Gateway Health Plan
Medicare Assured® HMO SNP

2012

PROVIDER OFFICE

POLICY AND PROCEDURE

MANUAL

US Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219-2704

For inquiries, please
call Provider Services
at 1-800-685-5205

Please visit our website at www.GatewayHealthPlan.com

QUICK REFERENCE 5

IMPORTANT PHONE NUMBERS 5
IMPORTANT ADDRESSES 6

INTRODUCTION 7

ABOUT THIS MANUAL 7
OVERVIEW OF GATEWAY HEALTH PLAN MEDICARE ASSURED® 7
History 7
Mission 8
Prospective Care Management 8
Gateway Lines of Business 8
Membership/Network 9
Continuing Quality Care 9
Wellness & Disease Management 9
Health Care Disparities 9
Community Involvement 10
Benefits of Gateway Health Plan Medicare Assured® 10
HOW DOES GATEWAY WORK? 10
Gateway's Medicare Assured® Practitioner Network 10
Gateway's Provider Relations Role 11
Primary Care Practitioner's Role 11
OUTPATIENT MENTAL HEALTH PROVIDERS 12
CONTRACTS/NO GAG CLAUSE 12
QUALITY IMPROVEMENT 12
Purpose of the Quality Improvement Program 12
Goal of the Quality Improvement Program 13
Objectives of the Quality Improvement Program 13
Scope of the Quality Improvement Program 14
Quality Improvement Manual 15
PATIENT SAFETY 16
PREVENTABLE SERIOUS ADVERSE EVENTS/HOSPITAL ACQUIRED CONDITIONS AND NEVER EVENTS 17
LIVING WILL DECLARATION 17
Advance Directives 17
MEMBER OUTREACH 18

MEMBER 19

THE ENROLLMENT/DISENROLLMENT PROCESS 19
MEMBER ID CARDS 19
DETERMINING ELIGIBILITY 20
PRIMARY CARE PRACTITIONER'S ROLE IN DETERMINING ELIGIBILITY 21
BENEFITS 21
Medical Benefits 21
Summary of Benefits 22
Prescription Drug Benefits 42
Drugs Covered 43

Self-Referred Services 45
MEMBERS' RIGHTS AND RESPONSIBILITIES 46

COVERAGE ARRANGEMENTS 47

PRIMARY CARE PRACTITIONER 49

PRIMARY CARE PRACTICE DASHBOARD REPORTS 49
ENCOUNTERS 50
Accurate Submission of Encounter Data 50
TRANSFER OF NON-COMPLIANT MEMBERS 52
TRANSFER OF MEDICAL RECORDS 52
APPOINTMENT STANDARDS 53

SPECIALTY CARE PRACTITIONER 55

VERIFYING ELIGIBILITY 55
REFERRALS 55
EMERGENCY SERVICES 55
APPOINTMENT STANDARDS 56

OB/GYN SERVICES 59

GENERAL INFORMATION 59
OBSTETRICAL NEEDS ASSESSMENT FORM 59
DIAGNOSTIC TESTING 59
APPOINTMENT STANDARDS 60

POLICIES AND PROCEDURES 61

POLICY CHANGES 61
PRACTITIONER EDUCATION AND SANCTIONING 61
PRACTITIONER DUE PROCESS 61
TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 62
TRANSLATORS DURING CLINICAL VISITS 62
CONFIDENTIALITY 62
FRAUD AND ABUSE 63
ENVIRONMENTAL ASSESSMENT STANDARDS 64
Environmental Assessment Standards 65
PROVIDER CHANGES 69

HOSPITAL SERVICES 71

INPATIENT ADMISSIONS 71
EMERGENCY ROOM 71
AMBULANCE SERVICES 71

REFERRALS AND AUTHORIZATIONS 75

REFERRALS 75
General Information 75
Primary Care Practitioner 75
Specialty Care Practitioners 75
Out-of-Plan Referrals 76

Referrals for Second Opinions 76
Self-Referral 76
AUTHORIZATIONS 77
Process for Requesting Prior Authorizations 77
Speech Therapy Services 79
Physical and Occupational Therapy 79
Durable Medical Equipment 79
Services Requiring Authorization 80
Prior Authorization Decision Timeframes and Notification 81
Home Infusion 82
Pharmacy Services 83
MANAGING CARE TRANSITIONS 83
NEW TECHNOLOGY 84

CLAIMS AND BILLING 85

CLAIMS 85
General Information 85
Timely Filing 86
Electronic Claims Submission 86
Requirements for Submitting Claims to Gateway Through Emdeon and RelayHealth 87
Claims Review Process 88
Administrative Claims Review 88
Coordination of Benefits 88
Claim Coding Software 89
BILLING 89
Billing Procedures 89
Family Planning Services 91
Surgical Procedure Services 92
Hospital Services 92
UB-04 Data Elements for Submission of Paper Claim Forms 92
CMS-1500 (08-05) Data Elements for Submission of Paper Claim Forms .. 94

APPEALS AND GRIEVANCES 95

INTRODUCTION 95
WHAT ARE APPEALS AND GRIEVANCES? 95
ACTING AS AN AUTHORIZED REPRESENTATIVE 96
APPEALS REGARDING HOSPITAL DISCHARGE 97
SKILLED NURSING FACILITY (SNF), HOME HEALTH (HHA) OR COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF) SERVICES 98
QUALITY IMPROVEMENT ORGANIZATION (QIO) REVIEW 98
APPEALS FOR COVERAGE OF OTHER MEDICAL SERVICES 99
IRE REVIEW 100
ADMINISTRATIVE LAW JUDGE REVIEW 101
MEDICARE APPEALS COUNCIL 101
FEDERAL COURT 101
APPEALS FOR COVERAGE OF PART D DRUGS 101

INDEPENDENT REVIEW ENTITY (IRE) 103
ADMINISTRATIVE LAW JUDGE (ALJ) REVIEW 104
MEDICARE APPEALS COUNCIL 105
FEDERAL COURT 105
MEMBER GRIEVANCES 106
First Level Grievance 107
Second Level Grievance 107
Expedited Grievances 107
QUALITY IMPROVEMENT ORGANIZATION REVIEW 108
How to File a Quality of Care Complaint with the QIO 108
PROVIDER APPEALS 108
First Level Appeal (The Informal Dispute Resolution Process) 109
Second Level Appeal (The Informal Dispute Resolution Process) 109

MODEL OF CARE 111

OVERVIEW 111
SNP MODEL OF CARE ELEMENTS 111
HOW THE MODEL OF CARE WORKS FOR A MEMBER 113
OTHER IMPORTANT INFORMATION ABOUT GATEWAY'S MODEL OF CARE 113

PREVENTIVE HEALTH, DISEASE AND CARE MANAGEMENT 115

PREVENTIVE HEALTH PROGRAM 115
DISEASE MANAGEMENT PROGRAMS 115
MOM Matters® Program 115
Asthma Program 116
Diabetes Program 117
Help Your Heart Cardiac Program 118
CARE MANAGEMENT 118
General Information 118
Criteria for Referrals to the Care Management Department 119
Complex Case Management: 119

INTRODUCTION TO CREDENTIALING 121

WHO IS CREDENTIALED? 121
PURPOSE OF CREDENTIALING 121
CREDENTIALING STANDARDS 121
ONGOING AND PERFORMANCE MONITORING 123
PRACTITIONER ABSENCES 124
DENIAL AND TERMINATION 124
DELEGATED CREDENTIALING 125

FORMS AND REFERENCE MATERIALS 127

Quick Reference

Important Phone Numbers

Call to Inquire About:	Telephone Number	Hours of Operation
Community Behavioral HealthCare Network of Pennsylvania (CBHNP) Member Services	1-866-755-7299	24 hours a day/7 days a week
Davis Vision – Provider Servicing	1-800-933-9371	Monday-Friday 8:00 AM to 6:00 PM
United Concordia Companies, Inc.	1-866-568-5467	Monday-Friday 8:00 AM to 8:00 PM
Digital Voice Assistant (DIVA) (Eligibility Check)	1-800-642-3515	24 hours a day/7 days a week
Gateway Health Plan® Hotline to report Fraud and Abuse or Compliance Concerns	(412) 255-4340 or 1-800-685-5235	24 hours a day/7 days a week
Gateway Health Plan® Utilization Medical Management	1-800-685-5207 Due to lower call volumes, the best time to call is between 8:30 AM and 11:30 AM. For urgent requests, please stay on the line to have your call serviced.	Monday-Friday 8:30 AM to 4:30 PM (Calls received during non-business hours are referred to 1-800-685-5209)
Gateway Health Plan® Member Services	1-800-685-5209	Monday-Friday 8:00 AM to 8:00 PM
Gateway Health Plan® Pharmacy (Non-Formulary Requests and Prior Authorization)	1-800-685-5215 Fax 1-888-447-4369	Monday-Friday 8:30 AM to 4:30 PM
Gateway Health Plan® Care Management	1-800-685-5212 Option 1—Care Management Option 2—Maternity/MOM Matters® Option 3—Cardiac/Asthma Option 4—Preventive Health Services	Monday-Friday 8:30 AM to 4:30 PM
Gateway Health Plan® Provider Services (Claim Inquiries, Eligibility Verification and Supplies)	1-800-685-5205	Monday-Friday 8:30 AM to 4:30 PM
Gateway Health Plan® Part D Prescriber Appeals	1-800-213-7083	24 hours a day/7 days a week
Gateway Health Plan® TTY/TDD (for all departments)	711 or 1-800-682-8706	24 hours a day/7 days a week
Health Management Corporation (Diabetes Disease Management Program)	1-866-366-9415	24 hours a day/7 days a week
National Imaging Associates (NIA) (Authorization for CT, MRI/MRA, Nuclear Cardiology, and PET Scans)	1-888-879-5922 or www.RadMD.com	Monday-Friday 8:00 AM to 8:00 PM
Fitness Assured®	1-877-211-3917 (TTY 1-877-440-5580)	Monday-Friday 8:30 AM to 5:30 PM
MTM (Transportation Services)	1-866-670-3063 (TTY 1-800-855-2880)	Monday-Friday 8:00 AM – 5:00 PM, Saturday 9:00 AM to 1:00 PM

Important Addresses

Corporate Office: Gateway Health Plan® US Steel Tower, Floor 41 600 Grant Street Pittsburgh, PA 15219-2704	***Claims Office***: Gateway Health Plan® Claims Processing Center P.O. Box 69359 Harrisburg, PA 17106-9359

Reason for Mailing	**Address**
Claims (Medical and Behavioral Health)	Gateway Health Plan® Claims Processing Department P.O. Box 69359 Harrisburg, PA 17106-9359
Claims Inquiries and Administrative Reviews	Gateway Health Plan® Attention: Claims Review US Steel Tower, Floor 41 600 Grant Street Pittsburgh, PA 15219
Member and Provider Appeals	Gateway Health Plan® Attention: Medicare Complaints Administrator US Steel Tower, Floor 41 600 Grant Street Pittsburgh, PA 15219
Initial Applications for Credentialing	Gateway Health Plan® Attention: Network Development US Steel Tower, Floor 41 600 Grant Street Pittsburgh, PA 15219
Recredentialing Applications	Gateway Health Plan® Attention: Credentialing US Steel Tower, Floor 41 600 Grant Street Pittsburgh, PA 15219
Practice Change Information	Gateway Health Plan® Attention: Provider Relations US Steel Tower, Floor 41 600 Grant Street Pittsburgh, PA 15219
Vision Claims	Davis Vision Attention: Vision Card Processing Unit P.O. Box 1525 Latham, NY 12110
Dental Claims	United Concordia Companies, Inc. Claims Processing PO Box 69427 Harrisburg, PA 17106-9427

Introduction

About This Manual

Gateway Health Plan *Medicare Assured®'s* success, as measured by the benefits received by the practitioners, members, the Centers for Medicare and Medicaid Services (CMS) and Gateway Health Plan® ("Gateway"), is dependent upon strong educational processes. Understanding Gateway's policies and procedures is essential. Gateway's Provider Relations, Provider Services, Member Services, and Member Outreach staff, among others, is committed to providing accurate, up-to-date, and comprehensive information to our member and practitioner populations through prompt and dedicated service. The Provider Office Policy and Procedure Manual is one way of providing participating practitioner offices with information regarding Gateway's policies and procedures. This manual should be considered as a general guideline for practitioner offices. Please retain all updates with your manual.

This Manual and any updates are available on our website: www.GatewayHealthPlan.com. Choose the link for *Medicare Assured® HMO SNP*.

Overview of Gateway Health Plan Medicare Assured®

History

In 2005, Gateway Health Plan® was awarded a contract by CMS to provide Medicare Part A, Part B and Part D services to dual eligible beneficiaries in Pennsylvania beginning January 2006.

Gateway Health Plan *Medicare Assured® HMO SNP* is a Medicare Advantage HMO Special Needs Plan (SNP) for individuals with Medicare Part A, Medicare Part B and Medicaid (Full Medicaid or Qualified Medicare Beneficiary (QMB)).

As of 2012 Gateway Health Plan *Medicare Assured®* is offered in 28 counties throughout the state of Pennsylvania, making it one of the largest Special Needs Plans in the nation for the dual-eligible population, serving individuals who are eligible for both Medicare and Medical Assistance.

Gateway offers the following benefits to members enrolled in *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 asthma programs, and smoking cessation
- Bathroom safety products

- Fitness Assured®, a fitness program to help members stay active (including an @Home Pak for home-bound members)
- Transportation

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 Gateway's development of wellness, education and outreach programs to improve immunization compliance, to identify high-risk pregnant women, and to provide effective case management for members with chronic conditions such as Asthma, Diabetes, chronic heart conditions, and HIV/AIDS.

Mission

Gateway emphasizes the development and delivery of innovative programs to positively affect the personal health of its members. Gateway maintains a healthcare delivery system that ensures the availability of high quality medical care for the Gateway member, based upon access, quality and financial soundness.

Prospective Care Management

Gateway's goal is to help improve the health and well-being of its members. In an ongoing effort to accomplish this goal, Gateway developed Prospective Care Management (PCM®), a proactive holistic approach to healthcare. By identifying the Behavioral, Environmental, Economic, Medical, Social and Spiritual (BEEMSS℠) issues a member faces, Gateway can design a plan to ensure that the member receives the care he or she needs.

Gateway Lines of Business

Gateway offers two products in Pennsylvania:

- Medicare Special Needs Plan
- Medicaid HMO

Unlike many health insurance companies, Gateway focuses entirely on serving the needs of the most vulnerable citizens – the poor, elderly and disabled. Since its inception, Gateway has focused on providing the best possible healthcare to a growing number of Medicaid members. Gateway offers care for all kinds of health needs – everything from regular doctor visits to emergency care.

In 1992, Gateway Health Plan®, Inc. was established as an alternative to Pennsylvania's Department of Public Welfare's Medical Assistance Program. For nearly 20 years, members have benefited from services such as disease management, health and wellness programs and preventive care. Gateway Health Plan® holds an "Excellent" rating from the National Committee for Quality Assurance (NCQA), an independent agency that accredits and certifies managed care organizations, for its Medicaid HMO product. Gateway Health Plan® is also

recognized with a five-star "Excellent" Member Quality Rating from the 2009 CAHPS Survey.

Membership/Network

Gateway Health Plan *Medicare Assured*® serves more than 27,000 members in Pennsylvania. Gateway Health Plan® has more than 249,000 members. Gateway's provider network includes more than 10,000 health care providers, over 130 hospitals, a network of pharmacies, home healthcare agencies and other related healthcare providers.

Continuing Quality Care

Healthcare is an ever-changing field and Gateway strives to stay on top of its members' needs. Gateway is committed to continuous improvement and providing high standards of quality in every aspect of service. This commitment is led by Gateway's 18-member Quality Improvement/Utilization Management 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 clinical guidelines in order to improve service and care for its members.

Wellness & Disease Management

Gateway is committed to improving the life of its members and working to find new ways to promote wellness, illness prevention and health education as demonstrated by the following programs:

- Preventive health care guidelines
- Free quit tobacco program
- Pediatric and adult immunization reminders
- Cardiac disease prevention program
- Free personalized programs to assist patients with diabetes, asthma and depression

Health Care Disparities

Gateway understands that in order to help improve our members quality of life, we must take into account their 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 and language barriers. Gateway is continuously working to close the gap in health outcomes by focusing on education and prevention. One example of how we are working to close the quality gap can be seen in our culturally sensitive diabetes disease management programs. In order to improve information based interventions at the point of care, Gateway pays for primary care practitioners to perform in office HbA1c tests. Test results are available in five minutes and can be administered by a non-clinician. For more information, please contact your Provider Relations Representative. In addition, Gateway has cross-cultural

education programs in place to increase awareness of racial and ethnic disparities in health care among our employees, members and providers.

Community Involvement

Gateway is an active partner in the community through many outreach and community based activities. Gateway strives to improve the health and quality of life of its members as well as the community-at-large.

- Gateway participates in community events and sponsorships and provides assistance to community and social agencies that also serve a high-risk, vulnerable population.
- Gateway continually develops a variety of outreach programs for adults and children to provide education on health, wellness and safety issues. These programs are offered to the community at no cost.
- Gateway informs and partners with individuals and organizations through the Health Literacy Initiative. The goal of the initiative is to develop and implement programs that positively impact health and well-being by helping people better understand and navigate the healthcare system.

Benefits of Gateway Health Plan *Medicare Assured®*

Gateway is a "win-win" situation for all: the member, the practitioner and applicable state and federal agencies.

Benefits to the Gateway Health Plan *Medicare Assured®* Member: In addition to receiving added benefits currently not covered by Medicare, Gateway members enjoy improved access to primary medical care, health and wellness programs.

Benefits to the Practitioner: Timely payments, simplified administrative procedures and dedicated provider servicing are benefits of being a Gateway Health Plan *Medicare Assured®* practitioner.

Benefits to Gateway: Gateway benefits by fulfilling our mission, which ensures the availability of high quality medical care for the dual eligible population to positively affect the personal health of our members.

How Does Gateway Work?

Gateway's *Medicare Assured®* Practitioner Network

Gateway contracts directly with primary and specialty care practitioners, hospitals, and ancillary providers to provide care for our membership. 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 practitioners must be culturally sensitive to the needs of our members. Participation in Gateway Health Plan *Medicare Assured*® in no way precludes participation in any other program with which the practitioner may be affiliated.

Gateway's Provider Relations Role

We are keenly aware that, to provide exceptional access and quality of health care to our members, it is essential that our providers and their staff have a solid understanding of the member's needs, our contract requirements and other protocols, as well as applicable contract standards and Federal and/or State regulations.

Within 30 calendar days of successful completion of provider credentialing and approval to participate in our network our Provider Relations Department provides introductory training to providers and their office staff. The Provider Manual is delivered and reviewed in detail at this on-site orientation. This provider 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 Relations Representative, who is responsible for ongoing education in their assigned Service Region. As a follow-up to the initial orientation session, the assigned Provider Relations Representative regularly contacts each provider and their staff to ensure that they fully understand the responsibilities outlined in the Provider Agreements and Manual.

Primary Care Practitioner's Role

The definition of a primary care practitioner is a "specific practitioner, practitioner group or a 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 primary care practitioner is responsible for the coordination of a member's healthcare needs and access to services provided by hospitals, specialty care practitioners, ancillary services and other healthcare services.

Although members may obtain some healthcare services by self-referral, the majority of their healthcare services are obtained either directly from or upon referral by the primary care practitioner. With the exception of self-referred services, all the member's care must be provided or referred (a paper referral form is not required) by the primary care practitioner except in a true medical emergency when time does not permit a member to contact his/her primary care practitioner. To ensure continuity and coordination of care, when a member self-refers for care, a report should be forwarded to the primary care practitioner. By focusing all of a member's medical decisions through the primary care

practitioner, Gateway is able to provide comprehensive and high quality care in a cost-effective manner.

> *Our goal 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.*

Outpatient Mental Health Providers

Gateway Health Plan *Medicare Assured*® provides coverage for outpatient mental health services for its membership through Community Behavioral HealthCare Network of Pennsylvania (CBHNP).

Please call CBHNP to access a participating network provider in the member's area, or use Gateway's on-line Provider Directory at www.GatewayHealthPlan.com.

Also, if you have a member who needs additional assistance in accessing an outpatient mental health provider or has questions, please direct the member to call CBHNP. (Refer to the Quick Reference section in this manual for the appropriate telephone number.)

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 available to them, regardless of benefit coverage limitations. There is no language in Gateway's contracts that prohibits open clinical dialogue between practitioner and patient.

Quality Improvement

Purpose of the Quality Improvement Program

The Quality Improvement (QI) Program's purpose is to ensure the quality, safety, appropriateness, timeliness, availability and accessibility of care and service provided to Gateway members. The comprehensive evaluation and assessment of clinical, demographic, and community data in conjunction with current scientific evidence is paramount to understanding the membership and developing effective programs to meet the identified needs. The development of health care programs must be done in collaboration with all partners including members, practitioners, community agencies, regulators, and Gateway staff, not only to meet the current health care needs of the members served but to begin to address the future needs of the members. Essential to the success of these partnerships and programs is the establishment of meaningful data collection and

measurement of outcomes to assess the improvements in the quality of care and to identify where opportunities exist for improvement.

Goal of the Quality Improvement Program

The QI Program focuses on monitoring and evaluating the quality and appropriateness of care provided by Gateway's health care provider network, and the effectiveness and efficiency of systems and processes that support the health care delivery system. Utilizing quality improvement concepts and appropriately recognized quality measurement tools and reports, Gateway focuses on assessing its performance outcomes to identify opportunities for improvement in the provision and delivery of health care and health plan services, satisfaction with care and services, and achieving optimum member health outcomes.

Of specific importance, the QI Program focuses on three key areas: (a) preventive health care, (b) prevalent chronic health care conditions and (c) service indicators. The Program strives to improve members' compliance with preventive care guidelines and disease management strategies, therapies that are essential to the successful management of certain chronic conditions, and identify opportunities to impact racial and ethnic disparities in healthcare. Also, the QI Program strives to improve patient safety by educating members and practitioners in regard to safe practices, by assessing and identifying opportunities to improve patient safety throughout the practitioner/provider network and by communicating to members and practitioners safety activities and provisions that may be in place throughout the network.

By considering population demographics and health risks, utilization of health care resources, and financial analysis, the organization ensures that the major population groups are represented in QI activities and health management programs chosen for assessment and monitoring. This information, along with high-volume/high-cost medical and pharmaceutical reports, health risk appraisal data, disease management and care management data, satisfaction survey information, and other utilization reports, will be used to identify members with special needs and/or chronic conditions and develop programs and services to assist in managing their conditions.

Objectives of the Quality Improvement Program

The objectives of the QI Program are consistent with Gateway's mission, commitment to effective use of health care resources, and to continuous quality improvement. To ensure that the current needs of the population are being reviewed, changes noted, programs implemented to address the needs of members, and to ensure continuous quality improvement, an annual QI/UM Work Plan is developed in conjunction with the Utilization Management Department.

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:
Implement a QI/UM Work Plan that identifies and assures completion of planned activities for each year:

- ✓ Ensure processes are in place using Total Quality Management values to assess, monitor, and implement actions when opportunities are identified regarding the utilization of health care resources, quality of care, and access to services;
- ✓ Based on assessment of the population, develop and update guidelines that address key health care needs, which are based on scientific evidence and recommendations from expert and professional organizations and associations;
- ✓ Conduct studies to measure the quality of care provided, including established guideline studies, evaluate improvements made, determine barriers and opportunities and develop actions to address those opportunities;
- ✓ Evaluate the utilization and quality performance of Gateway practitioners and vendors to assure Gateway standards are met and to identify both opportunities and best practices. In a group effort with practitioners and vendors, identify barriers, opportunities and apply interventions as needed;
- ✓ Conduct satisfaction surveys to determine member and provider satisfaction with Gateway services, organizational policies, and the provision of health care. Review results for barriers, opportunities and apply interventions to increase satisfaction and to improve the quality of care and services provided.

Scope of the Quality Improvement Program

Implementation and evaluation of the QI Program is embedded into Gateway's daily operations. The QI Program has available and will utilize appropriate internal resources, race and ethnic data, information systems, practitioners, and community resources to monitor and evaluate utilization of health care patterns, the continuous improvement process and to assure implementation of positive change. The scope of the program includes:

The scope of the Program includes:

- ✓ Enrollment
- ✓ Members' Rights and Responsibilities
- ✓ Network Accessibility and Availability, including those related to Special Needs
- ✓ Network Credentialing/Recredentialing
- ✓ Medical Record Standards
- ✓ Quality of Care Case Reviews
- ✓ Never Event Reviews

- ✓ Member, Provider and Employee Education
- ✓ Member and Provider Services
- ✓ Claims Administration
- ✓ Fair, Impartial and Consistent Utilization Review
- ✓ Evaluating the Health Care Needs of Members
- ✓ Preventive Health, Disease Management, and Case Management Services
- ✓ 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 1-800-685-5205.

Quality Improvement Manual

The Quality Improvement Manual is designed as a resource to assist practitioners in caring for Gateway members. The manual consists of clinical practice and preventive 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 and relevance to Gateway members. The use of guidelines permits Gateway Health Plan® to measure the impact of the guidelines on outcomes of care and may reduce inter-practitioner variation in diagnosis and treatment.

Clinical practice and preventive 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: Adult HIV Clinical Practice Guideline, Adult Preventive, Care of Adults with Diabetes Mellitus, Child Preventive, Cardiac Medical Management, Hypertension, Lead Screening and Follow-up Guideline, Management of the Patient with Asthma, Chronic Obstructive Lung Disease Guideline and Prenatal Care. In addition to the guidelines, the Medical Record Review procedure and standards are included. To facilitate distribution of the most current version of these guidelines and standards, they have been added to Gateway's web site at www.GatewayHealthPlan.com. A paper copy of the Quality Improvement Manual and individual guidelines are available upon request. For a paper copy, please contact the Quality Improvement Department at 412-255-1144.

Patient Safety

Patient safety is the responsibility of every healthcare professional. Health care errors can occur at any point in the health care delivery system and can be costly in terms of human life, function, and health care dollars. There is also a price in terms of lost trust and dissatisfaction experienced by both patients and health care 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 Quality Improvement Department how you can support compliance with our safety initiatives.

Gateway also works to ensure 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, Never Events, 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: http://www.nap.edu/books/0309068371/html/

JCAHO National Patient Safety Goals:
http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/

National Patient Safety Foundation: http://www.npsf.org/

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

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

Medical Record Reviews
Gateway performs several different medical record reviews to:

- Help ensure quality services are provided

- Allow for proper disease management
- Respond to regulator's requests
- Facilitate accurate and complete data is sent to CMS
- Allow for proper risk scoring by CMS of each member

Complete and accurate coding is essential for Gateway to accomplish the above objectives and our mission.

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, 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. The process includes a medical record review and possible telephonic or mail communication with the practitioner/provider. Upon final determination if an actual event has been discovered, Gateway will notify the practitioner/provider by mail that payment denial or retraction will occur. Should you have any questions, please contact your Provider Relations Representative or you may also contact Gateway's Provider Services Department at 1-800-685-5205.

Living Will Declaration

Advance Directives

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

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

As a participating provider within the Gateway Health Plan *Medicare Assured®* network, you are responsible for determining if the member has executed an advance directive and for providing education about advance directives when it is

requested. While there is no specific governmentally mandated form, you can request a copy of a "Living Will" form from Gateway's Quality Improvement Department by calling 412-255-1144. A copy of the "Living Will" form should be maintained in the member's medical record. Gateway's Medical Record Review Standards state that providers should ask members age 21 and older whether they have executed an advance directive and document the member's response in their medical records.

Providers will receive educational materials regarding a member's right to advance directives upon entering the Gateway practitioner network.

Member Outreach

Gateway practitioners can request assistance from the Member Services Department to provide additional education to members who need further explanation on such issues as the importance of keeping scheduled appointments.

Practitioners can refer non-adherent members for additional education regarding their benefits and services 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 Care Management Department at 1-800-685-5212 and press option 4. You can also fax the Member Outreach Form to the fax number listed on the Form.

Member

The Enrollment/Disenrollment Process

Gateway Health Plan *Medicare Assured*® Medicare Advantage Prescription Drug Plan (MA-PD) is a Special Needs Plan (SNP) for people with Medicare Part A, Medicare Part B and Medicaid (Full and QMB). The Centers for Medicare and Medicaid (CMS) has periods when beneficiaries can enroll or disenroll with/from Medicare plans throughout the year. These times are known as election periods. Because Gateway Health Plan *Medicare Assured*® is a Special Needs Plan (SNP), all of our members qualify for the Special Election Period (SEP) every month. The SEP permits our members to enroll and disenroll at any time throughout the year.

Members can enroll into our plan by using any of these methods:

- Mailing in a paper enrollment form
- Enrolling on-line through Medicare's website
- Downloading an enrollment form from Gateway's website at www.GatewayHealthPlan.com/Medicare - click on 'Become a Member' and mailing it in.
- By calling Gateway Health Plan *Medicare Assured*® at 1-877-GATEWAY (TTY users should call 711 or 1-800-682-8706).
- By contacting Medicare at: 1-800-MEDICARE or www.medicare.com.

Members can disenroll from our plan by completing a paper disenrollment form or sending a letter/fax to Gateway Health Plan *Medicare Assured*®. Members may also contact Medicare at 1-800-MEDICARE (TTY: 1-877-486-2048) or www.medicare.com. Members may also disenroll from Gateway Health Plan *Medicare Assured*® by simply enrolling in another HMO or Part D plan. Members should call Gateway Health Plan® or visit www.GatewayHealthPlan.com/Medicare for additional information.

Member enrollments are made effective the first day of the calendar month, and member disenrollments are made effective the last day of the calendar month.

Member ID Cards

Each *Medicare Assured*® member will receive an ID card. Each card is issued once, unless cards are requested or reissued due to a demographic or PCP change. ID Cards are good for as long as the person is a member of Gateway Health Plan *Medicare Assured*®.

(Sample of a Member ID Card)

Members age 21 and over will need to use their Gateway Health Plan *Medicare Assured*® ID card and keep their Medicaid Access card to use for services covered under Medical Assistance and to cover Medicare deductibles and coinsurance, as long as the provider also participates with Medicaid.

Members under the age of 21 will use their Gateway Health Plan *Medicare Assured*® ID card and their Medicaid HMO plan ID card. These members will need to keep their Medicaid Access card for non-Medical assistance services, such as transportation through the Medical Assistance Transportation Program (MATP) or cash assistance.

Determining Eligibility

Because of potential changes in a member's eligibility, each participating practitioner is responsible to verify a member's eligibility with Gateway Health Plan *Medicare Assured*® **BEFORE** providing services. Verifying a member's eligibility will ensure proper reimbursement for services. To verify a member's eligibility, the following methods are available to all practitioners:

1. Gateway Health Plan *Medicare Assured*® Identification Card: The card itself does **NOT** guarantee that a person is currently enrolled in Gateway Health Plan *Medicare Assured*®. Members are **NOT** required to return their identification cards when they are no longer eligible for Gateway Health Plan *Medicare Assured*®.

2. Gateway's Digital Voice Assistant (DIVA): The Gateway DIVA System (1-800-642-3515) is available 24 hours a day, 7 days a week. To verify member eligibility at each visit, practitioners follow a few simple steps, which are listed below:

Press 1 to verify eligibility

Member Identification Number?

Press 1 to verify eligibility using the patient's social security number, when prompted enter the patient's 9-digit social security number

Press 2 to verify eligibility using the patient's Gateway member identification number, when prompted enter the patient's 8-digit Gateway Health Plan *Medicare Assured*® identification number
Press 3 to verify eligibility using the patient's Medical Assistance recipient identification number, when prompted enter the patient's Medical Assistance recipient number (Note: This option can not be used for Gateway Health Plan *Medicare Assured*® members.)
Press 4 to verify eligibility using the patient's Medicare Health Insurance Claim (HIC) number, when prompted enter the patient's HIC number, followed by the # sign. (For letters press the corresponding key on your touch tone phone. For example: To enter an A, B, or C, press the 2 key. For Q, press the 7 key. For Z, press the 9 key.)
Press 0 to speak to a Provider Services Representative
Press 9 to repeat the menu

Verification of Date?
Press 1 to verify whether the patient is eligible TODAY
Press 2 to verify whether the patient is eligible on a specific date (enter date)
Press 9 to listen to the instructions again
Press 0 to speak to a Provider Services Representative

Additional Instructions:
Press 1 to receive additional information about the patient/member
Press 2 to receive the patient's primary care practitioner name and telephone number
Press 3 to fax information regarding the patient whose eligibility is being verified
Press 4 to verify eligibility for another patient/member
Press 5 to exit
Press 6 to return to the previous menu
Press 0 to speak to a Provider Services Representative

Primary Care Practitioner's Role in Determining Eligibility

Primary care practitioners 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 primary care practitioner 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 the Gateway Health Plan *Medicare Assured*® Provider Services Department for help in determining eligibility at 1-800-685-5205.

Benefits

Medical Benefits

Gateway Health Plan *Medicare Assured*® members are eligible for all the benefits covered under the Original (Fee-for-service) Medicare Program. In addition,

Gateway Health Plan *Medicare Assured*® offers additional benefits for dental, vision, hearing and health and wellness services. For a complete list of covered benefits, please refer to the Benefits Chart below, which is an excerpt from the member's Evidence of Coverage. A complete copy of the Evidence of Coverage booklet is located on our website at www.GatewayHealthPlan.com/Medicare. Members obtain most of their healthcare services either directly from their primary care practitioner or upon referral (approval in advance) by an in-network specialist/ancillary provider; except for services available on a self-referral basis, such as OB/GYN services and routine vision services. The primary care practitioner 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.

Summary of Benefits

The covered services listed in the Benefits Chart in this section are covered only when all requirements listed below are met:

- Services must be provided according to the Original Medicare coverage guidelines established by the Medicare Program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Medically necessary refers to services or supplies that: are proper and needed for the diagnosis or treatment of the member's medical condition; are used for the diagnosis, direct care, and treatment of the member's medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of the member or the member's doctor. Certain preventive care and screening tests are also covered.
- With few exceptions, covered services must be provided by plan providers, be approved in advance by plan providers, and some services may need to be authorized by our Plan.

In addition, some covered services require "prior authorization" by the Plan in order to be covered. Some of the covered services listed in the Benefits Chart in this section are covered only if the member's doctor or other plan provider gets "prior authorization" (approval in advance) from our Plan. Covered services that need prior authorization (approval ahead of time) are marked in the Benefits Chart with an asterisk (*).

NOTE: The chart on the following pages provides the Gateway Health Plan *Medicare Assured*® cost-sharing, NOT the original Medicare cost sharing. Cost-sharing is paid by Medicaid depending upon the member's Medicaid eligibility.

If you have any questions about this plan's benefits or costs, please contact Gateway Health Plan *Medicare Assured® HMO SNP* for details.		
Benefit Category	**Original Medicare**	**Gateway Health Plan *Medicare Assured® HMO SNP***
1. **Premium and Other Important Information**	In 2011, the monthly Part B Premium is $0 and the yearly Part B deductible is $0. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	General *** All cost sharing in this Summary of Benefits is based on your level of Medicaid eligibility.** $0 monthly plan premium.* This plan covers all Medicare-covered preventive services with zero cost sharing. In-Network $0 yearly deductible.* $3,400 out-of-pocket limit. This limit includes only Medicare-covered services.
2. Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16)	You may go to any doctor, specialist or hospital that accepts Medicare.	In-Network You must go to network doctors, specialists, and hospitals. No referral required for network doctors, specialists, and hospitals.

If you have any questions about this plan's benefits or costs, please contact Gateway Health Plan *Medicare Assured® HMO SNP* for details.		
Benefit Category	**Original Medicare**	**Gateway Health Plan *Medicare Assured® HMO SNP***
INPATIENT CARE		
3. Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	For each benefit period: Days 1 - 60: $0 deductible* Days 61- 90: $0 per day* Days 91 - 150: $0 per lifetime reserve day* Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.	In-Network $0 yearly deductible.* $175. per day co-payment.* No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
4. Inpatient Mental Health Care	Same deductible and co-payment as inpatient hospital care (see "Inpatient Hospital Care" above). 190 day limit in a Psychiatric Hospital.	In-Network $0 yearly deductible.* $115. per day co-payment, days 1-15.* Plan covers 60 lifetime reserve days. $0 co-payment per lifetime reserve day.* For hospital days: Days 91-190: $0 co-payment per day.* Contact the plan for details about coverage in Psychiatric Hospital beyond 190 days. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

If you have any questions about this plan's benefits or costs, please contact Gateway Health Plan *Medicare Assured® HMO SNP* for details.		
Benefit Category	**Original Medicare**	**Gateway Health Plan *Medicare Assured® HMO SNP***
5. Skilled Nursing Facility (SNF) (In a Medicare-Certified skilled nursing facility)	In 2011, the amounts for each benefit period after at least a 3-day covered hospital stay: Days 1-20: $0 per day* Days 21 – 100: $0 per day* 100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you may have.	<u>General</u> Authorization rules may apply. <u>In-Network</u> $0 yearly deductible.* $0 co-payment for SNF services.* You will not be charged additional cost sharing for professional services. For non-Medicare-covered SNF stays: Days 1-20: Medicare defined copayment amount Days 21-100: Medicare defined copayment amount Plan covers up to 100 days each benefit period. No prior hospital stay is required.
6. Home Health Care (Includes medically necessary intermittent skilled nursing care, home health aide services and rehabilitation services, etc.)	$0 co-payment.	<u>General</u> Authorization rules may apply. <u>In-Network</u> $0 co-payment for Medicare-covered home health visits.*
7. Hospice	You pay part of the cost for outpatient drugs. You must get care from a Medicare-covered hospice.	<u>In-Network</u> You must get care from a Medicare-certified hospice.

If you have any questions about this plan's benefits or costs, please contact Gateway Health Plan *Medicare Assured® HMO SNP* for details.		
Benefit Category	**Original Medicare**	**Gateway Health Plan *Medicare Assured® HMO SNP***
OUTPATIENT CARE		
8. Doctor Office Visits	0% coinsurance.	General See "Physical Exams," for more information. In-Network 20% co-insurance for each primary care doctor visit for Medicare-covered benefits.* 20% co-insurance for the cost of each in-area, network urgent care Medicare-covered visit.* 20% co-insurance for each specialist doctor visit for Medicare-covered benefits.*
9. Chiropractic Services	Routine care not covered. 0% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified provider.	General Authorization rules may apply. In-Network 20% co-insurance for Medicare-covered visits.* Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.
10. Podiatry Services	Routine care not covered. 0% coinsurance for medically necessary foot care, including care for medical conditions affecting the low limbs.	In-Network 20% co-insurance for Medicare-covered podiatry benefits.* 20% co-insurance of the cost for each routine visit.* Medicare-covered podiatry benefits are for medically-necessary foot care.

If you have any questions about this plan's benefits or costs, please contact Gateway Health Plan *Medicare Assured® HMO SNP* for details.		
Benefit Category	**Original Medicare**	**Gateway Health Plan *Medicare Assured® HMO SNP***
11. Outpatient Mental Health Care	0% coinsurance for most outpatient mental health services.	General Authorization rules may apply. In-Network 40% co-insurance for Medicare-covered Mental Health visits.* 40% co-insurance for each Medicare-covered visit with a psychiatrist.*
12. Outpatient Substance Abuse Care	0% coinsurance.	General Authorization rules may apply. In-Network 20% co-insurance for Medicare-covered visits.*
13. Outpatient Services/Surgery	0% coinsurance for the doctor. 0% of outpatient facility.	In-Network 20% co-insurance for each Medicare-covered ambulatory surgical center visit.* 20% co-insurance for each Medicare-covered outpatient hospital facility visit.*
14. Ambulance Services (Medically necessary ambulance services)	0% coinsurance.	General Authorization rules may apply. In-Network 20% co-insurance for Medicare-covered ambulance benefits.*
15. Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	0% coinsurance for the doctor. Specified co-payment for outpatient hospital emergency room (ER) facility charge. You don't have to pay the emergency room co-payment if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. NOT covered outside the U.S. except under limited circumstances.	General 20% co-insurance for Medicare-covered emergency room visits.* Not covered outside the U.S. except under limited circumstances. Contact the Plan for more details.

If you have any questions about this plan's benefits or costs, please contact Gateway Health Plan *Medicare Assured® HMO SNP* for details.		
Benefit Category	**Original Medicare**	**Gateway Health Plan *Medicare Assured® HMO SNP***
16. Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	0% coinsurance, or a set co-payment. NOT covered outside the U.S. except under limited circumstances.	General 20% co-insurance for Medicare-covered urgent-care visits.*
17. Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy, Respiratory Therapy Services, Social/Psychological Services and more)	0% coinsurance.	General Authorization rules may apply. In-Network 20% co-insurance for Medicare-covered Occupational Therapy visits.* 20% co-insurance for Medicare-covered Physical and/or Speech and Language Therapy visits.* 20% co-insurance for Medicare-covered Cardiac Rehab services.*
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18. Durable Medical Equipment (Includes wheelchairs, oxygen, etc.)	0% coinsurance.	General Authorization rules may apply. In-Network 20% co-insurance for Medicare-covered items.*
19. Prosthetic Devices (Includes braces, artificial limbs and eyes, etc.)	0% coinsurance.	General Authorization rules may apply. In-Network 20% co-insurance for Medicare-covered items.*

If you have any questions about this plan's benefits or costs, please contact Gateway Health Plan *Medicare Assured® HMO SNP* for details.		
Benefit Category	**Original Medicare**	**Gateway Health Plan *Medicare Assured® HMO SNP***
20. Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (Includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/glaucoma test, and foot exam/therapeutic soft shoes)	0% coinsurance. Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	In-Network 20% co-insurance for Diabetes Self-Monitoring Training.* 20% co-insurance for Nutrition Therapy for Diabetes.* 20% co-insurance for Diabetes supplies.*
21. Diagnostic Tests, X-rays, and Lab Services.	0% coinsurance for diagnostic tests and x-rays. $0 co-payment for Medicare-covered lab services. Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.	General Authorization rules may apply. In-Network 20% co-insurance for Medicare-covered: - therapeutic radiology services* - diagnostic procedures and tests* - lab services* - X-rays* - diagnostic radiology services (not including X-rays).*

If you have any questions about this plan's benefits or costs, please contact Gateway Health Plan *Medicare Assured® HMO SNP* for details.		
Benefit Category	**Original Medicare**	**Gateway Health Plan *Medicare Assured® HMO SNP***
PREVENTIVE SERVICES		
22. Bone Mass Measurement (For people with Medicare who are at risk)	No coinsurance, co-payment or deductible. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions..	General Authorization rules may apply. In-Network 20% co-insurance for Medicare-covered bone mass measurement.*
23. Colorectal Screening Exams (For people with Medicare age 50 and older)	No coinsurance, co-payment or deductible for screening colonoscopy or screening flexible sigmoidoscopy. Covered when you are high risk or when you are age 50 and older.	In-Network $0 co-payment for Medicare-covered colorectal screenings.* 0% of the cost for additional screenings.* No limit on the number of covered colorectal screenings.
24. Immunizations (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)	$0 co-payment for Flu and Pneumonia and Hepatitis B vaccines. . You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	In-Network $0 co-payment for Flu and Pneumonia vaccines.* $0 co-payment for Hepatitis B vaccine.* No referral needed for Flu and Pneumonia vaccines.
25. Mammograms (Annual Screening) (For women with Medicare age 40 and older)	No coinsurance, co-payment or deductible. No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	In-Network $0 co-payment for Medicare-covered screening mammograms.* $0 co-payment for additional screening mammograms.* No limit on the number of covered screening mammograms

If you have any questions about this plan's benefits or costs, please contact Gateway Health Plan *Medicare Assured® HMO SNP* for details.		
Benefit Category	**Original Medicare**	**Gateway Health Plan *Medicare Assured® HMO SNP***
26. Pap Smears and Pelvic Exams (For women with Medicare)	No coinsurance, co-payment or deductible for Pap smears. No coinsurance, co-payment or deductible for Pelvic and clinical breast exams. Covered once every 2 years. Covered once a year for women with Medicare at high risk. 0% coinsurance for Pelvic Exams.	In-Network $0 co-payment for Medicare-covered pap smears and pelvic exams.* 0% of the cost for additional pap smears and pelvic exams.* No limit on the number of covered pap smears and pelvic exams.
27. Prostate Cancer Screening Exams (For men with Medicare age 50 and older)	0% coinsurance for the digital rectal exam. $0 for the PSA test and other related services. Covered once a year for all men with Medicare over age 50.	In-Network $0 co-payment for Medicare-covered prostate cancer screening.* 0% of the cost for additional screening(s).* No limit on the number of covered prostrate cancer screenings.
28. End-Stage Renal Disease	0% coinsurance for renal dialysis. 0% coinsurance for Nutrition Therapy for End-Stage Renal Disease. Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	In-Network 20% co-insurance for renal dialysis.* 20% co-insurance for Nutrition Therapy for End-Stage Renal Disease.*

If you have any questions about this plan's benefits or costs, please contact Gateway Health Plan *Medicare Assured® HMO SNP* for details.		
Benefit Category	**Original Medicare**	**Gateway Health Plan *Medicare Assured® HMO SNP***
29. Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Home Infusion Drugs, Supplies, and Services** 20% co-insurance for home infusion drugs that would normally be covered under Part D. This cost-sharing amount will also cover the supplies and services associated with home infusion of these drugs. General $0 year deductible for Part B-covered drugs.* 20% co-insurance for Part B covered chemotherapy drugs and other Part B covered drugs.* **Drugs covered under Medicare Part D.** General This plan uses a formulary. The Plan will send you the formulary. You can also see the formulary at www.GatewayHealthPlan.com/Medicare on the web. Different out-of-pocket costs may apply for people who - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Services). Your in-network prescription coverage may be limited to the Plan's service area. This means that if you travel outside the service area, you may have to pay the full cost of your prescription. In certain emergencies, your drugs will be covered if you get them at an out-of-network pharmacy although you may have to pay additional charges. Contact the Plan for details.

If you have any questions about this plan's benefits or costs, please contact Gateway Health Plan *Medicare Assured® HMO SNP* for details.		
Benefit Category	**Original Medicare**	**Gateway Health Plan *Medicare Assured® HMO SNP***
29. Prescription Drugs (continued)		Total yearly drug costs are the total drug costs paid by you, the plan, and Medicare. The Plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Gateway Health Plan *Medicare Assured® HMO SNP* for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the Plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed

If you have any questions about this plan's benefits or costs, please contact Gateway Health Plan *Medicare Assured® HMO SNP* for details.		
Benefit Category	**Original Medicare**	**Gateway Health Plan *Medicare Assured® HMO SNP***
29. Prescription Drugs (continued)		on the Plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. <u>In-Network:</u> You pay $0 yearly deductible. **Initial Coverage** Depending on your income and institutional status, you pay the following: For generic drugs (including brand drugs treated as generic), either: • A $0 co-payment; or • A $1.10 co-payment; or • A $2.60 co-payment. For all other drugs, either: • A $0 co-payment; or • A $3.30 co-payment; or • A $6.50 co-payment. **Retail Pharmacy:** You can get drugs the following way(s): • one-month (30-day) supply. **Long term Care Pharmacy:** You can get drugs the following way(s): • one-month (31-day) supply.

If you have any questions about this plan's benefits or costs, please contact Gateway Health Plan *Medicare Assured® HMO SNP* for details.		
Benefit Category	**Original Medicare**	**Gateway Health Plan *Medicare Assured® HMO SNP***
29. Prescription Drugs (continued)		**Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you pay $0 co-payment. **<u>Out-of-Network</u>** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside the Plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Gateway Health Plan *Medicare Assured® HMO SNP*. You can get drugs the following way: • one-month (30-day) supply. **<u>Out-of-Network Initial Coverage</u>** Depending on your income and institutional status, you will be reimbursed by Gateway Health Plan *Medicare Assured®* (HMO SNP) up to the full cost of the drug minus the following: For generic drugs purchased out-of-network (including brand drugs treated as generic), either: • A $0 co-payment; or • A $1.10 co-payment; or

If you have any questions about this plan's benefits or costs, please contact Gateway Health Plan *Medicare Assured® HMO SNP* for details.		
Benefit Category	**Original Medicare**	**Gateway Health Plan *Medicare Assured® HMO SNP***
29. Prescription Drugs (continued)		• A $2.60 co-payment for generic drugs. For all other drugs purchased out-of-network, either: • A $0 co-payment; or • A $3.30 co-payment; or • A $6.50 co-payment. **<u>Out-of-Network Catastrophic Coverage</u>** You be reimbursed in full for drugs purchased out-of-network.
30. Dental Services	Preventive dental services (such as cleaning) not covered.	<u>In-Network</u> 20% co-insurance for Medicare-covered dental benefits.* • Up to 1 oral exam(s) every six months. • Up to 1 cleaning(s) every six months. • Up to 1 dental x-ray(s) every six months. Plan offers additional comprehensive dental benefits Members may receive one set of dentures every 5 years. $500 limit for comprehensive dental benefits every two years.
31. Hearing Services	Routine hearing exams and hearing aids not covered. 0% coinsurance for diagnostic hearing exams.	<u>In-Network</u> 20% co-insurance for Medicare-covered diagnostic hearing exams* $0 co-payment for: - routine hearing tests.* - fitting-evaluations for a hearing aid.* $0 co-payment for hearing aids.* $1,000 limit for routine hearing aids every two years.

If you have any questions about this plan's benefits or costs, please contact Gateway Health Plan *Medicare Assured® HMO SNP* for details.		
Benefit Category	**Original Medicare**	**Gateway Health Plan *Medicare Assured® HMO SNP***
32. Vision Services	0% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	In-Network 20% co-insurance for diagnosis and treatment for diseases and conditions of the eye.* And, up to 1 routine eye exam(s) every three months. $0 co-payment for – One pair of eyeglasses or contact lenses after each cataract surgery.* – Up to 1 pair(s) of glasses every year, OR – Up to 1 pair(s) of contacts every year. $150 limit for eye wear every year.
33. Welcome to Medicare; and Annual Wellness Visit	When you join Medicare Part B, then you are eligible as follows: During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare exam or an Annual Wellness visit. After your first 12 months, you can get one Annual Wellness visit every 12 months. There is no coinsurance, co-payment or deductible for either the Welcome to Medicare exam or the Annual Wellness visit. The Welcome to Medicare exam does not include lab tests.	In-Network $0 co-payment for routine exams. Limited to 1 exam(s) every year. $0 co-payment for the required Medicare-covered initial preventive physical exam and annual wellness visits.* $0 co-payment for Medicare-covered HIV screening.* HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.

If you have any questions about this plan's benefits or costs, please contact Gateway Health Plan *Medicare Assured® HMO SNP* for details.		
Benefit Category	**Original Medicare**	**Gateway Health Plan *Medicare Assured® HMO SNP***
34. Health/Wellness Education	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies. $0 co-payment for HIV Screening. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.	In-Network This Plan covers the following health/wellness education benefits. • Written health education materials, including newsletters • Additional Smoking Cessation • Health Club Membership/Fitness Classes • Other Wellness Benefits $0 co-payment for Medicare-covered smoking cessation counseling session.* $0 co-payment for each Medicare-covered HIV Screening.* HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.
35. Transportation (Routine)	Not covered.	General Authorization rules may apply In-Network $0 co-payment for up to 36 one-way trip(s) to Plan-approved location(s) every year.
36. Acupuncture	Not covered.	In-Network This Plan does not cover Acupuncture.

Dental Services

Gateway Health Plan *Medicare Assured*® recognizes the importance of good dental health. Members are eligible to receive the following:

Routine Dental Services

- One (1) oral exam every six (6) months,
- One (1) cleaning every six (6) months
- One (1) dental x-ray every six (6) months, and
- One (1) panoramic x-ray every five (5) years.

Comprehensive Dental Services

- Up to $500 every two (2) years toward minor restorations (such as fillings), simple extractions and denture repair.
- One set of dentures every five (5) years.

Transportation Services

Gateway Health Plan *Medicare Assured*® members are eligible to receive at no cost:

- 36 one-way trip(s) to Plan-approved locations every calendar year
- Includes non-emergent transportation to doctor visits; dental, vision, hearing, and behavioral health services; and to pharmacies and fitness centers.
- Authorization and scheduling rules may apply.

Health Management Programs

Gateway Health Plan *Medicare Assured*® cares about members health and well-being. We believe good service means doing our best to help members stay healthy, lead an active lifestyle, and improve members quality of life.

Gateway Health Plan *Medicare Assured*® has special programs available for members to address heart disease, diabetes, and asthma and can provide information about health education and wellness services such as smoking cessation. Nurse care managers are available to help members stay on top of things (qualifications apply).

Hearing Services

In addition to routine hearing exams, Gateway Health Plan *Medicare Assured*® members will receive fittings and evaluations for hearing aids. In addition, members are covered up to $1,000 for hearing aids every two (2) years.

Vision Services

Gateway Health Plan *Medicare Assured*® members are eligible to receive four (4) routine eye exams every calendar year. In addition, Gateway Health Plan *Medicare Assured*® also provides:

Eyeglasses
- One (1) pair of eyeglasses every calendar year.
- Members may receive vendor frames and standard lenses, or
- Receive up to $90 toward non-vendor frames

OR,

Contacts
- One (1) pair of standard contact lenses every calendar year, or
- Up to $150 toward specialty contact lenses every calendar year.

If members wish to purchase eyewear that totals more than $150, members will be responsible for the difference in price.
No referral is needed to take advantage of this benefit; simply members select a vision care provider in our participating provider network.

Fitness Assured® Wellness Program

Members of Gateway Health Plan *Medicare Assured*®, are automatically eligible for our ***Fitness Assured***® program. Designed to help keep members feeling fit, *Fitness Assured*® offers members the opportunity to enjoy a membership to a network fitness center and access to resources that promote exercise and a healthy diet.

We understand that sometimes going to a Fitness Center isn't an option for our members. To help members stay fit while at home, Gateway Health Plan *Medicare Assured*® can provide members with home fitness products.

Bathroom Safety Items

Gateway Health Plan *Medicare Assured*® can help members make their bathroom a safer place. Gateway Health Plan *Medicare Assured*® members may receive up to $100 a calendar year for bathroom safety products (such as bath/shower chairs, bathtub rails and bathtub stool or bench).

ADDITIONAL INFORMATION ON PLAN BENEFITS

Skilled Nursing Facility

There is a 100 day limit for each skilled nursing facility admission. Members must work with their provider to get authorization from Gateway Health Plan *Medicare Assured*® before they are admitted to a skilled nursing facility. If members do not get authorization, members may be responsible for charges incurred.

General Exclusions

In addition to any exclusions or limitations described in the Benefits Chart or anywhere else in the Evidence of Coverage booklet, **the following items and services aren't covered except as indicated by Gateway Health Plan *Medicare Assured*®:**

1. Services not considered reasonable and necessary, according to the standards of Original Medicare, unless these services are otherwise listed by our Plan as a covered service.
2. Experimental medical and surgical procedures, equipment and medications, unless covered by the Original Medicare. However certain services may be covered under a Medicare-approved clinical research study.
3. Surgical treatment of morbid obesity, except when it is considered medically necessary and covered under the Original Medicare plan.
4. Private room in a hospital, except when it is considered medically necessary.
5. Private duty nurses.
6. Personal items in member's rooms at a hospital or skilled nursing facility, such as a telephone or a television.
7. Full-time nursing care in member's homes.
8. Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps members with activities of daily living, such as bathing or dressing.
9. Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
10. Fees charged by member's immediate relatives or household members.
11. Meals delivered to members homes.
12. Elective or voluntary enhancement procedures, services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
13. Cosmetic surgery or procedures because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
14. Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
15. Orthopedic shoes, unless they are part of a leg brace and are included in the cost of the brace or the shoes are form a person with diabetic foot disease.
16. Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
17. Radial keratotomy, LASIK surgery, vision therapy and other low vision aids.
18. Outpatient prescription drugs including drugs for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
19. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
20. Acupuncture.
21. Naturopath services (uses natural or alternative treatments).
22. Counseling or referral services that *Medicare Assured*® objects to based on moral or religious grounds. In the case of *Medicare Assured*®, we won't give counseling or referral services related to contraceptive services, female

sterilization services, male sterilization services and abortion services. To the extent these services are covered by Medicare, they will be covered through an alternative process.

23. Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our Plan, we will reimburse veterans for the difference. Members are still responsible for cost-sharing amount.

Any of the services listed above that aren't covered will remain not covered even if received at an emergency facility.

At any time during the year, the Medicare program can change its national coverage. Since Gateway covers what Original Medicare covers, we would have to make any change that the Medicare program makes. These changes could be to increase or decrease benefits, depending on the Medicare program changes.

Prescription Drug Benefits

Full prescription drug benefits are available to all members. Prescriptions must be filled by a Gateway participating pharmacy in order to be covered by Gateway. When a member travels outside of the Gateway service area and must access a non-participating pharmacy, the member should utilize any Argus contracted Pharmacy and the claims should be billed to Gateway via the Argus Network.

Gateway contracts with Argus to develop a network of chain, independent, home infusion and long-term care pharmacies in order to provide pharmaceuticals to Gateway members. A list of participating pharmacies can be obtained by contacting Gateway's Member Services Department at 1-800-685-5209.

Prescriptions are available to members who are eligible for pharmacy coverage when written by a Gateway practitioner. As long as a member's Medical Assistance coverage is in effect, Gateway Health Plan *Medicare Assured*® will pay for the first $2,930 in covered prescription drug costs. Members are not responsible for any deductible. There is $1.10 or $2.60 co-payment for generic prescription drugs and $3.30 or $6.50 co-payment for brand name prescription drugs, depending on their income level. After a member's total yearly prescription drug costs exceed $2,930 in costs, members are responsible for a $1.10 or $2.60 co-payment for each covered generic prescription drug or preferred drug that is a multi-source drug and $3.30 or $6.50 for each covered brand name prescription drug, depending on their income level. Once a member's yearly prescription drugs costs exceed $6,657.50, they pay nothing for their prescription drugs.

PRESCRIPTION DRUG COVERAGE

Formulary

Visit www.GatewayHealthPlan.com/Medicare for the most recent version of the formulary.

Co-payments

***Medicare Assured®* Member Co-Payment Tier**	**Yearly Prescription Drug Expense**		
	Initial Coverage Period	Coverage Gap	Catastrophic Coverage
Tier 1 Generic	Members pay $1.10 or $2.60 for each covered generic prescription drug, depending on your income level.	Members pay $1.10 or $2.60 for each covered generic prescription drug, depending on your income level.	Members pay $0 for each covered generic prescription drug.
Tier 2 Brand Name	Members pay $3.30 or $6.50 for each covered brand name prescription drug, depending on your income level.	Members pay $3.30 or $6.50 for each covered brand name prescription drug, depending on your income level.	Members pay $0 for each covered brand name prescription drug.

Please Note: The Plan may place limits on the amount of medication a member may receive. Members can receive up to a 31-day supply of medication for prescriptions filled at an in-network pharmacy.

Gateway utilizes a closed formulary. Practitioners are requested to prescribe medications included in the formulary whenever possible.

Some formulary medications may have additional requirements or limits on coverage. These requirements and limits may include: prior authorization, quantity limits or step therapy. If use of a formulary medication is not medically advisable for a member, you must complete a Non-Formulary Drug Exception Form. Please refer to the *Forms and Reference Materials Section* of this manual for a copy of this form. Please refer to the *Referral and Authorization Section* of this manual for information regarding requesting non-formulary drugs.

Drugs Covered

- ✓ Legend drugs listed in the closed formulary
- ✓ Non-formulary drugs which have been granted a formulary exception for an individual member
- ✓ Insulin/disposable syringes/needles
- ✓ Compounded medication of which at least one ingredient is a covered prescription drug
- ✓ Contraceptives

Gateway Health Plan *Medicare Assured*® places a limit on the amount of medication a member can receive at the pharmacy. The limit is an amount normally prescribed by the practitioner, but must not exceed a 31-day supply. Prescriptions can be refilled up to 12 months from the original prescription date as authorized by the practitioner.

Drug Exclusions:

- A Medicare Prescription Drug Plan can't cover a drug that would be covered under Medicare Part A or Part B.
- A Medicare Prescription Drug Plan can't cover a drug purchased outside the United States and its territories.
- A Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug's label as approved by the Food and Drug Administration) of a prescription drug only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are: American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and USPDI or its successor.) If the use is not supported by one of these reference books, known as compendia, then the drug is considered a non-Part D drug and cannot be covered by our Plan.

In addition, by law, certain types of drugs or categories of drugs are not normally covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs."

These drugs include:

Non-prescription drugs (or over-the counter drugs)	Drugs when used for treatment of anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or to promote hair growth
Drugs when used for the relief of cough or colds symptoms	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale	Barbiturates and Benzodiazepines
Drugs, such as Viagra, Cialis, Levitra, and Caverject, when used for the treatment of sexual or erectile dysfunction	

Self-Referred Services

Members may refer themselves for the following types of care:

- Routine Women's Health Care
- Pap Smears
- Pelvic Exams
- Mammograms
- Flu Shots
- Pneumonia Vaccinations
- Specialists Visits
- Prostate Screening
- Colorectal Screening
- Bone Mass Measurements
- Diabetes Monitoring Training
- Dialysis
- Vision Exams
- Hearing Exams

Members' Rights and Responsibilities

All Gateway members have rights and responsibilities. They are as follows:

GATEWAY HEALTH PLAN *Medicare Assured*®
MEMBERS' RIGHTS AND RESPONSIBILITIES

Member Rights

- Provide information in a way that works for the member (in languages other than English that are spoken in the Plan service area, in Braille, in large print, or other alternate formats, etc.)
- Right to be treated with fairness and respect
- Right to the privacy of member medical records and personal health information
- Right to see plan providers and get covered services and drugs within a reasonable period of time
- Right to know his/her treatment choices and participate in decisions about his/her health care
- Right to use advance directives (such as a living will or a power of attorney)
- Right to make complaints and ask to have decisions made reconsidered
- Right to get information about his/her health care coverage and costs
- Right to get information about Gateway Health Plan®, Gateway Health Plan *Medicare Assured*®, and plan providers

Member Responsibilities

- To get familiar with his/her coverage and the rules he/she must follow to get care as a member.
- To give his/her doctor and other providers the information they need to care for him/her, and to follow the treatment plans and instructions that he/she and his/her doctors agree upon.
- To act in a way that supports the care given to other patients and helps the smooth running of his/her doctor's office, hospitals, and other offices.
- To pay his/her plan premiums and any co-payments he/she may owe for the covered services you get.
- To let Gateway Health Plan *Medicare Assured*® know if he/she has any questions, concerns, problems, or suggestions.

Coverage Arrangements

All participating practitioners must ensure 24-hour, 7 days-a-week coverage for members. Coverage arrangements should be made with another Gateway participating practitioner or practitioners who have otherwise been approved by Gateway. All encounters must be billed under the name of the rendering practitioner, not the member's assigned primary care practitioner. Reimbursement will be paid directly to the participating covering primary care practitioner.

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 primary care practitioner. 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, found in the *Forms and Reference Materials Section* of this Manual. 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.

Primary care practitioners agree that, in their absence, timely scheduling of appointments for members shall be maintained.

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Primary Care Practitioner

Each member in a family has the freedom to choose any participating primary care practitioner, and a member may change to another primary care practitioner should a satisfactory patient-practitioner relationship not develop. A primary care practitioner 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 primary care practitioner may, upon sixty (60) 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 primary care practitioner's practice, including applications in process.

Through Gateway's model of Prospective Care Management, 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.

Primary Care Practice Dashboard Reports

Primary care practitioners and their practice staff are challenged with handling and processing mountains of clinical mail from a myriad of sources. In response, we are making efforts to reduce the number of individual clinical mailings we send by consolidating that information into a compact, easily understandable Primary Care Practice Dashboard Report.

The Report is delivered quarterly (January, April, July, October) and contains data on members in your practice who are due for or missing chronic care and preventive services. Data includes member contact information, self-disclosed racial and ethnic information, preventive care (e.g., cervical cancer screening, mammography, etc.) and chronic care (e.g., diabetic testing, gaps in pharmacy fills for hypertension and asthma controllers, etc.) services for which we have no "Medical" or "Physician Office" claims or encounter submission.

Information in the Primary Care Practice Dashboard Report is compiled from claims and pharmacy data. The dashboard highlights members for whom claims and pharmacy data does not show the presence of a recommended test or treatment. This doesn't necessarily mean that the test or treatment has not been done; it indicates that Gateway has not received a claim or encounter submission indicating the service was performed.

Information in the Dashboard is intended to be a practice tool that supports evidence-based care, not as a "report card." It does not, nor is it intended to

replace your professional clinical judgment as a patient's treating physician. While we provide this information to assist you, remember that our Care Management staff is simultaneously reaching out to members through our Prospective Care Management model of care. PCM® is designed to engage and help members follow preventive care and chronic care treatment recommendations and remain connected to their doctors.

Streamlining

- Schedule patients for annual physicals to review all of their needs.
- Schedule follow-up appointments before patients leave the office.
- Have a reminder system. Let patients know by mail or phone of an upcoming appointment to help minimize "no shows."
- Arrange for patients with chronic conditions to have blood work drawn a week before their next appointment. This allows the doctor to have more information at the time of the visit and reduces the amount of required follow-up communication.
- Make use of in-office testing (e.g., HbA1c, Spirometry testing, etc.), a reimbursed service by Gateway.

Encounters

Primary care practitioners are required to report to Gateway all services they provide for Gateway members by submitting complete and accurate claims. All Gateway providers are contractually required to submit encounters for all member visits and all charted diagnosis' that the member may suffer from.

Accurate Submission of Encounter Data

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, and;
- ✓ 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 primary care practitioners, encounter data is essential as many of Gateway's quality indicators are based on this information. Gateway evaluates primary care practitioner encounter data in two ways. The rate of submitted encounters per member for individual primary care practitioner practices is measured and compared to a peer average based on specialty (Family Medicine, Pediatric, 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.

It is very important that all diagnosis codes that are applicable to the member be submitted on every claim, especially chronic conditions. The expected rate of submission for encounters is 100%. Gateway provides support and education to practices as indicated by their encounter submission rates.

CMS uses the Hierarchical Condition Categories (HCC) model to assign a risk score to each Medicare beneficiary. Accurate and complete reporting of diagnosis codes on encounters is essential to the HCC model. Physicians must establish the diagnosis in the medical record and coders must use the ICD-9-CM coding rules to record each diagnosis. Chronic illnesses should be coded on each encounter along with the presenting illness. This will help to ensure that CMS has complete data when determining the member's risk score.

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

2003 Physicians & Medicare+Choice Risk Adjustment CD at
cmstraining@aspensys.com

Official Coding Guidelines on CDC Website
www.cdc.gov/nchs/icd9.htm

Coding Clinic for ICD-9-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: www.cdc.gov/nchs/data/icd9/icdguide.pdf

There are two volumes which consist of:
The Disease Tabular (Numeric) and is known as Volume I of ICD-9-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.

The Disease Index (Alphabetic) and is known as Volume II of ICD-9-CM. This volume is an index of all diseases and injuries categorized in ICD-9-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 subterms 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.

Transfer of Non-Compliant Members

Primary care practitioners 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; and (b) to observe, protect and promote the rights of members as patients. Primary care practitioners shall not seek to transfer a member from his/her practice based on the member's health status. However, a member whose behavior would preclude 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.

Should an incidence of inappropriate behavior 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 to the Medicare Enrollment Department at:

Gateway Health Plan®
Attention: Medicare Enrollment Department
US Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219-2740.

The Enrollment Department notifies the requesting practitioner in writing when the transfer has been accomplished. If the member requests not to be transferred, the primary care practitioner will have the final determination regarding continuation of primary care services.

Primary care practitioners 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

Primary care practitioners are required to transfer member medical records or copies of records to newly designated primary care practitioners within seven (7) business days from receipt of the request from the member or the member's new primary care practitioner, without charging the member.

Primary care practitioners are required to transfer member medical record or copies of records to newly designated Managed Care Organizations within seven (7) business days from receipt of the request from the Centers for Medicare and Medicaid Services or its agent.

Appointment Standards

Primary care practitioners agree to meet Gateway's appointment standards, as follows:

REQUIREMENT	STANDARD
Wait time for Urgent, but Non-Emergent Care Appointment	Within 24 hours
Wait time for Non-Urgent Care, but in need of Attention Appointments	Within 1 week
Wait time for a Routine or Preventive Care Appointment	Within 30 days
After Hours Care Accessibility	Access to a practitioner 24 hrs/7 days a week
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 Medical Condition visit or is treating a member with a difficult need.

- A member should be seen by a practitioner as expeditiously as the member's condition warrants, based on the severity of symptoms. If a practitioner is unable to see the member within the appropriate timeframe, Gateway will facilitate an appointment with a participating or non-participating practitioner, if necessary.

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Specialty Care Practitioner

Verifying Eligibility

Specialty care practitioners must verify eligibility prior to rendering services to ensure reimbursement. Gateway's eligibility verification line can be reached at 1-800-642-3515, 24 hours a day, 7 days a week.

Referrals

The primary care practitioner is responsible for the coordination of a member's healthcare needs and access to services provided by specialists. Therefore, all Gateway members must obtain a valid referral **(a paper referral form is not required)** from their primary care practitioner prior to receiving specialty services except for the services that can be accessed by self-referral. When a Gateway member schedules an appointment with a specialist, the office should remind the member that a referral from their primary care practitioner 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 and document the referral in the patient's medical record. Primary care practitioners can issue a referral to a specialist either verbally or through a script given to the patient.

If the specialty care practitioner determines other services are needed in addition to those authorized by the primary care practitioner, a treatment plan must be completed and forwarded to the primary care practitioner for notation in the patient's medical record to assure continuity and coordination of care. The primary care practitioner can then issue additional referrals based upon the recommendations of the specialty care practitioner.

A specialist CANNOT refer a patient to another specialist. The primary care practitioner must refer the member to another specialist. If a specialist recommends that another specialist should see the patient, the specialist must contact the primary care practitioner, and the primary care practitioner may then examine the patient and/or review the consult report prior to referring the patient to another specialist.

Referral form submission and referral numbers are NOT necessary when submitting claims for specialty care services.

The specialist is responsible for providing written correspondence to the member's primary care practitioner for continuity and coordination of care.

Emergency Services

Federal and state regulations prevent us from requiring members to contact a primary care practitioner, specialist or the plan prior to seeking emergency care. The decision by a member to seek emergency care is based upon "prudent

layperson" standard. Per CMS guidelines: "An **emergency medical condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part."

Emergency services are covered inpatient and outpatient services that are:
Furnished by a provider qualified to furnish emergency services; and needed to evaluate or stabilize an emergency medical condition.

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 primary care practitioner of the emergency services within one (1) business day when the emergency room visit occurs over a weekend. Members should be directed to the closest appropriate emergency provider.

Appointment Standards

All specialty care practitioners including Allergists, General Surgeons, Otolaryngologists, Certified Nurse Practitioners and Orthopedists agree to meet Gateway's appointment standards, as follows:

REQUIREMENT	STANDARD
Wait time for an Urgent, but Non-Emergent Care Appointment	Within twenty-four (24) hours from the date of referral
Wait time for a Non-Urgent, but in need of Attention Appointment	Within 1 week from the date of referral
Wait time for a Routine Care Appointment	Within 30 days from the date of referral
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 Medical Condition visit or is treating a member with a difficult need.

- A member should be seen by a practitioner as expeditiously as the member's condition warrants, based on the severity of symptoms. If a practitioner is unable to see the member within the appropriate timeframe, Gateway will facilitate an appointment with a participating or non-participating practitioner, if necessary.

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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 contact Gateway to verify eligibility of the member.

Gateway permits its primary care practitioners to perform routine gynecological exams and pap tests and provide care during pregnancy if they are so trained and equipped in their office.

Obstetrical Needs Assessment Form

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 Obstetrical Needs Assessment Form, found in the *Forms and Reference Materials Section* of this Manual, must be completed.

The Obstetrical Needs Assessment Form should immediately be faxed to Gateway and then filed in the member's medical record. The Obstetrical Needs Assessment Form should be updated at the 28-32 week visits and also at the post-partum visit. These two updates should also be faxed to Gateway immediately following completion.

The purpose of the Obstetrical Needs Assessment Form is to help identify risk factors early in the pregnancy and engage the woman in care management. For that reason, the Obstetrical Needs Assessment Form must be faxed to Gateway's MOM Matters® Department within 2-5 business days of the intake visit and at least 30 days prior to delivery.

Diagnostic Testing

Fetal Non-stress Tests and Ultrasounds can be performed in the OB/GYN's office or at a hospital without an authorization from Gateway.

Mammograms performed at a participating hospital require a prescription.

Appointment Standards

Appointment standards for OB/GYN practitioners including Certified Nurse Midwifes are as follows:

REQUIREMENT	STANDARD
Wait time for an Urgent, but Non-Emergent Care Appointment	Within twenty-four (24) hours from the date of referral
Wait time for a Non-Urgent, but in need of Attention Appointment	Within 1 week from the date of referral
Wait time for a Routine Care Appointment	Within 30 days from the date of referral
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 Medical Condition visit or is treating a member with a difficult need.

- A member should be seen by a practitioner as expeditiously as the member's condition warrants, based on the severity of symptoms. If a practitioner is unable to see the member within the appropriate timeframe, Gateway will facilitate an appointment with a participating or non-participating practitioner, if necessary.

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.

Policy Changes

In order for Gateway to be in compliance with Federal and State Laws, Regulations and Regulatory Bulletins governing the Medicare and Medicaid Program in the course of providing services, Provider and its staff will be bound by all applicable federal and state Medicare and Medicaid laws and regulations. Providers will comply with all applicable instructions, bulletins and fee schedules promulgated under such laws and all applicable program requirements of regulatory agencies regarding the Medicare and Medicaid programs.

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

Practitioner Education and Sanctioning

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 Quality Improvement Nurses, Provider Relations Representatives and Gateway Medical Directors. Network practitioners who do not improve through the provider education process will be referred to the Gateway Quality Improvement/Utilization Management Committee for evaluation and recommendations. To request additional information or to obtain a copy of this policy, please contact Gateway's Provider Services Department at 1-800-685-5205.

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 Health Care 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 1-800-685-5205.

TITLE VI of the Civil Rights Act of 1964

Practitioners are expected to comply with the Civil Rights Act of 1964. Title V of the Act pertains to discrimination on the basis of national origin or limited English proficiency. 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.

Translators During Clinical Visits

Practitioner offices are expected to address the need for interpreter services in accordance with the Americans with Disabilities Act (ADA). Each practitioner is obligated to identify those Members who may require such assistance and arrange and coordinate oral translation, oral interpretation and sign language services and pay for such services. Members may not be held liable for the cost of such services. Gateway will assist practitioners in locating resources upon request. Practitioner offices are required to adhere to the Americans with Disabilities Act guidelines, Section 504, the Rehabilitation Act of 1973 and related federal and state requirements that are enacted from time-to-time.

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.

Practitioners may obtain copies of documents that explain legal requirements for translation services or request further assistance by contacting Gateway's Provider Services Department at 1-800-685-5205.

Confidentiality

Through contractual agreements, all practitioners and providers participating with Gateway have agreed to abide by all policies and procedures regarding member confidentiality. The performance goal for confidentiality is for practitioners to secure patient records from public access.

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:
   - 42 USC 1296a(a)(7)
   - 42 CFR § 431,300
   - The Mental Health Procedures Act, 50 P.S. §§7101
   - Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164
   - 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. 11-5 (Feb 17, 2009) and related regulations

2. Assure that member records, including information obtained for any purpose, are considered privileged information and, therefore, are protected by obligations of confidentiality.
3. 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, and disease management. Gateway follows the requirements of HIPAA and limits its requests to the amount of PHI that is minimally necessary to meet the payment, treatment or operational function. All other requests for release of or access to PHI will be handled in accordance with federal and state regulations.
4. Environmental security of confidential information is conducted by all providers and practitioners treating Gateway members. This includes both internal and external monitoring of practice and provider sites. Provider and practitioner sites must comply with the Environmental Assessment standards that require that patient records be protected from public access.

Fraud and Abuse

Gateway Health Plan® has a comprehensive policy for handling the prevention, detection and reporting of fraud and abuse. It is Gateway's policy to investigate any action by members, employees or practitioners that affects the integrity of Gateway and/or the Medicare Program.

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

If fraud or abuse is suspected, whether it is by a member, employee or practitioner, it is your responsibility to immediately notify Gateway at (412) 255-4340. Gateway maintains a Recipient Restriction Program, which restricts members who mis-utilize medical services or pharmacy benefits. Gateway enforces and monitors these restrictions.

It is Gateway's policy to discharge any employee, terminate any practitioner or recommend any member be withdrawn from the Medicare Program who, upon investigation, has been identified as being involved in fraudulent or abusive activities.

Some common examples of fraud and abuse are:

- Billing for services not rendered
- Billing for supplies not being purchased or used
- Billing more than once for the same service
- Dispensing generic drugs and billing for brand name drugs
- Falsifying records
- Performing inappropriate or unnecessary services

Environmental Assessment Standards

Gateway has established specific guidelines for conducting Environmental Assessment Site Visits, including medical record-keeping standards, at primary care practitioner practices. An initial Environmental Assessment 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 Environmental Assessment Standards.

A Provider Relations Representative will schedule an on-site visit at each office site to conduct an Environmental Assessment. The Environmental Assessment must be conducted with the Office Manager or with a practitioner of the practice. The Provider Relations Representative will complete the Initial Environmental Assessment Form and tour the office as well as interview staff and examine the appointment schedule. The Gateway Provider Relations Representative will assess the office for evidence of compliance with the Environmental Assessment Standards.

Upon completion of the review, the Provider Relations Representative will conduct an exit interview with the Office Manager and/or practitioner. The results of the Environmental Assessment will be reviewed. Non-compliance issues must be addressed with a corrective action plan within 30-days of receipt for non-compliant standards.

The Provider Relations Representative will conduct a follow-up visit within 90 days or until the office site is compliant. The Medical Director will review the Environmental Assessment as 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 Quality Improvement/Utilization Management Committee for review. Special circumstances may be granted based upon size, geographic location of the practice, and potential harm to members. The Provider Relations Representative will communicate the final results to the practitioners.

An Environmental Assessment 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 Quality Improvement/Utilization Management 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 Health Plan® Provider Relations Representatives conduct site visits to assess practice compliance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 for those practices as determined by the Department of Public Welfare.

Environmental Assessment Standards

PHYSICAL ACCESSIBILITY AND APPEARANCE
Parking
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.
Exterior Path of Travel
1. The path of travel is at least 36" wide, except at doorways and gates. 2. The Surface in the exterior path of travel is stable, firm and slip resistant.
Curb Ramps
1. There are curb ramps where the path of travel crosses a curb. 2. There are curb ramps at least 36" wide. 3. The slope of the curb ramps is less than or equal to 1:12.
Ramps
1. If a route has changes in level greater than ½", a ramp is provided. 2. The slope of the ramp is no greater than 1:12 for each run of the ramp. 3. There is a level landing at the top and bottom of each run, at least as wide as the ramp and 60" in length. 4. If the ramp changes direction, there is a landing at least 60" x 60". 5. Ramps are non-slip. 6. If the ramp rises more than 6", or has a horizontal run longer than 72", there are handrails on each side. 7. The width of the ramp is at least 36" wide or if handrails are present, the clear width between railings is at least 36" wide.

Building Entrance
1. There is directional signage indicating the locations of an entrance for use by people with disabilities. 2. If there is signage, the entrance shows the International Symbol for Accessibility. 3. There are no steps or changes in level at the entrance or in route to the entrance greater than ½" high. 4. The entrance door has at least a 32" clear opening width. 5. The door handle is operable without tight grasping or twisting of the wrist. 6. There is a threshold that is at least 1/2" or less in height.
Airlock Doors
1. If there are two doors in a series, the space between them is at least 48" plus the width of any door swinging into the space. 2. The airlock door has at least a 32" clear opening width. 3. The airlock door handle is operable without tight grasping or twisting of the wrist. 4. There is a threshold that is ½ " or less in height.
Stairs
1. The use of stairs is not necessary to access the provider's office.
Elevators
1. The Elevator door provides a clear opening width of at least 36". 2. The Elevator operating controls are no higher than 54".
Interior Spaces
1. The route to all provider spaces is at least 36" wide.
Hallway Doors
1. Doors on interior paths of travel have at least 32" of clear opening width. 2. Door handles are operable without tight grasping or twisting of the wrist.
Provider Entrance
1. The door into the provider space is at least a 32" clear opening width. 2. Door handles are operable without tight grasping or twisting of the wrist. 3. Thresholds are at least ½" or less in height.
Provider Interior Path
1. Pathways to waiting rooms and receptionist desk are unobstructed and at least 36" wide.
Provider Interior Doors
1. Doors on the Provider interior path of travel have at least 32" of clear opening width.
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.

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 30 days.
2. Waiting time to schedule a preventive care appointment must be scheduled within 30 days.
3. Waiting time to schedule an urgent care appointment must be no more than 24 hours.
4. Waiting time to schedule non-urgent care, but in need of attention appointment must be no more than 1 week.
5. Wait time in the waiting room should be no more than 30 minutes or at any time no more than up to 1 hour when the physician encounters an unanticipated urgent medical visit or is treating a patient with a difficult need.
6. Practice must have at least 20 hours of patient scheduling time per week per office.
7. There must be open appointments on the schedule for emergencies.
8. Emergency care must be seen immediately or referred to an emergency facility.
9. Practice must have physician coverage arrangements for vacations, etc.
10. Waiting time to schedule an appointment for any new patient diagnosed with HIV must be within seven days of enrollment.
11. Waiting time to schedule an appointment for an SSI patient must be within forty-five days of enrollment.

OFFICE PROTOCOLS

1. The office must have a recall system for patients who miss appointments and document in 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 attempts must be made.
2. **PCP and PCP/Specialist Only** – The Office is able to perform EPSDT screens. (Offices whose panel limit is 21 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 ensure 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 24 hours a day, 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.

Provider Changes

The Gateway Health Plan® physician agreement indicates 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. Please refer to the Practice/Provider Change Request Form in the front of this Manual.

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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 outpatient surgical procedures by contacting Gateway's Utilization Management Department at 1-800-685-5207. In the case of an emergent or urgent admission, the Gateway admitting physician, hospital or member must notify Gateway's Utilization Management Department within one business day of receiving care.

Gateway will accept the primary care practitioner's, ordering practitioner's, 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 Utilization Management Representative refers to the Gateway Medical Director if criteria or established guidelines and/or policies are not met for a determination. The ordering practitioner is offered a peer review opportunity with the Gateway Medical Director for all potential denial determinations.

During the discharge planning process, if Gateway is notified by the Quality Improvement Organization (QIO) that the member disagrees with the attending physician's discharge, a written detailed notice of discharge will be provided to the member through a process agreed upon by the hospital and Gateway and will be provided to the member within the timeframes established by CMS.

Emergency Room

Members are informed through the Evidence of Coverage (a copy of the Evidence of Coverage is mailed to members upon enrollment, and every year in October) how and when to utilize emergency services. Emergency services do not require prior authorization. If a member is unsure whether to go to the emergency room, the member is instructed to call his/her primary care practitioner for advice.

Ambulance Services

Transportation by ambulance does not require an authorization when it is emergent or for end stage renal dialysis services. All other non-emergent transportation requires an authorization by Gateway's Utilization Management Department. Gateway considers emergent transportation as transportation that allows immediate access to medical or behavioral health care 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 911 transportation or transport to a psychiatric facility for a member under a psychiatric commitment order without an authorization from Gateway.

Gateway also considers the following situations emergent, and thus does not require authorization when rendered by a Gateway participating ambulance provider:

- 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.
- End Stage Renal Dialysis Center

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

If a non-participating provider renders the above services, an authorization from Gateway is required. Ambulance transportation by non-participating providers to End Stage Renal Dialysis Centers does not require authorization.

Although there is no pre-authorization required for participating or non-participating ambulance transport for a member with ESRD for dialysis services, the ambulance transport must meet Medicare's medical necessity program coverage criteria in order for payment to be made.

Authorization for non-emergent ambulance transportation is required by Gateway's Utilization Management Department. Gateway considers non-emergent transportation, as transportation for a patient that does not require immediate access to medical or behavioral health care 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 (if medically necessary and approved by Gateway)

A Gateway participating ambulance provider should be contacted to render non-emergent transportation when possible.

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.

All air ambulance services require an authorization from Gateway's Utilization Management Department.

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Referrals and Authorizations

Referrals

(Paper referrals are not required)

General Information

Referrals are necessary in order to preserve the primary care practitioner's Gatekeeper relationship with the patient. Referrals allow the primary care practitioner to approve specialty services for members on their panel.

To determine which services require a referral or authorization, please refer to Gateway's Quick Reference Guide for Referrals and Authorizations in the *Forms and Reference Materials Section* of this Manual.

Primary Care Practitioner

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

To issue a referral, document the referral in the patient's medical record including the number of visits or length of time of each referral. **Primary care practitioners are not required to use a specific Referral Form for submission to the specialist or Gateway**. Notification to the specialist is necessary, but can be made verbally or through a script given to the patient.

Specialty Care Practitioners

When a Gateway member schedules an appointment with a specialist, the office should remind the member that a referral from their primary care practitioner 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 from the primary care practitioner, either through a written script or letter, or verbal confirmation provided by the primary care practitioner. This referral should be documented in the patient's medical record.

If other services are needed in addition to those authorized by the primary care practitioner, a treatment plan must be completed and forwarded to the primary care practitioner for notation in the patient's record to assure continuity and coordination of care. The primary care practitioner can then issue additional referrals based upon the recommendations of the specialty care practitioner.

Except for OB/GYN providers, a specialist CANNOT refer a patient to another specialist. The primary care practitioner or the woman's OB/GYN provider must refer the member to another specialist. If a specialist recommends that another specialist should see the patient, the specialist must contact the referring primary care practitioner or OB/GYN, and the primary care practitioner or OB/GYN may then examine the patient and/or review the consult report prior to referring the patient to another specialist.

Referral Form submission and referral numbers are NOT necessary when submitting claims for specialty care services.

Out-of-Plan Referrals

Occasionally, a member may need to see a specialty care practitioner outside of Gateway's provider network. When the need for out-of-plan services arises, the primary care practitioner must contact Gateway's Utilization Management Department to obtain an authorization. The Utilization Management Department will review the request and make arrangements for the member to receive the necessary medical services with a specialty care practitioner in collaboration with the recommendations of the primary care practitioner. Every effort will be made to locate a specialty care practitioner within an accessible distance to the member.

Referrals for Second Opinions

Second opinions from a qualified health care professional may be requested by a member. When requesting a second opinion consultation, Gateway recommends that you issue a referral to an in-network qualified health care professional that is not in practice with the practitioner who rendered the first opinion. If an in-network, qualified health care professional is not available, contact Gateway's Utilization Management Department to assist in arranging for the second opinion of an out-of-network provider and obtaining authorization for the service.

Self-Referral

Members may refer themselves for the following types of care:

- Routine Women's Health Care
- Pap Smears
- Pelvic Exams
- Mammograms
- Flu Shots
- Pneumonia Vaccinations
- Specialists Visits
- Prostate Screening
- Colorectal Screening
- Bone Mass Measurements
- Diabetes Monitoring Training
- Dialysis
- Vision Exams
- Hearing Exams

Authorizations

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 may benefit from case management or disease management. Authorization is the responsibility of the admitting practitioner or ordering provider and can be obtained by calling the Gateway Health Plan *Medicare Assured*® Utilization Management Department. (Refer to the section listed as the Process for Requesting Prior Authorization.) Gateway's *Medicare Assured*® Utilization Management Department assesses the medical appropriateness of services using nationally-recognized criteria, such as McKesson's InterQual® Criteria, the Centers for Medicare and Medicaid Services' (CMS) definition of medical necessity and CMS National and Local Coverage Determinations when authorizing the delivery of healthcare services to plan members.

The CMS definition of medically necessary specifically states that a service must be medically necessary to be covered, which means that it must be reasonable and necessary for the purpose of diagnosing or treating illness or injury to improve the functioning of a malformed body member. It refers to services or supplies that: are proper and needed for the diagnosis or treatment of the member's medical condition; are used for the diagnosis, direct care, and treatment of the member's medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of the member or the doctor.

Process for Requesting Prior Authorizations

The Utilization Management Department is committed to assuring prompt, efficient delivery of healthcare services and to monitor quality of care provided to Gateway Health Plan *Medicare Assured*® members. The Utilization Management Department can be contacted between the hours of 8:30 AM and 4:30 PM, Monday through Friday at 1-800-685-5207. When calling before or after operating hours or on holidays, practitioners are asked to leave a voicemail message and a Utilization Management Representative will return the call the next business day. Urgent requests or questions are directed to call 1-800-685-5209. A Gateway Health Plan *Medicare Assured*® Medical Director is available for review of these requests when necessary.

If faxing information, speak with a Utilization Management Representative first and when requested, fax the information to the Utilization Management Representative's attention. The Representative will inform you of the name and fax number.

Authorization is the responsibility of the admitting practitioner or ordering provider. If a service requires authorization and is being requested by a specialist, the specialist's office may call Gateway to authorize the service. Hospitals may verify authorization by calling the Gateway Health Plan *Medicare Assured*® Utilization

Management Department. When requesting authorization of elective procedures, Gateway recommends calling the Utilization Management Department a minimum of two (2) working days in advance when possible.

When a call is received, the information given 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.

The following information may be needed to authorize a service. Please have this information available before placing a call to the Utilization Management Department:

- Member Name and Birthdate
- Gateway Health Plan *Medicare Assured*® ID Number
- Procedure Code, if applicable (CPT4, HCPCS)
- DME Codes and Cost of Item(s), when applicable
- Date of Service
- Name of Admitting/Treating Practitioner
- Name of the Practitioner requesting the Service
- Practitioner's Gateway ID Number
- Any other pertinent clinical information such as:
    - Diagnoses/Co-morbidities
    - Age
    - Complications
    - Progress of treatment
    - Medical history
    - Previous test results
    - Current medications
    - Psychosocial situation
    - Home environment/social situation, when applicable.

When Utilization Management has authorized services provided by a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) and it has been determined that coverage for the services will end, the Utilization Management staff will coordinate with the SNF, HHA, or CORF through a process agreed upon by the facility/agency and Gateway to provide the appropriate notification (Notice of Medicare Non-Coverage) to the member. The notification will inform the member of the discontinuation of the service and will be provided to the member within the timeframes established by CMS. (Refer to the *Forms and Reference Materials Section* for a Notice of Medicare Non-Coverage.)

Speech Therapy Services

The Utilization Management Department may request a plan of treatment for a speech therapy request. The plan of treatment should include the following information:

- Examination and evaluation results which support the use of therapy interventions
- Functional assessments/evaluation
- Objective physical and functional limitations
- Number, frequency and modalities and or procedures, required to achieve measurable goals
- Plan of treatment including any revisions
- Name of the ordering physician
- Prognosis for potential restoration of function in a reasonable period of time
- Patient's physical progress toward measurable goals
- Medical necessity of services

Physical and Occupational Therapy

The Utilization Management Department may request a plan of treatment for a physical therapy and occupational therapy request. The plan of treatment may include the following information:

- Examination and evaluation results which support the use of therapy interventions
- Functional assessments/evaluation
- Objective physical and functional limitations
- Type of treatment to be used including body areas to be treated
- Number, frequency and modalities and or procedures required to achieve measurable goals
- Prognosis for potential restoration of function in a reasonable period of time
- Member's physical progress toward measurable goals
- Revisions to original plan of treatment
- Medical necessity of services.

Durable Medical Equipment

For DME, medical supplies and orthotics and prosthetics the following information is needed when requesting authorization:

- Name of requested equipment or medical supply, appropriate code (HCPCS), cost
- Rental vs. purchase request
- Amount of items requested—Over what period of time (if requesting rental)
- Clinical Information to Support the medically necessary service request

Services Requiring Authorization

Utilization Management prior authorization is required on the following services:

- Elective Inpatient Admissions (including rehabilitation, skilled nursing facility and long-term acute care hospital)
- Short Procedures Unit/Ambulatory Surgery Center
- Durable Medical Equipment (DME), Orthotic and Prosthetic Services and Medical Supplies $500 or greater
- Home Health Services
- Chiropractic Services (Chiropractic services are covered to correct a subluxation by means of manual manipulation of the spine)
- Outpatient Rehab (physical therapy, occupational therapy, speech therapy and cardiac rehab)
- Non-emergent Ambulance Transportation
- Experimental/Investigational Services
- Cosmetic Services
- Non-participating provider (exception: emergency room; dialysis, emergency ambulance transport)

Urgent/emergent admissions require notification to the Utilization Management Department by the next business day.

Organ transplants require prior authorization and must be performed at a Medicare-approved transplant center, per CMS requirements. The following types of transplants are covered: corneal, kidney, pancreas, liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell.

Requests for elective or emergent inpatient care, outpatient psychiatric partial hospitalization, psychiatric and neuropsychiatric testing and ECT treatment for *Medicare Assured*® members require prior authorization through Community Behavioral HealthCare Network of Pennsylvania (CBHNP) at 1-866-755-7299. CBHNP staff is available 24 hours a day, 7 days a week.

Requests for select outpatient elective radiological services require prior authorization. These requests must be called to National Imaging Associates (NIA), Monday through Friday from 8:00 AM to 8:00 PM at 1-888-879-5922. NIA requires authorization for the following services:

- CT
- MRI/MRA
- Nuclear Cardiology
- PET Scans

Davis Vision Provider Service Representatives are available at 1-800-933-9371, Monday through Friday from 8 am to 8 pm and Saturday from 9 am to 4 pm.

Prior Authorization Decision Timeframes and Notification

Standard Decisions:

For precertification requests, the Gateway Health Plan *Medicare Assured*® Utilization Management Department will make a decision to approve, deny or limit authorization of the service request as expeditiously as the member's health condition requires, but no later than 14 calendar days from the receipt of the request. Verbal notification of the decision will be made to the provider on behalf of the member. The Utilization Management Department will notify the requesting provider and member in writing on all medical necessity denial or limited authorization determinations no later than 14 calendar days from the receipt of the request.

For urgent precertification requests, the Gateway Health Plan *Medicare Assured*® Utilization Management Department will make a decision to approve, deny or limit authorization of the service request as expeditiously as the member's health condition requires, but no later than 72 hours from the receipt of the request. Verbal notification of the decision will be made to the provider on behalf of the member. The Utilization Management Department will notify the requesting provider and member in writing on all medical necessity denial or limited authorization determinations. Written notification will occur within 3 calendar days from the verbal notification.

For concurrent review requests, the Gateway Health Plan *Medicare Assured*® Utilization Management Department will make a decision to approve, deny or limit authorization of the service request as expeditiously as the member's health condition requires but no later than 24 hours from receipt of request for service. Verbal notification of the decision will be made to the provider on behalf of the member. The Utilization Management Department will notify the requesting provider and member in writing on all medical necessity denial or limited authorization determinations. Written notification will occur within 3 calendar days from the verbal notification.

For medical necessity denial or limited authorization determinations, the Utilization Management Department will instruct the requesting provider on how to contact the Medical Director for a peer review discussion.

Expedited Decisions:

For expedited requests, the Gateway Health Plan *Medicare Assured*® Utilization Management Department will make a decision to approve, deny or limit authorization of the service request as expeditiously as the member's health

condition requires, but no later than 72 hours from the receipt of the request. The Utilization Management Department will notify the requesting provider and the member in written notification on all expedited determinations. Written notification will occur within 3 calendar days from the verbal notification.

For medical necessity denial or limited authorization determinations, the Utilization Management Department will instruct the requesting provider on how to contact the Medical Director for a peer review discussion.

Home Infusion

Requests for home infusion medications may be called or faxed into Gateway's Pharmacy Department. Faxed requests should be on the Home Infusion Drug Request Form, which can be found in the *Forms and Reference Material Section* of this Manual. The completed form should contain the following information: Drug name, dose, frequency and duration requested, diagnosis, provider of service for the nursing visits, and medical supplies related to the infusion. If the requested drug is a non-formulary drug, the request form should also include formulary medications tried and failed or medical rationale for non-formulary drug.

Please Note: Formulary IV antibiotics do not require authorization from the Pharmacy Department. Please call Utilization Management directly to obtain nursing visit and supply authorization. The medications will adjudicate automatically on-line through our claims processor (Argus).

Gateway's Pharmacy Department will review the request for the drug to be administered via home infusion.

If approved, an electronic authorization will be entered. No authorization number for the drug is needed. Gateway's Pharmacy Department will notify the requesting physician of the final decision.

Gateway's Pharmacy Department will notify the Utilization Management Department of the drug authorization. Gateway's Utilization Management will then contact the infusion provider with the authorization number for the per diem rate for the supplies as well as one nursing visit per week and any additional nursing visits noted on the Home Infusion Drug Request Form. The authorization will be for the same duration that the Pharmacy Department has approved the drug.

If additional nursing visits are needed the provider must contact Gateway's Utilization Management Department to obtain the authorization.
If the approved drug therapy is to continue for a longer duration than initially authorized, the provider must contact Gateway's Pharmacy Department to obtain additional authorization.

Important Phone numbers:
Pharmacy Phone: 1-800-685-5215

Pharmacy Fax: 1-888-447-4369
Utilization Management Phone: 1-800-685-5207

Infused enteral products are covered up to $500 without an authorization. A separate authorization from Gateway's Utilization Management Department for the infusion services is required.

Pharmacy Services

Gateway Health Plan *Medicare Assured*® *HMO SNP* utilizes a closed formulary. Physicians are encouraged to prescribe formulary medications when medically appropriate. If changing to a formulary medication is not medically advisable for a member, a practitioner must initiate a Request for Non-formulary Drug Coverage by faxing the Request for Non-formulary Drug Exception Form, found in the *Forms and Reference Materials Section* of this manual, to 1-888-447-4369 during normal business hours, or by calling the Gateway Health Plan® Pharmacy Department at 1-800-685-5215, during off-hours and weekends. Practitioners should assure that all information on the form is available when calling. The Request for Non-formulary Drug Exception Form can also be found on Gateway's website. The form may be photocopied. You can also request a copy of the form by calling the Gateway Pharmacy Department.

All requests submitted with the necessary clinical information will be reviewed and a decision made as expeditiously as the member's health condition requires, but no later than 72 hours after receipt of the request by the Gateway Health Plan Pharmacy Department. If the request requires an expedited review, a decision will be made within 24 hours.

In certain cases, Gateway will automatically authorize a temporary supply of a non-formulary drug to allow you sufficient time to transition the member to a formulary alternative or request a non-formulary exception. A temporary supply is also authorized in certain cases to allow you sufficient time to pursue a formulary exception for drugs that require a prior authorization or step therapy, or exceed our quantity limits.

Managing Care Transitions

Gateway's Utilization Management (UM) Department makes a special effort to coordinate care when members transition from one setting to another, particularly as members are being discharged from a hospital to another setting. When care transitions are not coordinated adequately, patients can be at risk of poor quality care, gaps in needed care and patient safety risks. UM supports care transition coordination throughout the prior authorization process, including collaborating practitioners and providers who deliver patient care. When patients are experiencing a care transition, the sending setting of care must provide a patient care plan to the receiving setting within one business day of the transition notification. Sharing a comprehensive care plan increases continuity and coordination of care across the settings and helps prevent patient risks. A patient

care plan includes patient-specific information that is relevant to the member's clinical condition and health status. A care plan may contain medical and non-medical information, such as a current problem list, allergies/sensitivities, medication regimen, baseline physical and cognitive functioning and advance directives. The patient care plan may be included within documents often called discharge summaries, transfer summaries or patient instructions. Additionally, changes to the member's health status or patient care plan should be communicated to the member or the member's responsible party within a reasonable timeframe, but no later than three days after the change is identified.

Some ways that Gateway helps to facilitate safe care transitions are: identifying unplanned and planned care transitions; establishing a single point of contact for member support throughout the care transition process; and communicating with the member, the member's PCP and treating providers. At least annually, Gateway also measures the effectiveness of practitioners and providers in sending the patient care plans to the receiving setting care providers within the timeframes. This is accomplished through an annual provider satisfaction survey and medical record review.

New Technology

Any new technology identified during the Utilization Management review process, and requiring authorization for implementation of the new technology will be forwarded to the Medical Director and/or Physician Advisor for authorization. If there is a question about the appropriate governmental agency approval of the technology, the Medical Director and/or Physician Advisor 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. The technology will also be investigated through CMS National and Local Coverage Determinations. If the technology has not been reveiwed by appropriate governmental regulatory bodies, the Medical Director and/or Physician Advisor will discuss the need for the specifically requested technology with the primary care practitioner and may consult with a participating specialist from the Gateway expert panel regarding the use of the new technology. The new technology review will be presented to the Gateway QI/UM Committee. If it is determined that no other approved technology is available and/or the Medical Director and/or Physician Advisor and consultants feel that the possibility for a positive outcome would be achieved with the use of the new technology, approval may be given. Gateway will consider those specific medical items, services, treatment procedures or technologies not specifically identified as non-covered or non-reimbursable by Medicare as defined within National Coverage Determinations.

Claims and Billing

Claims

General Information

Procedures for Gateway are as follows:

- Payment for CPT and HCPCS codes are covered to the extent that they are HIPAA compliant. Gateway utilizes CMS place of service codes to process claims, and they are the only place of service codes that are accepted.

- Hospitals should bill on an original UB-04 Form, and other providers, including ancillary providers should bill using an original CMS-1500 (08-05) Form.

- Gateway does accept bills through electronic data interchange (EDI) and encourages facilities and providers to submit claims via this format.

- Electronic claims must include NPI provider number and may continue to include the Gateway ID Number (Legacy Number) as a secondary identifier. Correct/current practitioner information identified as the Gateway Provider ID Number (Legacy Number) must be entered on all paper claims. Gateway Provider ID numbers are 5 or 7 digits. EDI claims submitted without an NPI will be rejected.

- Correct/current member information, including Gateway Health Plan *Medicare Assured*® Member ID Number, must be entered on all claims. The format is 8 or 12 digits for the Gateway member number. Gateway member number or HIC number in alpha and numeric format will be accepted on Electronic claims. Gateway prefers that the Gateway ID number be submitted to assure that the claim is processed under the correct individual.

- Please allow four to six weeks for a remittance advice. It is the practitioner's responsibility to research the status of a claim.

- Gateway encourages providers to submit initial bills within 180 days from the date of service, however any initial claim not submitted within 180 days must be submitted within 365 days from the date of service. Initial bills submitted after 365 days will be denied as untimely.

- Corrected claims or requests for review are considered if information is received within the 120-day follow-up period from the date on the remittance advice.

- Gateway is secondary to any commercial plan. Claims must be submitted within Gateway's timely filing guidelines.

- For other than inpatient hospital confinements paid as Part A, Gateway pays the lesser of the billed amount or the allowable amount.

- Inpatient hospital claims must be submitted with an MS-DRG Code.

- Providers of obstetric services are reimbursed on a global basis for deliveries. Individual visits are not reimbursed and should not be billed.

Timely Filing

Practitioners are encouraged to submit a complete original, initial CMS-1500 (08-05) or UB-04 Form within 180 calendar days after the date of service. If you bill on paper Gateway will only accept paper claims on a CMS-1500 (08-05), or a UB-04 Form. No other billing forms will be accepted.

Practitioners must bill within 365 calendar days from the date of an Explanation of Benefits (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 120 calendar days from the date of the corresponding remittance advice. All claims submitted after the 365-day period following receipt of the EOB or after the 120-day follow-up period from the date on the remittance will be denied.

Any claim that has been submitted to Gateway but does not appear on a remittance advice within 60 days following submission should be researched by the practitioner. Call Gateway's Provider Services Department to inquire whether the claim was received and/or processed.

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 Health Plan *Medicare Assured*®, please refer to the following grid for Emdeon Payer IDs and RelayHealth CPIDs(Clearinghouse Process ID):

CPID	PAYER NAME	PAYER ID	CLAIM TYPE
2298	Gateway Health Plan *Medicare Assured*®	60550	Professional
2912	Gateway Health Plan *Medicare Assured*®	60550	Institutional

Requirements for Submitting Claims to Gateway Through Emdeon and RelayHealth

To submit claims to Gateway Health Plan *Medicare Assured*® please note the Pennsylvania Payer ID Number is 60550. 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 HIC 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 Claims Acknowledgment Report. A claim can be rejected if it does not include an NPI and current procedure and diagnosis codes. To ensure 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 Claim Report (CPI 652.01)
- RelayHealth – Claims Status Reject 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. However, the following cannot be submitted as attachments along with electronic claims at this time:

- Claims with EOBs
- Services billed by report

Claims Review Process

Gateway will review any claim that a practitioner feels was denied or paid incorrectly. The request may be conveyed in writing (per instructions below), or verbally through Gateway's Provider Services Department if the inquiry relates to an administrative issue. Please forward hard copy information via mail to the Claims Review Department along with all of the appropriate documentation, i.e. the actual claim, medical records, and notations regarding telephone conversations, in order to expedite the review process. Initial claims that are not received within the timely filing limit will not qualify for review. All follow-up review requests must be received within 120 calendar days of the initial remittance advice.

Administrative Claims Review

Claims that need to be reviewed based upon administrative or processing issues are handled by a Provider Services Representative via a phone call to Gateway. For inquiries requiring documentation or received in the mail, Claims Review Representatives evaluate whether the documentation attached to the claim is sufficient to allow it to be reconsidered. Claims that qualify for adjustments will be reprocessed, and claim information will appear on subsequent remittance advices. Claims that do not qualify for reconsideration will be forwarded to the Appeals Department for review. All review requests must be received within 120 days of the initial remittance advice.

Please refer to the *Appeals and Grievances Section* of the manual for information on procedures for Appeals submitted by providers on behalf of a member.

Claims inquiries for administrative reviews should be mailed to: Gateway Health Plan®, Attention: Claims Review Department, US Steel Tower, Floor 41, 600 Grant Street, Pittsburgh, PA 15219-2704.

Coordination of Benefits

Some Gateway Health Plan *Medicare Assured*® members have other insurance coverage. Gateway follows Medicare coordination of benefits rules. Gateway does not deny or delay approval 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.

Please note the following criteria applies and designates when Gateway is not the primary plan for Medicare covered members:

- Enrollee is 65+ years, and covered by an Employer Group Health Plan (EGHP) because of either current employment or current employment of a spouse of any age and the employer employs 20 or more employees.
- Enrollee is disabled, and covered by an Employer Group Health Plan because of either current employment or a family member's current employment, and the employer that sponsors or contributes to the Large EGHP plan employs 100 or more employees.

- For an enrollee entitled to Medicare solely on the basis of end-stage renal disease and Employer Group Health Plan coverage (including a retirement plan), the first 30 months of eligibility or entitlement to Medicare.
- Workers' compensation settlement proceeds are available.
- No-fault or liability settlement proceeds are available.

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 Explanation of Benefits, the practitioner should submit a claim to Gateway. The practitioner must:

1. Follow all Gateway authorization and billing 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 365 days of the date of the primary carrier's EOB.
4. 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.

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.

Claim Coding Software

Gateway uses a fully automated coding review product that programmatically evaluates claim payments to verify the clinical accuracy of processing claims in accordance with clinical editing criteria. This coding program contains complete sets of rules that correspond to CPT-4, HCPCS, ICD-9, AMA, and CMS guidelines as well as industry standards, medical policy and literature and academic affiliations. CCI (Correct Coding Initiative) edits are applied solely to Incidental and Mutually Exclusive outcomes while the coding software applies other editing criteria. The program used at Gateway is designed to ensure data integrity for ongoing data analysis and reviews procedures across dates of service and across providers at the claim level.

Billing

Billing Procedures

A "clean claim" as used in this section means a claim that has no defect, impropriety, lack of any required substantiating documentation, including the substantiating documentation needed to meet the requirements for encounter data, or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirement for equivalent claims under Medicare.

In addition, a claim shall be considered "clean" if 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 (08-05) 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-9 surgical diagnosis code(s) (as applicable);
6. Name of practitioner/provider and applicable NPI number;
7. Provider tax identification number;
8. Valid CMS place of service code(s);
9. Billed charge amount for each covered service;
10. Primary carrier EOB when patient has other insurance;
11. All applicable ICD-9-CM diagnosis codes—inpatient claims include diagnoses at the time of discharge or in the case of emergency room claims, the presenting ICD-9-CM diagnosis code;
12. MS-DRG code for inpatient hospital claims.

Gateway processes medical expenses upon receipt of a correctly completed CMS-1500 (08-05) Form and hospital expenses upon receipt of a correctly completed UB-04. Sample copies of a UB-04 and a CMS-1500 (08-05) 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 ensure reimbursement to the correct payee, the correct NPI number must be included on every claim. If the NPI number submitted for the provider does not match the vendor (payee) in Gateway's records, Gateway will issue payment to the correct vendor assigned to the provider based on the tax identification number received on the claim.

To comply with processing requirements, primary care practitioners and specialty care practitioner must submit claims under the individual practitioner NPI number rather than the practice or group identification number. Submissions for anesthesiology, pathology, radiology, and emergency room practitioner groups must also include the individual practitioner NPI number. Any claim billed on a CMS-1500 (08-05) Form must include the individual practitioner NPI in box 33 on the 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.

All claims must have complete and accurate ICD-9-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 for Pennsylvania is: Gateway Health Plan *Medicare Assured*®, Claims Processing Department, P.O. Box 69359, Harrisburg, PA 17106-9359.

Any questions concerning billing procedures or claim payments can be directed to Gateway's Provider Services Department at 1-800-685-5205.

Family Planning Services

Gateway Health Plan *Medicare Assured*® members are eligible for all of the benefits covered under the Medicare Program. All prospective and current Gateway Health Plan *Medicare Assured*® members receive information about specific counseling and referral services that are normally part of the Medicare benefit package, but for which Gateway cannot directly provide due to objections based on moral or religious grounds. Gateway has made alternate arrangements for Medicare covered counseling or referral services related to contraceptive services, female sterilization services, male sterilization services and abortion services. Gateway Health Plan *Medicare Assured*® members may self-refer to a participating Medicare provider for these services. All family planning services, as noted above, for Gateway Health Plan *Medicare Assured*® members are paid using an alternate process.

For practitioners and facilities, family planning services are defined as all **Medicare** covered evaluation, diagnostic or surgical services provided with a diagnosis code in series V25, or V26.1, V26.22, V26.51, V26.52, V26.8, V26.9 and by the CPT codes listed on the following page related to contraception and abortion services. (Follow Medicare guidelines for submission of sterilization services.)

Contraceptive Services	Abortion Services
11976 – Removable implantable contraceptive capsule	59840 - Induced abortion by dilation and curettage
58301 – Removal of IUD	59841 - Induced abortion by dilation and evacuation
	59850 - Induced abortion by one or more intraamniotic injections
	59851 - Induced abortion by one or more intraamniotic injections with D&C or evac
	59852 - Induced abortion…with hysterotomy
	59855 - Induced abortion by one or more vaginal suppositories
	59856 - Induced abortion…with D&C or evac
	59857 - Induced abortion…with hysterotomy
	59866 - Multifetal pregnancy reduction

All CPT codes related to abortions must be billed with the "**G7**" modifier. Providers must complete the Medicare abortion certification forms and retain in their medical records. A copy of the certification form is **NOT** required with your claim submission.

CPT codes shall be implemented and updated in accordance with the release and implementation of updates by the Center for Medicare and Medicaid Services.

Surgical Procedure Services

Gateway determines reimbursement of surgical procedures upon the clinical intensity of each procedure and reimburses at 100% for the most clinically intensive surgery, and 50% for the subsequent procedures. Reimbursement for more than 5 procedures requires medical record documentation. Pre- and post-operative visits will only be reimbursed to the extent that they qualify for payment according to the follow-up criteria.

Hospital Services

Hospital claims are submitted to Gateway on a UB-04. To assure that claims are processed for the correct member, the member's 8-digit Gateway identification number must be used on all claims. 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. Please review field numbers below carefully as many of them differ from the former UB-92 format.

UB-04 Data Elements for Submission of Paper Claim Forms

EDI requirements must be followed for Electronic claims submissions

Field	Description	Requirements
1	Provider Name, Address, City, State, Zip, Telephone, Fax, Country Code	Required
2	Pay to Name, Address, City, State, Zip	Required If Different from Billing Provider in Field 1
3a	Patient Control Number	Required

Field	Description	Requirements
3b	Medical Record Number	Not Required
4	Type of Bill	Required – If 4 Digits Submitted, the Lead 0 will be Ignored
5	Federal Tax Number	Required
6	Statement Covers Period	Required
7	Unlabeled Field	Not Used
8a	Patient Name	Required
9	Patient Address	Required
10	Birthdate	Required
11	Patient Sex	Required
12	Admission Date	Required for Inpatient and Home Health
13	Admission Hour	Not Required
14	Type of Admission/Visit	Required, If Inpatient
15	Source of Admission	Required
16	Discharge Hour	Not Required
17	Patient Status	Required
18-28	Condition Codes	May be Required in Specific Circumstances (Consult CMS Criteria)
29	Accident State	Not Used
30	Unlabeled Field	Not Used
31-34	Occurrence Codes and Dates	May be Required in Specific Circumstances (Consult CMS Criteria)
35-36	Occurrence Span Codes and Dates	Required, If Inpatient
37	Unlabeled Field	Not Used
38	Responsible Party Name and Address	Not Required
39-41	Value Codes and Amounts	Required, If Inpatient
42	Revenue Codes	Required
43	Revenue Descriptions	Required
44	HCPCS/Rates/HIPPS Codes	Required, If Outpatient
45	Service Dates	Required, If Outpatient
46	Service Units	Required
47	Total Charges	Required
48	Non-covered Charges	Required, If Applicable
49	Unlabeled Field	Not Used
50	Payer Identification	Required
51	Health Plan ID	Not required
52	Release of Information Certification Indicator	Required
53	Assignment of Benefits	Not Used
54	Prior Payments	Required, If Applicable
55	Estimated Amount Due from Patient	Not Required
56	National Provider ID	Required – NPI Number
57	Other Provider ID	Gateway Health Plan® Practitioner Identification Number should be entered on paper claims only- legacy number reported as secondary identifier to NPI on electronic claims
58	Insured's Name	Required, If Applicable
59	Patient Relationship to Insured	Required, If Applicable
60	Certificate-Social Security Number-Health Insurance Claim-Identification Number	Gateway Member Identification Number Required
61	Insurance Group Name	Required, If Applicable
62	Insurance Group Number	Required, If Applicable
63	Treatment Authorization Code	Required, If Applicable
64	Document Control Number	Not Required
65	Employer Name	Required, If Applicable
66	Diagnosis and Procedure Code Qualifier	Required
67	Principal Diagnosis Code	Required (Coding for Present on Admission data required)
67A-67Q	Other Diagnosis Codes	Required (Coding for Present on Admission data required)
68	Unlabeled Field	Not Used
69	Admitting Diagnosis Code	Required
70A-70C	Patient Reason for Visit	Not Required
71	Prospective Payment System (PPS) Code	Required for DRG Code – If 4 Digits Submitted, the Lead 0 will be Ignored
72	External Cause of Injury Codes	Not Used
73	Unlabeled Field	Not Used
74	Principal Procedure Code and Date	Required, If Applicable
74A-74E	Other Procedure Codes and Date	Required, If Applicable
75	Unlabeled Field	Not Used
76	Attending Provider Name and Identifiers (Including NPI)	May be Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send
77	Operating Provider Name and Identifiers (Including NPI)	May be Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send
78-79	Other Provider Name and Identifiers (Including NPI)	May be Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send
80	Remarks	May be Required in Specific Circumstances (Consult CMS Criteria)
81	Code – Code Field	Optional (Consult CMS Criteria)

CMS-1500 (08-05) Data Elements for Submission of Paper Claim Forms

EDI requirements must be followed for Electronic claims submissions

Field #	Description	Requirements
1	Insurance Type	Required
1a	Insured Identification Number	Gateway Health Plan® Member Identification Number
2	Patient's Name	Required
3	Patient's Birth Date	Required
4	Insured's Name	Required
5	Patient's Address	Required
6	Patient Relationship to Insured	Required
7	Insured's Address	Required
8	Patient Status	Required
9	Other Insured's Name	Required, If Applicable
9a	Other Insured's Policy or Group Number	Required, If Applicable
9b	Other Insured's Date of Birth, Sex	Required, If Applicable
9c	Employer's Name or School Name	Required, If Applicable
9d	Insurance Plan Name or Program Name	Required, If Applicable
10	Is Patient Condition Related to: a. Employment b. Auto accident c. Other accident	Required, If Applicable
10d	Reserved for Local Use	Not Required
11	Insured's Policy Group or FECA Number	Required
11a	Insured's Date of Birth, Sex	Required, If Applicable
11b	Employer's Name or School Name	Required, If Applicable
11c	Insurance Plan Name or Program Name	Required, If Applicable
11d	Is There Another Health Benefit Plan?	Required, If Applicable
12	Patient or Authorized Person's Signature	Required
13	Insured's or Authorized Person's Signature	Required
14	Date of Current: Illness OR Injury OR Pregnancy	Required, If Applicable
15	If Patient has had Same or Similar Illness, Give First Date	Not Required
16	Dates Patient Unable to Work in Current Occupation	Required, If Applicable
17	Name of Referring Practitioner or Other Source	Required, If Applicable
17a, b	Identification Number of Referring Practitioner	
18	Hospitalization Dates Related to Current Services	Required, If Applicable
19	Reserved for Local Use	May be Required in Specific Circumstances (Consult CMS Criteria)
20	Outside Lab	Not Required
21	Diagnosis or Nature of Illness or Injury	Required
22	Medical Resubmission Code	Not Required
23	Prior Authorization Number	Not Required
24a	Date(s) of Service	Required
24b	Place of Service	Required
24c	Type of Service	Not Required
24d	Procedures, Services, or Supplies CPT/HCPCS/Modifier	Required
24e	Diagnosis Code Pointer	Required
24f	Charges	Required
24g	Days or Units	Required
24h	EPSDT Family Plan	Not Required
24i	ID Qualifier	Required, if applicable
24j	Rendering Provider ID	Not Required
25	Federal Tax Identification Number	Required
26	Patient Account Number	Not Required
27	Accept Assignment	Not Required
28	Total Charge	Required
29	Amount Paid	Not Required
30	Balance Due	Not Required
31	Signature of Practitioner or Supplier including degrees or credentials	Gateway Individual Practitioner Name and Date Required
32	Service Facility Location Information	Facility Name and Address where Services were Rendered Required
33	Billing Provider Info and Phone #	Gateway Vendor (Payee) Name, Address, and Phone Number Required. NPI and Gateway Legacy Number should be Entered.

Appeals and Grievances

Introduction

Gateway encourages its members to let us know right away if they have questions, concerns, or problems related to covered services or the care that they receive. Members are encouraged to contact Member Services for assistance.

This section provides an outline of rules for making complaints in different types of situations. Federal law guarantees a member's right to make complaints regarding concerns or problems with any part of their medical care as a plan member. The Medicare program has set forth requirements for the filing and processing of member complaints. If a member or authorized representative files a complaint, we are required to follow certain processes when we receive it. We must be fair in how we handle it, and we are not permitted to disenroll or penalize a member in any way for making a complaint.

What are appeals and grievances?

Members have the right to make a complaint if he or she has concerns or problems related to coverage or care. "Appeals" and "grievances" are the two different types of complaints that can be made.

An "appeal" can be filed if a member asks Gateway to reconsider and change a decision we have made about what services or benefits are covered or what we will pay for a service or benefit. A member may file an appeal under these circumstances:

- If we refuse to cover or pay for services a member thinks we should cover
- If we or one of our plan providers refuses to render a service that a member believes should be covered
- If we or one of our plan providers reduces or cuts back on services or benefits that a member has been receiving, or
- If a member believes that we are stopping coverage of a service or benefit too soon

A "grievance" is the type of complaint that can be made if a member has any other type of problem with Gateway or one of our plan providers. For example, grievances may be filed if a member is experiencing a problem regarding the following situations:

- The quality of care by a plan provider
- Waiting times for appointments or in the waiting room
- Provider behavior
- Being able to reach someone by phone or get the information needed, or
- The cleanliness or condition of a provider's facilities

Generally, grievances should be filed directly with Gateway, but for matters related to quality of care, members also have the opportunity to file such complaints with a Quality Improvement Organization (QIO). THE QIO in Pennsylvania is Quality Insights of Pennsylvania. QIO reviews are discussed on page 96.

Acting as an Authorized Representative

Gateway will accept appeals made by the member and/or his or her authorized representative or the prescribing physician or other prescriber or a non-participating provider involved in the member's care. A member may have any individual (relative, friend, advocate, attorney, congressional staff member, member of advocacy group, or suppliers, etc.) act as his or her representative, as long as the designated representative has not been disqualified or suspended from acting as a representative in proceedings before CMS or is otherwise prohibited by law.

In order to act as a representative, the member and representative must complete the Appointment of Representative Form, which can be found in the Forms *and Reference Material Section* of this manual, or an equivalent document.

A representative must sign the appointment within thirty (30) calendar days of the member's signature. The appointment remains valid for a period of one year from either the date signed by the party making the appointment or the date the appointment is accepted by the representative, whichever is later. The appointment is valid for any subsequent levels of appeal on the claim or service in question unless the member specifically withdraws the representative's authority.

If the requestor is the member's legal guardian or otherwise authorized under State law, no appointment is necessary. Gateway Health Plan® will require submission of appropriate documentation, such as a durable power of attorney.

The prescribing physician or other prescriber or a non-participating provider who is involved in the member's care (upon providing notice to the member) may request an appeal on the member's behalf without having been appointed as the member's representative.

A provider that has furnished services or items to a member may represent that member on the appeal; however, the provider may not charge the member a fee for representation. Further, the provider appointed must acknowledge in a signed, dated statement that the member will not be held financially responsible for payment for the services under review. Providers who do not have a contract with Gateway must sign a "Waiver Of Liability" statement, which can be found in the *Forms and Reference Material Section* of this manual, that the provider will not require the member to pay for the medical service under review, regardless of the outcome of the appeal.

Appeals Regarding Hospital Discharge

There is a special type of appeal that applies only to hospital discharges. If a member feels that the Gateway coverage of a hospital stay is ending too soon, the member or his or her authorized representative can appeal directly and immediately to the Quality Improvement Organization (QIO). Quality Improvement Organizations are assigned regionally by the Centers for Medicare and Medicaid Services (CMS). The QIO for the state of Pennsylvania is Quality Insights of Pennsylvania. The QIOs are groups of health professionals that are paid to handle this type of appeal from Medicare patients. When such an appeal is filed on time, the stay may be covered during the appeal review. One must act very quickly to make this type of appeal, and it will be decided quickly.

If a member believes that the planned discharge is too soon, the member or his or her authorized representative may ask for a QIO review to determine whether the planned discharge is medically appropriate. The Important Message from Medicare document given to the member within two days of admission and copied to the member within two days of discharge provides the appeal information as well as the QIO name and telephone number.

In order to request a QIO review regarding a hospital discharge, the member or his or her authorized representative must contact the QIO no later than noon of the first working day after the written notice is provided. If this deadline is met, the member is permitted to stay in the hospital past the planned discharge date without financial liability. If the QIO reviews the case, it will review medical records and provide a decision within one full working day after it has received the request and all of the medical information necessary to make a decision. If the QIO decides that the discharge date was medically appropriate, the member will have no financial liability until noon of the calendar day after the QIO provides its decision. If the QIO decides that the discharge date was too soon and that continued confinement is medically appropriate, we will continue to cover the hospital stay for as long as it is medically necessary.

If the member or his or her authorized representative does not ask the QIO for a review by the deadline, the member or authorized representative may ask Gateway for an expedited appeal. If the member or authorized representative asks us for an expedited appeal of the planned discharge and stays in the hospital past the discharge date, he or she may have financial liability for services provided beyond the discharge date. This depends on the expedited appeal decision. If the expedited appeal decision is in the member's favor, we will continue to cover the hospital care for as long as it is medically necessary. If the expedited appeal decision is that continued confinement was not medically appropriate, we will not cover any hospital care that is provided beyond the planned discharge date, unless an IRE review overturns our decision.

Skilled Nursing Facility (SNF), Home Health (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) Services

There is another special type of appeal that applies only when coverage will end for SNF, HHA or CORF services. If a member feels that coverage for these services is ending too soon, he or she can appeal directly and immediately to the QIO. As with hospital services, these services may be covered during the appeal review if filed on time.

If Gateway Health or the facility decides to end coverage for such a stay, the member is provided with a written Notice of Medicare Non-Coverage (NOMNC) at least two (2) calendar days before coverage ends. The member or authorized representative will be asked to sign and date this document. Signing the document does not mean that the member agrees to the decision, only that the notice was provided. After the NOMNC is completed, the provider must retain a copy in the provider's records.

Quality Improvement Organization (QIO) Review

For these types of services, members have the right by law to ask for an appeal of a termination of coverage. As will be explained in the notice referenced above, the member or his or her authorized representative can ask the QIO to do an independent review of whether terminating coverage is medically appropriate.

The notice will provide the name and phone number of the appropriate QIO agency. If the member receives the termination notice two days before coverage is scheduled to end, the member must contact the QIO no later than noon of the day the notice is received. If the notice is received more than two (2) days prior to the scheduled end in coverage, the QIO must be contacted no later than noon of the day before the scheduled termination of coverage.

If the QIO reviews the case, the QIO will ask for the member's opinion about why the services should continue. The response is not required in writing. The QIO will also look at medical information, talk to the doctor, and review other information that Gateway provides to the QIO. It is *very important* that the provider *immediately* faxes all of the member's medical records to the QIO for their review. Gateway will provide both the member and the QIO a copy of the explanation for termination of coverage of these services.

After reviewing all the information, the QIO will decide whether it is medically appropriate for coverage to be terminated on the date that has been set for you. The QIO will make this decision within one full day after it receives the information necessary to make a decision. If the QIO decides in favor of the member, will continue to cover the stay for as long as medically necessary. If the QIO decides that our decision to terminate coverage was medically appropriate, the member will be responsible for paying the SNF, HHA or CORF charges after the

termination date that appears on the advance notice. Neither Original Medicare nor Gateway will pay for these services. If the member agrees to discontinue receiving services on or before the date given on the notice, there will be no financial liability.

If the member or his or her authorized representative does not ask the QIO for a review in a timely manner, the member or authorized representative may request an expedited appeal. It is important to note that if the member or authorized representative requests an expedited appeal regarding termination and services continue to be provided, the member may have financial liability if services are provided beyond the termination date.

If Gateway staff decides upon expedited appeal review that services are medically necessary to continue, we will continue to cover the care for as long as medically necessary. If the decision is not in the member's favor, we will not cover any of the care that was provided beyond the termination date, and the member may be financially responsible.

Appeals for Coverage of Other Medical Services

There are several steps that members may use to request care or payment from Gateway. If we deny all or part of a request for coverage of services or payment for services, a member may ask for us to reconsider our decision. This is called an appeal or request for reconsideration. A member or his or her authorized representative may call Member Services for assistance in filing an appeal. All appeals must be filed within sixty (60) calendar days of any Gateway initial denial notice. Additional time may be granted for good cause.

At each step, qualified personnel evaluate the request and a decision is made. If the decision is not in the member's favor, there are subsequent appeal options that are available.

After Gateway has issued an organization determination, a member or authorized representative may file an appeal. The first step of the appeal process is referred to as a request for reconsideration. If the member's medical condition warrants it, an expedited appeal may be requested. Gateway staff will make every effort to gather all the information needed in order to make a decision about the appeal. Qualified individuals who were not involved in making the initial coverage determination will review the appeal. Members also have the right to obtain and provide additional information as part of the appeal. Additional information in support of the member's appeal may be provided in writing or in person at the following address:

Gateway Health Plan *Medicare Assured® HMO SNP*
Attention: Medicare Complaints Administrator
US Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219-2704

Information may also be provided as follows:

Fax: 412-255-4503
Telephone: 1-800-685-5209

Members also have the right to ask us for a copy of the information that pertains to their appeal. Members may reach the Medicare Complaints Administrator as indicated above in order to make such a request.

For a decision about payment for care already received, the appeal must be finalized by Gateway within sixty (60) days, which includes payment for the services or forwarding the appeal to the Independent Review Entity (IRE) for review. For a standard review about medical care not yet provided, Gateway must finalize the appeal within thirty (30) days or sooner if the member's health condition warrants. For expedited appeals regarding medical care, Gateway has up to seventy-two (72) hours to make a decision, but will make it sooner if the member's life, health, or ability to regain maximum function requires it. All adverse reconsideration decisions are automatically forwarded to the Independent Review Entity (IRE) for review. Also, if we do not issue a decision within the standard or expedited as outlined above, the appeal will be automatically forwarded to the IRE for review. The IRE has a contract with CMS and is not part of Gateway.

If the member requests an extension, or if we find that some information is needed that would be beneficial to the member in this review, an extension of up to fourteen (14) calendar days may be granted. The fourteen (14) day extension is also an option with expedited appeal. If we do not issue a decision by the end of the extended time period, the appeal is automatically forwarded to the Independent Review Entity (IRE) for review.

Upon completion of the reconsideration, the member and parties to the appeal will be notified of either the approval of the service or payment or that the appeal has been forwarded to the IRE.

IRE Review

Gateway will notify the member and provider in writing when an appeal has been forwarded to the IRE for review. The member may request a copy of the file that is provided to the IRE for review. The IRE will review the request and make a decision about whether Gateway must provide the care or payment for the care in question. For appeals regarding payment of services already received, the IRE has up to sixty (60) calendar days to issue a decision. For standard appeals regarding medical care not yet provided, the IRE has up to thirty (30) calendar days to issue a decision. For expedited appeals regarding medical care, the IRE has up to seventy-two (72) hours to make a decision. These timeframes can be extended by up to fourteen (14) calendar days if more information is needed and the extension is in the member's best interest.

The IRE will issue its decision in writing to both the member (or authorized representative) and the plan. If the decision is not in the member's favor, the member may have the opportunity to pursue coverage of the services through the review of an Administrative Law Judge.

Administrative Law Judge Review

If the IRE decision is not in the member's favor, and if the dollar value of the contested benefit meets minimum requirements the member or his or her authorized representative may ask for an Administrative Law Judge (ALJ) to review the case. The ALJ also works for the federal government. The IRE decision letter will instruct the member how to request an ALJ review.

During an ALJ review, the member may present evidence, review the record, and be represented by an attorney. The ALJ will not review the appeal if the dollar value of the medical care is less than the minimum requirement, and there are no further avenues for appeal. The ALJ will hear the case, weigh all of the evidence and make a decision as soon as possible.

The ALJ will notify all parties of the decision. The party against which the decision is made has the opportunity to request a review by the Medicare Appeals Council/Departmental Appeal Board. The decision issued by the ALJ will inform the member how to request such a review.

Medicare Appeals Council

The party against whom the ALJ decision is made has the right to request the review by the Medicare Appeals Council (MAC). This Council is part of the federal department that runs the Medicare program. The MAC does not review every case it receives. When it receives a case, the MAC decides whether to conduct the review. If they decide not to review the case, either party may request a review by a Federal Court Judge; however, the Federal Court Judge will only review cases when the amount in controversy meets the minimum requirement.

Federal Court

The party against whom the Medicare Appeals Council decision is made has the right to file the case with Federal Court if the dollar value of the services meets the minimum requirements. If the dollar value of the service in question is less, the Federal Court Judge will not review it and there is no further right of appeal.

Appeals for Coverage of Part D Drugs

Gateway encourages its members to contact us through Member Services with any questions concerns or problems related to prescription drug coverage. As with medical services, Gateway also has processes in place to address various types of complaints that members may have regarding their prescription drug benefits.

Prescribing physicians or other prescribers who feels that an enrollee's life or health is in serious jeopardy may have immediate access to the Part D appeal process by calling 1-800-213-7083. Prescribers may also use this number to address process or status questions regarding the Part D appeal process.

An "appeal" is any part of the procedures that deal with the review of an unfavorable coverage determination. A member or his or her authorized representative may file an appeal if he or she wants Gateway to reconsider and change a decision we have made about what Part D prescription drug benefits are covered or what we will pay for a prescription drug.

It is important to note that if Gateway approves a member's exception request for a non-formulary drug, the member may not request an exception to the copayment that applies to that drug.

Problems getting a Part D prescription drug that may be addressed by an appeal are as follows:

- If the member is not able to get a prescription drug that may be covered
- If a member has received a Part D prescription drug that may be covered but we have refused to pay for the drug.
- If we will not pay for a Part D prescription drug that has been prescribed because it is not on the formulary.
- If a member disagrees with the copayment amount.
- If coverage of a drug is being reduced or stopped.
- If there is a requirement to try other drugs before the prescribed drug is covered
- If there is a limit on the quantity or dose of the drug.

There are several steps that members may use to request care or payment from Gateway. At each step, qualified personnel evaluate the request and a decision is made. If the decision is not in the member's favor, there are subsequent appeal options available.

After Gateway has issued an organization determination, a member or authorized representative or prescribing physician or other prescribers may file an appeal, also commonly referred to as a request for redetermination. All appeals must be filed within sixty (60) calendar days from the date of the coverage determination. If the member's life, health, or ability to regain maximum function is in jeopardy, an expedited appeal may be requested. Gateway staff will make every effort to gather all the information needed in order to make a decision about the appeal. Qualified individuals who were not involved in making the coverage determination will review each request. Members have the right to obtain and provide additional information as part of the appeal. Additional information in support of the member's appeal may be provided in writing or in person at the following address:

Gateway Health Plan *Medicare Assured® HMO SNP*
Attention: Medicare Complaints Administrator
US Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219-2704

Information may also be provided by fax at 412-255-4503 or by telephone at 1-800-685-5209. Members also have the right to ask us for a copy of the information that pertains to their appeal. Members may reach the Member Complaints Administrator as indicated above in order to make such a request.

Upon completion of the redetermination, the member and parties to the appeal will be notified of the decision. For a standard decision about a Part D drug, which includes any request for reimbursement for a Part D drug that has already been provided, Gateway has up to seven (7) calendar days to issue a decision and authorize or pay for the drug in question. If the member's health condition requires it, the decision will be issued sooner. If Gateway does not issue a decision within seven (7) calendar days, the request will automatically be forwarded to the Independent Review Entity (IRE) for review.

For an expedited appeal regarding Part D drugs that have not been provided, Gateway has up to seventy-two (72) hours to issue a decision and authorize the requested medication. If the member's health condition requires it, the decision will be issued sooner. If an expedited appeal was requested and Gateway does not comply with the seventy-two (72) hour timeframe, the case will automatically be forwarded to the IRE for review.

If the redetermination does not result in the approval of the drug under review, the member may ask for review by an IRE. It is important to note that IRE review of Part D drug denials is not automatic as it is for medical services. The IRE has a contract with the federal government and is not part of Gateway.

Independent Review Entity (IRE)

The member or his or her authorized representative must submit a request to the IRE in writing within sixty (60) calendar days of the appeal decision notice. An expedited IRE is also available if the member's condition requires it. The IRE's name and address will be included in this notice. If a member requests review by IRE, the IRE will review the request and make a decision about whether Gateway must cover or pay for the medication. For an expedited IRE review, the IRE must issue a decision within seventy-two (72) hours. For a standard IRE review, the IRE has up to seven (7) calendar days to issue the decision.

The IRE will issue its decision in writing, explaining the reasons for the decision. If the decision is in the member's favor and the member has already paid for the medication, Gateway will reimburse the member within thirty (30) calendar days of

the IRE's decision. We will also send the IRE confirmation that we have honored their decision. If the decision is in the member's favor and the member has not yet received the drug, Gateway will authorize the medication within seventy-two (72) hours of receiving the decision notice. Confirmation will be sent to the IRE in this situation as well. If an expedited IRE review was conducted, Gateway will authorize the medication within twenty-four (24) hours of receiving the IRE's decision notice.

If the member is not satisfied with the result of the IRE review, he or she may request the review by an Administrative Law Judge.

Administrative Law Judge (ALJ) Review

If the decision is not in the member's favor, the member or his or her authorized representative may request the review by an ALJ. In order to request a review by an ALJ, the value of the drug in question must meet minimum requirements. To calculate the amount in controversy, the dollar value of the drug will be projected based on the number of refills prescribed for the requested drug during the plan year. This projected value includes co-payments, all expenses incurred after the member's expenses exceed the initial coverage limit and any expenses paid by other entities. Claims may also be combined to meet the dollar value requirement if the claims involve the delivery of Part D drugs to the member, if all claims have been reviewed by the IRE, each of the combined requests are filed in writing within the sixty (60) day filing limit, and the hearing request identifies all of the claims to be heard by the ALJ.

The request must be made in writing within sixty (60) calendar days of the date of the IRE decision. The member may request an extension of the deadline for good cause. During the ALJ review, the member or appointed representative may present evidence, review the record, and be represented by counsel.

The ALJ will hear the member's case, weigh all of the evidence submitted, and issue a decision as soon as possible. The ALJ will issue a decision in writing to all parties.

If the decision is in the member's favor and the member has already received and paid for the drug in question, Gateway will reimburse the member within thirty (30) calendar days from the date we receive the ALJ decision. If the decision is in the member's favor and the member has not yet received the drug in question, Gateway will authorize the medication within seventy-two (72) hours of the date we receive the ALJ decision. In cases where an expedited ALJ review was requested, Gateway will authorize the medication within twenty-four (24) hours of receiving the ALJ notice.

If the ALJ rules against the member, the ALJ notice will provide instructions on how to request a review by the Medicare Appeals Council.

Medicare Appeals Council

If the decision of the ALJ is not in the member's favor, Medicare Appeals Council (MAC) review may be requested. The MAC is part of the federal department that runs the Medicare program. There is no minimum dollar value for the MAC to conduct a review. The MAC does not review every case it receives. When it gets a case, it decides whether to review the case. If the MAC decides not to review the case, a written notice will be issued, and this notice will advise the member if any further action can be taken with respect to the request for review. The notice will instruct the member how to request a review by a Federal Court Judge.

If the MAC reviews the case, it will inform all parties of its decision in writing. If the decision is in the member's favor and the member has already received and paid for the drug in question, Gateway will reimburse the member within thirty (30) calendar days of receiving the MAC notice. If the decision is in the member's favor, but the member has not yet received the drug in question, Gateway will authorize the drug within seventy-two (72) hours of receiving the MAC notice. If an expedited MAC review was requested and the decision is in the member's favor, Gateway will authorize the drug within twenty-four (24) hours of receiving the MAC notice.

If the MAC reviews the case and the decision is not in the member's favor, the member may request a judicial review, but only if the dollar value of the medication meets minimum requirements.

Federal Court

If the member is not satisfied with the decision made by the MAC, in order to request judicial review of the case, the member must file civil action in a United States District Court. The MAC letter will explain how to do this. The dollar value of the drug in question must meet the minimum requirement to go to a Federal Court. The federal judiciary is in control of the timing of any decision.

If the Judge decides in the member's favor, Gateway is obligated to authorize or pay for services under the same time constraints as outlined above. If the Judge issues a decision that is not in the member's favor, the decision is final and there is no further right of appeal.

Amount in Controversy, Federal Minimum Requirements for Filing

Appeal Level	Calendar Year 2007	Calendar Year 2008	Calendar Year 2009	Calendar Year 2010	Calendar Year 2011
ALJ Hearing	$110	$120	$120	$130	$130
Judicial Review	$1,130	$1,180	$1,220	$1,260	$1,300

Member Grievances

A grievance is different from an appeal in that it usually does not involve coverage or payment for benefits. Concerns about failure to pay for a certain drug or service should be addressed through the appeals processes.

The member grievance process may be used to address other problems related to coverage, such as:

- Problems with waiting on the phone or in the pharmacy.
- Disrespectful or rude behavior by pharmacists or other staff.
- The cleanliness or condition of a network pharmacy.
- If a member disagrees with our decision not to expedite a request for coverage determination.
- If Gateway does not provide a decision within the required timeframe.
- If Gateway does not forward a case to an IRE if we do not comply with required timeframes for reconsideration.
- If Gateway does not provide the member with required notices.

Members also have the opportunity to file expedited grievances under certain conditions. See page (107).

Members are encouraged to contact our Member Services first in order to be provided with immediate assistance. Our staff will try to resolve any complaint over the telephone. If a written response is requested, one will be provided. If our Member Services staff is not able to resolve the telephone complaint, we will provide a written response to the member. Gateway employs a formal, multi-disciplinary process to review member grievances. Members may file a grievance by calling our Member Services Department or by writing to the following address:

Gateway Health Plan *Medicare Assured® HMO SNP*
Attention: Medicare Complaints Administrator
US Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219-2704

If the member would like to have someone else file a grievance for him or her, an Appointment of Representative Form must be completed, which can be found in the *Forms and Reference Material Section* of this manual. Grievances must be filed within 60 days of the date of the incident. Upon receipt of any grievance, Gateway will send the member a confirmation letter. The confirmation letter will ask the member to sign and return a form confirming that the complaint has been filed.

First Level Grievance

The member or his or her authorized representative will have the opportunity to submit any information, documentation or evidence regarding the grievance. The First Level Grievance Committee will review all of this information in making their decision. The Committee will send a written response as quickly as the case requires based on the member's health status, but no later than thirty (30) calendar days after receiving the grievance. We may extend the timeframe by up to fourteen (14) calendar days if you request the extension or if we justify a need for additional information and the delay is in your best interest.

Second Level Grievance

If the member is not satisfied with the decision of the First Level Grievance Committee, he or she may ask for a Second Level Grievance Review. A Second Level Grievance review can be requested in the same manner as outlined above, but must be filed within forty-five (45) calendar days of the date of receiving the First Level Grievance decision letter.

Once Gateway receives such a request, a Second Level Grievance Committee Hearing will be scheduled. The member is given at least fifteen (15) days notice for this hearing. The member may participate in this hearing in person or by telephone. Participation in this hearing is not required. The Second Level Grievance Committee will investigate the grievance and send the member a decision letter as quickly as the case requires based on the member's health status, but no later than thirty (30) calendar days after receiving your grievance.

Expedited Grievances

Gateway Health Plan *Medicare Assured*® also has a process in place when it may be necessary to expedite the review of a grievance because the member's life, health, or ability to regain maximum function is in jeopardy. Members may file expedited grievances in the following circumstances:

- When we have extended the timeframe to make an Organization Determination.
- When we have extended the timeframe to resolve a standard request for Reconsideration.
- When we have refused to grant a Member's request for an expedited Organization Determination.
- When Gateway has refused to grant a Member's request for an expedited Reconsideration (Appeal).

The circumstances outlined above are the **only** times that an expedited grievance review is available.

When an expedited grievance is filed, an Expedited Grievance Hearing is immediately scheduled to occur within twenty-four (24) hours of receiving the request. As with Second Level Grievances, the member or appointed

representative may participate in this hearing, but participation is not required. All affected parties will be notified of the decision by telephone within twenty-four (24) hours of filing the Expedited Grievance, and a letter explaining the decision will follow within three (3) days.

Quality Improvement Organization Review

Complaints concerning the quality of care received under Medicare may be investigated and acted upon by Gateway under the internal grievance process or by an independent organization called the Quality Improvement Organization (QIO) or by both. For example, if member believes that his or her pharmacist provided the incorrect dosage of a prescription or was prescribed a medication in error, the enrollee may file a complaint with the QIO in addition to or instead of a complaint filed under the plan sponsor's grievance process. For any complaint filed with the QIO, Gateway must cooperate with the QIO in resolving the complaint.

How to File a Quality of Care Complaint with the QIO

QIOs are assigned regionally by CMS. For members who reside in Pennsylvania, quality of care complaints filed with the QIO must be made in writing to the following address:

Quality Insights of Pennsylvania
2601 Market Place Street
Suite 320
Harrisburg, PA 17110

There is no filing limit for quality of care grievances.

Provider Appeals

Any provider may file a formal 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 Reconsideration or Redetermination processes. The formal 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 received by Gateway within ninety (90) calendar days of the date of the denial notice. All written appeals must be sent to:

Gateway Health Plan®, Inc.
Medicare Complaints Administrator
US Steel Building, 41st Floor
600 Grant Street
Pittsburgh, PA 15219-2704

First Level Appeal (The Informal Dispute Resolution Process)

The Gateway Provider Appeal Committee will resolve all First Level Appeals as soon as possible after receipt of all necessary information, but no more than thirty (30) calendar days from the date received. The Appeal Committee will be comprised of one (1) or more Gateway staff members who were not involved in the initial review. The First Level Appeal Committee will inform the provider of its decision in a written decision notice.

Second Level Appeal (The Informal Dispute Resolution Process)

If the provider is not in agreement with the first level appeal decision, the provider may request a Second Level Appeal. The provider must submit a written request for a Second Level Appeal to Gateway within thirty (30) calendar days of the date of the First Level Appeal decision letter. The Appeal Committee will be comprised of one (1) or more staff members who were not involved in any previous level of review. The provider will have the opportunity to participate in person or by telephone conference call in the second level appeal review. The provider must notify the Complaints Administrator in writing of the intent to participate. The Complaints Administrator will provide written notice of the hearing date at least fifteen (15) days in advance.

All Second Level Appeals will be resolved within forty-five (45) days from the date received. The Second Level Appeal Committee will inform the provider of its decision in a written decision notice. The decision of the Second Level Appeal Committee is final and binding.

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Model of Care

Overview

Gateway Health Plan® (Gateway) offers a Special Needs Plan (SNP), *Medicare Assured*®, for individuals who have Medicare Parts A and B, and Full or Qualified Medicare Beneficiary (QMB) Medicaid eligibility. These individuals are referred to as "dual-eligibles".

As a SNP, Gateway is required by the Centers for Medicare and Medicaid Services (CMS) to administer a Model of Care Plan. The SNP Model of Care Plan is the architecture for care management policy, procedures, and operational systems.

SNP Model of Care Elements

1. **Staff Structure and Care Management Roles**

   - There are three essential care management roles within Gateway's Model of Care:

     - Administrative Roles – These roles involve the day-to-day operations of the plan such as processing enrollments, paying claims, and handling appeals and grievances.

     - Service Delivery Roles – These roles involve providing care to the beneficiary, including such things as Advocating, Informing and Educating Beneficiaries, Identifying and Facilitating Access to Community Resources, and ensuring that the member receives the care he/she needs.

     - Oversight Roles – These include oversight of both Administrative and Clinical functions. Some examples include Monitoring Model of Care Compliance, Assuring Statutory and Regulatory Compliance, and Evaluating the Model of Care Effectiveness; And, Monitoring the Interdisciplinary Care Team (see below), Assuring Timely and Appropriate Delivery of Services and Assuring Seamless Transitions and Timely Follow-up to care, and Conducting Chart Reviews

2. **Provider Network Having Specialized Expertise and Use of Clinical Guidelines**

   - Gateway contracts with a network of providers with the clinical expertise pertinent to the *Medicare Assured*® population. The providers go through appropriate credentialing processes and are expected to use appropriate clinical guidelines in the care of Gateway's members.

3. Health Risk Assessment (HRA)

- Health Risk Assessments are a set of questions designed to provide Gateway with an overview of a member's health status and risks. Shortly after enrolling, each member is asked to complete a Health Risk Assessment, either by paper or over the phone. Reassessments are performed at least annually thereafter.

4. Interdisciplinary Care Team (ICT)

- EACH member of *Medicare Assured*® is assigned to an Interdisciplinary Care Team based upon his/her level of need as indicated by the assessment of the HRA. The composition of the team varies based on the needs of the member. Under most circumstances, the member's Primary Care Physician (PCP) is included on the ICT. Whenever possible, the member or member's caregiver is included as part of the team.

5. Individualized Care Plan (ICP)

- An individualized care plan contains goals, objectives and plan of care for the member. The ICP is developed by the ICT based on needs identified by the Health Risk Assessment.

6. Communication Network

- Gateway has a communication network to facilitate communication between the Plan, the member, providers, and when necessary the ICT. Communication is primarily handled via printed materials / reports, faxes, and telephone calls.

7. Performance and Health Outcomes

- Performance and health outcomes are measured in a variety of ways within Gateway. Some of these include the Medicare Health Outcomes Survey (HOS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, the Healthcare Effectiveness Data and Information Set (HEDIS) measures, various member surveys, and analysis of encounter data.

8. Measurable Goals.

- Using CMS guidelines, Gateway has established Model of Care goals that measure, and attempt to improve outcomes for things such as Access to Medical, Mental Health, and Social Services; Access to Preventable Health Services; and Cost-effective Service Delivery.

9. Model of Care Training

- Model of Care Training is provided to Gateway *Medicare Assured*® employees, sub-contractors, and providers at time of hire / contract, and annually thereafter.

How the Model of Care Works for a Member

- Shortly after a member enrolls with *Medicare Assured*®, the member is given a Health Risk Assessment. The assessment is mailed to the member as part of the member's new member packet. The member is asked to complete and return the form. If the form is not returned within a specified period of time, Care Management outreaches to that member by telephone.

- The completed Health Risk Assessment is reviewed, and based on that review, the member is assigned to an Interdisciplinary Care Team (ICT).

- The ICT develops the member's Individualized Care Plan (ICP). Input is gathered from the primary care physician (PCP) whenever applicable.

- The ICP is communicated to the member, the member's primary care physician (PCP), and other ICT members as appropriate; normally by mail.

- The member receives care as indicated on his/her ICP.

- At least annually, the member receives another health assessment to determine if the needs of the member have changed.

Other Important Information about Gateway's Model of Care

- Gateway recognizes that member's care needs are varied and are subject to change. Policies and procedures have been put in place to allow members to receive the level of care management needed for their particular circumstance.

- Members may be referred for Care Management in a variety of ways:
  - Providers may call 1-800-685-5212, option 1
  - Members may self-refer by calling 1-800-685-5212, option 1.
  - Gateway employee via an internal process.

- Oversight of the Model of Care Plan is handled by the Medicare Administration Department. Specific questions with regard to the Model of Care Plan should be addressed with your Gateway Provider Representative.

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Preventive Health, Disease and Care Management

Preventive Health Program

The Gateway Health Plan *Medicare Assured*® Preventive Health Program focuses on the importance of health screening and early detection of diseases. Key interventions of the program include:

- Reminders for Preventive Health screenings
- Telephonic outreach to assist members in scheduling mammograms when indicated
- Physician notification of members overdue for mammograms and/or pap smears
- Member newsletters with articles focusing on the importance of Preventive Health
- Health screening information on the Gateway Health Plan *Medicare Assured*® website

For more information, please call 1-800-685-5212 and press option 4 to speak with an Outreach Representative.

Disease Management Programs

MOM Matters® Program

The MOM (Maternity Outreach and Management) Matters® Prenatal Program offers maternity care coordination to improve the frequency of prenatal and postpartum care to reduce the incidence of low birth weight, pre-term deliveries and 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 identified pregnant Gateway members are automatically enrolled once we identify them with one of the high risk maternity conditions via the OB Needs Assessment Form. Maternity Care Managers telephonically contact these members. Members are able to opt-out if they choose.

The program will provide the following member benefits and support:

- Patient education
- Prenatal educational packet mailed to all identified pregnant members
- Home care and DME needs are coordinated through the Gateway Care Manager
- Information on smoking with referral to the state Quitline
- Member newsletter with related maternity articles
- MOM Matters®information via Gateway Health Plan® website
- Prenatal Reward Program

Provider benefits and support:
- Support from care managers and other health care staff to ensure that your patients understand how to best manage their condition and self evaluate their health status.
- Health education information mailed to all identified pregnant members
- Telephonic care management and coordination of care for high risk patients
- An enrollment notification form is faxed to the OB provider upon member eligibility for the program
- A bonus payment to PCPs and OB/GYNs for rendering initial prenatal visit within the first trimester.

Membership in the MOM Matters® Prenatal Program is voluntary. If at any time your patients wish to stop participating in the program, they only need to call.

For more information or to refer a patient to the MOM Matters® Prenatal Program call 1-800-685-5212, and press option 2.

Asthma Program

"AIR" (Asthma Intervention gets Results) Gateway® is an asthma management program emphasizing patient education, self-management, practitioner education and support to increase appropriate medication use and reduce acute care asthma utilization.

Gateway members with asthma between the ages of 2 and 56 years of age are enrolled in the program. Care Managers telephonically contact members identified as being at high risk for complications secondary to their asthma. Members are automatically enrolled once identified with asthma. They are able to opt-out if they choose.

Referral to the AIR Gateway® Program can be made by telephone or by completion of the Asthma/Cardiac Fax Referral Form which is located in the *Forms and Reference Material Section* of this manual.

The program will provide the following member benefits and support:
- Patient education and self-management tools
- Asthma education
- Asthma action plan
- Information on smoking with referral to the state Quitline
- Member newsletter with asthma related articles
- AIR Gateway® information via Gateway Health Plan® website

Provider benefits and support:
- Support from our care managers and other health care staff to ensure that your patients understand how to best manage their condition and self evaluate their health status

- An enrollment notification form is faxed to the PCP upon member eligibility for case management
- Patient education and assistance with co-existing conditions, smoking cessation and medication compliance supports optimal self-management

Membership in the Asthma Program is voluntary. If at any time your patients wish to stop participating in the program, they only need to call.

For more information or to refer a patient to the AIR Gateway® Asthma Program call 1-800-685-5212, and press option 3.

Diabetes Program

Gateway's Diabetes Program emphasizes education and personal responsibility for diabetic control to reduce the need for hospitalizations, ER visits and prevention of diabetic complications. Care Managers are available by phone for members and physicians.

All adult and pediatric Gateway members with Type 1 or Type 2 diabetes are eligible for this program. Members are automatically enrolled once we identify them with diabetes. They are able to opt-out if they choose.

The program will provide the following member benefits and support:

- Support from nurses and other health care staff to ensure that your patients understand how to best manage their condition and self evaluate their health status
- Members with diabetes receive educational materials and may call to join the care management program
- Targeted reminders to patients who are due for screenings
- Home care and DME needs are coordinated via collaboration with Gateway's Utilization Management Department.
- Member newsletter with diabetes related articles
- Diabetic information via Gateway Health Plan® website

Provider benefits and support:

- Diabetic educational materials are mailed to your patients
- An enrollment notification form is forwarded to the primary care practitioner upon member eligibility for case management
- Patient education with co-existing conditions, smoking cessation and glucometer use reduces likelihood of hospital admissions

For more information or to refer a patient to the Diabetes Program, call 1-866-685-5212.

Help Your Heart Cardiac Program

The Help Your Heart Cardiac Program provides patient education and self-empowerment for medication adherence to reduce the need for hospitalizations and ER visits and to delay the onset of cardiac complications.

Gateway members, age 21 or older, with a diagnosis of CHF, Ml, and CAD are eligible for the program. Members are automatically enrolled once we identify them with one of these cardiac conditions.

Referral to the Help Your Heart Program can be made by telephone or by completion of the Asthma/Cardiac Fax Referral Form which is located in the *Forms and Reference Material Section* of this manual.

The program will provide the following member benefits and support:

- Patient education and self-management tools
- Cardiac information
- High-risk cardiac patients with inpatient admissions receive telephonic case management
- Information on smoking with referral to the state Quitline
- Member newsletter with cardiac related articles
- Help Your Heart information via Gateway Health Plan® website
- Home care and DME needs are coordinated through the Gateway Care Manager

Provider benefits and supports:

- Support from our care managers and other health care staff to ensure that your patients understand how to best manage their condition and self evaluate their health status
- Cardiac specific educational materials are mailed to patients
- An enrollment notification form is faxed to the primary care practitioner upon member eligibility for care management
- Patient education for co-existing conditions, smoking cessation, medication compliance and weight supports optimal self-management

Membership in the Cardiac Program is voluntary. If at any time your patients wish to stop participating in the program, they only need to call.

For more information or to refer a patient to the Help Your Heart Program, call 1-800-685-5212 for Pennsylvania providers, and press option 3.

Care Management

General Information

The goal of the Care Management Department is to intervene in medically or socially complex cases that may benefit from increased coordination of services to

optimize health and prevent disease. The Care Management Department is staffed by individuals with medical or social work backgrounds in the following areas: obstetrics, oncology, medical/surgical, HIV/AIDS, substance abuse, mental health, and physical rehabilitation.

A Care Manager is available at 1-800-685-5212, option 1, Monday through Friday from 8:30 AM to 4:30 PM to assist with coordination of the member's healthcare needs. When calling after hours or on holidays, please refer to the Quick Reference section in this manual for the Member Services phone number.

Care management is a creative and collaborative process involving skills such as assessment, planning, coordination and advocacy. Care management facilitates optimal patient outcomes. Early intervention is essential to maximize treatment options while minimizing potential complications associated with catastrophic illnesses or injury and exacerbation of chronic conditions. The care management process includes:

1. Assessment
2. Planning
3. Intervention
4. Quality Monitoring
5. Evaluation/Reassessment

The responsibilities of case management include:

- Liaison with various healthcare practitioners, community social service agencies, advocacy groups and other agencies that the *Medicare Assured*® population may interface with;
- Case management of members with serious and complex needs;
- Coordination of services between primary care, specialty, ancillary, and behavioral health practitioners within and outside the network;
- Facilitation of members' access to city, county and state and 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 Care Management Department

The following problems and/or diagnoses are examples of appropriate referrals to the Care Management Department:

- Adults with Serious and Complex Medical Needs
- Mental Health or Substance Abuse Issues
- Social Issues (social isolation, hunger, housing, domestic violence)

Complex Case Management:

Gateway Health Plan *Medicare Assured*® provides a Complex Case Management program for eligible members. Gateway's Care Managers help to identify and provide disease and condition specific education. Care Managers can also assist

members with lifestyle management, address preventative health issues, medication reconciliation, identify benefits and community resources, and help to coordinate care with providers.

Please contact the Care Management department to make a referral if your patient has any of these diagnoses:

- Cancers in active treatment
- Symptomatic HIV/AIDS
- Chronic Obstructive Pulmonary Disease (COPD)
- New Traumatic Brain Injury with significant cognitive deficits
- New spinal cord injury with paralysis
- Stage IV Heart Disease
- Multiple chronic conditions

Please call Pennsylvania *Medicare Assured*®: 1-800-685-5212, Option 1.

Gateway Health Plan *Medicare Assured*® will review the request for enrollment and make the final decision for inclusion in the program.

Introduction to Credentialing

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), a Certified Nurse Midwife (CNM), a Certified Registered Nurse Practitioner (CRNP), 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, Home Infusion Therapy, Hospice, Rehabilitation Facilities, Freestanding Surgery Centers, Freestanding Radiology Centers, Portable X-ray Suppliers, End Stage Renal Disease Facilities, Clinical Laboratories, Outpatient Physical Therapy and Speech Therapy providers, Rural Health Clinics, Federally Qualified Health Centers Orthotic and Prosthetic providers. (This listing is subject to change.)

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.

Credentialing Standards

Gateway has established credentialing and recredentialing policies and procedures that meet CMS, DOH, DPW, 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 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:

- Active individual Master Provider Index (MPI) number
- Active individual National Provider Identifier (NPI) number
- Active status of participation in the Medicare and/or Medical Assistance Programs and free of sanctions
- Acceptable malpractice history as subject to decision by Gateway Medical Directors and Legal Counsel
- Unexpired professional liability coverage as mandated by state law, no less than $500,000 per occurrence, $1,500,000 per aggregate and coverage provided by the Medical Care Availability and Reduction of Error Fund (Mcare) or Federal Tort Coverage
- A current unrestricted license
- Active staff/clinical privileges (where applicable) that include admitting privileges in appropriate specialty that are current and in good standing
- Chiropractors are exempt from hospital privileges
- Board certification in practicing specialty is required
- Practitioners who practice solely in rural areas may be exempt from board certification requirements with acceptable education, training and CME documentation
- Foreign graduates must submit an ECFMG certificate
- Gateway recognizes the American Board of Medical Specialties (ABMS)
- Copy of current, unencumbered DEA certificate
- Fully completed and signed application
- Curriculum Vitae and/or Work History to include month and year
- 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 recredentialed at least every three (3) years in order to continue participation within Gateway. This helps to ensure Gateway's continued compliance with National Committee for Quality Assurance (NCQA), Department of Public Welfare (DPW), Center for Medicare and Medicaid Services (CMS) and the Department of Health (DOH), as well as to uphold the integrity and quality of the networks. 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 Plan *Medicare Assured*® Confidentiality of Practitioner/Provider Credentialing Information Policy and Procedure.

Ongoing and 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 Excluded Parties Listing Service (EPLS) 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 Quality Improvement/Utilization Management Committee for review and decision and/or immediately 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 complaint reports, which reveals member complaints, filed against practitioners. The Credentialing Department will review and investigate all complaints regarding: attitude of provider, provider treatment, quality issues of physician, and any complaints regarding adverse events. If after investigation the complaint is considered viable, it is documented.

Depending upon the severity level of the complaint(s), the practitioner may be sent to the Medical Director for review and recommendation, sent to Quality Improvement/Utilization Management Committee for review and decision and/or terminated and outcome presented to Quality Improvement/Utilization Management 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 an approved sabbatical. However, it is the practitioner's or his/her office's responsibility to notify Gateway in writing that the practitioner is called to active duty or beginning the leave, as well as 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 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, it 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 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.

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FORMS AND REFERENCE MATERIALS

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