital Association (AHA)

CMS, the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), and the National Center for Health Statistics (NCHS) together have developed official coding guidelines. The guidelines can be found at: http://www.cdc.gov/nchs/data/icd/icd10cm_guidelines_2014.pdf
There are two volumes which consist of:

1. **The Disease Tabular (Numeric)** and is known as Volume I of ICD-10-CM. Numeric listing of codes organized by body system. This volume provides more detail than the Alphabetic Index on conditions included and excluded in the code selected. Another code in the same category may represent the diagnostic description better than the one indicated in the Disease Index.

2. **The Disease Index (Alphabetic)** and is known as Volume II of ICD-10-CM. This volume is an index of all diseases and injuries categorized in ICD-10-CM. When a code is listed after the description, it means the reader should look up that code in the Disease Tabular section to determine if that is the most specific code to describe the diagnosis. The index is organized by main terms and sub terms that further describes or specifies the main term. In general, the main term is the condition, disease, symptom, or eponym (disease named after a person), not the organ or body system involved.

**Vaccines For Children**

Children under nineteen years of age receiving medical assistance are eligible for the Vaccines for Children (VFC) Program. All PCPs will be reimbursed for the administration of any vaccine covered under the VFC Program when a claim is received with the appropriate immunization code. Any procedures for immunizations not covered under the VFC Program, but covered by Gateway, will be reimbursed fee-for-service. Please reference the PCPs agreement for fee schedules or additional information.

**Oral Health Risk Assessment**

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

Since April, 2010, Gateway has reimbursed those PCPs properly certified for the application of topical fluoride varnish a fee-for-service payment for rendering this service. Only those PCPs who received a certificate for completing the on-line training module titled “Oral Health Risk Assessment” qualified for the fee-for-service reimbursement. The “Oral Health Risk Assessment” training module has been discontinued and replaced with the Society of Teachers of Family Medicine’s “Smiles for Life” Continuing Medical Education (CME) course. (Refer to MA Bulletin 09-12-27, 31-12-27). If you’ve already completed the “Oral Health Risk Assessment” on-line training, recertification through “Smiles for Life” is not required.

Physicians interested in providing topical fluoride varnish in the office for their Gateway patients under the age of five and receive the $18.00 reimbursement must submit a copy of the training certificate to:
Addition of Newborns
When a member selects Gateway, the member’s effective date is usually the first or the fifteenth of the month. When the member is a newborn, the member may be added any time of the month. Because newborn information is reported to Gateway retroactively, newborns will show up as a retroactive addition to the primary care practitioner’s monthly panel listing. Newborns will be effective on their date of birth or the date the newborn was added to the member’s grant.

Services rendered during the newborn hospital stay are paid on a fee-for-service basis.

Processing PCP Change Requests
When a member wishes to change his or her PCP, the change is processed under the following guidelines:

- When the request is received prior to the twenty-fifth of the current month, the new effective date will be the first of the following month. For example, if a member’s request is received on October 7th, the member will be effective November 1st with the new PCP.
- When the request is received on or after the twenty-fifth of the current month, the new effective date will be the first of the subsequent month. For example, if a member’s request is received on October 28th, the member will be effective December 1st with the new PCP.
- If the member requests to change his or her PCP immediately, an exception to the above guidelines can be made if the situation warrants.

FQHC/RHC Provider Changes Process
Gateway Health physician agreement indicates that participating providers must submit written notice ninety (90) calendar days prior to the date the provider intends to terminate. There is also sixty (60) days’ notice required if you plan to close your practice to new patients and thirty (30) days’ notice required for a practice location change. Whenever a FQHC/RHC have a New Adds (physician or group), Demographic changes and Terminations occur within a FQHC/RHC practice location(s), a FQHC/RHC Roster Template must be completed and sent to Gateway within the timeframe indicate above.

Please refer to the FQHC/RHC Roster Template Instructions and FQHC/RHC Roster Template which can be found on the Gateway Health website at www.gatewayhealthplan.com, under the Provider section, Provider Resources, FQHC-RHC Resources.
Transfer of Non-Compliant Members

PCPs agree:

(a) Not to discriminate in the treatment of his/her patients, or in the quality of services delivered to Gateway members on the basis of race, sex, age, religion, place of residence, health status, or source of payment.
(b) To observe, protect and promote the rights of members as patients.

PCPs shall not seek to transfer a member from his/her practice if such transfer would violate these rules. However, a member whose behavior precludes delivery of optimum medical care may be transferred from the practitioner’s panel. Gateway’s goal is to accomplish the uninterrupted transfer of care for a member who cannot maintain an effective relationship with a given practitioner.

Additionally, in order to assist Gateway practitioners in the management of members who violate office policy in regard to scheduled appointments, Gateway has instituted the following Member No-Show Policy:

*Gateway will recognize the individual practitioner’s written office policy in regard to scheduled appointments. Gateway practitioners are responsible for recording no-show appointments in the member’s medical record.*

When a transfer is being conducted due to member no-show, the practitioner’s notification should indicate that the practitioner wants to transfer the member to another PCPs practice. Per DHS Policy #99-10-14, practitioners may not bill MA recipients for missed appointments.

Should an incidence of inappropriate behavior or member non-compliance with no-show policies occur, and transfer of the member is desired, the practitioner must send a letter requesting that the member be removed from his/her panel including the member’s name and Gateway ID Number, and, when applicable, state their no-show policy, and the member(s) who has (have) violated the policy to the Provider Relations Department at:

*Gateway Health*SM
Attention: Provider Relations
Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222

All written requests are forwarded to the Enrollment Department within forty-eight hours of receipt. The Enrollment Department notifies the original practitioner in writing when the transfer has been completed. If the member requests not to be transferred, the PCP will have the final determination regarding continuation of primary care services.
When the request is received prior to the twenty-fifth of the month, the new effective date will be the first of the following month. When the request is received on or after the twenty-fifth of the current month, the new effective date will be the first of the subsequent month. An exception to the above guidelines can be made if the situation warrants an immediate transfer. PCPs are required to provide emergency care for any Gateway member dismissed from their practice until the member transfer has been completed.

**Transfer of Medical Records**
PCPs are required to transfer member medical records or copies of records to newly designated primary care practitioners within fourteen (14) business days from receipt of the request from DHS, its agent, the member, or the member’s new PCP, without charging the member.

**Coordination of Behavioral Health and Physical Health Services**
No mental health or drug and alcohol services are covered by Gateway except for emergency room services, home healthcare, pharmacy services, and emergency transportation services. Gateway is responsible for all emergency and non-emergency transportation in an ambulance to an emergency room and to a behavioral health facility. All prescribed medications are dispensed through the Gateway pharmacy network. This includes drugs prescribed by both physical health and behavioral health practitioners. Exceptions are that the Behavioral Health Managed Care Organization (BH-MCO) is responsible for the payment of Methadone and LAAM when used in the treatment of a substance abuse disorder, and when prescribed and dispensed by BH-MCO service practitioners.

Emergency services provided in general hospital emergency rooms are the responsibility of Gateway regardless of the diagnosis or services provided. An exception is emergency room evaluations for voluntary or involuntary commitments pursuant to the 1976 Mental Health Procedures Act (50 P.S. Section 7101, et seq), which are the responsibility of the BH-MCO.

Both PCPs and behavioral health clinicians have the obligation to coordinate care of mutual patients in accordance with state and federal confidentiality laws and regulations. This includes, but is not limited to:
- Obtaining appropriate releases to share clinical information.
- Making referrals for social, vocational, education, or human services when a need is identified through assessment.
- Notifying each other of prescribed medications.
- Being available for consultation when necessary.

Referrals are not necessary for members to receive the services of a behavioral health practitioner.
Gateway may cover home healthcare services ordered by a BH-MCO practitioner if the order meets the regulatory requirements found in 55 Pa. Code § 1249, et seq. (relating to Home Healthcare Services) and meets Gateway coverage requirements.

Please refer to the Quick Reference section of this manual for a listing of BH-MCO’s or behavioral health agencies and their corresponding telephone number, county serviced, and services provided.
Telemedicine

Overview
While providing services face-to-face to Gateway members should be provided whenever possible, the Plan recognizes there are instances when face-to-face consultations are not feasible. Telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment. Telemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care (e.g., face-to-face consultations or examinations) between provider and patient. This definition is modeled on CMS definition of telehealth services. Gateway does not restrict the performance of telehealth/telemedicine services to rural locations only and allows for PCPs to provide this service. Any eligible member can receive telemedicine/telehealth primary care services regardless of where they are located. PCPs are able to render services using interactive telecommunication technology to their Gateway assigned members.

PCPs may bill for these services with Place of Service Code 02 along with the following procedure codes and appropriate pricing modifiers, as necessary, and the GT informational modifier: 99212 – 99215. As appropriate, providers are also able to bill for the telehealth originating site facility fee with procedure code Q3014.

The telemedicine service must be two-way, real time interactive communication between the patient and the physician at the distant site. Telemedicine does not include the use of a telephone call, facsimile machines, electronic mail systems or remote patient monitoring devices. A smart phone can be employed if there is simultaneous audio and video capabilities.

In addition to fully documenting in the patient’s medical record services related to telemedicine, providers should fully document the specific interactive telecommunication technology used to render the consultation, along with reason the service was conducted using the technology.

Specialists may provide and bill for telemedicine services as outlined in the DHS Bulletin #09-12, 31-12-31, 33-12-30, which can be found via the following link: http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/d_005993.pdf
Appointment Standards

PCPs agree to meet Gateway’s appointment standards, as follows:

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>MEASUREMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wait time for an Emergent Appointment</td>
<td>Immediately seen or referred to an emergency facility.</td>
</tr>
<tr>
<td>Wait time for Urgent Care Appointment</td>
<td>Within twenty-four (24) hours.</td>
</tr>
<tr>
<td>Wait time Routine Appointments</td>
<td>Within ten (10) business days.</td>
</tr>
<tr>
<td>Wait time for a Health Assessment/General Physical Examinations and First Examinations</td>
<td>Within three (3) weeks of enrollment.</td>
</tr>
</tbody>
</table>
| After-hours Care Accessibility                                           | Access to a practitioner twenty-four (24) hrs./seven (7) days a week  
  - A live person, recording or auto attendant will direct patients in the case of a true emergency to call 911 or go to the nearest emergency room.  
  - An on-call physician is available after-hours.                                                                                               |
| Waiting time in the Waiting Room                                         | No more than thirty (30) minutes or up to one (1) hour when the MD encounters an unanticipated urgent visit or is treating a member with a difficult need.                                                   |
| Wait time for new member EPSDT Screens (Applies to PCPs who treat members under age of 21) | Within forty-five (45) days from the effective date of enrollment unless the child is already under the care of a PCP and is current with screens and immunizations.                              |
| Wait time for first time Appointment with Persons known to be HIV Positive or Diagnosed with AIDS | Within seven (7) days from the effective date of enrollment, unless member is already in active care with a PCP or specialist.                                                                            |
| Wait time for first appointment with member who is a Supplemental Security Income (SSI) or SSI-related consumer | Within forty-five (45) days of enrollment unless the member is already in active care with a PCP or specialist.                                                                                           |
| Wait time for first trimester visit (Applies to PCPs who provide prenatal care) | Within ten (10) business days of the member being identified as being pregnant.                                                                                                                           |
| Wait time for second trimester visit (Applies to PCPs who provide prenatal care) | Within five (5) business days of the member being identified as being pregnant.                                                                                                                          |
| Wait time for third trimester visit (Applies to PCPs who provide prenatal care) | Within four (4) business days of the member being identified as being pregnant.                                                                                                                          |
| Wait time for high-risk pregnancies (Applies to PCPs who provide prenatal care) | Within twenty-four (24) hours of identification of high risk.                                                                                                                                           |
| Missed Appointment                                                        | Conduct outreach whenever a member misses an appointment and document in the medical record. Three (3) attempts with at least one attempt to include a telephone call.                                           |
**EPSDT - Growing Up with Gateway℠**

**General Information**

Gateway’s Growing Up with Gateway℠ Program is based upon the federally mandated EPSDT Program for medical assistance eligible children under the age of twenty-one years. Through the EPSDT Program, children are eligible to receive regular medical, developmental, dental, vision, hearing screens, and laboratory services to assure that they receive all medically necessary services, without regard to medical assistance covered services.

**Helpful Guidelines**

- The required screens and tests are outlined by the Pennsylvania EPSDT Program Periodicity Schedule, which is reflective of the AAP Periodicity Schedule. PCPs are required to follow this schedule to determine when the necessary screens and tests are to be performed.
- PCPs are required to ensure all children under the age of twenty-one have timely access to EPSDT services and are responsible for ensuring continued coordination of care for all members due to receive EPSDT services.
- New members must be seen within forty-five (45) days from the effective date of enrollment, unless the child is already under the care of a PCP and is current with screens and immunizations.
- PCPs are required to arrange for medically necessary follow-up care after a screen or encounter.
- If a PCP is unable to comply with the requirements of the EPSDT program, they must make arrangements for EPSDT screens to be performed elsewhere by a Gateway participating provider.
- Alternative PCPs and specialists should forward a copy of the completed progress report to the PCP so it can be placed in the member’s chart.

**Care Coordination**

Growing Up with Gateway℠ staff works collaboratively in coordinating medically necessary services for members. Staff provides outreach via telephone and mail, to members to provide education and assistance with scheduling appointments, transportation, and other issues that prevent access to healthcare. Staff is available to outreach to members identified by the PCP offices who are delayed with screens and/or immunizations or who are non-adherent with appointments.

For any member with abnormal findings, or who does not show for his/her appointment, or who needs assistance with any indicate issue, please complete and fax to Gateway the Member Outreach Form, located in the Forms and Reference Material Section of this manual, so Gateway may attempt to contact and assist the member.
The PCP is responsible for contacting new members that are identified on encounter lists as not adhering to EPSDT periodicity and immunization schedules. Each Gateway PCP /specialist is responsible for providing the health screens for Gateway members. Each practitioner must report the results of the screens to Gateway, as well as communicate demographic information (e.g. telephone number, address, alternate address) to staff to assist with scheduling, locating, and addressing compliance issues. Gateway verifies that PCP and specialists for special needs are able to provide EPSDT services at the time of the practitioner’s office site visit.

To contact the Growing Up With Gateway℠ Unit please call 1-800-392-1147.

**Required Screens, Tests, and Immunizations**
Gateway follows the recommended periodicity schedule as approved by the American Academy of Pediatrics, the Bright Futures Periodicity Schedule, and adopted by DHS. Please reference these updated guidelines on the Gateway website.

To determine a the appropriate age range for required screens and tests, please refer to the Pennsylvania EPSDT Age Range Requirements for Screening Visits Desk Guide, located in the Forms and Reference Material Section of this manual or on the Gateway website.

Gateway follows recommended childhood immunization schedules approved by the CDC and Prevention Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians.

To facilitate distribution of the most current version of these schedules, they can be found on Gateway’s website under Medicaid guidelines.

**Developmental Surveillance**
Per the Periodicity Schedule, developmental surveillance should be performed at all EPSDT visits.

Developmental surveillance and structured screening for developmental delays and Autism Spectrum Disorders (ASD) are separate elements of a comprehensive health assessment performed during every preventive care office visit or EPSDT screening visit. Surveillance and is the observation of a child to identify whether the child may be at risk of developmental delay. The AAP recommends that providers perform and document the following as part of surveillance:

- Elicit and attend to parent concerns about their child’s development.
- Update the child’s developmental progress.
• Make accurate and informed observations of the child in the areas of language and cognitive abilities, social, and emotional health, and physical development which are appropriate to the child’s age and developmental stage.
• Identify the presence of risk and protective factors.
• Document all surveillance activities and findings.

Any developmental issues identified through surveillance should be addressed by conducting a structured screening for developmental delays or ASDs, or both. Structured screenings differ from surveillance in that a validated tool is used to conduct the structured screening.

**Structured Developmental Screenings**

Structured screening for developmental delays and ASDs is the use of standardized, scientifically validated tools to identify and refine a recognized risk. Structured screening focused on the identification of additional risk factors by targeting specific developmental milestones in language and cognitive abilities, fine and gross motor skills, and social interactions as well as signs and symptoms of ASDs. Providers should also conduct structured screening outside of the recommended screening periodicities if medically necessary.

It is the provider’s responsibility for ensuring that they continue to use tools that are validated at the time they conduct the structured screening. Providers may select a specific validated screening tool that is the most suitable tool for the provider’s practice.

There are several resources available to assist providers in identifying structured screening tools to use in practice and remaining up to date on validated screening tools. These resources can be found on Gateway’s website.

**Developmental Screening**

Per the Periodicity Schedule, developmental screening should be completed at the following visits:
- Nine (9) to eleven (11) month visit.
- Eighteen (18) month visit.
- Thirty (30) month visit.

Children with Elevated Blood Lead Levels (EBLL) should receive additional developmental screenings by their PCP outside of the recommended time frames.

**Autism Screening**

Per the Periodicity Schedule, autism screening should be completed during the following visits:
- Eighteen (18) and twenty-four (24) month visit.
When the validated screening tool identifies a child as needing further evaluation, a diagnostic evaluation should be performed by the provider. If unable to provide the diagnostic evaluation, the PCP should refer to an appropriate specialist or the early intervention program.

Providers should refer for early intervention services through the CONNECT Helpline at 1-800-692-7288.

Providers may additionally refer members for care coordination services when a structured Developmental or Autism Screening indicates the need for further evaluation. For this referral, please complete and fax/mail the Member Outreach Form, located in the Forms and Reference Material Section of this manual, so a Care Navigator may contact the member.

The provider must maintain the completed structured developmental/ASD screening in the member’s medical record.

**Blood Lead Level Screening**

The Pennsylvania EPSDT Periodicity Schedule requires that all children under age seven (7) receive a minimum of two blood lead screenings as part of EPSDT well child screenings, regardless of the individual child’s risk factors. The tests for lead screening should be conducted during the nine (9) to eleven (11) month screening and the second test for lead should be conducted during the twenty-four (24) months screening. Please refer to the Pennsylvania EPSDT Periodicity Schedule for further testing clarification.

The CDC and Prevention requires the use of a blood lead test when screening children for lead poisoning. The CDC and Prevention recommends that a provider use venous blood samples for the blood lead screening, when feasible as elevated initial blood lead results obtained on capillary screening specimens are presumptive and should be confirmed using a venous specimen. A blood lead screening should be done by a blood lead measurement of either a venous or capillary (finger stick) blood specimen. If screening is collected via capillary and is \( \geq 5 \) µg/dL, a second venous blood lead measurement should be taken to confirm the results.

If a child has a blood lead level of \( \geq 5 \) µg/dL, providers should refer for early intervention services through the CONNECT Helpline at 1-800-692-7288.

The PCP can use either their designated laboratory or Kirby Health Center Laboratory to process blood lead samples. If you choose to send blood lead samples to Kirby Health Center, you must use the sample Lead Analysis ID form. The form is only for Gateway members, and when completing the form please verify the member’s eligibility. All demographic information, including the practitioner name, member name, member
address, member date of birth, Gateway member identification number, and the date of service must be completed for the sample to be processed.

A supply kit of Gateway Lead ID Forms, postage-paid mailers, instructions, capillectors or filter papers for sample collection, and supply reorder forms may be requested through Kirby Health Center Laboratory by calling 1-888-841-6699. When ordering a supply kit, please identify yourself as a participating Gateway practitioner.

**Environmental Lead Investigation (ELI)**

In accordance with guidance from the CDC, a provider should manage the condition of a child who is found to have an elevated blood lead level that is greater than or equal to 5 µg/dL.

Management should include follow-up blood tests and consideration of possible sources of contamination including housing, food, and toys. Locating the source of lead contamination is an integral part of the management and treatment of lead toxicity.

A provider should submit an order to an enrolled ELI provider for a comprehensive ELI for a Gateway member under twenty-one years of age with a blood lead screening result of at least 5 µg /dl and where there is suspicion of environmental influences for lead contamination. The order for a comprehensive ELI must include a primary diagnosis code of toxic effect of lead and its components.

Gateway will cover ELI for members under twenty-one years of age who are enrolled on Gateway Medicaid within the following parameters:

- Services must be provided by a participating Gateway ELI provider.
- Member must have a venous BLL result of at least 5 µg /dl based on venous draw.
- Limited to one ELI per household.
- A provider order is required. No prior authorization from Gateway is needed.

**Immunizations**

Both state and federal regulations require that immunizations be brought up to date during health screens and any other visits the child makes to the office. The importance of assessing the correct immunization status cannot be overly stressed. In all instances, the practitioner’s records must show immunization history and documentation must include the date of the immunization, the signature of the person administering the immunization, and the name and lot number of the antigen. This will provide the necessary basis for further visits and immunizations.

HEDIS evaluates the timely administration of all recommended childhood and adolescent immunizations. The Immunizations for adolescent’s measure was revised to include the HPV vaccine. The measures assess the percentage of children who have the dose(s) in accordance with the Recommended Child and Adolescent 2019
Immunization Schedules. In 2019 the schedules have been broken out into three separate tables to include by age, a catch-up schedule and by medical indications.

Gateway follows recommended childhood immunization schedules approved by the CDC Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics and the American Academy of Family Physicians. To facilitate distribution of the most current version of the new schedules, it is available on Gateway’s website under Medicaid guidelines. A paper copy is available upon request. For a paper copy, please contact the Provider Services Department at 1-800-392-1147.

**Dental**

The Pennsylvania Periodicity Schedule follows the American Academy of Pediatric Dentistry. A dental assessment at every well-child visit, through observation, should be conducted. In addition, an oral health risk assessment is recommended at the twelve (12) month, eighteen (18) month through six (6) year well-child visits. Fluoride varnish assessment is also recommended at this age. The child should be referred to a dental home when the first tooth erupts, but no later than twelve (12) months of age and the child should see the dentist every six (6) months thereafter. The dentist must check for the following and initiate treatment or refer as necessary:

- Caries
- Fillings Present
- Missing Teeth (permanent)
- Oral Infection

**EPSDT Screening and Billing Guide**

*A complete coding and billing matrix based on the PA EPSDT Schedule can be found on the Gateway EPSDT website.*

- All EPSDT screening services including vaccine administration fees should be submitted to Gateway either on a CMS-1500 or the corresponding 837P format for EDI claims within sixty (60) days from the date of service. *(Gateway cannot accept an EPSDT screen on a UB-04 or the corresponding 837I format.)*

- An EPSDT screen is complete when codes from each service area required for that age, including the appropriate E&M codes, are documented. Consult the current Pennsylvania Children’s Checkup (EPSDT) Program Periodicity Schedule and Coding Matrix as well as the Recommended Childhood Immunization Schedule for screening eligibility information and the services required to bill for a complete EPSDT screen.

- Claims will be paid at the provider’s EPSDT rate only if the appropriate E&M code and EP modifier are submitted.
With the exception of the dental component for clinics that do not offer dental services, FQHCs/RHCs may not bill for partial screens.

Gateway uses fully automated coding review software. The software programmatically elevates claim payments in accordance with CPT-4, HCPCS, ICD-10, AMA and CMS guidelines as well as industry standards, medical policy and literature, and academic affiliations.

**CMS-1500 Paper Format Requirements**

- All EPSDT screening services must be reported with the age-appropriate E&M code (99381-99385, 99391-99395, 99431 and 99435) along with the EP modifier.
- The EP modifier must follow the evaluation and management code in the first line of block 24D on the claim form. Use CPT Modifier (52 or 90) plus CPT code when applicable.
- Appropriate ICD-10 diagnosis codes must be noted in Box 21.
- Report visit code ‘03’ in box 24(h) of the CMS-1500 when providing EPSDT screening service.
- Report 2-character EPSDT referral code for referrals made or needed as a result of the screen in box 10(d) on the CMS-1500. Codes for referrals made or needed as a result of the screen are:
  
  YO – Other  
  YV – Vision  
  YH – Hearing  
  YB – Behavioral  
  YM – Medical  
  YD – Dental

**CMS-1500 EDI Format Requirements**

- All EPSDT screening services must be reported with the age-appropriate E&M code (99381-99385, 99391-99395, 99431, and 99435) along with the EP modifier.
- The EP modifier must follow the E&M code in the first position on the claim form. Use CPT Modifier (52 or 90) plus CPT code when applicable.
- Appropriate ICD-10 diagnosis codes must be noted in Box 21.
- Populate the SV111 of the 2400 loop with a “yes” for an EPSDT claim (this is a mandatory federal requirement).
- Populate the Data Element CLM12 in the 2300 Claim Information Loop with “01” (meaning EPSDT).

- Populate NTE01 of the NTE segment with “ADD”. This means that additional information is available in ‘field’ NTE02 (see below).
- Populate NTE02 of the NTE segment of the 2300 Claim Information Loop with appropriate referral codes:
  
  YO – Other  
  YV – Vision  
  YH – Hearing  
  YB – Behavioral  
  YM – Medical  
  YD – Dental

**EPSDT Authorization for Specialty Care**
If a member needs to be referred for specialty care as a result of an EPSDT screening, a standard referral must be issued by the primary care practitioner.

Hospital admissions and some outpatient surgical procedures require authorization from the UM Department. Please refer to Referral and Authorization Section for additional information.

**Behavioral Health**

Members under age 21 who require behavioral health services should be referred to the appropriate BH-MCO serving the member’s county of residence.
Specialty Care Practitioner

Verifying Eligibility
Due to frequent changes in a member’s eligibility, specialty care practitioners must verify eligibility prior to rendering services to assure reimbursement. This can be done by calling Gateway’s telephonic eligibility verification system - IVR. IVR can be reached by calling 1-800-642-3515 and is available twenty-four (24) hours a day, seven (7) days a week. The Pennsylvania MA Member EVS can be reached at 1-800-766-5EVS (5387) twenty-four (24) hours a day, seven (7) days a week. Specialty care practitioners may also use NaviNet to verify the existence of a referral.

Specialty Care Office Visit
Gateway members receive specialty care services from participating practitioners through a telephonic referral issued by the primary care practitioner office. Gateway’s IVR may be used by PCPs and OB/GYN practitioners to issue a referral, or by specialty care practitioners to verify the existence of a valid referral by calling 1-800-642-3515.

Referrals
All Gateway members must obtain a valid referral from their PCP prior to receiving specialty services except for the services that can be accessed by a self-referral. The only exception to this is for Neonatologists who may issue a referral to other participating hospitals and/or specialists for babies discharged from the NICU who require service before seeing their PCP. Referrals should be issued under the baby’s ID number. If the baby does not have an ID number, the practitioner should call Gateway’s UM Department for authorization.

If additional specialty care or diagnostic testing not authorized on the original referral is needed, please contact the member’s PCP to obtain another Gateway referral. However, if the procedures are being performed on the same date of service and in the same office as indicated on the original referral, another referral is not necessary. The specialist is responsible for providing written correspondence to the member’s PCP for coordination and continuity of care.

Reimbursement
Payment by Gateway is considered payment in full. Under no circumstance, including but not limited to non-payment by Gateway for approved services may a provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from or have any recourse against a Gateway member.

This provision does not prohibit collection of copayments. Refer to the Member Benefit Section of this manual for information on copayments. Members cannot be denied a service if they are unable to pay their copayment. Members are responsible up to a maximum of $90 for adult MA and $180 for adult GA every six months. Gateway will reimburse the member for any applicable
copays based upon claims submission that exceed the maximum from January through June and again from July through December of each year.

This provision shall not prohibit collection of copayments on Gateway's behalf made in accordance with the terms of the enrollment agreement between Gateway and the member/subscriber/enrollee.

Practitioners may directly bill members for non-covered services; provided, however, that prior to the provision of such non-covered services, the practitioner must inform the member:
- Of the service(s) to be provided.
- That Gateway will not pay for or be liable for said services.
- Of the member's rights to appeal an adverse coverage decision as fully set forth in the Provider Manual.
- Absent a successful appeal, that member will be financially liable for such services.

Refer to the Claims and Billing Section of this manual for additional information regarding submission of claims.

**Emergency Services**

All Gateway members are informed that they must contact their primary care practitioner for authorization prior to seeking treatment for non-life or limb threatening conditions in an emergency room. However, Gateway realizes that there are situations when a member is under the care of a specialty care practitioner for a specific condition, such as an OB/GYN during pregnancy, and the member may contact the specialist for instructions.

If a specialty care practitioner directs a member to an emergency room for treatment, the specialty care practitioner is required to immediately notify the hospital emergency room of the pending arrival of the patient for emergency services. The specialty care practitioner is required to notify the PCP of the emergency services within one (1) business day when the emergency room visit occurs over a weekend. Every effort should be made to direct members to Gateway participating hospitals.

**Specialists Functioning as Primary Care Practitioners**

As a result of the Commonwealth of Pennsylvania’s HealthChoices Program, specialists in the HealthChoices counties may function as a PCP for members with special needs, complex illnesses, or conditions. In order for a specialist to function as a PCP, the specialist must be approved by the Gateway Medical Director.
**Appointment Standards**

Specialty care practitioners agree to meet Gateway’s appointment standards, as follows:

<table>
<thead>
<tr>
<th>Practitioner Type</th>
<th>Requirement</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Specialist</td>
<td>Wait time for an Emergent Appointment.</td>
<td>Immediately seen or referred to an emergency facility.</td>
</tr>
<tr>
<td>All Specialist</td>
<td>Wait time for Urgent Care Appointment</td>
<td>Within twenty-four hours</td>
</tr>
<tr>
<td>Specialty Types:</td>
<td>Wait time for Asymptomatic Regular/Routine Appointment.</td>
<td>Within fifteen (15) business days from the date of referral.</td>
</tr>
<tr>
<td>Dermatology, Dentist, Orthopedic Surgery, Otolaryngology, Pediatric Allergy &amp; Immunology, Pediatric Endocrinology, Pediatric Gastroenterology, Pediatric General Surgery, Pediatric Hematology, Pediatric Infectious Disease, Pediatric Nephrology, Pediatric Neurology, Pediatric Oncology, Pediatric Pulmonology, Pediatric Rehab Medicine, Pediatric Rheumatology, Pediatric Urology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialties not listed above</td>
<td>Wait time for Routine Appointments.</td>
<td>Within ten (10) business days.</td>
</tr>
<tr>
<td>All Specialist</td>
<td>Wait Time in the Waiting Room for routine care.</td>
<td>Average office waiting time no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated Urgent Medical Condition visit or is treating a member with a difficult medical condition need.</td>
</tr>
<tr>
<td>All Specialist</td>
<td>Wait time for first time appointment with Persons known to be HIV positive or diagnosed with AIDS.</td>
<td>Within seven (7) days from the effective date of enrollment, unless member is already in active care with a PCP or specialist.</td>
</tr>
<tr>
<td>All Specialist</td>
<td>Wait time for first time appointment with member who is a Supplemental Security Income (SSI) or SSI-related consumer.</td>
<td>Within forty-five (45) days of enrollment unless the member is already in active care with a PCP or specialist.</td>
</tr>
<tr>
<td>All Specialist</td>
<td>Missed Appointment</td>
<td>Conduct outreach whenever a member misses an appointment and document in the medical record. Three (3) attempts with at least one attempt to include a telephone call.</td>
</tr>
</tbody>
</table>
OB/GYN Services

General Information
To eliminate any perceived barrier to accessing OB/GYN services, Gateway allows all female members to self-refer to any participating OB/GYN for any OB/GYN related condition, not just for an annual exam or suspected pregnancy. When a member self-refers to the OB/GYN, the OB/GYN’s office is required to verify eligibility of the member. Gateway members may also self-refer for family planning services.

Gateway permits its PCPs to perform routine gynecological exams and pap tests and provide care during pregnancy if they are so trained and equipped in their office. PCPs who provide obstetrical services must bill in accordance with Gateway guidelines and may only provide obstetrical services to those patients assigned to their panel.

Obstetrical Needs Assessment Form (ONAF)
The first visit with an obstetrical patient is considered to be the intake visit, or if a patient becomes a Gateway member during the course of her pregnancy, her first visit as a Gateway member is considered to be her intake visit. At the intake visit, an ONAF (MA552), the DHS statewide form, is available at http://www.dhs.pa.gov and under the Medicaid Forms & Reference Materials section at www.GatewayHealthPlan.com.

As of September 1, 2017, providers are able to submit the ONAF via Gateway’s NaviNet online form submission tool and through OPTUM online submission process by logging in at obcare.optum.com. Providers still have the option to fax completed ONAFs. The fax number is 1-888-225-2360. The form should immediately be submitted and then filed in the member’s medical record. The ONAF should be updated at the twenty-eight (28) to thirty-two (32) week visits and also at the post-partum visit. These two updates should also be submitted to Gateway immediately following completion.

The purpose of the ONAF is to help identify risk factors early in the pregnancy and engage the woman in care management. For that reason, the ONAF MUST be submitted to Gateway’s MOM Matters* Team within two (2) to five (5) business days of the intake visit. The ONAF is not a claim. However, the ONAF must be received by Gateway in order to process the claim for the intake visit. Please submit claims on a CMS-1500 within one hundred eighty (180) days to receive payment for the intake package. Please refer to the Coding subsection of OB/GYN for appropriate billing of ONAF regarding the prenatal provider incentive.

Coding
Under the per visit reimbursement structure, the following procedure codes should be used when billing Gateway. All prenatal visits and dates of service must be included on the CMS-1500 form and identified with E&M codes (99201 – 99205 and 99211 – 99215) only. The U9 pricing modifier must follow the code in the first position on the claim form. Please do not use the State’s pricing
or informational modifiers on any other Healthy Beginning codes for submission to Gateway. Delivery charges must be identified with CPT codes.

Gateway will reimburse providers a payment of $200 plus the contracted percentage increase for initial prenatal visits rendered within the first trimester. Please bill as indicated below to receive payment:

- The initial prenatal visit must be rendered within the first trimester and the ONAF must be completed during the visit and submitted to Gateway’s MOM Matters® department within two (2) to five (5) business days of the visit.
- To receive the bonus payment, providers must report the following: 99429-HD (First Trimester Outreach), T1001-U9 (Initial Risk Assessment), an E&M codes (99201 – 99205 and 99211-99215) with a U9 modifier. All three codes must be reported together on the same claim form, along with a diagnosis of pregnancy, to allow the bonus payment. Additionally, FQHC’s must use the T1015 code with the above mentioned guidelines.
- **Payment will NOT be made, unless all codes/modifiers referenced above are reported on the same claim.** The ONAF is not a claim form; however, the ONAF must be received by Gateway and documented in our claims system prior to receipt of the claim to allow the appropriate payment.
- If the member’s first prenatal visit doesn’t occur within the first trimester then code 99429-HD should not be billed. However, the first visit with an obstetrical patient is considered to be the intake visit. If a patient becomes a Gateway member during the course of her pregnancy, her first visit as a Gateway member is considered to be her intake visit. At the intake visit, an ONAF must be completed and a claim submitted with code T1001-U9, pregnancy diagnosis code and an E&M codes (99201 – 99205 and 99211-99215) with a U9 modifier for reimbursement.

<table>
<thead>
<tr>
<th></th>
<th>Low Risk Pregnancy</th>
<th>High Risk Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1st Trimester</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Patient</td>
<td>99201 – U9</td>
<td>99202 – U9</td>
</tr>
<tr>
<td>Established Patient</td>
<td>99211 – U9</td>
<td>99212 – U9</td>
</tr>
<tr>
<td><strong>Use one 1st trimester E&amp;M code plus 99429-HD, pregnancy diagnosis code and T1001-U9 to receive $200 bonus payment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2nd Trimester</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Patient</td>
<td>99203 – U9</td>
<td>99204 – U9</td>
</tr>
<tr>
<td>Established Patient</td>
<td>99213 – U9</td>
<td>99214 – U9</td>
</tr>
<tr>
<td><strong>Basic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>High Risk</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3rd Trimester</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Patient</td>
<td>99205 – U9</td>
<td>99205 – U9</td>
</tr>
<tr>
<td>Established Patient</td>
<td>99215 – U9</td>
<td>99215 – U9</td>
</tr>
</tbody>
</table>

Gateway recognizes the need for multiple services on one date of service for a pregnant member. Please follow CPT guidelines and usage of modifier-25 for reimbursement of multiple distinct services. For example, a member can receive a prenatal office visit and a fetal non-stress test on
the same day. In this instance, the appropriate fetal NST CPT can be submitted and a modifier-25 should be applied to the distinct E&M service provided on the same day.

Additionally, all applicable encounter diagnosis codes should be submitted to capture all services rendered.

### Other Maternity Services

<table>
<thead>
<tr>
<th>Services</th>
<th>CPT Code 1</th>
<th>CPT Code 2</th>
<th>Additional Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fetal Non-stress Test</td>
<td>S9025</td>
<td>Fetal Biophysical Profile</td>
<td>76818</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Global Fee)</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Childbirth</td>
<td>S9436</td>
<td>Childbirth Preparation Review</td>
<td>S9437</td>
</tr>
<tr>
<td>Preparation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Risk Assessment</td>
<td>T1001</td>
<td>Nutritional Counseling</td>
<td>S9470</td>
</tr>
<tr>
<td>Smoking Cessation Counseling</td>
<td>G9016</td>
<td>Substance Abuse Problem Identification and Referral Counseling</td>
<td>H0004</td>
</tr>
<tr>
<td>Genetic Risk Assessment</td>
<td>99205 TF or HD (as modifiers)</td>
<td>Parenting Program</td>
<td>S9444</td>
</tr>
<tr>
<td>Outreach Visit (maximum of 3 per pregnancy)</td>
<td>H1002</td>
<td>Urgent Transport (car)</td>
<td>A0425</td>
</tr>
<tr>
<td>In-depth Psycho-social</td>
<td>H0004</td>
<td>Prenatal Exercise Series</td>
<td>S9451</td>
</tr>
<tr>
<td>Counseling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Transport (Public Carrier)</td>
<td>T2003</td>
<td>Mileage Additional Allowance</td>
<td>A0425</td>
</tr>
</tbody>
</table>

### OB/GYN Referrals

If an OB/GYN determines that assessment or treatment by another specialty care practitioner is necessary, the OB/GYN is required to contact the member’s PCP to request a referral to a specialist. The OB/GYN practitioner is responsible for providing written correspondence to the member’s PCP for coordination and continuity of care.

The OB/GYN cannot refer a member directly to another specialty care practitioner with the exception of participating Perinatologists.

Refer to the Referral and Authorization section of this manual for additional information regarding the OB/GYN Referral.

### Diagnostic Testing

Fetal non-stress tests and obstetrical ultrasounds can be performed in the OB/GYN’s office or at a hospital without an authorization or a referral from Gateway. Please follow above mentioned CPT billing guidelines and use modifier -25 when billing two distinct services on same date of service.

All other testing or procedures related to OB/GYN services requiring the member to use a hospital can be approved via the OB/GYN referral.

Neither a referral nor script is required for a screening mammogram performed at a participating hospital.
Medical Assistance Sterilization/Hysterectomy Consent Forms

DHS requires that Gateway members sign a Medical Assistance Sterilization Consent Form (MA-31), or a Medical Assistance Patient Hysterectomy Consent Form (MA-30), at least thirty (30) days prior to receiving the requested procedure.

Newborns

Newborns of Gateway mothers will be covered by Gateway for services rendered during the neonatal period. DHS requires that the hospital submit the MA-112 Form for each newborn to the mother’s assigned County Assistance Office. All charges for newborns that become enrolled in the plan, other than hospital bills covering the confinement for both mom and baby, are processed under the newborn name and newborn Gateway identification number.

Universal OB Access Program Follow-up Requirements

<table>
<thead>
<tr>
<th>Item</th>
<th>OB Referral?</th>
<th>Authorization?</th>
<th>Type of PCP Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IN OFFICE SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Gynecological Exam</td>
<td>No</td>
<td>No</td>
<td>Summary Report</td>
</tr>
<tr>
<td>Other Related Gynecological Services</td>
<td>No</td>
<td>No</td>
<td>Summary Report</td>
</tr>
<tr>
<td>Suspected Pregnancy</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>Initial Intake</td>
<td>No</td>
<td>No</td>
<td>OB Risk Assessment Form</td>
</tr>
<tr>
<td>Prenatal Visits</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>Identification of New Risk Factors</td>
<td>No</td>
<td>No</td>
<td>Updated Risk Assessment</td>
</tr>
<tr>
<td>Other Related OB Services</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>Prenatal Support Services</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>Fetal Non Stress Test</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td><strong>OUT OF OFFICE SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPU/Ambulatory Surgery Services*</td>
<td>No</td>
<td>Yes</td>
<td>Summary Report</td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>No</td>
<td>Yes</td>
<td>Summary Report</td>
</tr>
<tr>
<td>Home Healthcare/Hospice Services/IV Infusion</td>
<td>No</td>
<td>Yes</td>
<td>None</td>
</tr>
<tr>
<td>Mammogram</td>
<td>No</td>
<td>No</td>
<td>Summary Report</td>
</tr>
<tr>
<td>OB Ultrasound</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>Fetal Non Stress Test</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>STAT Laboratory Services**</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>Other Outpatient Diagnostic Tests</td>
<td>No</td>
<td>No</td>
<td>Summary Report</td>
</tr>
<tr>
<td>Delivery and Discharge Services</td>
<td>No</td>
<td>No</td>
<td>Summary Report</td>
</tr>
</tbody>
</table>
*These services can be authorized by calling Gateway’s UM department at 1-800-392-1147. Home Health visits should be offered to all newborns.

**A referral is required only if the hospital is not the member’s designated lab. If you are unsure of the hospital’s laboratory status, please call Provider Services at 1-800-392-1147.

***Gateway will cover four (99501) postpartum home visits in one hundred eighty (180) days.

**Family Planning Guidelines**

All family planning benefits provided under Gateway are administered by Adagio Health, Inc. If a Gateway patient presents for family planning benefits, practitioners need to be aware of the following:

- The patient’s Gateway eligibility can be verified by calling 1-800-642-3515.
- Family planning patients DO NOT need a referral from their PCP under federal mandate.
- If a family planning patient becomes pregnant, she may self-refer to her OB/GYN for prenatal care. DHS permits members to see any participating or non-participating practitioner for family planning services only.
- The Sterilization Consent Form (MA-31) must be obtained from the patient thirty (30) days prior to the procedure.
- The appropriate documentation must be PREAUTHORIZED at least five (5) business days prior to the procedure by calling Adagio Health, Inc. at 1-800-532-9465.

Post-partum tubal ligations must be preauthorized by Adagio Health, Inc. All outpatient laboratory testing should be ordered with a prescription through the member’s PCP or OB/GYN practitioner according to the PCPs designated laboratory.

Reversals of tubal ligations, vasectomies, and infertility treatments ARE NOT covered by Gateway.


**Appointment Standards**

Appointment standards for OB/GYN practitioners are as follows:

<table>
<thead>
<tr>
<th>Trimester</th>
<th>Appointment Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Trimester</td>
<td>Within ten (10) business days of the member being identified as being pregnant.</td>
</tr>
<tr>
<td>Second Trimester</td>
<td>Within five (5) business days of the member being identified as being pregnant.</td>
</tr>
<tr>
<td>Third Trimester</td>
<td>Within four (4) business days of the member being identified as being pregnant.</td>
</tr>
<tr>
<td>High-Risk Pregnancies</td>
<td>Within twenty-four (24) hours of identification of high-risk by Gateway or the maternity care provider, or immediately if an emergency exits.</td>
</tr>
</tbody>
</table>
### Additional standards that apply to all specialists including OB/GYNs:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wait time for an Emergent Appointment</td>
<td>Immediately seen or referred to an emergency facility.</td>
</tr>
<tr>
<td>Wait time for Urgent Care Appointment</td>
<td>Within twenty-four (24) hours.</td>
</tr>
<tr>
<td>Wait time for Routine Appointments</td>
<td>Within ten (10) business days.</td>
</tr>
<tr>
<td>Wait Time in the Waiting Room for routine care</td>
<td>Average office waiting time no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated Urgent Medical Condition visit or is treating a Member with a difficult medical condition need.</td>
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<tr>
<td>Wait time for first time appointment with Persons known to be HIV positive or diagnosed with AIDS</td>
<td>Within seven days from the effective date of enrollment, unless member is already in active care with a PCP or specialist.</td>
</tr>
<tr>
<td>Wait time for first time appointment with member who is a Supplemental Security Income (SSI) or SSI-related consumer</td>
<td>Within forty-five (45) days of enrollment unless the Member is already in active care with a PCP or specialist.</td>
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<tr>
<td>Missed Appointment</td>
<td>Conduct outreach whenever a member misses an appointment and document in the medical record. Three (3) attempts with at least one (1) attempt to include a telephone call.</td>
</tr>
</tbody>
</table>
Policies and Procedures

Gateway has developed policies and procedures to provide guidelines for identifying and resolving issues with practitioners who fail to comply with the terms and conditions of the applicable Practitioner Agreement, Gateway policies and procedures, or accepted Utilization Management Standards, and Quality Improvement Guidelines.

Reporting Suspected Abuse and Neglect

The Gateway Pennsylvania Medicaid Provider Agreements (Professional and Hospital Agreements, version Feb 2017) address the requirement to ensure that ER staff and physicians know the procedures for reporting suspected abuse and neglect.

- Provider Agreement Language: Provider represents and warrants to MCO that emergency room staff and physicians providing covered services under the agreement, if any, know the procedures for reporting suspected abuse and neglect.

As a Gateway participating provider you are considered a Mandated Reporter. As a Mandated Reporter you are required by law to report suspected child abuse and/or neglect. It is vitally important that Mandated Reporters understand how to recognize child abuse and how to make reports that are timely, complete, and accurate. As a Mandated Reporter, you must report suspected abuse immediately, either by phone or electronically.

Child abuse is defined as when an individual acts or fails to prevent something that causes serious harm to a child under the age of eighteen (18). This harm can take many forms, such as serious physical injury, serious mental injury, or sexual abuse or exploitation. To learn more about Child Protective Services Law, 23 Pa.C.S. § § 6301—6385 go to:

www.pacode.com/secure/data/055/chapter3490/subchapatoc.html

ChildLine provides information, counseling, and referral services for families and children to ensure the safety and well-being of the children of Pennsylvania.

To report:

- Call ChildLine at 1-800-932-0313. The toll-free intake line is available twenty-four (24) hours a day seven (7) days a week to receive reports of suspected child abuse. As a Mandated Reporter, you must provide your name and contact information when making the call.
- Electronic reports may be submitted directly to ChildLine via the Child Welfare Information Solution portal. This option is only available to Mandated Reporters.

Pennsylvania Family Support Alliance (PFSA) supports Mandated Reporters by offering education, training, and resources on their website. Go to www.pa-fsa.org/About-Us/Understanding-Child-Abuse-Neglect-in-Pennsylvania/Reporting-Abuse-Childline to learn about:

- How PFSA Supports Mandated Reporters.
- Understanding Mandated Reporting.
• Recognizing Child Abuse & Neglect.
• Resources for Mandated Reporters.
• Mandated Reporters Training.

**Obligation to Screen Employees for exclusion from Medicare and Medicaid**

PA Medicaid Bulletin #99-11-05 requires all providers to screen employees, contractors, and subcontractors, individuals, and entities, against the exclusion databases as required by 42 CFR §455.436 to determine if they have been excluded from participation in Medicare or Medicaid. No Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded. 42 CFR § 1001.1901(b). DHS has advised providers to conduct self-audits to determine compliance with this requirement and report any discovered exclusion of an employee or contractor, either an individual or entity, to DHS’ Bureau of Program Integrity (BPI). Below are links to the exclusion databases:

1. Federal Department of Health & Human Services, Office of Inspector General – List of Excluded Individuals and Entities  
   https://oig.hhs.gov/exclusions/
2. Federal General Services Administration, System for Award Management  
   https://www.sam.gov/portal/SAM/#11
3. PA Department of Human Services – Medicheck System  
   http://www.dhs.pa.gov/publications/medichecksearch/

**Compliance with the Federal Deficit Reduction Act of 2005 and the federal False Claims Act**

Section 6032 of the Deficit Reduction Act of 2005, requires any network provider receiving annual Medicaid payments of at least $5 million (cumulative, from all sources) to:

1. Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
2. Include as part of such written policies detailed provisions regarding the network provider’s policies and procedures for detecting and preventing fraud, waste, and abuse.
3. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and the provider’s policies and procedures for detecting and preventing fraud, waste, and abuse.
Department of Human Services (DHS) Policy Changes
In order for Gateway to meet the standards set forth by the DHS’ standard contract, Gateway must promptly implement new policies or changes in policy at the request of DHS.

Provider manuals must be updated to reflect any program or policy change(s) made by the Department via MA Bulletin within six (6) months of the effective date of the change(s), or within six (6) months of the issuance of the MA Bulletin, whichever is later, when such change(s) affect(s) information that the PH-MCO is required to include in its provider manual. Gateway is committed to notifying all appropriate practitioners, via any appropriate medium, within sixty (60) days of receipt of the notice of a new policy or policy change when sufficient notice is provided by DHS.

Additionally, practitioners need to be aware that no regulatory order or requirement of the Departments of Insurance, Health or Human Services shall be subject to arbitration with Gateway.

Practitioner Education, Sanctioning and Termination
Gateway practitioners will be monitored for compliance with administrative procedures, trends of inappropriate resource utilization, potential quality of care concerns, and compliance with medical record review standards. Practitioner education is provided through QI nurses, PALs, and Gateway Medical Directors. Network practitioners who do not improve through the provider education process will be referred to the Gateway QI/UM Committee for evaluation and recommendations.

Gateway conducts ongoing monitoring of Medicare and Medicaid sanction information by utilizing the OIG report and the DHS Medicheck Sanctions report. If a participating provider is found on either report, the provider’s file is pulled for further investigation and presented to the QI/UM Committee for a decision. Upon notification from DHS that a provider has been terminated due to loss of licensure and/or criminal convictions, Gateway will immediately move forward with terminating the provider from its network. The effective date of termination will be the same date utilized by DHS.

Practitioner Due Process
Gateway has established a policy and procedure to define the situations when due process procedures are afforded to practitioners, and to specify the due process procedures available in accordance with federal and state regulations, in particular the Healthcare Quality Improvement Act of 1986.

The Practitioner Due Process Policy will be updated in accordance with federal and state regulations. To request additional information or to obtain a copy of this policy, please contact Gateway’s Provider Services Department at 1-800-392-1147. TITLE VI of the Civil Rights Act of 1964.

Practitioners are expected to comply with Title VI of the Civil Rights Act of 1964 that prohibits race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation discrimination in programs receiving federal funds. Practitioners are obligated to take reasonable steps to provide meaningful access to services for
members with limited English proficiency, including provision of translator services as necessary for these members.

**Access and Interpreters for Members with Disabilities**

Practitioner offices are expected to address the need for interpreter services in accordance with the Americans with Disabilities Act (ADA). Each practitioner is expected to arrange and coordinate interpreter services to assist members who are hearing impaired. Gateway will assist practitioners in locating resources upon request. Gateway offers the Member Handbook and other Gateway information in large print, braille, cassette tape, or computer diskette at no cost to the member. Please instruct members to call Member Services at 1-800-392-1147 to request these other formats.

Practitioner offices are required to adhere to ADA guidelines, Section 504, the Rehabilitation Act of 1973 and related federal and state requirements that are enacted from time-to-time.

Practitioners may obtain copies of documents that explain legal requirements for translation services by contacting Gateway’s Provider Services Department at 1-800-392-1147. For interpreter services, please contact a qualified medical interpretation service such as Voiance or Language Line Services. Practitioner offices can contact the AT&T Language Line at 1-800-874-9426 for assistance with Limited English Proficient (LEP) patients and the PA State Relay line at 711 or 1-800-682-8706 for patients with hearing impairments.

Voiance language services offers Gateway providers a special rate of $1.00 per minute for interpreter services after paying a $75 one time activation fee. Using a toll-free number, Gateway providers will be able to connect with a bilingual interpreter here, in the United States, in any of 200 languages.

Voiance’s training model was used as a reference by the National Council on Interpreting in Healthcare to inform the development of national certification standards.

To sign up for Voiance’s service, simply fill out the online sign-up form:
http://www.voiance.com/gateway/

For more information on Voiance and how to sign-up to access an interpreter, you can call (866) 742-9080 ext. 1 or visit our page on the Voiance website: http://www.voiance.com/gateway/

**Confidentiality**

All practitioners and providers participating with Gateway have agreed to abide by all Gateway policies and procedures regarding member confidentiality.

Under these policies, the practitioner or provider must meet the following:
1. Provide the highest level of protection and confidentiality of members’ medical and personal information used for any purposes in accordance with federal and state laws or regulations including the following:
   - The Mental Health Procedures Act, 50 P.S. §§7101 et seq.
   - Patient Medical Records, 28 Pa. Code §115.27.
   - Pennsylvania Confidentiality of HIV-Related Information Act 35 P.S. §§ 7601 et seq.
   - The Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub.L.No. 111-5 (Feb 17, 2009) and related regulations.
   - 42 U.S.C. § 1396a (a) (7) – State plan for medical assistance.
   - 42 C.F.R. § 431.300 et seq. – Medical Assistance – Safeguarding Information on Applicants and Recipients.
   - 73 P.S. § 2301 et seq. – Pennsylvania Breach of Personal Information Notification Act.

2. This includes implementing policies and procedures for managing access to and use of race, ethnicity, and language data.

3. Assure that member records, including information obtained for any purpose, are considered privileged information and, therefore, are protected by obligations of confidentiality.

4. Assure that a member’s individually identifiable health information as defined by HIPAA, also known as Protected Health Information (PHI), necessary for treatment, payment, or healthcare operations (TPO) is released to Gateway without seeking the consent of a member. This information includes PHI used for claims payment, continuity and coordination of care, accreditation surveys, medical record audits, treatment, quality assessment and measurement, quality of care issues, medical management, appeals, case management, and disease management. Further, providers will assure that PHI for TPO will be made available to the DHS, Department of Health, Department of Insurance or Business Associates of Gateway for use without member consent. All other requests for release of or access to PHI will be handled in accordance with federal and state regulations. Gateway follows the requirements of HIPAA and limits its requests to the amount of PHI that is minimally necessary to meet the treatment, payment, or operational function.

5. The member, or a member’s representative with appropriate authority under state and federal law, shall have access to view and/or receive copies of the medical record upon request. There is no charge for the copied medical record if the record is sent to another practitioner or provided directly to the member. The request must allow reasonable notice and follow the specific procedures of the practitioner or provider.

6. All providers are required to conduct environmental security of confidential information and monitor practice and provider sites. Provider and practitioner sites must comply with the Environmental Assessment (EA) standards that require that patient records be protected from public access.

7. Medical records must be available for all member visits for established patients.
Fraud, Waste and Abuse (FWA)

Gateway has a comprehensive policy for handling the prevention, detection and reporting of fraud, waste and abuse (FWA). It is Gateway's policy to investigate any action by members, employees or practitioners that affects the integrity of Gateway and/or the Medical Assistance Program.

Providers are responsible to know the following FWA definitions as applicable to Medicaid:

- **Fraud**: An intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting. Fraud can be committed by many entities, including a health plan, a subcontractor, a provider, a state employee, or a member among others.

- **Waste**: Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs. 
  o Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

- **Abuse**: Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid/Medicare Programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the RFP, Medicaid contracts, Medicare manuals, and the requirements of state or federal regulations) for health care in a managed care setting.
  o Abuse can be committed by the health plan, subcontractor, provider, state employee, or a member, among others. Abuse also includes member practices that result in unnecessary cost to the Medicaid/Medicare Programs, the health plan, a subcontractor, or provider.

- **Compliance Program**: To ensure compliance with FWA requirements of Medicaid contracts, Gateway and providers will have:
  o Written policies, procedures, and standards of conduct readily available for all employees which outlines Gateway's commitment to a FWA program,
  o Effective training and education related to FWA for all employees, first tier and downstream entities, or subcontractors,
  o Mechanisms to report compliance issues or FWA,
  o Enforcement standards through publicized disciplinary guidelines,
  o Provisions for internal monitoring and auditing, and
  o Provisions to promptly take action to detected offenses and develop corrective action initiatives.

- **Payment Integrity**: A multi-faceted team within Gateway that is involved in detecting and investigating FWA. In addition, the team works to ensure that claims are paid correctly by both pre-pay and post-pay auditing methods and in accordance to recipient benefits and provider contracts.

As a participating practitioner with Gateway, your contract requires you to comply with Gateway's policies and procedures for the detection and prevention of FWA. Such compliance may include referral of information regarding suspected or confirmed FWA to Gateway and submission of
statistical and narrative reports regarding FWA detection activities.

Gateway’s policies and procedures follow the guidelines set forth by CMS. For further information on FWA, providers should refer to the CMS website: https://www.cms.gov/Outreach-and-Education/Look-Up-Topics/Fraud-and-Abuse/Fraud-page.html.

It is Gateway’s policy to discharge any employee, terminate any practitioner, or recommend any member be withdrawn from the Medicaid program who, upon investigation, has been identified as being involved in fraudulent, wasteful, or abusive activities. If FWA is suspected, whether it is by a member, employee, or practitioner, it is your responsibility to immediately notify Gateway at 412-255-4340 or 1-800-685-5235.

Some common examples of fraud, waste and abuse are:

- Billing or charging Medical Assistance recipients for covered services.
- Balance billing.
- Billing for services not rendered.
- Billing for supplies not being purchased or used.
- Billing separately for services in lieu of an available combination code.
- Billing more than once for the same service.
- Upcoding.
- Dispensing generic drugs and billing for brand name drugs.
- Falsifying records.
- Performing inappropriate or unnecessary services.

**Payment Integrity Recovery Requirements:**
Gateway has payment integrity functions that are responsible for ensuring claims payment accuracy and to detect and prevent FWA which include:

- Pre-payment claims edits.
- Retrospective claims reviews.
- Provider education.
- FWA investigations and audits.

Gateway’s payment integrity functions rely on reimbursement policies, medical record standards, and coding requirements that are outlined in the following: Centers for Medicare and Medicaid Services (CMS), American Medical Association (AMA), National Correct Coding Initiative (NCCI), National Committee for Quality Assurance (NCQA), and state Medicaid regulations. Additionally, all claims should be coded and documented in accordance with the HIPAA Transactions and Code Sets which includes: ICD-10-CM, National Drug Codes (NDC), Code on Dental Procedures and Nomenclature, HCPCS Codes, CPT Code, and Other HIPAA code sets.

Gateway will conduct pre-payment and retrospective reviews of claims and medical records to ensure claims accuracy and record standards. Gateway will recover claims payments that are contrary to national and industry standards. Gateway will conduct progressive reviews, such that, providers may be requested to submit additional samples or documentation during the reviews. If any of the payment
integrity efforts identify overpayments, the following activities will occur:

- Gateway will comply with all federal and state guidelines to identify overpayments,
- Gateway will pursue recoveries of overpayment through claims adjustments with recoveries by claims offsets or provider checks within sixty (60) days,
- Gateway will refer suspected FWA to appropriate agencies, such as Medicaid oversight and CMS Medics; and
- Gateway may recommend corrective actions that may include pre-payment review, payment suspension, and potential termination from Gateway’s provider network.

Gateway may pursue overpayments for the following reasons (but is not limited to):

<table>
<thead>
<tr>
<th>Reason</th>
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<tr>
<td>NCCI Procedure to Procedure (PTP) edits</td>
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<tr>
<td>NCCI Medically Unlikely (MUE) edits</td>
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<tr>
<td>NCCI Add-On Code edits</td>
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<tr>
<td>Retrospective coordination of benefits</td>
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<td>Retrospective termed member eligibility</td>
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<td>Retrospective rate adjustments</td>
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<tr>
<td>Incorrect fee schedule applied to claim</td>
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<tr>
<td>Provider excluded</td>
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<tr>
<td>Provider license terminated or expired</td>
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<tr>
<td>Provider does not meet the requirements to render services</td>
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<tr>
<td>Different rendering provider</td>
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<tr>
<td>No authorization or invalid authorization</td>
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<tr>
<td>Inaccurate claim information</td>
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<tr>
<td>Duplicate claims</td>
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<tr>
<td>Non-covered service</td>
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<tr>
<td>Outpatient services while member was inpatient</td>
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<tr>
<td>Overlapping services</td>
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<tr>
<td>Patient different than member</td>
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<tr>
<td>Per diem services billed as separate or duplicate charges</td>
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<tr>
<td>Services provided outside of practice standards</td>
</tr>
<tr>
<td>Group size exceeds limitations</td>
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<tr>
<td>No services provided including no-shows and cancellations</td>
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<tr>
<td>Missing records</td>
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<tr>
<td>Missing physician orders</td>
</tr>
<tr>
<td>Missing medication records</td>
</tr>
<tr>
<td>Missing laboratory results</td>
</tr>
<tr>
<td>Invalid code or modifier</td>
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<tr>
<td>Invalid code combinations</td>
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<tr>
<td>Diagnosis codes that do not support the diagnosis or procedure</td>
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<tr>
<td>Add-on codes reported without a primary procedure code</td>
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<tr>
<td>Clinical documentation issues</td>
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<tr>
<td>Claims documentation issues</td>
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<tr>
<td>Insufficient documentation</td>
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Gateway’s Payment Integrity Audit
At times, Gateway’s payment integrity team will conduct audits regarding FWA. If selected for an audit, the provider will receive a letter from the primary investigator, or delegates that have been contracted by Gateway, requesting medical records or the identification of an overpayment. The letter will include specific instructions on how to respond. Additionally, Gateway partners with multiple vendors to conduct various post-payment audits or reviews. Such audits or reviews could include:

- Retrospective data mining review.
- Subrogation.
- Inpatient chart review.

Vendor specific questions should be directed to Gateway’s Provider Services by calling 1-800-392-1145.

Overpayments
Gateway, its providers, and its members are responsible for the identification and return, regardless of fault, of overpayments. In the event that Gateway makes an overpayment to a provider, Gateway must recover the full amount of that overpayment. Additionally, if a provider identifies an overpayment from Gateway, the provider is responsible for returning the overpayment in full at the time of discovery.

Provider Self-Audit (Self-Identified Overpayment)
Federal and state regulations require providers to routinely audit claims for overpayments. Gateway has a process in place for our network providers to report the receipt of a self-identified overpayment.

Providers must notify Gateway in writing of the reason for the self-identified overpayment and should provide payment within sixty (60) calendar days. If the claim is over three (3) years old a check is preferred, however, retraction is preferred for claims that are less than three (3) years old. For claims retraction, providers can submit the Provider Self-Audit form that is located on the provider portal. It is imperative that providers include the explanation of the self-audit and the claims they represent. If a listing of claims is not provided, Gateway cannot guarantee that the claims will not be included in separate audits, for the same reason. Please provide a listing of claims as requested on the Provider Self-Audit/Overpayment Form. Conversely, if providers use an extrapolation calculation to determine payment, a description of that methodology and the calculation should be included with your submission.

Deposit of a provider check or retraction of the requested claims does not constitute complete agreement to the submitted self-audit results or overpayment amount. Gateway’s Payment Integrity Department may contact the provider to discuss self-audit results as necessary. The overpayment letter and check (if applicable) should be sent directly to:

<table>
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<tr>
<th>Potential fraudulent activities</th>
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<tr>
<td>Excessive services</td>
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<td>Altered/forged records</td>
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Information to Submit for Self-Identified Overpayment

When submitting information for an identified overpayment, please include the following:

- Provider Information (i.e.; Name, NPI, TIN, Contact information, etc.),
- Self-Audit / Overpayment Information,
- Period of claims.
  - For claims more than two years old, please provide a check
  - For claims less than two years old, retraction of claims is preferred
- List of affected claims and/or extrapolation calculation used to determine overpayment amount.
- Other information (as required).

Medical Record Requests and Standards

Gateway may request copies of medical records from the provider in connection with claims overpayment or for cases involving alleged FWA. If Gateway requests medical records, the provider must provide copies of those records at no cost to Gateway. This includes notifying any third party who may maintain medical records of this stipulation. In addition, the provider must provide access to any medical, financial or administrative records related to the services provided to our members within thirty (30) calendar days of Gateway’s request or sooner.

Gateway requires providers to have medical records that comply with CMS, AMA, NCCI, NCQA, HIPAA Transactions and Code Sets, Medicaid regulations, and Medicare manuals as well as other applicable professional associations and advisory agencies. Providers should follow the below guidelines for basic medical records:

- Providers are responsible for following all requirements under Federal and State regulations, publications, and bulletins that are pertinent to the treatment and services provided.
- Providers should follow the medical record standards as defined in Medicaid contracts, provider contracts, provider manuals, and all regulations.
- Providers are responsible for having compliance programs that prevent and detect FWA and report and return overpayments within sixty (60) days of identification.
- Providers must have member records that include all Medicaid requirements, are individual and kept secure.
- Providers are responsible for obtaining the appropriate order, referral, or recommendation for service.
- All documentation must meet the requirements of the service codes that are submitted on the claims form.
- All progress notes and billing forms must be completed after the session.
- All documentation and medical record requirements must be legible.
- All amendments or changes to the documentation must be signed and dated by the clinician amending or changing the documentation.
- All requirements for documentation must be completed prior to the claim form submission date.
- Each medical record should be individualized and unique and should include a patient identifier on every page. (No clone or copying and pasting of medical records)

<table>
<thead>
<tr>
<th>Consent to Treatment</th>
<th>Valid for dates of service</th>
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<tbody>
<tr>
<td></td>
<td>Identifies the patient</td>
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<tr>
<td></td>
<td>Signed and dated by patient</td>
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<tr>
<td></td>
<td>Signed, dated, and credentialed by clinician</td>
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<tr>
<td></td>
<td>Lists the types of services and/or treatments</td>
</tr>
<tr>
<td></td>
<td>Includes the benefits and any potential risks</td>
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<tr>
<td></td>
<td>Includes alternative services and/or treatments</td>
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<td></td>
<td>Must be easy to read and legible</td>
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<tr>
<th>Release of Information for Payment</th>
<th>Valid for dates of service</th>
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<tr>
<td></td>
<td>Identifies the patient</td>
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<tr>
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<td>Signed and dated by patient</td>
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<tr>
<td></td>
<td>Signed, dated, and credentialed by author/clinician</td>
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<tr>
<td></td>
<td>Lists the types of services and/or treatments</td>
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<td></td>
<td>Must be easy to read and legible</td>
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<tr>
<th>Privacy Practices</th>
<th>Valid for dates of service</th>
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<td>Identifies the patient</td>
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<tr>
<td></td>
<td>Signed and dated by patient</td>
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<tr>
<td></td>
<td>Signed, dated, and credentialed by author/clinician</td>
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<tr>
<td></td>
<td>Must be easy to read and legible</td>
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<tr>
<th>Medical Information</th>
<th>Must contain the minimum personal biographical data: DOB, Gender, Address, Home Telephone Number, Employer, Occupation, Work Telephone Number, Marital Status, Name of Next of Kin, Next of Kin Telephone Number</th>
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<tbody>
<tr>
<td></td>
<td>Allergies and adverse reactions</td>
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<td></td>
<td>Significant illnesses and medical conditions</td>
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<tr>
<td></td>
<td>Medical history, such as family history, psychosocial history, medical-surgical history, baseline physicals, and periodic updates</td>
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<tr>
<td></td>
<td>High risk behaviors (Tobacco/cigarette, alcohol, substance abuse, HIV/STD, nutrition, social and emotional risks, etc.)</td>
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<tr>
<td></td>
<td>Laboratory and other studies ordered</td>
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<tr>
<td></td>
<td>Continuity of care is documented</td>
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<tr>
<td></td>
<td>Immunizations and dates</td>
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<td></td>
<td>Must be easy to read and legible</td>
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</table>
Policies and Procedures

| Treatment Plan | Valid for dates of service |
|               | Identifies the patient     |
|               | Signed and dated by clinician (witness or author’s identification) |
|               | Documents that member or guardian reviewed or participated with the development of the treatment plan |
|               | Addresses the chief complaint and clinical finding with a plan of care consistent with standards of care and clinical practice |
|               | Identifies the diagnosis |
|               | Identifies interventions and goals of treatments |
|               | Documents necessity for treatment |
|               | Reviews are completed timely as applicable |
|               | Must be easy to read and legible |

| Progress / Clinical Entry Note | Dates of Service |
|                               | Identifies the patient |
|                               | Signed, dated, and credentialed by author/clinician |
|                               | Start and stop times for time based services |
|                               | Units of service |
|                               | Place of service |
|                               | Note is missing narrative/description of services |
|                               | Note does not identify the treatment goals and objectives |
|                               | Note does not list symptoms and behaviors |
|                               | Note does not identify follow-up or next steps in treatment |
|                               | Corresponding encounter or timesheets as applicable |
|                               | Must be easy to read and legible |

| Medication List | Medication prescribed |
|                | Signed and dated by clinician |
|                | Lists dosages, dates, and refills |
|                | References the side effect and symptoms |
|                | Must be easy to read and legible |

**Pennsylvania Medical Assistance Hotline to Report Fraud and Abuse**

DHS has established a MA Provider Compliance Hotline, 1-866-379-8477, to report suspected fraud and abuse committed by any entity providing services to MA recipients. The hotline operates between the hours of 8:30 A.M. and 3:30 P.M., Monday through Friday. Voicemail is available at all other times. Callers may remain anonymous and may call after hours and leave a voicemail if they prefer.

Suspected fraud and abuse may also be reported via the website at: [www.dhs.state.pa.gov](http://www.dhs.state.pa.gov). Information reported via the website or email can also be done anonymously. The website contains additional information on reporting fraud and abuse.

**Recipient Restriction Program**

In cooperation with DHS, Gateway maintains a Recipient Restriction Program, which restricts members who miss-utilize medical services or pharmacy benefits. Gateway enforces and monitors
these restrictions through the following process:

- Identifying members who are over-utilizing and/or miss-utilizing medical services.
- Evaluating the degree of abuse including review of pharmacy and medical claims history, diagnoses, and other documentation, as applicable.
- Proposing whether the member should be restricted to obtaining services from a single, designated provider for a period of five (5) years.
- Forwarding case information and supporting documentation to Bureau of Program Integrity (BPI) at the address below, for review to determine appropriateness of restriction and to approve the action.
- Upon BPI approval, sending notification via certified mail to member of proposed restriction, including reason for restriction, effective date and length of restriction, name of designated provider(s), and option to change provider, with a copy to BPI.
- Sending notification of member’s restriction to the designated provider(s) and the County Assistance Office.
- Enforcing the restrictions through appropriate notifications and edits in the claims payment system.
- Preparing and presenting the case at a DHS fair hearing to support restriction action.
- Monitoring subsequent utilization to ensure compliance.
- Changing the selected provider per the member’s or provider’s request, within thirty (30) days from the date of the request.
- Continuing a member restriction from the previous delivery system as a member enrolls with Gateway, with written notification to BPI.
- Reviewing the member’s services prior to the end of the five year period of restriction to determine if the restriction should be removed or maintained, with notification of the results of the review to BPI, member, provider(s), and CAO.

Gateway members have the right to appeal a restriction by requesting a DHS fair hearing. Members may not file a complaint or grievance with the PH-MCO regarding the restriction action. A request for a DHS fair hearing must be in writing, signed by the member and sent to:

Department of Human Services  
Office of Administration Bureau of Program Integrity  
Division of Program and Provider Compliance  
Recipient Restriction Section  
P. O. Box 2675  
Harrisburg, Pennsylvania 17105-2675  
Phone: 717-772-4627
Environmental Assessment (EA) Standards

Gateway has established specific guidelines for conducting EA Site Visits, including medical record-keeping standards, at primary care practitioner practices. An initial EA will be conducted at all primary care practitioner and dental practitioner office sites as part of the credentialing process. Gateway’s subcontracted vendor conducts all site visits for contracted dental providers. The purpose of the site visit is to assure that practitioners are in compliance with Gateway’s EA standards.

A PAL will schedule an on-site visit at each office site to conduct an EA. The EA must be conducted with the office manager or with a practitioner of the practice. The Provider Account Liaison will complete the initial EA form and tour the office as well as interview staff and examine the appointment schedule. The Gateway Provider Account Liaison will assess the office for evidence of compliance with the EA standards.

Upon completion of the review, the PAL will conduct an exit interview with the office manager and/or practitioner. The results of the EA will be reviewed. Non-compliance issues must be addressed with a corrective action plan within thirty (30) days of receipt for non-compliant standards.

The PAL will conduct a follow-up visit within ninety (90) days or until the office site is compliant. The Medical Director will review the EA part of the initial credentialing process. If any of the standards are not met, the Medical Director will assess the potential impact of the discrepancy to patient care and evaluate the corrective action plan. If the plan is reasonable, the practitioner will continue with the credentialing process. If the plan is not acceptable, the Medical Director may suggest a different corrective action plan or delay the credentialing process until the issue is resolved. If the office is not agreeable to correcting the identified problem, the information will be presented to the QI/UM committee for review. Special circumstances may be granted based upon size, geographic location of the practice, and potential harm to members. The PAL will communicate the final results to the practitioners.

An EA will not be conducted if a new practitioner joins an office site or if the practitioner relocates to an office that has already been reviewed and meets Gateway standards. When credentialing a new practitioner who joins an existing office site, the documentation from that site visit for that office will be included in the new practitioner’s initial credentialing file prior to the QI/UM committee review. Site visits for relocated offices must be conducted prior to the practitioner’s recredentialing date. The documentation of that site visit will be included in the recredentialing file.

Gateway PALs conduct site visits to assess practice compliance with the ADA and Section 504 of the Rehabilitation Act of 1973 for those practices as determined by DHS.

### Environmental Assessment Standards

<table>
<thead>
<tr>
<th>PRIMARY CARE PRACTITIONER</th>
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<tr>
<td>ENVIRONMENTAL ASSESSMENT STANDARDS</td>
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<th>PHYSICAL ACCESSIBILITY AND APPEARANCE</th>
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<tr>
<td>Parking</td>
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</tbody>
</table>
1. Parking Lot should have 96" wide parking spaces available for vans and cars that also have an adjacent 96" wide striped access isle.
2. Parking Lot spaces that are handicap accessible have a sign or signs that will not be blocked by parked vehicles, and that display the International Symbol of Accessibility and provide "van-accessible" designation.
3. The designated parking space for handicap accessibility is the 96" accessible space closest on the path of travel to the entrance.

<table>
<thead>
<tr>
<th>Exterior Path of Travel</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The path of travel is at least 36&quot; wide, except at doorways and gates.</td>
</tr>
<tr>
<td>2. The Surface in the exterior path of travel is stable, firm and slip resistant.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Curb Ramps</th>
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</thead>
<tbody>
<tr>
<td>1. There are curb ramps where the path of travel crosses a curb.</td>
</tr>
<tr>
<td>2. There are curb ramps at least 36&quot; wide.</td>
</tr>
<tr>
<td>3. The slope of the curb ramps is less than or equal to 1:12.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Ramps</th>
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</thead>
<tbody>
<tr>
<td>1. If a route has changes in level greater than ½&quot;, a ramp is provided.</td>
</tr>
<tr>
<td>2. The slope of the ramp is no greater than 1:12 for each run of the ramp.</td>
</tr>
<tr>
<td>3. There is a level landing at the top and bottom of each run, at least as wide as the ramp and 60&quot; in length.</td>
</tr>
<tr>
<td>4. If the ramp changes direction, there is a landing at least 60&quot; x 60&quot;.</td>
</tr>
<tr>
<td>5. Ramps are non-slip.</td>
</tr>
<tr>
<td>6. If the ramp rises more than 6&quot;, or has a horizontal run longer than 72&quot;, there are handrails on each side.</td>
</tr>
<tr>
<td>7. The width of the ramp is at least 36&quot; wide or if handrails are present, the clear width between railings is at least 36&quot; wide.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Building Entrance</th>
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</thead>
<tbody>
<tr>
<td>1. There is directional signage indicating the locations of an entrance for use by people with disabilities.</td>
</tr>
<tr>
<td>2. If there is signage, the entrance shows the International Symbol for Accessibility.</td>
</tr>
<tr>
<td>3. There are no steps or changes in level at the entrance or in route to the entrance greater than ½&quot; high.</td>
</tr>
<tr>
<td>4. The entrance door has at least a 32&quot; clear opening width.</td>
</tr>
<tr>
<td>5. The door handle is operable without tight grasping or twisting of the wrist.</td>
</tr>
<tr>
<td>6. There is a threshold that is at least 1/2&quot; or less in height.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Airlock Doors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If there are two doors in a series, the space between them is at least 48&quot; plus the width of any door swinging into the space.</td>
</tr>
<tr>
<td>2. The airlock door has at least a 32&quot; clear opening width.</td>
</tr>
<tr>
<td>3. The airlock door handle is operable without tight grasping or twisting of the wrist.</td>
</tr>
<tr>
<td>4. There is a threshold that is ½ &quot; or less in height.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stairs</th>
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</thead>
<tbody>
<tr>
<td>1. The use of stairs is not necessary to access the provider's office.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Elevators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Elevator door provides a clear opening width of at least 36&quot;.</td>
</tr>
<tr>
<td>2. The Elevator operating controls are no higher than 54&quot;.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interior Spaces</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The route to all provider spaces is at least 36&quot; wide.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hallway Doors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Doors on interior paths of travel have at least 32&quot; of clear opening width.</td>
</tr>
<tr>
<td>2. Door handles are operable without tight grasping or twisting of the wrist.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Entrance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The door into the provider space is at least a 32&quot; clear opening width.</td>
</tr>
<tr>
<td>2. Door handles are operable without tight grasping or twisting of the wrist.</td>
</tr>
<tr>
<td>3. Thresholds are at least ½&quot; or less in height.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Interior Path</th>
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</thead>
<tbody>
<tr>
<td>Pathways to waiting rooms and receptionist desk are unobstructed and at least 36&quot; wide.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Interior Doors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Doors on the Provider interior path of travel have at least 32&quot; of clear opening width.</td>
</tr>
</tbody>
</table>
Exam Rooms
1. Doorways to exam rooms provide a minimum clear opening width of 32”.
2. Exam and treatment rooms must provide for patient confidentiality

Bathroom Facilities
1. Support rail(s) are present in bathroom facilities.
2. Minimum door width of 32”.
3. Minimum clearance of 18” measured from the center of the commode to walls on either side.
4. Minimum depth of bathroom or stall of 66: or proportionately wider side clearance.

Waiting Area
1. Waiting area must adequately accommodate size of practice, and there must be a minimum of 4 chairs, or 2 per physician, whichever is greater.
2. The waiting area and treatment areas must be clean and neat.
3. There must be at least one exam room per physician.
4. There must be at least one treatment room in a specialty office if office procedures are done. (No requirement for PCPs).

Drug Storage
1. Pharmaceuticals must be stored in an area that is not accessible to patients.
2. Narcotics must be stored in a locked area and a log must be kept.
3. There should be a separate refrigerator for storage of immunizations, medical supplies.

MEDICAL RECORD KEEPING
1. All providers must maintain current and comprehensive medical records which conform to standard medical practices.
2. Patient records must be secure from public access at all times.
3. The office must have a written confidentiality policy that applies to all staff.
4. Records are documented legibly.
5. Office must have an organized filing system to insure prompt retrieval of patient records. (alphabetically, social security numbers)
6. There must be a single chart for each patient. If family records are kept, individual records must be clearly delineated.
7. Records must identify the member on each page.
8. All medically related patient phone calls documented in the medical record.
9. Office recalls missed appointments and makes documentation in the medical record.
10. Chart Documentation:
   o Allergy or NKA visible in the same place on every record.
   o Patient medical history in each record. Is there a medical history in each patient record?
   o Treatment/progress notes in each patient record.
   o Problem List in the medical record. (PCPs and PCP Specialists Only)
   o Standard place in the medical record for preventive care/immunizations (PCPs and Specialists only).

**IF PROVIDER RELATIONS HAS QUESTIONS OR CHART DOES NOT MEET THE STANDARD THEN A COPY OF ONE RECORD NEEDS TO BE GIVEN TO QI FOR REVIEW.

SCHEDULING/AVAILABILITY/OFFICE PROTOCOLS

SCHEDULING

PCPs and PCP/Specialists Only
1. Waiting time to schedule a routine appointment must be no more than ten (10) business days.
2. Waiting time to schedule a health assessment/preventive physical examination and first examination must be scheduled within three (3) weeks.
3. Waiting time to schedule an urgent care appointment must be no more than twenty-four (24) hours.
4. Waiting time to schedule non-urgent care, but in need of attention appointment must be no more than one (1) week for Medicare Assured®.
5. Waiting time to schedule an EPSDT screen for a new member assigned to the practice must be within forty-five (45) days of the effective date of enrollment.
6. Wait time in the waiting room should be no more than thirty minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated urgent medical visit or is treating a patient with a difficult need.
7. Practice must have at least twenty (20) hours of patient scheduling time per week per office.
8. There must be open appointments on the schedule for emergencies.
9. Emergency care must be seen immediately or referred to an emergency facility.
10. Practice must have physician coverage arrangements for vacations, etc.
11. Waiting time to schedule an appointment for any new patient diagnosed with HIV must be within seven days of enrollment.

**OFFICE PROTOCOLS**

1. The office must have a recall system for patients who miss appointments and document in the Medical Record whether a postcard, or a telephone call was made/sent. At least one attempt to contact the member must be made by telephone. At least three (3) attempts must be made.
2. **PCP and PCP/Specialist Only** – The Office is able to perform EPSDT screens. Offices whose panel limit is twenty-one and under. Should the PCP be unable to conduct the necessary EPSDT Screens, the PCP is responsible and willing to arrange to have the necessary EPSDT Screens conducted by another network practitioner and assure that all relevant medical information, including the results of the EPSDT Screens, are incorporated into the Member’s PCP medical record.

**EMERGENCY CARE**

1. **PCP and PCP/ Specialist** – A Physician must be available twenty-four (24) hours a day, seven (7) days per week directly or through on-call arrangements for urgent or emergency care and provide triage and appropriate treatment or referrals for treatment. This can be accomplished by answering machine, or answering service.

**EXIT INTERVIEW WITH OFFICE**

- Review the Environmental Assessment Standards and your findings at this time. Provide the standards for the medical record review process and give approximate date for completion of the credentialing process.
Hospital Services

Inpatient Admissions

In order for Gateway to monitor the quality of care and utilization of services by our members, all Gateway practitioners are required to obtain an authorization number for all hospital admissions and certain outpatient surgical procedures by submitting authorization requests electronically via NaviNet (Refer to Online Authorization section) or by contacting Gateway’s UM Department at 1-800-392-1147 in advance of services being rendered, except in urgent or emergent situations. In the event services are needed urgently and/or emergently, authorization must be requested within three (3) business days from arrival. Failure to obtain a timely authorization may result in the administrative denial of your claim without regard to medical necessity. Claims with an untimely authorization will be denied D170 - authorization not timely. This is not subject to appeal.

Gateway will accept the primary care practitioner, ordering practitioner, or the attending practitioner’s request for an authorization of non-emergency hospital care; however, no party should assume the other has obtained authorization. Gateway will also accept a call from the hospital’s Utilization Review Department.

The UM representative refers to the Gateway Medical Director if criteria or established guidelines are not met for medical necessity. The ordering practitioner is offered a peer review opportunity with the Gateway Medical Director for all potential denial determinations.

Hospital Transfer Policy

When a Gateway member requires hospitalization, Gateway’s policy is to have the service rendered in a Gateway participating hospital. However, Gateway recognizes that it may not be possible to follow this general policy when a member presents to the closest medical facility due to a medical emergency. When the medical condition of the member requires an admission to a non-participating hospital, the member will be transferred within twenty-four (24) hours of stabilization, when appropriate.

In order to determine that the member is medically stable for transfer the Gateway UM staff will concurrently monitor the condition of the patient by communicating with the hospital’s Utilization Review staff and the attending practitioner. Gateway will coordinate all necessary transportation for the timely transfer of the member.

Outpatient Surgery Procedures

Gateway practitioners may utilize a hospital’s Short Procedure Unit (SPU) or Ambulatory Surgery Unit (ASU) for any authorized medically necessary procedure.

Medical necessity reviews may be required for certain procedures. To verify if authorization is required refer to the Quick Reference Guide on Gateway’s website or utilize the Code Lookup feature on NaviNet in advance of services being rendered, except in urgent or emergent situations.
In the event services are needed urgently and/or emergently, authorization must be requested within one (1) business day from arrival. Please submit authorization requests electronically via NaviNet (refer to Online Authorization section) or call Gateway’s UM department claims with an untimely authorization will be denied D170-authorization not timely. This is not subject to appeal.

**Emergency Room**

The definition of an emergency is: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(a) Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
(b) Serious impairment to bodily functions.
(c) Serious dysfunction of any bodily organ or part.

The following conditions are examples of those most likely to require emergency treatment:

- Danger of losing life or limb
- Poisoning
- Chest pain and heart attack
- Overdose of medicine or drug
- Choking
- Heavy bleeding
- Car accidents
- Possible broken bones
- Loss of speech
- Paralysis
- Breathing problems
- Seizures
- Criminal attack (mugging or rape)
- Heart attack
- Blackouts
- Vomiting blood

Gateway members have been informed, through the Member Handbook, of general instances when emergency care is typically not needed. These are as follows:

- Cold
- Sore throat
- Small cuts and burns
- Ear ache
- Vomiting
- Rash
- Bruises
- Swelling
- Cramps
- Cough

In all instances, when a member presents to an emergency room for diagnosis and treatment of an illness or injury, the hospital’s pre-established guidelines allow for the triage of illness and injury.

All follow-up care after an emergency room visit must be coordinated through the primary care practitioner. Members are informed via the Member Handbook to contact their primary care practitioner for a referral for follow-up care in instances such as:

- Removal of stitches
- Cast check
- Changing of bandages
- Further testing
Ambulance Services

Emergent transportation (302 or 911), including air ambulance, does not require authorization by Gateway. Gateway considers emergent transportation as transportation that allows immediate access to medical or behavioral healthcare and without such access could precipitate a medical or a behavioral health crisis for the patient. Either a participating or non-participating ambulance provider may render 302 or 911 transportation without an authorization from Gateway.

Gateway also considers the following situations emergent, and thus does not require authorization:
- ER to ER.
- ER to Acute Care or Behavioral Health Facility.
- Acute Care to Acute Care or Behavioral Health Facility.
- Hospital-to-Hospital, when a patient is being discharged from one hospital and being admitted to another.

Providers should bill the above types of transports with the appropriate non-emergent, basic life support code and the modifier HH.

Authorization for non-emergent ambulance transportation is not required by Gateway’s UM department in advance of services being rendered. Gateway considers non-emergent transportation as transportation for a patient that does not require immediate access to medical or behavioral healthcare and/or if not provided would not result in a medical or a behavioral health crisis as non-emergent. Non-emergent transportation may include the following scenarios:
- Ambulance transports from one facility to another when the member is expected to remain at the receiving facility, which may include the following:
  - Hospital to Skilled Nursing Facility (SNF)
  - SNF to Hospital (non-emergent)
  - Hospital to Rehabilitation Facility
  - Rehabilitation Facility to Hospital (non-emergent)
- Ambulance transport to home upon discharge.
- Ambulance transport from home to a PCP office.

A Gateway participating ambulance provider should be contacted to render non-emergent transportation when possible. Non-participating non-emergent ambulance trips would require authorization.

Ambulance transportation from one facility to another for diagnostic testing or services not available at the current facility, with the expectation of the member returning to the original facility upon completion of service, is the responsibility of the originating facility and does not require an authorization from Gateway. The originating facility should assume the cost for this type of transport even if for unforeseen circumstances, the member remains at the receiving facility. The originating facility may contact any ambulance service of their choosing to provide transport in this scenario only.
Members should be referred to MATP program transportation services, including wheelchair van transportation.

**Important Reminders Regarding the Submission of Implant Invoices**

In an effort to assist providers in receiving appropriate compensation for implant services and/or high cost pharmaceuticals, it is imperative that providers abide by the following claim and invoice submission guidelines when submitting their claims for reimbursement.

Outlined below are some important reminders and steps that are often overlooked which can lead to delayed payments and claim denials for implant services and/or high cost pharmaceuticals.

When submitting an implant services claim and/or high cost pharmaceuticals, Gateway asks that providers follow the important guidelines noted below:

- The original claim must be submitted timely and services must be billed in accordance with the facility’s contract terms.
  - Please ensure the patient’s name and ID number are on every page associated with the claim that needs to be paid.
  - Please circle the number of units and cost associated with the services to be paid and provide a breakdown of the costs if necessary.

- Providers may fax the implant and/or high cost pharmaceuticals invoice to 1-844-207-0334 for processing. When submitting via fax, please include the following:
  - The fax cover sheet must include the phrase “Implant Invoice Claim” or “High Cost Pharmaceuticals” in the subject line.
  - A copy of both the claim and the invoice must be included in the fax.
  - A copy of the packing slip with the patient name circled should also be included.

Gateway would like to take this opportunity to provide some additional reminders to facilities when submitting claims that include implant invoices:

- All claims, including implant invoices are subject to timely filing and follow up guidelines as well as the Gateway coding edits.
- Providers MUST follow the Appeals Process if it is felt that the denial of the claim is Incorrect.
- If the surgery is denied, the implant charges will also be denied.
- Date of Service, Billed Charges, etc. must match that of the invoice.
- Providers should expect to receive payment within approximately 40 days after submission of a clean claim and invoice. Provider Services can provide assistance with inquiries on those claims and invoices that have been submitted but have received no response.

If there are any questions regarding this process, please do not hesitate to contact Provider Services.
Continuity and Coordination of Care

Specialists, hospital, and skilled nursing facilities must ensure compliance with the continuity and coordination of care requirements, by ensuring that all discharge summaries and progress reports are reported back to the member’s PCP. Continuity and coordination of care across settings is a regulatory requirement.

Care across settings, such as between PCP and specialists, presents many challenges to the continuity of information, relationships, and treatment.

Much of Gateway’s membership is made up of the most vulnerable individuals – some of whom suffer from severe or chronic illnesses. Enhanced communication is imperative across all the touch-points within these patients’ care in order to make the informed decisions which will ensure their well-being. Failure to share information about the care of a patient can result in suboptimal outcomes, increased costs, and medical errors.

It is to the benefit of both the patient and healthcare professional to communicate any reports, therapies, medications and concerns identified by providers across treatment settings. For additional continuity of care concerns or assistance, please contact your Provider Account Liaison.
Referrals and Authorizations

General Information
Referrals and authorizations are necessary in order to preserve the PCPs relationship with the patient. Both processes allow Gateway to assist the PCP with managing the care of its member population. The major differences between referrals and authorizations are highlighted below:

- Referrals allow the PCP to approve specialty services for members on their panel.
- Authorizations allow Gateway to confirm:
  - Eligibility of the member prior to receiving services.
  - To assess the medical necessity and appropriateness of care.
  - To establish the appropriate site for care.
  - To identify those members who would benefit from care management.

In certain instances, members do not require a referral from the primary care practitioner to see a participating specialty care practitioner. For the following services, members can self-refer:

- OB/GYN Services.
- Family Planning Services (family planning services do not have to be rendered by a participating provider).
- Dental services.
- Routine vision.
- Chiropractic services (an authorization must be obtained by the chiropractic office, including the initial evaluation).
- Mental health/substance abuse services.

Referrals
When a PCP determines that a member requires medical services or treatment outside of the PCPs office, the PCP must issue a referral to a participating facility or specialty care practitioner. If services are performed in a hospital setting, the referral should be issued to the hospital’s provider identification number. **PCPs may not issue referrals to other PCPs.**

Voice Activated Referral
Gateway’s IVR may be used by PCPs and OB/GYNs to issue a referral, and by specialty care practitioner and hospitals to verify and review a referral. To use the system, call 1-800-642-3515, and please follow the prompts, or use the guide below for a quick reference.

TO ENTER A REFERRAL TO A SPECIALIST OR HOSPITAL

To Enter a Referral, PCPs will need:

- Their Gateway Group Provider ID Number.
- Member ID number.
- Group ID for the specialist/hospital to which you are referring.
PCPs will need to:

- Call 1-800-642-3515.
- Press 2 to enter a new referral.
- Enter the member’s ID number as it appears on the member’s ID card.
- Enter the group provider number of the specialist/hospital to which the PCP is referring the member.
- Enter the PCPs group provider ID number.
- Are the Provider and Specialist Valid?
  - No
    - Press 1 to re-enter specialist and provider.
    - Press # to go to the main menu.
    - Press 0 to speak to someone (Call sent to provider services).
      - If you are an OBGYN please press 1.
      - If you are an OBGYN attempting to create a referral, please be aware that referrals now need to be made using the downloadable referral form. You can find the referral form by going to https://www.gatewayhealthplan.com/.
    - All other press 2.
  - Yes
    - Press 1 for general referral for 3 visits within the next ninety (90) days.
    - Press 2 for allergy or pain management services for nine (9) visits within the next ninety (90) days.
- Enter the beginning date for the referral.
  - Press 1 to save the referral.
  - Press 2 to discard the referral.
  - Press # to discard the referral and go back to the main menu.

To Review a Referral

- Call 1-800-642-3515.
- Press 3 to Review a referral.
- Enter the member’s ID number as it appears on the member’s ID card.
  - Press 1 for PCP.
    - Enter the plan ID of the provider.
  - Press 2 for hospital or specialist.
    - Enter the Plan ID of the hospital or specialist.
- If referral exists the most current one is read out.
  - Press 1 for more information.
  - Press 2 for the next referral.
  - Press 3 for a different member id.
  - Press 4 for a different provider.
  - Press 5 for a fax.
  - Press # to go to the main menu.
  - Press 0 to speak with someone (Call sent to provider services).
Paper Referrals

Gateway understands that there may be instances when a PCP is unable to use IVR. A downloadable version of the PCP Referral Form is available on our website. 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. The OB/GYN Referral Form is only available in a downloadable version.

Please use the following procedure to complete your downloaded paper referral form:

1. Check your practice’s PCP Member List, call Gateway’s Eligibility Verification Line, or go NaviNet to verify the member’s eligibility.
2. Assure that the needed service does not require prior authorization from Gateway.
3. Select a participating specialist or facility appropriate for the member’s medical needs from Gateway’s Provider On-line Directory. If an appropriate provider is not listed in the directory, please call Provider Services for assistance.

Once a participating provider is selected from Gateway’s On-Line Directory, the PCPs office completes the following sections of the Referral Form:

1. Primary Care Information:
   - Complete the PCP name, practice address, and telephone number.
   - Fill in the Practice’s seven digit Gateway provider ID number.
2. Patient Information
   - Complete the patient’s name.
   - Fill in the member’s eight digit Gateway member ID number.
   - Complete the diagnosis and/or complaint field being as specific as possible. The diagnosis can be an ICD-10 (preferred) code or a written description.
3. Specialty provider or facility information
   - Specialty Care Provider: Complete the specialist group name and Gateway provider ID Number for services rendered at office site only.
   - Facility Provider: Complete the facility name and Gateway facility ID number for services rendered at outpatient facility to allow both facility and practitioner services to be covered.
4. Referral Services
   - If you are referring a member for services that do not require authorization, you can check the appropriate service and specify additional information as requested on the form.
5. PCP Signature
   - The paper referral form must be signed by the member’s PCP. If an office staff member completes the referral, the staff member must place their initials after the practitioner’s stamp or signature. AN UNSIGNED PAPER REFERRAL FORM IS NOT VALID.
6. Referral Date
   - The referral form must be dated. If the referral form is not dated, Gateway will date according to receipt date at the claim office. Payment for referral and authorized services is contingent upon the patient being an enrolled Gateway member at the time of the service.
Out-of-Plan Referrals
Occasionally, a member may need to see a healthcare provider outside of Gateway’s provider network. When the need for out-of-plan services arises, the primary care practitioner must contact Gateway’s UM department to obtain an authorization prior to making the referral and prior to services being rendered. The UM department will review the request and make arrangements for the member to receive the necessary medical services with an appropriate provider in collaboration with the recommendations of the PCP and for as long as Gateway is unable to provide the service with a participating, in-network provider. Every effort will be made to locate a healthcare provider within an accessible distance to the member. If Gateway makes arrangements for the member to receive out-of-network services, it will coordinate payment to ensure that the cost to the member is no greater than it would be if the service was furnished in-network.

Referrals for Second Opinions
Gateway ensures member access to second opinions. Second opinions may be requested by Gateway, the member, or the PCP. Gateway will provide for a second opinion from a qualified health care provider within the network or arrange for the member to obtain one outside the network, at no more cost to the member than if the service was provided in-network. The second opinion specialist must not be in the same practice as the attending physician and must be a participating provider of Gateway. Out-of-network referrals may be authorized when no participating provider is accessible to the member or when no participating provider can meet the member’s needs.

Referrals for Second Surgical Opinions
Second surgical opinions may be requested by Gateway, the member, or the PCP. When requesting a second surgical opinion consultation, Gateway recommends that you issue a referral to a consulting practitioner who is in a practice other than that of the attending practitioner, or the practitioner who rendered the first opinion and possesses a different tax identification number than the attending practitioner. Gateway provides for second opinions from an in-network provider or arranges for the member to obtain a second opinion outside of the network, at no more cost to the member than if the service was obtained in-network.

Specialty Care Practitioners
When a Gateway member schedules an appointment with a specialist, the office should remind the member that a referral from the PCP is needed in order to receive treatment from the specialist, with the exception of a self-referred benefit. Specialty care practitioners should verify the existence of a valid referral through NaviNet or the IVR System by calling 1-800-642-3515 prior to providing treatment.

If other services are needed in addition to those authorized by the PCP, a treatment plan must be completed and forwarded to the PCP for authorization. The PCP can then issue additional referrals based upon the recommendations of the specialty care practitioner.
Since specialists cannot refer members to other specialists, the PCP must refer the member to another specialist. If a specialist recommends that the patient should be seen by another specialty care practitioner, the specialist must contact the PCP, and the PCP may then examine the patient and/or review the consult report prior to referring the patient to another specialist. The only exception to this is for neonatologists who may issue a referral to other participating specialists for babies discharged from the NICU who require service before seeing their PCP. Referrals should be issued under the baby’s Gateway ID Number. If the baby does not have an ID Number, the practitioner should call Gateway’s UM department for authorization.

In unusual situations, the specialist or primary care practitioner may contact Gateway’s UM department at 1-800-392-1147.

**Renal Dialysis Services**

Outpatient renal dialysis services when provided by a network provider does not require an authorization, but does require a referral from the member’s PCP. Member eligibility must be verified prior to rendering services by calling the Member Eligibility Verification Line at 1-800-642-3515.

If renal dialysis services are provided by a non-network provider, then an authorization is required; in addition to a referral from the PCP.

In-home renal dialysis services require an authorization from Gateway’s UM department.

**Audiology and Speech Therapy**

Gateway members under the age of 21 are eligible to receive audiology services including hearing aids and ear molds. The member’s PCP must issue a referral for audiology services to a participating, licensed practitioner, licensed audiologist, or an outpatient hospital clinic. Prior to dispensing aids and/or ear molds, the audiology practitioner must obtain authorization through the ordering practitioner from Gateway’s UM department. Reimbursement rates for hearing aids, ear molds, repair parts, and any specialty items not covered on the MA Fee Schedule should be negotiated at the time of authorization, prior to rendering services.

**Self-Referral**

Members may refer themselves for the following types of care:

**Dental**

When a member joins Gateway, the member may self-refer to any participating United Concordia Dental dentist directly without a referral from the PCP. Should specialty dental care be needed, the dentist can refer the member to a dental specialist.

Certain oral surgery procedures, such as removal of partial or total bony impacted wisdom teeth, and procedures which involve cutting of the jaw, are covered by Gateway through Gateway’s
panel of oral surgery providers. Members requiring these services must be referred by their PCP to a Gateway participating oral surgeon. The primary care dentist may need to provide x-rays or other information to the PCP to facilitate the referral. The oral surgeon is responsible for authorizing surgical procedures with Gateway prior to rendering the service (procedures provided in the oral surgeons office are not subject to the authorization process). When a dental procedure requires the use of a Special Procedures Unit (SPU), the dental provider must contact United Concordia Dental for authorization prior to the services being rendered.

Emergency
Members are informed through the Member Handbook how and when to utilize emergency services.

Eye Examinations
Gateway members may self-refer to any Davis Vision participating provider for a routine eye exam. Corrective lenses and frames may be obtained through any participating optician, optometrist, or ophthalmologist. **There is no need for the PCP to issue a referral.** Should the member require additional medical services, rendered by a participating ophthalmologist or optometrist, the member will require a referral from the PCP.

Mental Health/Substance Abuse
Members are permitted to self-refer for mental health and substance abuse services. Please refer to the Quick Reference section of this manual for the telephone numbers for members to call.

OB/GYN Services
Female Gateway members may self-refer to any participating OB/GYN for any condition, not just for an annual exam or suspected pregnancy. When a member self-refers to the OB/GYN’s office, the OB/GYN’s office is required to contact Gateway to verify eligibility of the member.

Standing Referrals
Gateway allows for a standing referral to a specialist for sixty (60) days or to serve as a PCP in certain pre-authorized situations. The specialist must be an existing Gateway practitioner, must be agreeable to following Gateway’s requirements for acting as a PCP, and must receive prior authorization by Gateway’s Medical Director. Practitioners interested in obtaining more information regarding this process should contact Provider Services at 1-800-392-1147.

Authorization Process
The function of an authorization is to confirm the eligibility of the member, verify coverage of services, assess the medical necessity and appropriateness of care, establish the appropriate site for care, and identify those members who would benefit from care management or disease management. Gateway’s UM department assesses the medical appropriateness of services using McKesson’s Interqual Procedure Criteria, approval criteria based on a Medical Director’s review of the latest medical literature and citations, and DHS/HealthChoices definition of medical necessity when authorizing the delivery of healthcare services to plan members.
The definition of medical necessity is:
A service or benefit is medically necessary if it is compensable under the MA program and if it meets any one of the following standards:

- The service, item, procedure or level of care will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- The service, item, procedure or level of care will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, or disability.
- The service, item, procedure or level of care will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

Determination of medical necessity for covered care and services, whether made on a prior authorization, concurrent review, retrospective review, or exception basis, must be documented in writing.

The determination is based on medical information provided by the member, the member’s family/caretaker and the PCP, as well as any other providers, programs, or agencies that have evaluated the member.

All such determinations must be made by qualified and trained healthcare providers. A healthcare provider who makes such determinations of medical necessity is not considered to be providing a healthcare service under this agreement.

**Requesting Precertification**

The UM department is committed to assuring prompt, efficient delivery of healthcare services and to monitor quality of care provided to Gateway members. Authorization is the responsibility of the admitting practitioner or ordering provider and can be obtained by submitting requests electronically (refer to Online Authorizations below) or by calling Gateway’s UM department at 1-800-392-1147. If a service requires authorization and is being requested by a participating specialist, the specialist’s office must call Gateway to authorize the service. Hospitals may verify authorization by calling the Gateway UM department.

When an authorization request is received, the information will be reviewed, and the member’s eligibility verified. However, since a member’s eligibility may change prior to the anticipated date of service, eligibility must be verified on the date of service.

If an authorized service is not able to be approved as proposed by the practitioner, alternate programs such as home healthcare, rehabilitation, or additional outpatient services may be suggested to the practitioner by the UM staff. If an agreement cannot be reached between the practitioner and the UM staff, the case will be referred to a Gateway Medical Director for review. A practitioner may appeal the decision within one hundred eighty (180) days of the date of the
denial notice. Please refer to the Practitioner Complaints and Grievances section of this manual for the process to appeal a decision.

The following services require a prior authorization from Gateway or have a payment policy applied:

- **Inpatient Admissions.**
  - Hospital inpatient admissions.
  - All other inpatient admissions (e.g. acute, skilled nursing facility, and rehabilitation).

- **Outpatient Services:**
  - Potentially experimental, investigational, or cosmetic services.
  - Durable medical equipment and any non-standard (i.e. deluxe) DME.
  - Outpatient therapies (physical, occupational, speech, and chiropractic) excluding evaluations.
  - Home health care.
  - Prosthetics.
  - Hospice.
  - Transplantation services.
  - Radiology management (NIA).
  - Other covered procedures/codes.

- **Non Covered Benefits/Procedures**
  - Non covered benefits will not be paid unless special circumstances exists. Always review member benefits to determine covered and non-covered services.

Authorization does not guarantee payment of claims. A service or supply will be reimbursed by Gateway only if it is medically necessary, a covered service, and provided to an eligible member. The authorization process continues to be subject to the maximum unit and program exception policies.

**Online Authorization**

Gateway providers now have the capability to submit authorization requests electronically via NaviNet for the following services:

- Skilled Nursing Facility (SNF) Admission and Continued Stay Review – Medicaid Only.
- Acute Inpatient Admission and Continued Stay Review.
- Notification of Discharge (Acute IP Discharge).
- Behavior Health Admission/Continued Stay Review Psych. – Medicare Only.
- Behavior Health Substance Abuse Admission/Continued Stay Review – Medicare Only.
- Behavior Health Discharge – Medicare Only.
- Behavior Health Outpatient Requests – Medicare Only.
- Chiropractic Visits.
- Durable Medical Equipment (DME) Requests.
- Obstetrical Needs Assessment Form (ONAF).
• Outpatient Therapy PT/OT/ST.
• Private Duty Nurse (PDN) Standard Letter of Medical Necessity (LOMN) – Medicaid Only.
• Rehab Admission and Continued Stay Review – Medicaid Only.

**Note:** You will be able to initiate authorization requests by selecting Gateway under My Health Plans after logging in to NaviNet. Next, you'll select Authorization Submission from the Authorization Submission fly-out menu. Complete the Selection Form by filling in the patient's information and selecting the appropriate category.

Gateway has enhanced the functionality of the electronic authorization feature of the Provider Portal to improve efficiency and by eliminating unnecessary requests for prior authorizations. You can now easily enter the procedure code(s) for the service(s) being requested to determine if a prior authorization is required.

**Calling Utilization Management (UM)**

The UM department can be contacted at 1-800-392-1147 between the hours of 8:30 AM and 4:30 PM, Monday through Friday. When calling before or after operating hours or on holidays, practitioners are asked to leave a voicemail message and a UM Representative will return the call the next business day. Prior authorization is required for scheduled or elective care prior to services being rendered. In the event of urgent or emergent services, the practitioner must notify the plan within three (3) business days from arrival.

The following information is needed to authorize a service. Please have this information available before placing a call to the UM department:

1. Member name.
2. Member’s eight digit Gateway ID number.
3. Diagnosis (ICD Code or precise terminology).
4. Procedure code (CPT-4, HCPCS, or MA coding) or billing codes for durable medical equipment requests.
5. Treatment plan.
6. Date of service.
7. Name of admitting/treating practitioner.
8. Name of the practitioner/provider requesting the authorized treatment.
9. NPI.
10. History of the current illness and treatments.
11. Any other pertinent clinical information.

Failure to follow the prior authorization process may result in the administrative denial of your claim regardless of medical necessity, except in the case of emergently provided services where you attempted to authorize services within three (3) business days from the admission. It is the responsibility of the provider to submit a request for a retrospective authorization when outside of their control, an authorization was not obtained. Along with the authorization the provider must submit justification as to why an authorization was not requested such as the member was
incapacitated, the member provided the wrong insurance information at the time of service, or the procedure meets the definition of requiring emergency stabilization along with all relevant medical records to:

Gateway Health
Attention: Retrospective Authorization
P.O. Box 22278
Pittsburgh, PA 15222
Or by
Fax to: 1-855-501-3904

**Outpatient Imaging Services**

Requests for select outpatient radiological services require prior authorization. Prior authorization is required for the following outpatient imaging procedures:

- CT/CTA.
- CCTA.
- MRI/MRA.
- PET scan.
- Nuclear cardiology/MPI.
- Muga scan.
- Stress echocardiography.

The ordering physician can obtain prior authorization through the NIA Magellan’s website at [www.RadMD.com](http://www.RadMD.com) or by calling into the dedicated toll-free phone number, Monday through Friday 8:00 AM to 8:00 PM at 1-800-424-4890. A separate authorization number is required for each procedure ordered.

**Chiropractic Services**

Any participating practitioner must request prior authorization for chiropractic services by calling Gateway’s UM department at 1-800-392-1147. All visits require authorization by Gateway and must be medically necessary. Member eligibility must be verified prior to rendering services by calling the Member Eligibility Verification Line at 1-800-642-3515. Members may self-refer for chiropractic services; however, the chiropractic office must call Gateway for authorization including the initial evaluation.

All course of treatments are subject to medical necessity determination based on Gateway’s criteria guidelines. All chiropractic services requested for children under the age of thirteen are referred to Gateway’s Medical Director for review. Only one (1) visit per day can be authorized.

Participating chiropractors may not render radiological services in the office. X-rays may only be done at a Gateway participating facility, and no authorization will be given for these services to be done in a chiropractic office setting. Members requiring radiological services (including CT or MRI) or other diagnostic testing should be referred back to their PCP.
Durable Medical Equipment (DME)
Gateway members are eligible to receive any covered and medically necessary durable medical equipment. When ordering durable medical equipment, these procedures are followed:

- An authorization by UM is always required for any item not covered by Medical Assistance, services provided by non-participating DME vendor, or when a miscellaneous code is requested.
- Due to frequent interruptions of Pennsylvania Medical Assistance coverage, Gateway strongly recommends that all providers verify eligibility if the need for an item or service extends beyond the calendar month in which the authorization was given.
- All medical supplies including wound care, ostomy, enteral products, diapers, and incontinence products must be obtained through a contracted DME vendor as opposed to a participating pharmacy.
- Oral enterals must be obtained through a participating durable medical equipment provider. Please do not direct members to retail pharmacies such as Giant Eagle, Rite Aid, etc. for these services.
- Incontinence items will be covered by Gateway without requesting an Explanation of Benefits (EOB) from any other plan.

The following information will provide assistance to offices when ordering durable medical equipment services:

- Patient name, Gateway ID number, prior authorization number (if applicable).
- Durable medical equipment vendor/provider NPI number.
- Ordering practitioner/provider, including NPI number.
- Diagnosis.
- Name of requested equipment, MA fee schedule code, cost.
- Indicate purchase or a rental request.
- Amount of items requested—over what period of time (if requesting rental).
- Clinical information to support the request.

To request a precertification for durable medical equipment, please call Gateway’s UM department at 1-800-392-1147.

Skilled Nursing Facility
Should a member be in need of admission to a nursing facility, the PCP, attending practitioner, hospital Utilization Review Department, or the nursing facility must contact the Gateway UM department at 1-800-392-1147 for new requests to obtain prior authorization. Gateway will coordinate the necessary arrangements between the PCP and the nursing facility to provide the member with continuity and coordination of care.

At the time the Skilled Nursing Facility services are approved, the Gateway UM reviewer will provide the name, phone, and fax number of the PCP in order to fax any discharge instructions to ensure coordination of discharge services.
**Outpatient Therapy Services**

All Outpatient Therapy treatment services including physical therapy, occupational therapy, and speech therapy, cardiac and pulmonary rehab require a prior authorization from Gateway’s UM department. The outpatient therapist or the ordering provider of the therapy must contact Gateway’s UM department to request a precertification by contacting 1-800-392-1147. The therapy provider will be asked to fax the current progress notes, plan of treatment, and goals, which support the medical necessity of the therapy services.

**Acute Inpatient Rehabilitation Facility**

Should a member be in need of admission to an Acute Inpatient Rehabilitation Facility, the PCP, attending practitioner, hospital Utilization Review Department, or the rehabilitation facility must contact the Gateway UM department at 1-800-392-1147 for new requests for a prior authorization. For ongoing reviews, contact your assigned reviewer.

**Home Healthcare**

Gateway encourages the use of home-based services as an alternative to hospitalization when medically appropriate in order to:

- Allow for timely and appropriate discharge from the hospital.
- Avoid unnecessary admissions of members who could effectively be treated at home.
- Permit members to receive care in greater comfort due to familiar surroundings.

Home-based services may include, but are not limited to the following type of services:

- Skilled Nursing
- Speech Therapy
- Hospice
- Home Health Aid
- Physical Therapy
- Infant Care (after initial two postpartum visits)
- Occupational Therapy
- High-Risk Pregnancy
- Social Services

Gateway coordinates medically necessary non-shift care home healthcare needs with the ordering practitioner and the home healthcare provider through prior authorization. Prior authorization is required for all home-based services. Please call Gateway’s UM department at 1-800-392-1147. Authorization is required for all home-based services. Gateway will accept the request for home health request directly from the home health provider.

Due to frequent interruptions of Pennsylvania MA coverage, Gateway strongly recommends verification of eligibility if the need for an item or service extends beyond the calendar month in which the authorization was given.
**Pediatric Shift Care Services**

Gateway’s Special Needs Unit Case Managers staff coordinate medically necessary shift care services with the ordering practitioner and the home healthcare provider through prior authorization. Case Managers can be reached at 1-800-392-1147, follow the prompts to the Special Needs Unit, Private Duty Team. Case Managers can be contacted between the hours of 8:30 AM and 4:30 PM, Monday through Friday.

Should a member be in need of shift care services, the member’s PCP or a specialist rendering care to the member may submit a letter of medical necessity to Gateway’s Special Needs Unit Case Management.

The following information will provide assistance to physicians when ordering shift care services:

- Specify the level of care being requested.
- Specify hours per day being requested and schedule.
- Outline care the member requires assistance with during hours services are being requested.
- Summary of the member’s past medical history including review of current conditions driving need for shift care services, along with prognosis and treatment plan.
- Outline of all caregivers supporting the member’s care.
- If caregiver’s ability to render care is limited, detail, and provide documentation.
- If a caregiver’s availability to render care is limited, detail, and provide documentation.

**Home Infusion**

Nursing visits and supplies related to home infusion services do not require an authorization. Refer to the formulary regarding authorization requirements for infusion drugs.

**Hospice Services**

Should a member be in need of hospice services including: home hospice, inpatient hospice, continuous care, and respite, the PCP, attending physician, or hospice agency should contact Gateway’s UM department. Gateway will coordinate the necessary arrangements between the PCP and the hospice provider in order to assure continuity and coordination of care.

Due to frequent interruptions of Pennsylvania MA coverage, Gateway strongly recommends verification of eligibility if the need for an item or service extends beyond the calendar month in which the authorization was given.

**New Technology**

Any new technology identified during the UM review process, requiring authorization for implementation of the new technology will be forwarded to the Medical Director for authorization. If there is a question about the appropriate governmental agency approval of the technology, the Medical Director will investigate the status of the technology with the agency, consult appropriate specialists related to the new technology, and/or utilize the contracted...
services of Hayes, Inc. for information related to the new technology. If the technology has not been approved by the appropriate governmental regulatory bodies, the Medical Director will discuss the need for the specifically requested technology with the PCP and may consult with a participating specialist from the Gateway expert panel regarding the use of the new technology. If it is determined that no other approved technology is available and/or the Medical Director and consultants feel that the possibility for a positive outcome would be achieved with the use of the new technology, approval may be given with the stipulation that the provider obtain the necessary signatures from the member needed for any investigational treatment/procedures.
Claims and Billing

Member Billing Policy
Payment by Gateway is considered payment in full. Under no circumstance, including but not limited to non-payment by Gateway for approved services, may a provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from or have any recourse against a Gateway member. Per DHS policy #99-10-14, practitioners may not bill MA recipients for missed appointments.

This provision does not prohibit collection of copayments. Refer to the Member Benefit Limitations and Copayments section of this manual for information on copayments. Members cannot be denied a service if they are unable to pay their copayment. Members are responsible up to a maximum of $90 for adult MA and $180 for adult GA every six months. Gateway will reimburse the member for any applicable copays based upon claims submission that exceed the maximum from January through June and again from July through December of each year.

This provision shall not prohibit collection of copayments on Gateway's behalf made in accordance with the terms of the enrollment agreement between Gateway and the member/subscriber/enrollee.

Practitioners may directly bill members for non-covered services; provided, however, that prior to the provision of such non-covered services, the practitioner must inform the member:

- Of the service(s) to be provided.
- That Gateway will not pay for or be liable for said services.
- Of the member’s rights to appeal an adverse coverage decision as fully set forth in the Provider Manual.
- Absent a successful appeal, that member will be financially liable for such services.

Claims

General Information
Procedures for Gateway are as follows:

- Payment for CPT and HCPCS codes are covered to the extent that they are recognized by Medical Assistance. Correct coding (procedure, diagnosis, HCPCS) must be submitted for each service rendered. Gateway utilizes CMS place of service codes to process claims, and they are the only place of service codes that are accepted. Gateway will add new codes to the respective fee schedules effective the first of the month upon receipt of notification from DHS.
- Hospitals should bill on an original UB-04 form, and other providers, including ancillary providers, should bill using an original CMS-1500 form.
• Gateway does accept bills through electronic data interchange (EDI) and encourages facilities and providers to submit claims via this format.
• Correct/current practitioner information, including Gateway provider ID number, must be entered on all claims. The format is five (5) or seven (7) digits.
• Correct/current member information, including Gateway member ID number, must be entered on all claims. The format is six (6) or eight (8) digits.
• Outpatient drug claims billed by dispensing prescribers must include correct and applicable NDCs and units on the claim.
• Please allow four to six weeks for a remittance advice. It is the practitioner’s responsibility to research the status of a claim.
• Gateway does not accept handwritten claims.
• Payment by Gateway is considered payment in full. In no circumstance, including but not limited to non-payment by Gateway for non-approved services may a practitioner bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Gateway member.
• Gateway is the payer of last resort when any commercial or Medicare plan covers the member. Gateway is obligated to process claims involving auto insurance or casualty services as the primary payer if bills do not include a notation or payment by any insurance that is not a commercial or Medicare plan. Claims must be submitted within Gateway’s timely filing guidelines.
• Any reimbursement or coding changes made by DHS to its current inpatient and outpatient fee schedules shall be implemented by Gateway the month DHS notifies Gateway of such change. There will be no adjustments made to previously processed claims due to any retroactive change implemented by DHS.
• Terminated Providers must agree to meet the same terms and conditions as participating Providers to be eligible for payment for services provided to a Gateway Member.

Timely filing criteria for initial bills are one hundred eighty (180) days from the date of service. Corrected claims or requests for review are considered if information is received within the one hundred eighty (180) day follow-up period from the first dated remittance advice.

Timely Filing
Practitioners must submit a complete original, initial CMS-1500 or UB-04 form within one hundred eighty (180) calendar days after the date of service. If you bill on paper Gateway will only accept paper claims on a CMS-1500, or a UB-04 Forms. No other billing forms will be accepted. Paper claims that are not received on original forms with red ink may delay final processing as original forms are required for every claim submission.

All EPSDT claims and primary care services must be submitted within sixty (60) calendar days from the date of service.

Practitioners must bill within sixty (60) days from the date of an EOB from the primary carrier when Gateway is secondary. An original bill along with a copy of the EOB is required to process
the claim. Requests for reviews/corrections of processed claims must be submitted within one hundred eighty (180) days from the date of the corresponding remittance advice. All claims submitted after the one hundred eighty (180) day period for initial claims or after the one hundred eighty (180) day follow-up period from the first dated remittance will be denied.

Any claim that has been submitted to Gateway but does not appear on a remittance advice within sixty (60) days following submission should be researched by the practitioner. Claims status inquiries can be researched via NaviNet.

Exceptions to timely filing criteria are evaluated upon receipt of documentation supporting the request for the exception. Upon approval, exceptions are granted on a one-time basis, and the claim system is noted accordingly.

**Electronic Claims Submission**

Gateway can accept claims electronically through Emdeon or RelayHealth. Gateway encourages practitioners to take advantage of our electronic claims processing capabilities. Submitting claims electronically offers the following benefits:

- Faster claims submission and processing.
- Reduced paperwork.
- Increased claims accuracy.
- Time and cost savings.

For submission of professional or institutional electronic claims for Gateway, please refer to the following grid for Emdeon Payer IDs and RelayHealth CPIDs Clearinghouse Process ID):

<table>
<thead>
<tr>
<th>CPID</th>
<th>PAYER NAME</th>
<th>PAYER ID</th>
<th>CLAIM TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>8472</td>
<td>Gateway HealthSM</td>
<td>25169</td>
<td>Professional</td>
</tr>
<tr>
<td>4569</td>
<td>Gateway HealthSM</td>
<td>25169</td>
<td>Institutional</td>
</tr>
</tbody>
</table>

**Requirements for Submitting Claims to Gateway through Emdeon and RelayHealth**

To submit claims to Gateway please note the Pennsylvania Payer ID Number is 25169. Gateway has a health plan specific edit through Emdeon and RelayHealth for electronic claims that differ from the standard electronic submission format criteria. The edit requires:

- A Gateway assigned 8-digit member identification number, the member number field allows 6, 8, or 12 digits to be entered. For practitioners who do not know the member’s Gateway identification number it is acceptable to submit the member’s Recipient Number on electronic claims.

In addition to edits that may be received from Emdeon and RelayHealth, Gateway has a second level of edits that apply to procedure codes and diagnosis codes. Claims can be successfully transmitted to Emdeon and RelayHealth, but if the codes are not currently valid they will be rejected by Gateway. Practitioners must be diligent in reviewing all acceptance/rejection reports.
to identify claims that may not have successfully been accepted by Emdeon, RelayHealth, and Gateway. Edits applied when claims are received by Gateway will appear on an EDI Report within the initial acceptance report or ClaimsAcknowledgment Report. A claim can be rejected if it does not include an NPI and current procedure and diagnosis codes. To assure that claims have been accepted via EDI, practitioners should receive and review the following reports on a daily basis:

- Emdeon - Provider Daily Statistics (RO22).
- Emdeon - Daily Acceptance Report by Provider (RO26).
- Emdeon - Unprocessed Claim Report (RO59).
- RelayHealth - Claims Acknowledgment Report (CPI 651.01).
- RelayHealth - Exclusion Report (CPI 652.01).
- RelayHealth - Claims Status Report (CPA 425.02).

If you are not submitting claims electronically, please contact your EDI vendor for information on how you can submit claims electronically. You may also call Emdeon directly at 1-877-469-3263 or RelayHealth at 1-800-545-2488.

Gateway will accept electronic claims for services that would be submitted on a standard CMS-1500 (08-05) or a UB-04 Form. Effective October 1, 2017, Gateway will accept electronic COB transactions via 837 processing in accordance with the implementation guides for both 837 Professional and Institutional processing. Submitting COB claims electronically will save providers time and eliminate the need for paper claims with copies of the other payer’s EOB attached. This will increase quality, consistency, and speed of payment.

Please consult with your software vendor to insure they have electronic COB submission capability and work with your EDI vendor to review the HIPAA implementation guide and submission requirements.

The following cannot be submitted as attachments along with electronic claims at this time:

- Services billed by report.
- The PCP referral form (paper version).
- The OB/GYN referral form (paper version).

**Electronic Remittance Advice**

Providers may receive Electronic claims Remittance Advice (ERA). Gateway uses Emdeon to transfer the 835 Version 4010A Healthcare Claim Remittance Advice to claim submitters.

The Companion Documents provide information about the 835 Claim Remittance Advice Transaction that is specific to Gateway and Gateway’s trading partners. Companion Documents are intended to supplement the HIPAA Implementation Guides. Rules for format, content, and field values can be found in the Implementation Guides available on the Washington Publishing Company’s website at www.wpc-edi.com.
Due to the evolving nature of HIPAA regulations, these documents are subject to change. Substantial effort has been taken to minimize conflicts or errors.

There is a distinct data variation between the current Gateway Claims Remittance Advice and the 835 Transaction. The difference occurs in the code sets that tell claim submitters the results of each claim’s adjudication. Few Gateway and HIPAA Adjustment Reason Codes have solid, unambiguous matches at the same level of detail. A crosswalk has been created in attempt to ease the code set transition and can be located on Gateway’s website at [https://www_gatewayhealthplan.com](https://www_gatewayhealthplan.com) and going to “For Providers”, then “Electronic Claims”.

**Claims Review Process**

Gateway will review any claim that a practitioner feels was denied or paid incorrectly. These are requests that are not regarding medical necessity rather are administrative in nature such as, but not limited to, disputes regarding the amount paid, denials regarding lack of modifiers, refunded claim payments due to incorrect payment, or coordination of benefit issues. The request may be conveyed via fax to 1-844-207-0334 if the inquiry relates to an administrative issue. The provider can also submit a request through the Provider Portal via Naivnet. Please forward all the appropriate documentation, i.e. the actual claim in order to expedite the review process. Initial claims that are not received within the one hundred eighty (180) day timely filing limit, or the sixty (60) day limit for EPSDT services, will not qualify for review. All follow-up review requests must be received within one hundred eighty (180) calendar days of the initial remittance advice.

Gateway cannot accept verbal requests to retract claim overpayments. Providers may complete and submit a refund form or a letter that contains all of the information requested on this form. This form has been recently updated and is available in the Form and Reference Material section under Providers on our website.

This form, together with all supporting materials relevant to the claim reversal request being made including but not limited to EOB from other insurance carriers and the refund check should be mailed to the address below.

Claims inquiries for administrative reviews should be mailed to:

Gateway Health  
Attention: Claims Review Department  
Four Gateway Center  
444 Liberty Ave., Suite 2100  
Pittsburgh, PA 15222-1222  
Or Fax: 1-844-207-0334
Coordination of Benefits

Some Gateway recipients have other insurance coverage. Gateway, like the Pennsylvania MA program, is the payer of last resort on claims for services provided to members with other insurance coverage. Gateway may not delay or deny payment of claims unless the probable existence of third party liability is established at the time the claim is submitted.

Note: Effective with claims processed on or after July 1, 2009, Gateway will process and pay EPSDT as primary even when our records indicate Gateway is secondary and a primary plan exists. If an EOB is attached to the EPSDT then coordination of benefits will be applied. We will continue to coordinate benefits and require the primary EOB.

Note: In Compliance with the Bipartisan Budget Act of 2018 (Pub. L. 115-123) and the PA Department of Human Services (DHS) cost avoidance for claims for prenatal services, effective with claims processed on or after April 1, 2019, providers are required to utilize the member’s third party resource(s) prior to submitting claims for prenatal services to Gateway. The CMS bulletin on this topic can be located at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib060118.pdf

All prenatal claims must have the primary EOB attached for payment consideration. If a claim is received and no EOB is attached and the services are related to prenatal the claim will deny, D192 - DENIED- RESUBMIT PRENATAL SERVICES WITH DELIVERY CHARGE AND PRIMARY EOB. IF the members primary pays globally all delivery claims will need to include office visits. The delivery charge must be on the first line and office visits should be billed on additional lines. Coordination will begin with the delivery line. No office visit will deny for timely filing when the delivery claim is received within the timely allowance for EOB submission. Procedure codes do not have to match the primary EOB. Please be aware that secondary coverage for covered fee-for-service items is provided according to a benefit-less-benefit calculation.

In order to receive payment for services provided to members with other insurance coverage, the practitioner must first bill the member’s primary insurance carrier using the standard procedures required by the carrier. Upon receipt of the primary insurance carrier’s EOB, the practitioner should submit a claim to Gateway. The practitioner must:

1. Follow all Gateway referral and authorization procedures.
2. File all claims within timely filing limits as required by the primary insurance carrier.
3. Submit a copy of the primary carrier’s EOB with the claim to Gateway within sixty (60) days of the date of the primary carrier’s EOB.
4. Be aware that secondary coverage for covered fee-for-service items is provided according to a benefit-less-benefit calculation.
5. The amount billed to Gateway must match the amount billed to the primary carrier. Gateway will coordinate benefits; the provider should not attempt to do this prior to submitting claims.

Per DHS, Gateway is considered the primary insurer when auto or casualty claims are involved. When a claim is submitted by a practitioner without an EOB from the auto insurance or a casualty plan, and the original bill does not include any notation of a primary payer payment, Gateway
must take a primary position on the claim and not deny to the extent that plan criteria was followed. The practitioner has the option of submitting an original claim, however it must be submitted within one hundred eighty (180) days. These claims will be denied for timely filing if they are not received within one hundred eighty (180) days of service. The sixty (60) day rule for Third Party Liability does apply to auto and casualty when the practitioner attaches either an EOB or auto casualty exhaustion letter. If the practitioner submits the claim with the EOB, Gateway will coordinate benefits, however, if the EOB is submitted after Gateway has paid as the primary insurance plan, Gateway shall return overpayment to DHS.

If a member indicates they no longer have primary coverage, but the State System contains information indicating other medical coverage is still active, the member should contact his or her caseworker to have the State System updated. If this is not possible, the practitioner may contact the primary carrier and request written verification of the coverage.

When Gateway receives a letter from the primary carrier indicating that the member no longer has coverage, Gateway will use the letter to investigate the situation and verify if the coverage is cancelled and if there is a new plan covering the member. If Gateway’s investigation confirms that the member no longer has primary coverage, Gateway will submit an electronic request to the state to update the system. Gateway will update our system immediately and reprocess claims finalized within the one hundred eighty day period prior to the date of the onset of the investigation.

Gateway is a payer of last resort when any commercial or Medicare plan covers the member. Gateway is obligated to process claims involving auto insurance or casualty services as the primary payer if bills do not include a notation or payment by any insurance that is not a commercial or Medicare plan. Claims must be submitted within Gateway’s timely filing guidelines.

Gateway’s claims processing procedures comply with the department’s third party liability requirements in neither delaying nor denying payment of otherwise covered treatment or services unless the probable existence of third party liability is identified in Gateway’s records for the member at the time the claims are submitted. Gateway is obligated to pay and chase collection for services that may be covered by commercial plans when Gateway has paid as primary and there is other insurance on the member record.

**Primary Care Services**

PCPs are required to report all the services they provide for Gateway members to Gateway. To facilitate reporting, Gateway will accept encounter information on the CMS-1500 Form or the claim can be submitted via EDI. Charges for encounters/visits should be submitted within sixty (60) days from the date of service but will be accepted up to one hundred eighty (180) days from the date of service. The encounter information will be reported back to the primary care practitioner on a remittance advice. Capitated services will show a payment amount of zero. Services reimbursed outside of the base capitation will indicate a payment amount and will include a check for the sum of the services provided.

Capitated PCPs will receive full capitation payment from Gateway for those members with other
insurance coverage. Secondary coverage for all primary care services, including any deductible or co-insurance amounts not covered by the primary carrier, will be covered by the Gateway capitation payment. Practitioners are required to report all services provided to Gateway members by submitting a claim with a copy of the EOB regardless of whether or not additional payment is expected. Members seeking care, regardless of primary insurer, are required to contact their primary care practitioner and use participating practitioners or obtain appropriate authorization for practitioners outside of the network.

All MA eligible recipients under nineteen (19) years of age are eligible for Vaccines For Children (VFC) vaccines. Providers should follow the CDC’s recommendations about implementing a two-directional borrowing policy when vaccine supplies are depleted. For this policy, providers purchase an initial inventory of appropriate private stock vaccines, and if the private stock vaccine is not used and is nearing the expiration date, the clinic can use the private stock on VFC eligible children and document on the borrowing form that private stock vaccine was administered to a VFC-eligible child because the private stock was short-dated. The clinic can then replace the used private stock with VFC vaccine and document when that private stock was replaced.

Since April, 2010 Gateway has reimbursed those Primary PCPs properly certified for the application of topical fluoride varnish a fee-for-service payment for rendering this service. Only those PCPs who received a certificate for completing the on-line training module titled "Oral Health Risk Assessment" qualified for the fee-for-service reimbursement. Gateway has been notified that the “Oral Health Risk Assessment” training module has been discontinued and replaced with the Society of Teachers of Family Medicine’s “Smiles for Life” continuing medical education (CME) course. (Refer to MA Bulletin 09-12-27, 31-12-27). If you’ve already completed the "Oral Health Risk Assessment" on-line training recertification through the “Smiles for Life” is not required.

Physicians interested in providing topical fluoride varnish in the office for their Gateway PA Medicaid patients under the age of five and receive the $18.00 reimbursement must submit a copy of the training certificate to:

Gateway Health
Attention: Provider Relations Department
444 Liberty Avenue, Suite 2100
Pittsburgh, Pa 15222-1222
Or fax to 1-855-451-6680

At the top of the certificate, please include your thirteen digit MA provider identification number and/or Gateway Individual Provider Number. PCPs will not be reimbursed for providing the topical fluoride varnish before we have a copy of the training certificate on file. Your practice will receive written notification confirming receipt of your certificate and provide a date when you may begin billing procedure code 99188 and receive reimbursement.
**Specialty/Fee-For-Service Providers**

If a member has other coverage, the other carrier is always the primary insurer. The specialist will bill the other insurer and the other insurer will issue payment with an EOB statement (EOB), which outlines the payment made for each procedure. The specialist will then submit a copy of the EOB with a copy of the claim to Gateway for secondary coverage. The claim must be received by Gateway within sixty (60) days of the date of the EOB. If required, all Gateway authorization and referral requirements must be met in order for payment to be issued. If the member has commercial insurance, and the commercial carrier’s payment is greater than Gateway’s payment if Gateway were primary, then the following reimbursement example would apply. The primary carrier amount is the basis for the benefit determination of Gateway’s liability when the practitioner is a participating practitioner with the primary plan. The primary carrier allowable paid amount is used as the basis for the benefit determination of Gateway’s liability when there is a patient responsibility remaining after the primary carrier has processed the claim.

**Example of Practitioner Participating with Primary Plan:**

<table>
<thead>
<tr>
<th>Practitioner Charges</th>
<th>$1,500.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Carrier Allowable</td>
<td>$1,000.00</td>
</tr>
<tr>
<td>Primary Payment (80% of Allowable)</td>
<td>$800.00</td>
</tr>
<tr>
<td>Gateway Allowable if Primary</td>
<td>$600.00</td>
</tr>
<tr>
<td>Gateway compares the Primary Carrier Payment to the Gateway Allowable</td>
<td>$800.00 vs. $600.00</td>
</tr>
<tr>
<td>Gateway does not issue payment</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**Example of Patient Responsibility remaining after Primary Plan Payment:**

<table>
<thead>
<tr>
<th>Practitioner Charges</th>
<th>$1,500.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Allowable</td>
<td>$1,000.00</td>
</tr>
<tr>
<td>Primary Payment (80% of Allowable)</td>
<td>$800.00</td>
</tr>
<tr>
<td>Patient Responsibility Under Primary Plan</td>
<td>$200.00</td>
</tr>
<tr>
<td>Gateway Allowable if Primary</td>
<td>$850.00</td>
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<tr>
<td>Gateway compares the Primary Carrier Payment to the Gateway Allowable</td>
<td>$800.00 vs. $850.00</td>
</tr>
<tr>
<td>Gateway Issues Payment</td>
<td>$50.00</td>
</tr>
</tbody>
</table>

**Medicare**

Gateway member’s twenty-one (21) or younger may have Medicare Fee-For-Service. When Medicare is the other insurance, the following processing criteria applies:

- Referrals and authorizations are not required for services covered by Medicare. Once Medicare benefits have been exhausted, or if a service is not covered by Medicare, Gateway referral and authorization criteria will apply.
- For Medicare Part A and Medicare Part B services, coverage is provided according to a benefits-less-benefits calculation.

Gateway determines the amount that would normally be paid under the plan using the allowable amount from the Medicare Plan as the billed amount. If the amount Gateway would pay is more than the amount Medicare pays, then Gateway may pay the difference up to the maximum allowable, contingent on the benefit-less-benefit calculation. If the amount Gateway would pay is equal to or less than the amount Medicare pays, Gateway does not issue any additional payment. For Medicare services that are not covered by MA or Gateway, Gateway must pay cost sharing to
the extent that the payment made under Medicare for the service and the payment made by Gateway does not exceed 80% of the Medicare approved amount.

<table>
<thead>
<tr>
<th>Example A</th>
<th>Example B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner Charges</td>
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</tr>
<tr>
<td>Deductible is Satisfied</td>
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</tr>
<tr>
<td>Medicare Allowable</td>
<td>$1,000.00</td>
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<tr>
<td>Medicare Payment (80% of Allowable)</td>
<td>$800.00</td>
</tr>
<tr>
<td>Gateway Allowable if Primary</td>
<td>$600.00</td>
</tr>
<tr>
<td>Gateway compares the Medicare Payment to the Gateway Allowable</td>
<td>$800.00 vs. $600.00</td>
</tr>
<tr>
<td>Gateway does not issue payment</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Example C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner Charges</td>
</tr>
<tr>
<td>Medicare Allowable</td>
</tr>
<tr>
<td>Medicare Applies $50.00 to Satisfy the Deductible</td>
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<tr>
<td>Medicare Payment (80% of Allowable) Remaining After Deductible is Satisfied</td>
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<tr>
<td>Gateway Allowable if Primary</td>
</tr>
<tr>
<td>Gateway compares the Medicare Payment to the Gateway Allowable</td>
</tr>
<tr>
<td>Gateway Issues Payment for the Difference</td>
</tr>
</tbody>
</table>

**Private Duty Nursing**

Gateway coordinates benefits with a commercial plan using a benefits-less-benefits approach for limited nursing care services and for expanded services. However, for these specific services only, the total amount billed to the primary plan will be the basis for the benefit determination of Gateway’s liability.

<table>
<thead>
<tr>
<th>Example A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Charges</td>
</tr>
<tr>
<td>Primary Carrier Allowance</td>
</tr>
<tr>
<td>Primary Carrier Payment</td>
</tr>
<tr>
<td>Gateway Allowable If Primary</td>
</tr>
<tr>
<td>Gateway compares the Primary Carrier Payment to the Gateway Allowable</td>
</tr>
<tr>
<td>Gateway Issues Payment</td>
</tr>
</tbody>
</table>

Gateway’s normal claims processing procedures for members with other primary insurance require that a primary carrier EOB be submitted for each date of service.

In an effort to improve provider cash flow and to facilitate administrative procedures, Gateway provides an optional EOB exception process for extended nursing services. When the primary carrier has denied all extended nursing services, providers can submit the primary carrier’s denial letter to Gateway. Gateway will determine if the letter is accepted in lieu of EOBs for a defined period of time. This procedure eliminates the need to submit primary carrier EOBs with

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**Claims and Billing**
each claim submitted to Gateway. Gateway’s exception procedure for nursing services is as follows:

1. Submit medical records to the review committee of the primary insurance plan. Please allow adequate time for the review to be completed prior to the onset of services that you want Gateway to consider for primary coverage. Upon receipt of the letter from the primary plan, please forward to a Gateway Claims Reviewer at:

   Gateway HealthSM
   Attention: Claims Review Department
   Four Gateway Center
   444 Liberty Avenue, Suite 2100
   Pittsburgh, PA 15222-1222

   Faxed correspondence will not be accepted. Letters must be received by Gateway within one month of the date on the denial letter. (See examples #1 and #2 following). Gateway’s review will be completed within three weeks of receipt.

2. Following the review, Gateway will send written documentation advising the provider if the letter was accepted. If the denial letter is now accepted, EOBs must be submitted with each claim to Gateway.

3. If Gateway takes a primary position, the time period for which the letter has been accepted will be specified in the letter sent to you. Beginning April 1, 2004, when Gateway accepts a denial letter and takes a primary position, it will be valid for the balance of the calendar year. The provider would need to submit another denial letter the beginning of the next calendar year. When benefits are exhausted under the primary carrier or whenever there is a change of coverage during a calendar year, the process for EOBs/denial letters will need to be re-assessed (See Example #3). If there are gaps in the allowable time period, any services rendered during the time period not covered by the allowable dates in the exception letter will require that EOBs be submitted from the primary plan, or Gateway will not be able to coordinate benefits for those charges.

4. In order for claims to be processed without delay, the services billed must align with the correct dates of services and procedure codes authorized and in accordance with Gateway’s Private Duty Nursing Billing Guidelines.

5. For each patient, either EOBs or the EOB exception process must be consistently followed.

Example #1

Examples #2
Gateway determination – Gateway will require EOBS since nursing services exception letter was not received in thirty (30) days.

Example #3
EOBs received from primary insurance for January, February, and March. Benefits exhausted on March 25, 2004. Provider can continue to submit EOBS or revert to nursing services exception procedures for balance of calendar year.

Autism Act Claims Processing Procedures for Physical Therapy, Speech Therapy, and/or Occupational Therapy.

These procedures are effective July 1, 2009 for members under age twenty-one and the following criteria applies:
- Precertification/Authorization through Gateway’s UM department is required.
- Gateway will require a primary plan EOB.
  - If primary plan $36,000 annual payment limit has expired, EOB must include applicable denial.
  - If primary plan is a self-funded plan, EOB must include wording on the EOB.
- An alternate letter process rather than an EOB will be required annually to request exemption and will apply to this procedure as follows:
  - If Gateway is notified that the other insurance company is a self-funded plan and is exempt from the Autism Act, Gateway will require a letter from the insurance company. The letter will be evaluated for approval or denial. Letters should be sent directly to Gateway’s Claims Quality Review Department rather than the P.O. Box and should include the following wording:
    - Based on the Autism Insurance Act 62, the member is covered under XXXXX (Name of Company) and this is a self-funded plan.

Subrogation
According to Gateway’s agreement with DHS, if a member is injured or becomes ill through the act of a third party, medical expenses may be covered by casualty insurance, liability insurance, or litigation. Any correspondence or inquiry forwarded to Gateway by an attorney, practitioner of service, insurance carrier, etc. relating to a personal injury accident or trauma-related medical service, or which in any way indicates that there is, or may be, legal involvement, will be handled by Gateway’s Legal Department and will be forwarded to DHS’ Third Party Liability Department.

Claims submitted by a provider and without an EOB statement from auto insurance or casualty plans without any notation on the original bill of the primary payer, will be processed by Gateway similar to any other claims. Gateway may neither unreasonably delay payment nor deny payment of claims because they are involved in injury stemming from an accident, such as a motor vehicle accident, where the services are otherwise covered. Timely filing criteria of one hundred eighty (180) days applies and original claims must be received timely to be eligible for payment. EOB or auto/workers compensation/casualty exhaustion letters qualify for consideration if they are
received within 60 days of the date of the EOB/letter along with submission of the initial bill in order for Gateway to coordinate benefits.

However, if the auto/casualty EOB is submitted after Gateway has already paid as primary, claims cannot be adjusted, as Gateway must comply with criteria set by DHS.

All requests from legal representatives, and/or insurers for information concerning copies of patient bills or medical records must be submitted to Gateway’s legal department.

A cover letter identifying the date and description of the injury, requested dates of services for billing statements, and release of information signed by the member should be forwarded to the following address:

Gateway Health℠
Attention: Payment Integrity
Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222

Claim Coding Software
Gateway uses a fully automated coding review product that programmatically evaluates claim payments to verify the clinical accuracy of professional claims in accordance with clinical editing criteria. This coding program contains complete sets of rules that correspond to CPT-4, HCPCS, ICD-10, AMA, and CMS guidelines as well as industry standards, medical policy, and literature and academic affiliations. The program used at Gateway is designed to assure data integrity for ongoing data analysis and reviews procedures across dates of service and across providers at the claim, practitioner, and practitioner-specialty level.

Billing

Billing Procedures
A “clean claim” as used in this section means a claim for payment for a healthcare service that has no defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. A claim from a healthcare provider who is under investigation for fraud or abuse regarding that claim will not be considered a “clean claim”.

In addition, a claim shall be considered “clean” if the appropriate corresponding referral has been submitted or the appropriate authorization has been obtained in compliance with Gateway’s Policy and Procedure Manual and the following elements of information are furnished on a standard UB-04 or CMS-1500 form (or their replacement with CMS designations, as applicable) or an acceptable electronic format through a Gateway contracted clearinghouse:

1. Patient name.
2. Patient medical plan identifier.
3. Date of service for each covered service.
4. Description of covered services rendered using valid coding and abbreviated description.
5. ICD-10 surgical diagnosis code (as applicable).
6. Name of practitioner/provider and plan identifier.
7. Provider tax identification number.
8. Valid CMS place of service code.
9. Billed charge amount for each covered service.
10. Primary carrier EOB when patient has other insurance.
11. All applicable ICD-10-CM diagnosis codes—inpatient claims include diagnoses at the time of discharge or in the case of emergency room claims, the presenting ICD-10-CM diagnosis code.
12. DRG code for inpatient hospital claims.

Providers are encouraged to refer to the DHS Provider Quick Tips for Reporting Diagnosis Codes for Immunization Administration.

Gateway processes medical expenses upon receipt of a correctly completed CMS form and hospital expenses upon receipt of a correctly completed UB-04. Sample copies of a UB-04 and a CMS form can be found in the Forms and Reference Material section of this manual. A description of each of the required fields for each form is identified later in this section. Paper claim forms must be submitted on original forms printed with red ink.

A claim without valid, legible information in all mandatory categories is subject to rejection/denial. To assure reimbursement to the correct payee, the Gateway practitioner number must be included on every claim.

To comply with encounter data reporting, PCPs and specialty care practitioner must submit claims under the individual practitioner identification number rather than the practice or group identification number. CMS submissions for anesthesiology, pathology, radiology, and emergency room practitioner groups must also include the individual practitioner identification number. Any claim billed on a CMS form must include the individual practitioner identification number (box 31 on the CMS form). Please note that it is extremely important to promptly notify Gateway of any change that involves adding practitioners to any group practice, as failure to do so may result in a denial of service. Gateway will process claims utilizing individual practitioner numbers even if the individual practitioner number is not included on the claim. The only exception to the individual practitioner number requirement applies to UB charges for practitioner services when a remittance advice is issued to a hospital facility.

All claims must have complete and accurate ICD-10-CM diagnosis codes for claims consideration. If the diagnosis code requires, but does not include the fourth or fifth digit classification, the claim will be denied.

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. By signing a claim for services, the practitioner certifies that
the services shown on the claim were medically indicated and necessary for the health of the patient and were personally furnished by the practitioner or an employee under the practitioner’s direction. The practitioner certifies that the information contained in the claim is true, accurate, and complete.

Gateway’s Claim office address is”

Gateway Health℠
Attention: Claims Processing Department
P.O. Box 830249
Birmingham, AL 35283-0249

Any questions concerning billing procedures or claim payments can be directed to Gateway’s Provider Services Department at 1-800-392-1147.

Federally Qualified Health Centers/Rural Health Centers

Overview
Effective January 1, 2016, Gateway will pay all Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) rate(s) that are not less than the Fee-for-Service Prospective Payment System (PPS) rate(s), as determined by DHS. Beginning on or after December 1, 2016, Gateway will also make a payment separate from the PPS rate(s) to any FQHC that has opted–in to the Alternative Payment Methodology for inpatient deliveries. If HRSA approves a request for a change in scope of services involving the addition of a service that has never been provided or the discontinuance of an existing service, the FQHC must notify Gateway of the change in scope of services within 30 days of the issue date identified in block 1 of HRSA’s Notice of Grant Award. Additionally, any interim rate letter(s) received from PA DHS must be forwarded to Gateway within 10 days of receipt. These notifications should be directed via email to the attention of the assigned Gateway FQHC/RHC Contracting and Servicing Consultant, while also copying the following: GHPFinanceDHSInbox@GatewayHealthPlan.com and GHPContractMonitoringTeam@gatewayhealthplan.com.

The information below is intended as a reference for Medical Service Encounters only (Behavioral Health services must be billed to the BH-MCO in your county) for Gateway Pennsylvania Medicaid members. Providers should refer to Gateway’s dental benefit dental provider, United Concordia Dental (UCD), for instructions on submitting Dental Service Encounters.

Encounter Definition
Rates are charged for each encounter. An eligible encounter is defined as:
A. Medical Service Encounter: An encounter between a medical provider and a patient during which medical services are provided for the prevention, diagnosis, treatment, or rehabilitation of illness or injury. Family planning encounters and obstetrical encounters are a subset of medical encounters.
   i. Eligible Providers include:
      1. Physician (including Podiatrists)
      2. Mid-level Practitioners:
Claim Submission

- FQHCs and RHCs may submit claims for medical encounters provided to Gateway members on paper, CMS 1500 forms, or electronic 837P claim forms.
- Gateway encourages our FQHC/RHC providers to submit physician charges on CMS 1500 forms.
- Include the **Group Name**, Gateway group legacy # (not required but helpful) and **Group NPI#** in the equivalent of box 33 provider billing information field on the HCFA form. Remember to include the **rendering physician’s name** in box 31 with the rendering NPI in box 24j.
- PA/CRNPs CANNOT bill alone under Medicaid LOB, and MUST bill under the supervising physician.
  - **Reminder:** ALL practitioners MUST come over on the roster and be setup in Gateway’s credentialing/claims systems PRIOR to rendering service.
  - ALL FQHC/RHCs must have a collaborative agreement on file between the physician and extender(s) on staff.
- **The encounter code T1015 must be listed in addition to the related fee-for-service procedure codes in order for the claim to process.** This is essential for services needed to measure the quality of care provided, such as immunization codes and in office labs like Hemoglobin A1c and urine protein tests for diabetics. Total charges for the encounter should be billed with code T1015. **Claims submitted with just the T1015 will not be paid.**
- When processing Commercial and Gateway FQHC provider claims, the member information and DOS must match on both the claim & EOB claim when submitted to Gateway for COB purposes.
- A claim shall not be considered a clean claim unless and until it includes all information required including but not limited to, procedure codes for all services rendered during the visit, appropriate place of service codes, and complete diagnosis codes regardless of expected payment.
- All EPSDT screening services including vaccine administration fees are to be submitted to Gateway Health on a CMS-1500 or the corresponding 837P format for EDI claims within 60 days from the date of service.
- An EPSDT screen is complete when codes from each service area required for that age, including the appropriate evaluation and management codes are documented.
- EPSDT Claims will pay only if the appropriate evaluation and management code along with the EP modifier are submitted.
- As a reminder, FQHCs are “not permitted” to do incomplete screenings per EPSDT regulations. An ENTIRE EPSDT screening is required.
Multiple Encounter Submission

- Encounters with more than one eligible practitioner and multiple encounters with the same eligible practitioner that take place on the same date, at a single location, and that have the same diagnosis constitute a single encounter. The following two conditions are recognized for payment of more than one encounter rate on the same day:
  - After the first encounter, the member suffers a different illness or injury requiring additional diagnosis or treatment.
  - The patient has a medical visit, a behavioral health visit, or a dental visit on the same day.

- The medical necessity of multiple encounters must be clearly documented in the medical record. Providers must exercise caution when billing for multiple encounters on the same day, and such instances are subject to post-payment review to determine the validity and appropriateness of multiple encounters.

- Providers may not inappropriately generate multiple encounters by unbundling services that are routinely provided together during a single visit or scheduling multiple patient visits for services that could be performed at a single visit.

- Include only one encounter per claim. Claims with more than one encounter listed will be denied. When billing for more than one encounter per day, submit one claim for each encounter. On each claim, to indicate it is a separate encounter, enter “unrelated diagnosis” and the time of both visits in field 19 on the 1500 claim form or in the comments field when billing electronically.

- Documentation for all encounters must be kept in the member’s file.

Keeping your FQHC/RHC Roster current can help eliminate D22 or D47 denials
Please refer to the FQHC/RHC Roster Template Instructions and FQHC/RHC Roster Template which can be found on the Gateway Health website at www.gatewayhealthplan.com, under the Provider section, Provider Resources, FQHC-RHC Recourses

Department of Health and Human Services Centers for Medicare & Medicaid Services FQHC/RHC Billing References:

FQHC Medicare Billing
CMS FQHC Specific Payment G-HCPCS Codes - Preventive Health Services and Medical Health Services


RHC Medicare Billing
CMS RHC Specific Payment 9 series & G-HCPCS Codes - Preventive Health Services and Medical Health Services

Obstetrical Care Services
The first visit with an obstetrical patient is considered the intake visit, or if a patient becomes a Gateway member during the course of her pregnancy, her first visit as a Gateway member is considered to be her intake visit. At the intake visit, an ONAF must be completed. A copy of the ONAF must be submitted to Gateway’s MOM Matters® Department within two (2) to five (5) business days of the intake visit and at least thirty (30) days prior to delivery. The ONAF is not a claim, however, the ONAF must be received by Gateway in order to process the claim for the intake visit. Submit claims on a CMS-1500 within one hundred eighty (180) days to receive payment for the intake package. The intake package code is T1001-U9.

Obstetric practitioners are reimbursed on a per visit basis. All visits and dates of service must be included on the CMS-1500 form and identified with appropriate maternity codes for appropriate reimbursement. Delivery charges are to be coded with CPT codes. The date billed for a delivery code, in CPT code format, must be the actual date of service.

All charges for newborns that become enrolled in the plan are processed under the newborn name and newborn’s Gateway identification number. For prompt payment, please submit claims with the newborn patient information or the claim will be pended for manual research. Inpatient hospital bills for newborns should be submitted separately from the Mom’s confinement. Per diem payments for inpatient maternity services that cover the confinement for both Mom and baby will be issued under the mother’s Gateway identification number and the newborn’s claim will be processed for informational purposes only.

Surgical Procedure Services
Gateway reimburses surgical procedures billed by physicians in accordance with industry standard protocols and limits payment to a maximum of three (3) surgical procedures/operating sessions. Gateway determines reimbursement upon the clinical intensity of each procedure and reimburses at 100% for the most clinically intensive surgery, and 50% for the second and third procedures. Pre- and post-operative visits will only be reimbursed to the extent that they qualify for payment according to the follow-up criteria, regardless of whether a referral is on file or not.

An assistant surgeon may bill for one procedure per date of service, and will be reimbursed at twenty (20) percent of Gateway’s maximum allowable fee, as long as the surgical procedure code allows an assistant surgeon to be present for the surgery. If the assistant surgeon charges are submitted under the supervising physicians name, the AS modifier indicating this was a physician’s assistant must be included on the claim.

Anesthesia Services
Gateway processes anesthesia services based on anesthesia procedure codes only.
• All services must be billed in minutes. Fractions of a minute should be rounded to whole minutes (thirty (30) seconds or greater: round up; less than thirty (30) seconds: round
For billing purposes, the number of minutes of anesthesia time will be placed in space 24G on the CMS-1500 for providers who bill in paper format.

**Hospital Services**

Hospital claims are submitted to Gateway on a UB-04 form. To assure that claims are processed for the correct member, the member’s eight digit Gateway identification number must be used on all claims. Practitioners rendering services in an outpatient hospital clinic should include the group practice number of the practitioner’s group on the claim when submitting on a UB-04, while individual practitioner number must be reported when submitting claims on a CMS-1500 form. To aid in the recording of payment, patient account numbers recorded on the claim form by the practitioner are indicated in the Patient ID field on the Gateway remittance advice.


**UB-04 Data Elements for Submission of Claims for Paper Claims**

EDI Requirements Must be Followed for Electronic Claims Submissions

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Practitioner Name, Address, Phone Number</td>
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<td>2</td>
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<tr>
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<tr>
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<td>Statement Covers Period</td>
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<td>Covered Days</td>
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</tr>
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<td>8</td>
<td>Non-covered Days</td>
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</tr>
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<td>Coinsurance Days</td>
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<td>32-35</td>
<td>Occurrence Codes and Dates</td>
<td>Minimum of One Required, If Applicable</td>
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<td>36</td>
<td>Occurrence Span Codes and Dates</td>
<td>Minimum of One Required, If Applicable</td>
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<td>Internal Control Number</td>
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<td>38</td>
<td>Responsible Party Name and Address</td>
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<td>39-41</td>
<td>Value Codes and Amounts</td>
<td>Required for DRG Reimbursement, Value Code Record Type 41 must be entered as ZZ and DRG Code must be entered in Value Amount Field</td>
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<td>Revenue Codes</td>
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<td>Descriptions</td>
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<td>HCPCS/Rates</td>
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<td>Non-covered Charges</td>
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<td>Practitioner Number</td>
<td>Gateway HealthSM Practitioner Identification Number Required</td>
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<td>Release of Information Certification Indicator</td>
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<td>Assignment of Benefits</td>
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<td>Prior Payments</td>
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<td>Insured’s Name</td>
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<td>59</td>
<td>Patient Relationship to Insured</td>
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<td>60</td>
<td>Certificate-Social Security Number-Health Insurance Claim-Identification Number</td>
<td>Gateway Member Identification Number Required (10-digit MA Recipient Number acceptable for electronic claims)</td>
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<td>Group Name</td>
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<td>Treatment Authorization Code</td>
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<td>Employment Status Codes</td>
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<td>Employer Location</td>
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<td>Principal Diagnosis Code</td>
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<td>68-75</td>
<td>Other Diagnosis Codes</td>
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<td>76</td>
<td>Admitting Diagnosis Code</td>
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<td>Procedure Code Method Used</td>
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<td>80</td>
<td>Principal Procedure Code and Date</td>
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### Claims and Billing

**CMS 1500 Data Elements for Submission of Claims for Paper Claims**

**EDI Requirements Must be Followed for Electronic Claims Submissions**

<table>
<thead>
<tr>
<th>Field #</th>
<th>Description</th>
<th>Requirements</th>
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<tbody>
<tr>
<td>1</td>
<td>Insurance Type</td>
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<td>1a</td>
<td>Insured Identification Number</td>
<td>Gateway Health Member Identification Number Required (10-digit MA Recipient Number acceptable for Electronic Claims)</td>
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<td>2</td>
<td>Patient’s Name</td>
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<td>3</td>
<td>Patient’s Birth Date</td>
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<td>4</td>
<td>Insured’s Name</td>
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<td>Patient’s Address</td>
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<td>Patient Status</td>
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<tr>
<td>9</td>
<td>Other Insured’s Name</td>
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<tr>
<td>9a</td>
<td>Other Insured’s Policy or Group Number</td>
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<tr>
<td>9b</td>
<td>Other Insured’s Date of Birth, Sex</td>
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<tr>
<td>9c</td>
<td>Employer’s Name or School Name</td>
<td>Required, if Applicable</td>
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<tr>
<td>9d</td>
<td>Insurance Plan Name or Program Name</td>
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<tr>
<td>10d</td>
<td>Reserved for Local Use</td>
<td>Not Required (see instructions for EPSDT claims instructions)</td>
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<td>11</td>
<td>Insured’s Policy Group or FECA Number</td>
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<tr>
<td>11a</td>
<td>Insured’s Date of Birth, Sex</td>
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</tr>
<tr>
<td>11b</td>
<td>Employer’s Name or School Name</td>
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<td>11c</td>
<td>Insurance Plan Name or Program Name</td>
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<td>11d</td>
<td>Is There Another Health Benefit Plan?</td>
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<td>12</td>
<td>Patient or Authorized Person’s Signature</td>
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<td>13</td>
<td>Insured’s or Authorized Person’s Signature</td>
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<td>14</td>
<td>Date of Current Illness OR Injury OR Pregnancy</td>
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<td>15</td>
<td>If Patient has had Same or Similar Illness, Give First Date</td>
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<td>16</td>
<td>Dates Patient Unable to Work in Current Occupation</td>
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<td>17</td>
<td>Name of Referring Practitioner or Other Source</td>
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<td>17a</td>
<td>Identification Number of Referring Practitioner</td>
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<td>18</td>
<td>Hospitalization Dates Related to Current Services</td>
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<td>19</td>
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<td>Outside Lab</td>
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<td>Diagnosis or Nature of illness or injury</td>
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<td>Medical Resubmission Code</td>
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<td>Date(s) of Service</td>
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<td>Place of Service</td>
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<td>Type of Service</td>
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<td>Procedures, Services, or Supplies CPT/HPCS/Modifier</td>
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<td>Diagnosis Code</td>
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<td>24f</td>
<td>Charges</td>
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<td>24g</td>
<td>Days or Units</td>
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<td>24h</td>
<td>EPSDT Family Plan</td>
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<td>24i</td>
<td>EMG</td>
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<tr>
<td>24j</td>
<td>COB</td>
<td>Not Required for Gateway Primary Claims</td>
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<td>Requirements</td>
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<td>30</td>
<td>Balance Due</td>
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<tr>
<td>31</td>
<td>Signature of Practitioner or Supplier including degrees or credentials</td>
<td>Gateway Individual Practitioner Name and Date Required</td>
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<tr>
<td>32</td>
<td>Name and Address of Facility Where Services were Rendered</td>
<td>Name and Address Required</td>
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<tr>
<td>33</td>
<td>Practitioner’s, Supplier’s Billing Name, Address, Zip Code and Phone Number</td>
<td>Gateway Vendor Name, Address, and Number Required</td>
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</table>
Complaints, Grievances, and Fair Hearings

If a provider or Gateway does something that you are unhappy about or do not agree with, you can tell Gateway or DHS what you are unhappy about or that you disagree with what the provider or Gateway has done. This section describes what you can do and what will happen.

**COMPLAINTS**

What is a complaint?
A complaint is when you tell us you are unhappy with Gateway, your provider, or do not agree with a decision by Gateway.

Some things you may complain about:
- You are unhappy with the care you are receiving.
- You cannot get the service or item you want because it is not a covered service or item.
- You have not gotten services that Gateway has approved.

What should I do if I have a complaint?

**First Level Complaint**

To file a complaint, you can:
- Call Gateway at 1-800-392-1147/TTY 711 (1-800-654-5984) and tell us your complaint, or
- Write down your complaint and send it to us at:

  Gateway Health
  Attn: Appeals & Grievance
  P.O. Box 22278
  Pittsburgh, PA 15222, or
  Fax: 412-255-4503

- If you received a notice from Gateway telling you Gateway’s decision and the notice included a Complaint/Grievance Request Form, fill out the form and send it to Gateway by mail or fax.
- Your provider can file a complaint for you if you give the provider your consent in writing to do so.

When should I file a first level complaint?

Some complaints have a time limit on filing. You must file a complaint within sixty (60) calendar days of getting a letter telling you that:
- Gateway has decided that you cannot get a service or item you want because it is not a covered service or item.
- Gateway will not pay a provider for a service or item you received.
- Gateway did not decide a complaint or grievance you told us about within thirty (30) days.
- Gateway has denied your request to disagree with Gateway’s decision that you have to pay your provider.
You must file a complaint within sixty (60) calendar days of the date you should have gotten a service or item if you did not get a service or item. The time by which you should have received a service or item is listed below:

**New member appointment for your first examination...**

-成员 with HIV/AIDS  
  We will make an appointment for you...  
  with PCP or specialist no later than seven (7) days after you become a member in Gateway unless you are already being treated by a PCP or specialist.

-成员 who receive Supplemental Security Income (SSI)  
  with PCP or specialist no later than forty-five (45) days after you become a member in Gateway, unless you are already being treated by a PCP or specialist.

-成员 under the age of twenty-one (21)  
  with PCP for an EPSDT screen no later than forty-five (45) days after you become a member in Gateway, unless you are already being treated by a PCP or specialist.

-所有其他成员  
  with PCP no later than three (3) weeks after you become a member of Gateway.

**Members who are pregnant:**

-怀孕的妇女在她们的第一妊娠 trimester  
  We will make an appointment for you...  
  with OB/GYN provider within ten (10) business days of Gateway learning you are pregnant.

-怀孕的妇女在她们的第二妊娠 trimester  
  with OB/GYN provider within five (5) business days of Gateway learning you are pregnant.

-怀孕的妇女在她们的第三妊娠 trimester  
  with OB/GYN provider within four (4) business days of Gateway learning you are pregnant.

-怀孕的妇女有高风险的妊娠  
  with OB/GYN provider within twenty-four (24) hours of Gateway learning you are pregnant.

**Appointment with...**

-PCP  
  An appointment must be scheduled...  
  within twenty-four (24) hours.

-紧急医疗状况  
  with PCP within twenty-four (24) hours.
routine appointment within ten (10) business days.

health assessment/general physical examination within three (3) weeks.

Specialists (when referred by PCP)
urgent medical condition within twenty-four (24) hours of referral.

routine appointment with one of the following specialists:
• Otolaryngology
• Dermatology
• Pediatric Endocrinology
• Pediatric General Surgery
• Pediatric Infectious Disease
• Pediatric Neurology
• Pediatric Pulmonology
• Pediatric Rheumatology
• Dentist
• Orthopedic Surgery
• Pediatric Allergy & Immunology
• Pediatric Gastroenterology
• Pediatric Hematology
• Pediatric Nephrology
• Pediatric Oncology
• Pediatric Rehab Medicine
• Pediatric Urology

routine appointment with all other specialists within ten (10) business days of referral.

You may file all other complaints at any time.

**What happens after I file a first level complaint?**

After you file your complaint, you will get a letter from Gateway telling you that we have received your complaint, and about the first level complaint review process.

You may ask Gateway to see any relevant information we have about your complaint. You may also send information that may help with your complaint to Gateway.
You may attend the complaint review if you want to. You may appear at the complaint review in person, by phone, or by videoconference.

If you decide that you do not want to attend the complaint review, it will not affect our decision.

A committee of one or more Gateway staff who have not been involved in, and do not work for someone who was involved in, the issue you filed your complaint about will meet to make a decision about your complaint. If the complaint is about a clinical issue, a licensed doctor will be on the committee. Gateway will mail you a notice within thirty (30) days from the date you filed your first level complaint to tell you the decision on your first level complaint. The notice will tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page 139

**What to do to continue getting services:**
If you have been receiving services or items that are being reduced, changed or stopped and you file a complaint that is hand-delivered or postmarked within ten (10) days of the date on the letter (notice) telling you that the services or items you have been receiving are not covered services or items for you, the service or items will continue until a decision is made.

**What if I don’t like Gateway’s decision?**
You may ask for an external Complaint review, a Fair Hearing, or an external Complaint review and a Fair Hearing if the complaint is about one of the following:

- Gateway decision that you cannot get a service or item you want because it is not a covered service or item.

- Gateway decision to not pay a provider for a service or item you got.

- Gateway failure to decide a complaint or grievance you told Gateway about within thirty (30) days from when Gateway received your complaint or grievance.

- You not getting a service or item within the time by which you should have received it

- Gateway’s decision to deny your request to disagree with Gateway’s decision that you have to pay your provider.

You must ask for an external complaint review within fifteen (15) days of the date you got the first level complaint decision notice.
You must ask for a Fair Hearing within one hundred twenty (120) days from the date on the notice telling you the complaint decision.

For all other complaints, you may file a second level complaint within forty-five (45) days of the date you got the complaint decision notice.

Second Level Complaint
What Should I Do if I Want to File a Second Level Complaint?
To file a second level complaint:
- Call Gateway at 1-800-392-1147 (TTY users call 711 or 1-800-654-5984) and tell Gateway your second level complaint, or
- Write down your second level complaint and send it to Gateway by mail or fax, or
- Fill out the complaint request form included in your complaint decision notice and send it to Gateway by mail or fax.

Gateway’s address and fax number for second level complaints:

Gateway Health
Attn: Complaint and Grievance Department
P.O. Box 22278
Pittsburgh, PA 15222, or
Fax: 412-255-4503

What happens after I file a second level complaint?
After you file your Second Level Complaint, you will get a letter from Gateway telling you that Gateway has received your complaint, and about the Second Level Complaint review process.

You may ask Gateway to see any information Gateway has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about Complaint to Gateway.

You may attend the complaint review if you want to attend it. Gateway will tell you the location, date, and time of the complaint review at least seven (7) days before the complaint review. You may appear at the complaint review in person, by phone, or by videoconference. If you decide that you do not want to attend the complaint review, it will not affect our decision.

A committee made up of three or more people, including at least one person who does not work for Gateway, will meet to decide your second level complaint. Your complaint will be decided no later than forty-five (45) days after we receive your complaint.
A decision letter will be mailed to you within one (1) business days after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you don’t like the decision.

If you need more information about help during the Complaint process, see page 139

What if I do not like Gateway’s decision on my second level complaint? You may ask for an external review by either DOH or the Insurance Department. You must ask for an external review within fifteen (15) days of the date you received the second level complaint decision notice.

**External Complaint Review**

**How Do I Ask for an External Complaint Review?**
You must send your request for external review in writing to either:

- Pennsylvania Department of Health Bureau of Managed Care
  Health and Welfare Building, Room 912
  625 Forster Street
  Harrisburg, PA 17120-0701
  Telephone Number: 1-888-466-2787

- Pennsylvania Insurance Department Bureau of Consumer Services
  Room 1209, Strawberry Square
  Harrisburg, Pennsylvania 17120
  Telephone Number: 1-877-881-6388

If you ask, the Department of Health will help you put your complaint in writing.

The DOH handles complaints that involve the way a provider gives care or services. The Insurance Department reviews complaints that involve Gateway’s policies and procedures. If you send your request for external review to the wrong department, it will be sent to the correct department.

If you send your request for external review to the wrong department, it will be sent to the correct department.

**What Happens After I Ask for an External Complaint Review?**
The Department of Health or the Insurance Department will get your file from Gateway. You may also send them any other information that may help with the external review of your complaint.

You may be represented by an attorney or another person such as your representative during the external review.

A decision letter will be sent to you after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you don’t like the decision.
What to do to continue getting services:
If you have been getting the services or items that are being reduced, changed, or denied and your request for an external complaint review that is hand-delivered or postmarked within ten (10) days of the date on the notice advising Gateway’s first level complaint decision that you cannot get services or items you have been receiving because they are not covered services or items, the services or items will continue until a decision is made.

GRIEVANCES

What is a grievance?
When Gateway denies, decreases, or approves a service or item different than the service or item you requested because it is not medically necessary, you will receive a notice telling you Gateway’s decision.

A grievance is when you tell Gateway you disagree with Gateway’s decision.

What should I do if I have a grievance?
To file a grievance, you may do any of the following:
• Call Gateway at 1-800-392-1147/TTY 711 (1-800-654-5984) and tell us your grievance.
• Write down your grievance and mail it to:
  Gateway Health℠
  Attn: Appeals & Grievance Department
  P.O. Box 22278
  Pittsburgh, PA 15222, or
  Fax: 412-255-4503
  • Fill out the Complaint/Grievance Request Form included in the denial notice you got from Gateway and send it to Gateway by mail or fax.

When should I file a grievance?
You have sixty (60) calendar days from the date you receive the letter/notice that tells you about the denial, decrease, or approval of a different service or item for you.

What happens after I file a grievance?
After you file your grievance, you will receive a letter from Gateway telling you that we have received your grievance, and about the grievance review process.

You may ask Gateway to see any relevant information that Gateway used to make the decision you filed your grievance about at no cost to you. You may also send information that may help with your grievance to Gateway.

You may attend the grievance review if you want to attend it. Gateway will tell you the location, date, and time for the grievance review at least seven (7) days before the day of the grievance.
review. You may appear at the grievance review in person, by phone, or by videoconference. If you decide that you do not want to attend the grievance review, it will not affect our decision.

A committee of three or more people, including a licensed physician, will meet to decide your grievance. The Gateway staff on the committee will not have been involved in, and will not have worked for someone who was involved in, the issue you filed your grievance about. Gateway will mail you a notice within thirty (30) days from the date you filed your grievance to tell you the decision on your grievance. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the grievance process, see page 145.

**What to do to continue getting services:**
If you have been getting services or items that are being reduced, changed, or denied and you file a Grievance verbally, or that is faxed, postmarked, or hand-delivered within ten (10) days of the date on the notice telling you that the services or items you have been receiving are being reduced, changed, or denied, the services or items will continue until a decision is made.

**What if I don’t like Gateway’s decision?**
You may ask for an external grievance review or a Fair Hearing or you may ask for both an external grievance review and a fair hearing. An external grievance review is a review by a doctor who does not work for Gateway.

You must ask for an external grievance review within fifteen (15) days of the date you got the grievance decision notice.

You must ask for a fair hearing from DHS within one hundred twenty (120) days from the date on the notice telling you the grievance decision.

For information about Fair Hearings, see page 153
For information about external Grievance review, see below
If you need more information about help during the Grievance process, see page 145
External Grievance Review

How Do I Ask for External Grievance Review
To ask for an external grievance review, you may do any of the following:

- Call Gateway at 1-800-392-1147/TTY 711 (1-800-654-5984) and tell us your grievance.
- Write down your grievance and send it to us by mail:

  Gateway Health℠
  Attn: Appeals & Grievance Department
  P.O. Box 22278
  Pittsburgh, PA 15222

Gateway will send your request for external Grievance review to the Department of Health.

What Happens After I Ask for an External Grievance Review?
The Department of Health will notify you of the external grievance reviewer’s name, address, and phone number. You will also be given information about the external grievance review process.

Gateway will send your grievance file to the reviewer. You may provide additional information that may help with the external review of your grievance to the reviewer within fifteen (15) days of filing the request for an external grievance review.

You will receive a decision letter within sixty (60) days of the date you asked for an external grievance review. This letter will tell you the reason(s) for the decision and what you can do if you don’t like the decision.

What to do to continue getting services:
If you have been getting the services or items that are being reduced, changed, or denied and you ask for an external Grievance review verbally or in a letter that is postmarked or hand-delivered within ten (10) days of the date on the notice telling you Gateway’s Grievance decision, the services or items will continue until a decision is made.
Complaints, Grievances, and Fair Hearings

Expedited Complaints and Grievances

What can I do if my health is at immediate risk?
If your doctor or dentist believes that waiting thirty (30) days to get a decision about your complaint or grievance could harm your health, you, your doctor, or dentist can ask that your complaint or grievance be decided more quickly. For your complaint or grievance to be decided more quickly:

- You must ask Gateway for an early decision by calling Gateway at 1-800-392-1147/TTY 711 (1-800-654-5984), or faxing a letter or the complaint/grievance request form to 412-255-4503.

- Your doctor or dentist should fax a signed letter to 412-255-4503 within seventy-two (72) hours of your request for an early decision that explains why Gateway taking thirty (30) days to tell you the decision about your complaint or grievance could harm your health.

If Gateway does not receive a letter from your doctor or dentist and the information provided does not show that taking the usual amount of time to decide your complaint or grievance could harm your health, Gateway will decide your complaint or grievance in the usual time frame of thirty (30) days from when Gateway first got your complaint or grievance.

Expedited Complaint and Expedited External Complaint
Your expedited complaint will be reviewed by a committee that includes a licensed doctor. Members of the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your complaint about.

You may attend the expedited complaint review if you wish. You can attend the complaint review in person, but may have to appear by phone or by videoconference [MCO to include videoconferencing only if available] because Gateway has a short amount of time to decide an expedited complaint. If you decide that you do not want to attend the complaint review, it will not affect the decision.

Gateway will tell you the decision about your complaint within forty-eight (48) hours of when Gateway receives your doctor’s or dentist’s letter explaining why the usual time frame for deciding your complaint will harm your health or within seventy-two (72) hours from when Gateway receives your request for an early decision, whichever is sooner, unless you ask Gateway to take more time to decide your complaint. You can ask Gateway to take up to fourteen (14) more days to decide your complaint. You will also get a notice telling you the reason(s) for the decision and how to ask for expedited external complaint review, if you do not like the decision.

If you did not like the expedited complaint decision, you may ask for an expedited external complaint review from the Department of Health within two (2) business days from the date you get the expedited complaint decision notice. To ask for expedited external review of a complaint you may do any of the following:

- Call Gateway at 1-800-392-1147 (TTY users call 711 or 1-800-654-5984) and tell Gateway your complaint.
• Send an email to Gateway at MedicaidAppealFormsPF@GatewayHealthPlan.com.
• Write down your complaint and send it to Gateway by mail or fax:

Gateway Health
Attn: Complaint and Grievance Department
P.O. Box 22278
Pittsburgh, PA 15222, or
Fax: 412-255-4503

**Expedited Grievance and Expedited External Grievance**

A committee of three or more people, including a licensed physician will meet to decide your grievance. The Gateway staff on the committee will not have been involved in, and will not have worked for, someone who was involved in the issue you filed your grievance about.

You may attend the expedited grievance review if wish. You can attend the grievance review in person, but may have to appear by phone or by videoconference because Gateway has a short amount of time to decide the expedited grievance. If you decide that you do not want to attend the grievance review, it will not affect our decision.

Gateway will tell you the decision about your grievance within forty-eight hours of when Gateway receives your doctor’s or dentist’s letter explaining why the usual time frame for deciding your grievance will harm your health or within seventy-two (72) hours from when Gateway receives your request for an early decision, whichever is sooner, unless you ask Gateway to take more time to decide your grievance. You can ask Gateway to take up to fourteen (14) more days to decide your grievance. You will also get a notice telling you the reason(s) for the decision and what to do if you do not like the decision.

If you do not like the expedited grievance decision, you may ask for an expedited external Grievance review or an expedited fair hearing by DHS or both an expedited external grievance review and an expedited Fair Hearing.

You must ask for expedited external grievance review by the Department of Health within two (2) business days from the date you get the expedited decision notice. To ask for expedited external review of a Grievance you may do any of the following:

• Call Gateway at 1-800-392-1147 (TTY users call 711 or 1-800-654-5984) and tell Gateway your grievance.
• Send an email to Gateway at MedicaidAppealFormsPF@GatewayHealthPlan.com.
• Write down your grievance and send it to Gateway by mail or fax:

Gateway Health
Attn: Complaint and Grievance Department
P.O. Box 22278
Pittsburgh, PA 15222, or
Fax: 412-255-4503
Gateway will send your request to the Department of Health within twenty-four hours after receiving it.

You must ask for a Fair Hearing within one hundred twenty (120) days from the date on the notice telling you the expedited Grievance decision.

**What kind of help can I have with the complaint and grievance processes?**

If you need help filing your complaint or grievance, a staff member of Gateway will help you. This person can also represent you during the complaint or grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your complaint or grievance.

You may also have a family member, friend, lawyer, or other person help you file your complaint or grievance. This person can also help you if you decide you want to appear at the complaint or grievance review.

At any time during the complaint or grievance process, you can have someone you know represent you or act on your behalf. If you decide to have someone represent or act for you, tell Gateway, in writing, the name of that person and how we can reach him or her.

You or the person you choose to represent you may ask Gateway to see any information Gateway has about the issue you filed your complaint or grievance about at no cost to you.

You may call Gateway’s toll-free telephone number at 1-800-392-1147 (TTY users call 711 or 1-800-654-5984) if you need help or have questions about complaints and grievances, you can contact your local legal aid office at 1-800-322-7572 or call the Pennsylvania Health Law Project at 1-800-274-3258.

**Persons whose primary language is not English**

If you ask for language interpreter services, Gateway will provide the services at no cost to you.

**Persons with Disabilities**

Gateway will provide persons with disabilities with the following help in presenting complaints or grievances at no cost, if needed. This help includes:

- Provide sign language interpreters.
- Provide information submitted by Gateway at the complaint or grievance review in an alternative format. The alternative format version will be given to you before the review.
- Provide someone to help copy and present information.
DEPARTMENT OF HUMAN SERVICES FAIR HEARINGS

In some cases you can ask DHS to hold a hearing because you are unhappy about or do not agree with something Gateway did or did not do. These hearings are called fair hearings. You can ask for a fair hearing after Gateway decides your first or second level complaint or grievance.

What kind of things can I request a fair hearing about and by when do I have to ask for my fair hearing?

If you are unhappy because...

1) Gateway decided to deny a service or item because it is not a covered service or item;

   You must ask for a fair hearing...

   Within one hundred twenty (120) days of getting a letter from Gateway telling you its decision after you filed a complaint about this issue.

2) Gateway decided to not pay a provider for a service or item you got and the provider can bill you for the service or item;

   Within one hundred twenty (120) days of getting a letter from Gateway telling you its decision after you filed a complaint about this issue.

3) Gateway did not decide within thirty (30) days, a complaint or grievance you told Gateway about before;

   Within one hundred twenty (120) days of getting a letter from Gateway telling you that we did not decide your complaint or grievance within the time we were supposed to.

4) Gateway decided to deny, decrease or approve a service or item different than the service or item you requested because it was not medically necessary;

   Within one hundred twenty (120) days of getting a letter from Gateway telling you its decision after you filed a grievance about this issue.

5) Gateway did no provide a service or item by the time you should have received it.

   Within one hundred twenty (120) days of getting a letter from Gateway telling you its decision after you filed a complaint about this issue.
How do I ask for a fair hearing?
You must ask for a fair hearing in writing and send it to:

Department of Human Services
Office of Medical Assistance Programs – HealthChoices Program
Complaint, Grievance and Fair hearings
PO Box 2675
Harrisburg, PA 17105-2675

Your request for a fair hearing should include the following information:
- Member name.
- Member social security number and date of birth.
- Telephone number where you can be reached during the day.
- If you want to have the fair hearing in person or by telephone.
- Any letter you may have received about the issue you are requesting your fair hearing.

What happens after I ask for a fair hearing?
You will get a letter from DHS’ Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least ten (10) days before the date of the hearing.

You may come to where the fair hearing will be held or be included by phone. A family member, friend, lawyer or other person may help you during the fair hearing.

Gateway will also go to your fair hearing to explain why we made the decision or explain what happened.

If you ask, Gateway must give you (at no cost to you) any records, reports and other information we have that is relevant to what you requested your fair hearing about.

When will the fair hearing be decided?
If you ask for a fair hearing after a first level complaint or grievance decision, the fair hearing will be decided no more than sixty (60) days after the DHS gets your request.

If you ask for a fair hearing and did not file a first level complaint or grievance, or if you ask for a fair hearing after a second level complaint or grievance decision, the fair hearing will be decided within ninety (90) days from when the DHS gets your request.
If your fair hearing is not decided within ninety (90) days from the date DHS receives your request, you may be able to get your services until your fair hearing is decided. You can call DHS at 1-800-798-2339 to ask for your services.

**What to do to continue getting services:**

If you have been receiving services or items that are being reduced, changed or stopped and your request for a fair hearing is hand-delivered or postmarked within ten (10) days of the date on the letter (notice) telling you that Gateway has reduced, changed or denied your services or items or telling you Gateway decision about your first or second level complaint or grievance, your services or items will continue until a decision is made.

**What can I do if my health is at immediate risk?**

**Expedited Fair Hearing**

If your doctor or dentist believes that using the usual timeframes to decide your fair hearing will harm your health, you or your doctor/dentist can call the DHS at 1-800-798-2339 and ask that your fair hearing be decided faster. This is called an expedited fair hearing. You will need to have a letter from your doctor or dentist faxed to 717-772-6328 explaining why using the usual timeframes to decide your fair hearing will harm your health. If your doctor or dentist does not send a written statement, your doctor or dentist may testify at the fair hearing to explain why using the usual timeframes to decide your fair hearing will harm your health.

The Bureau of Hearings and Appeals will contact you to schedule the expedited fair hearing. The expedited fair hearing will be held by telephone within three (3) business days after you ask for the fair hearing.

If your doctor does not send a written statement and does not testify at the fair hearing, the fair hearing decision will not be expedited. Another hearing will be scheduled, and the time frame for the fair hearing decision will be based on the date you asked for the fair hearing.

If your doctor sent a written statement or testifies at the hearing, the decision will be made within three (3) business days after you asked for the fair hearing.

You may call Gateway at 1-800-392-1147/TTY 711 (1-800-654-5984) if you need help or have questions about fair hearings, you can contact your local legal aid office, Pennsylvania Legal Aid Network at 1-800-322-7572 or call the Pennsylvania Health Law Project at 1-800-274-3258.
Provider Appeals

Any provider may file a provider appeal to request the review of any post-service denial. This process is intended to afford providers with the opportunity to address issues regarding payment only. Appeals for services that have not yet been provided must follow the member grievance or complaint processes. The Provider Appeal Process must be initiated by the provider through a written request for an appeal. The written request for an appeal, along with all supporting documentation, must be sent to:

Gateway Health
Attention: Provider Appeals & Grievance
P.O. Box 22278 Pittsburgh, PA 15222, or
Fax: 1-855-501-3904

First Level Appeal (Informal Appeal)

1. To request a provider appeal, providers must make a written request for appeal which must be received by the plan within:
   a. Sixty (60) calendar days of the date of their denial notice denying an authorization unless otherwise negotiated by contract. In this instance, there is a denied authorization, however, services have already been provided.
   b. One hundred eighty (180) calendar days of the date of their denial notice denying a post-service claim unless otherwise negotiated by contract. When an authorization has been denied, the provider must adhere to the sixty (60) day time frame above, the one hundred eighty (180) days once the claim has denied does not apply.

2. When submitting a written request for an appeal, the provider is required to submit any and all supporting documentation including, but not limited to, a copy of the denied claim, the reason for the appeal, and the member’s medical records containing all pertinent information regarding the services rendered by the provider.

3. The Appeal Committee will be comprised of one or more Gateway staff members who were not involved in the initial review ensuring providers receive an equitable, unbiased decision based on evidence. All first level provider appeal reviews will be completed within sixty (60) days of the date the written request was received.

4. The provider will be informed of the decision in writing by mailing notification within sixty (60) days from receipt. This notification will include additional appeal rights as applicable (i.e. Second Level Provider Appeal) (see section B, below). If the appeal is approved, payment will be issued within sixty (60) calendar days of notification.
Second Level Appeal (Formal Appeal)

1. If the provider is not in agreement with the first level provider appeal committee’s decision, the provider may seek a second level provider appeal. A request for a second level provider appeal must be submitted to the plan in writing within sixty (60) calendar days of the date on the first level provider appeal decision letter, or as otherwise indicated by contract. All second level provider appeal requests must include rationale as to why the provider does not agree with the plans' first level provider appeal committee’s decision.

2. The appeal committee will be comprised of member(s) who were not involved in any previous level of review ensuring providers receive an equitable, unbiased decision based on evidence. At least one-fourth of the committee will include a health care provider and/or peer. The committee will have authority, training, and expertise to address/resolve the issue. All data available will be available to the committee to make a documented decision. All second level provider appeal reviews will be completed within sixty (60) calendar days of the date the second level provider appeal request was received.

3. The second level appeal committee will inform the provider of its decision in a written decision notice within sixty (60) days. This is the final level of appeal and the decision is binding, unless otherwise governed per contract.
Care Management

Gateway to Lifestyle Management SM
Gateway to Lifestyle Management SM (GTLM) provides patient education and self-empowerment for medication, diet and lab adherence, to reduce inpatient and emergency room utilization.

The program will provide the following member benefits and support:
- Welcome letter provides members with information about their condition/disease and about the GTLM program. The brochure includes information about how members can reach a case manager.
- Member newsletters provide the members with educational information about their condition.
- Gateway website provides educational material and has links to the Pennsylvania Quit Line to assist members with smoking cessation.
- General educational materials may be mailed such as flu or pneumonia reminders.
- Interactive Voice Response campaigns provide members with tips to help manage their condition.
- Text message programs may be offered to certain member populations.

Telephonic Management
Case Managers proactively reach out to higher-risk members to:
- Assess overall well-being.
- Determine the member’s understanding of their condition(s).
- Assess behavioral, economic, environmental, social, spiritual, and medical needs.
- Discuss lifestyle management issues including but not limited to diet, nutrition, meal planning, weight management, exercise, and smoking cessation.
- Refer members to a health educator, home health visits, behavioral health, or any other discipline if indicated.
- Communicate with member’s care team as needed.
- Perform medication reconciliation to assess compliance and understanding; assess for polypharmacy and multiple prescribers.
- Review claims for laboratory testing and follow up with member for results.
- Provide pillboxes if needed.

Provider benefits and support:
- Decrease inpatient and emergency room utilization.
- Increase appropriate lab testing and medication adherence.
- Emphasize the importance of making and keeping appointments and provide coaching on how to make the best use of the time with the provider.
- Encourage adherence to obtain flu and pneumonia immunizations.
- Provide education to assist your patients in understanding their condition and life style implications, and motivating them to take a proactive role in managing their health.
Provide feedback via the Physician Dashboard which identifies your patients enrolled in the GTLM programs and highlights testing they may need to manage their condition.

We would like to work with you to make a positive impact on your patient’s health! For more information or to refer a patient to any of the GTLM programs call 1-800-392-1147.

**Asthma Program**
The GTLM Asthma Program emphasizes patient education self-management, and medication adherence. The program aims to reduce the necessity of asthma related emergency room visits and reduce inpatient utilization in our asthma population.

Gateway members age two years and older are eligible for the program. The program encourages an active lifestyle while minimizing or preventing asthma exacerbations and improving quality of life. Members are automatically enrolled once they are identified with asthma, but are able to opt-out if they choose.

The program will help your patient:
- Identify and minimize their asthma triggers.
- Recognize early symptoms requiring medical attention.
- Understand the difference between a rescue inhaler and a controller medication and how to use both properly.
- Understand and prevent potential risks of uncontrolled asthma.
- Program includes pediatric specific learning materials.

For more information or to refer a patient to the Asthma Program call 1-800-392-1147.

**Diabetes Program**
The GTLM Diabetes Program emphasizes education and personal responsibility for diabetes management to reduce the need for hospitalizations, ER visits, and to prevent complications related to diabetes. All adult and pediatric Gateway members with Type-1 or Type-2 diabetes are eligible for this program. Members are automatically enrolled once they are identified with diabetes but are able to opt-out if they choose.

By participating in the Diabetes Program, your patients can receive:
- Education regarding co-existing conditions, smoking cessation, medication compliance and blood glucose monitoring.
- Calls from telephonic case managers for high-risk members.
- Reinforcement of your plan of care.
- Targeted telephonic and/or mailed reminders to patients who are due for diabetes-related lab/tests.
- Member newsletters with diabetes related articles.

For more information or to refer a patient to the diabetes program call 1-800-642-3550 and press option two (2).
Cardiac Program
The GTLM Cardiac Program emphasizes patient education, and support to help members with cardiac conditions take an active role in their well-being by adopting a heart healthy lifestyle by taking medications as prescribed and by understanding how to avoid sudden flare ups of their condition.

Gateway members with a diagnosis of AMI, Atrial Fibrillation, Chronic Heart Failure, Heart Failure Diagnosis, IVD, or MI are eligible for the program. Members are automatically enrolled once they are identified with one of these cardiac conditions but are able to opt out if they choose.

The program will help your patient:
• Learn the meaning of specific cardiac symptoms to prevent further cardiac damage.
• Understand the importance of lab tests for cholesterol and medications.
• Understand how other conditions play a part in worsening a cardiac condition.
• Understand when to call the physician and the key words to tell the office.

For more information or to refer a patient to the Cardiac Program, call 1-800-392-1147.

COPD Program
The GTLM COPD Program emphasizes patient education self-management, and medication adherence. The program promotes lifestyle modification and safety to reduce inpatient utilization, emergency room visits and preventable flare-ups.

Gateway members twenty-one years of age and older with a diagnosis of COPD are eligible for this program. Members are automatically enrolled once they are identified with COPD but are able to opt-out if they choose.

The program will help your patient:
• Understand the importance of medication adherence as well as proper use of their inhalers.
• Identify and avoid COPD triggers to help prevent an exacerbation and recognize when they should call their physician.
• Understand the role of supplemental oxygen and/or the benefits of a pulmonary rehabilitation program.
• Understand the importance of lifestyle modifications including smoking cessation.

For more information or to refer a patient to the COPD Program, call 1-800-392-1147.

MOM Matters® Program
The MOM Matters' Prenatal Program offers maternity care coordination to improve the frequency of prenatal and postpartum care, to reduce the incidence of low birth weight and pre-term deliveries, and to decrease the need for NICU admissions. This is a population-based program directed toward improving outcomes for all pregnant members. Specific interventions are
designed to identify and prospectively intervene with members at high risk for adverse pregnancy outcomes.

All Gateway members identified as pregnant are eligible for this program. Pregnant members are automatically enrolled but are able to opt-out if they choose.

The program will help your patient:
- Identify signs and symptoms of preterm labor or complications with the pregnancy.
- Understand lifestyle modifications to maintain a healthy pregnancy.
- Recognize how co-existing medical conditions can impact the pregnancy.
- Understand the importance of post-partum follow-up.
- Patient education and self-management tools.
- Information on smoking cessation with a referral to state Quitline.
- Member newsletters with pregnancy related articles.
- Home care coordinated through the member’s Gateway Health case manager.

For more information or to refer a patient to the MOM Matters® Prenatal Program call 1-800-392-1147.

**Special Needs Unit Case Management**

**General Information**

The goal of the SNU Case Management is to intervene in medically or socially complex cases that may benefit from increased coordination of services to optimize health and prevent disease. The SNU is staffed by individuals with medical or social service backgrounds in the following areas: oncology, medically complex children, HIV/AIDS, substance abuse, mental health, physical rehabilitation, and mental intellectual disability.

A SNU Case Manager is available at 1-800-392-1147, Monday through Friday from 8:30 AM to 4:30 PM to assist with coordination of the member’s healthcare needs.

The responsibilities of the SNU include:
- Liaison with various healthcare practitioners, community social service agencies, advocacy groups, and other agencies that the MA population may interface with.
- Case management of children with medically complex special needs.
- Coordination of services between primary care, specialty, ancillary, and behavioral health practitioners within and outside the network.
- Facilitation of dispute resolution including informing members of the complaint, grievance, and appeal mechanism that is available to the member. Facilitation of members’ access to city, county, and commonwealth social agencies for those members with complicated ongoing social service needs that affect their ability to access and use medical services.

**Criteria for Referrals to the Special Needs Unit Case Management Team**

The following problems and/or diagnoses are examples of appropriate referrals to the SNU:
• Children with Special Healthcare Needs (i.e., Cerebral Palsy).
• HIV/AIDS.
• Mental Health or Substance Abuse Issues.
• Intellectual Disability/Developmental Disabilities.
• High Risk Pregnancy.
• Social Issues (domestic violence, substitute care).

**Complex Case Management**

Gateway’s SNU provides a Complex Case Management program for eligible members. A Case Manager can help members better understand their health condition and benefits and can also help to coordinate health care services. A Case Manager can tell members about community organizations and resources that may meet their needs.

Eligible members may include:
• Members with multiple medical conditions.
• Members with a complex medical history.
• Members that need assistance to become more self-reliant in managing their health care.
• Members that are at risk of a hospital admission.

Please contact the SNU Case Management to make a referral to the Complex Case Management program at 1-800-392-1147. TTY users call (711) or 1-800-654-5984.

Gateway will review the request for enrollment and make the final decision for inclusion in the program.

**Chronic Case Management**

Gateway’s Special Needs Unit provides case management services for members with chronic illnesses not noted above. Case Managers focus on active condition monitoring, lifestyle management, preventive health, care coordination, and community resource referrals. To refer a member or discuss care coordination issues, contact SNU Case Management at 1-800-392-1147.

**School Based-School Linked Services**

Gateway’s Special Needs Team actively coordinates with the school based and school linked services throughout the State. Our Case Managers provide support and assistance as needed, to ensure that our members receive all required medical necessity services to allow for them to attend school. The CMs work closely with the member’s parent/guardian, the School based special needs staff, as well as the member’s physicians and specialists ensure that all required services are available for the member in the school setting. Call the Special needs team at 1-800-392-1147 asked to speak to a Special Needs Case Manager if you require assistance with school based/linked services.
Credentialing

Purpose of Credentialing
Credentialing is the process of performing a background investigation, as well as validation of a practitioner and provider’s credentials and qualifications. The credentialing and recredentialing processes also encompass a complete review of, to include but not limited to, malpractice histories, quality of care concerns, and licensure status. Gateway prides itself on the integrity and quality of the composition of the practitioner and provider networks.

Who is Credentialed?
Practitioners: Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic (DC), Doctor of Dental Medicine (DMD), Doctor of Dental Surgery (DDS), Doctor of Optometry (OD), Doctorate of Psychology (Ph.D), and Doctorate of Philosophy (Ph.D). (This listing is subject to change.)

Extenders: Physician Assistant (PA), Certified Nurse Practitioner (CRNP), Certified Nurse Midwife (CNM), a Clinical Nurse Specialist (CNS) and a Certified Nurse Practitioner (CNP). (This listing is subject to change.)

Facility and Ancillary Service Providers: Hospitals, Nursing Homes, Skilled Nursing Facilities, Home Health, Hospice, Rehabilitation Facilities, Ambulatory Surgical Centers, Portable X-ray Suppliers, End Stage Renal Disease Facilities, Outpatient Physical Therapy and Speech Therapy providers, Rural Health Clinics, and Federally Qualified Health Centers. (This listing is subject to change.)

Credentialing Standards
Gateway has established credentialing and recredentialing policies and procedures that meet CMS, DOH, DHS, and NCQA standards.

All information must be current and up-to-date to begin the credentialing process. Therefore, it is important to submit all applications and attachments in a timely manner with the most current information available.

In addition, extenders are required to submit a copy of their collaborative/written agreement with a Gateway participating supervising practitioner. This agreement would include the extender’s responsibilities and must be signed and dated by both the extender and the Gateway participating supervising practitioner. Any time there is a change in the extender’s supervising physician, the extender will be required to submit to Gateway, a current copy of his/her new collaborative/written agreement as indicated in his/her approval letter. Where applicable, the submittal of the collaborative/written agreement to Gateway must include a copy of the letter of approval from the State and if applicable, a DEA is required.
Gateway’s standards include, but are not limited to, the following:

- A current, unrestricted license.
- Fully completed and signed application, which includes an active individual Master Provider Index (MPI) number and National Provider Identifier (NPI) number.
- Curriculum Vitae and/or Work History to include month and year.
- Copy of current, unencumbered DEA certificate, if applicable.
- Current hospital admitting privileges for PCPs or appropriate coverage arrangement.
- Acceptable malpractice history as subject to decision by Gateway Medical Directors.
- Practitioners must maintain professional liability coverage as required by the state in which he/she practices or as outlined in the practitioner contractual agreement. For those self-insured a statement on letterhead indicating the providers are insured by a self-indemnification policy needs submitted.
- Active participation in the Medicare and/or MA programs; free of sanctions.
- Foreign graduates must submit an ECFMG certificate.
- Other items as deemed appropriate.

The credentialing/recredentialing process involves primary sourced verification of practitioner credentials.

Gateway’s Credentialing Department will notify practitioners, in writing, within forty-five (45) calendar days of receiving any information obtained during the credentialing or recredentialing process that varies substantially from the information provided by the practitioner. Practitioners have the right to correct erroneous information submitted by another party or to correct his or her own information submitted incorrectly. Applicants have ten (10) calendar days from the date of Gateway’s notification to submit written corrections and supporting documentation to Gateway’s Credentialing Department. A credentialing decision will not be rendered until the ten (10) calendar days have expired.

Practitioners, upon request, have the right to be informed of the status of their credentialing or recredentialing application. Practitioners also have the right to review any information submitted in support of their credentialing applications except for National Practitioner Data Bank (NPDB) and/or Healthcare Integrity Practitioner Data Bank (HIPDB) reports, letters of recommendation, and information that is peer review protected. A practitioner must submit a written request to review their credentialing information. All appropriate credentialing information will be sent by certified mail, overnight mail or carrier to the practitioner within ten (10) business days from the date that the Credentialing Department received the request.

All practitioners must be recredentialied at least every three years in order to continue participation with Gateway. This helps to assure Gateway’s continued compliance with NCQA, DHS, CMS, and DOH regulations, as well as to uphold the integrity and quality of the networks. Extensions of this timeframe will only be considered in the event the practitioner is on maternity leave, military leave or sabbatical. Otherwise, extensions cannot be granted.
Gateway is committed to protecting the confidentiality of all practitioner information obtained by the Credentialing Department as outlined in Gateway Health PlusSM Confidentiality of Practitioner/Provider Credentialing Information Policy and Procedure.

**Ongoing Performance Monitoring**
Gateway’s Credentialing Department conducts ongoing monitoring of sanctions, licensure disciplinary actions, and member complaints.

Sanction information is reviewed by utilizing the Office of Inspector General’s (OIG) report, the Medicare Opt Out Listing (CMS), the System for Award Management (SAM), and MediCheck in Pennsylvania. Information can also be obtained from the American Medical Association (AMA) and the National Provider Data Bank (NPDB) / Healthcare Integrity Practitioner Data Bank (HIPDB) as needed.

Monitoring of limitations on licensure is conducted on a monthly basis. If a Gateway participating practitioner is found on the OIG, Medicare Opt Out List, or State Board of Medicine disciplinary action report, the practitioner’s file is immediately pulled for further investigation. Depending on severity level of the sanction, the practitioner may be sent to the Medical Director for review and recommendation, sent to QI/UM committee for review and decision and/or terminated. In all instances, the information is reported to the QI/UM committee.

Monitoring of member complaints is conducted on a quarterly basis. The Gateway Credentialing Department reviews a practitioner complaint report, which reveals member complaints, filed against practitioners regarding: attitude of provider, provider treatment, quality issues of physician, and any complaints regarding adverse events. If the outcome of the complaint investigation substantiates the complaint, it is documented. Depending upon the number, severity and trends of the substantiated complaint(s), the practitioner’s file may be sent to the Medical Director for review and recommendation, sent to QI/UM committee for review and decision and/or immediately terminated and outcome presented to QI/UM committee.

Gateway’s recredentialing process includes a comprehensive review of a practitioner’s credentials, as well as a review of any issues that may have been identified through a member complaint report and/or quality of care database.

**Practitioner Absences**
Gateway continues to follow NCQA guidelines for practitioners called to active military service, on maternity leave or on an approved sabbatical. However, it is the practitioner or their office’s responsibility to notify Gateway in writing that the practitioner has been called to active duty or beginning the said leave, as well as provide an expected return date. The letter should also include the practitioner who will be covering during his or her leave. The Gateway Credentialing Department will not terminate the practitioner if they are called to active duty, on maternity leave or on an approved sabbatical if appropriate coverage is in place. Practitioner/practitioner’s
office should notify Gateway of practitioners return, as soon as possible, but not exceeding ten (10) business days from the practitioners return to the office. The Gateway Credentialing Department will determine, based upon the length of time, if the practitioner will have to complete a recredentialing application. If the practitioner requires recredentialing, the application must be completed within sixty (60) calendar days of the practitioner resuming practice.

**Denial and Termination**

In accordance with Gateway’s business practices, the inclusion of a practitioner in the Gateway Practitioner/Provider Network is within the sole discretion of Gateway.

Gateway conducts credentialing in a non-discriminating manner and does not make credentialing decisions based on an applicant’s type of procedures performed, type of patients, or a practitioner’s specialty, marital status, race, color, religion, ethnic/national origin, gender, age, sexual orientation, or disability. Gateway understands and abides by the Federal Regulation of the Americans with Disabilities Act whereby no individual with a disability shall on the sole basis of the disability be excluded from participation.

If a practitioner meets Gateway’s credentialing criteria, a Gateway Medical Director may approve the credentialing applicant. If a practitioner does not meet Gateway’s baseline credentialing criteria, the QI/UM committee will make a final determination on participation or continued participation. If a practitioner fails to submit information and/or documentation within requested time frames, processing of the practitioner application may be discontinued or terminated. All requests for recredentialing updates must be completed and returned in a timely manner. Failure to do so could result in denial or termination of participation.

Denial and termination decisions that are made based on quality concerns can be appealed and are handled according to Gateway’s Due Process Policy and Procedure. If necessary, the information is reported to the National Practitioner Data Bank and Bureau of Quality Management and Provider Integrity in compliance with the current 45 CFR Part 60 and the Health Care Quality Improvement Act, as well as State licensing boards.

Practitioners who want to request a review of a termination, other than for quality of care concerns, must submit a written request for the review along with any supporting documentation to Gateway within thirty (30) calendar days of the date of the certified notification.

**Delegated Credentialing**

Delegation is the formal process by which Gateway has given other entities the authority to perform credentialing functions on the behalf of Gateway. Gateway may delegate certain activities to a credentialing verification organization (CVO), Independent Practitioner Association (IPA), hospital, medical group, or other organizations that employ and/or contract with practitioners. Organizations must demonstrate that there is a credentialing program in place and the ability to maintain a program that continuously meets Gateway’s program
requirements. The delegated entity has authority to conduct specific activities on behalf of Gateway. Gateway has ultimate accountability for the quality of work performed and retains the right to approve, suspend, or terminate the practitioners and site. Any further sub delegation shall occur only with the approval of Gateway and shall be monitored and reported back to Gateway.
FORMS AND REFERENCE MATERIALS
https://www.gatewayhealthplan.com/provider/medicaid-resources

EPSDT FORMS AND REFERENCE MATERIALS
https://www.gatewayhealthplan.com/provider/medicaid-resources