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GATEWAY HEALTHSM
2015 Medicaid Provider Policy and Procedure Manual

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## Important Phone Numbers for Gateway Medicaid

<table>
<thead>
<tr>
<th>Call to Inquire About:</th>
<th>Telephone Number</th>
<th>Hours of Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Management</td>
<td>1-800-642-3550</td>
<td>Monday-Friday 8:30 AM to 4:30 PM</td>
</tr>
<tr>
<td>Option 1—Care Management</td>
<td></td>
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<tr>
<td>Option 2—Maternity/MOM Matters ®</td>
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<tr>
<td>Option 3—Asthma/ Cardiac/ COPD/ Diabetes</td>
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<tr>
<td>Option 4—Preventive Health Services/ EPSDT/Outreach</td>
<td></td>
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</tr>
<tr>
<td>Digital Voice Assistant (DIVA) (Eligibility Check/Generate and Review Referrals)</td>
<td>1-800-642-3515</td>
<td>24 hours a day/7 days a week</td>
</tr>
<tr>
<td>Fraud and Abuse and Compliance Hotline</td>
<td>(412) 255-4340 or 1-800-685-5235</td>
<td>24 hours a day/7 days a week</td>
</tr>
<tr>
<td>Medical Management (Utilization Management)</td>
<td>1-800-392-1146</td>
<td>Monday-Friday 8:30 AM to 4:30 PM (Voicemail during off hours. The call will be returned the next business day.) Please do not leave multiple voicemail messages or call for the same authorization request on the same day.</td>
</tr>
<tr>
<td>Member Services</td>
<td>1-800-392-1147</td>
<td>Monday-Friday 8:00 AM to 8:00 PM</td>
</tr>
<tr>
<td>Pharmacy (Non-Formulary Requests and Prior Authorization)</td>
<td>1-800-528-6738</td>
<td>Monday-Friday 8:30 AM to 4:30 PM</td>
</tr>
<tr>
<td>Provider Services (Claims Inquiries and Eligibility Verification)</td>
<td>1-800-392-1145</td>
<td>Monday-Friday 7:00 AM to 5:00 PM</td>
</tr>
<tr>
<td>Regulatory Affairs (Provider and Member Appeals)</td>
<td>1-800-392-1145</td>
<td>Monday-Friday 8:30 AM to 4:30 PM</td>
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<tr>
<td>TTY/TDD (for all departments)</td>
<td>711</td>
<td>Monday-Friday 8:30 AM to 4:30 PM</td>
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## Additional Helpful Telephone Numbers:

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<tbody>
<tr>
<td>Adagio Health (Authorization/Family Planning)</td>
<td>1-800-532-9465</td>
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<tr>
<td>Davis Vision – Provider Servicing</td>
<td>1-800-773-2847</td>
<td>Monday-Friday 8:00 AM to 6:00 PM</td>
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<tr>
<td>Eligibility Verification System (EVS) (5387)</td>
<td>1-800-766-5EVS</td>
<td></td>
</tr>
<tr>
<td>MA Provider Compliance Hotline (Fraud and Abuse Reporting)</td>
<td>1-866-379-8477</td>
<td>Monday-Friday 8:30 AM to 3:30 PM</td>
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### Call to Inquire About:

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<th>Hours of Operation</th>
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<td>MA Provider Enrollment Applications (In-process (Inpatient and Outpatient Provider Only))</td>
<td>717-772-6140</td>
<td>Monday-Friday 8:30 AM to 3:30 PM</td>
</tr>
<tr>
<td></td>
<td>717-772-2571</td>
<td>Monday-Friday 8:30 AM to 5:00 PM</td>
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<tr>
<td>Long Term Care Provider</td>
<td></td>
<td></td>
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<tr>
<td>National Imaging Associates (NIA)</td>
<td>1-800-424-4890</td>
<td>Monday-Friday 8:00 AM to 8:00 PM</td>
</tr>
<tr>
<td>(Authorization for MRI/MRA, CT/CTA, CCTA, PET Scan, Nuclear Cardiology/MPI, Muga Scan, and Stress Echocardiography)</td>
<td>Or <a href="http://www.RadMD.com">www.RadMD.com</a></td>
<td></td>
</tr>
<tr>
<td>United Concordia Dental (Dental benefit provider)</td>
<td>1-866-568-5467</td>
<td>Monday-Friday 8:00 AM to 8:00 PM</td>
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### Important Addresses

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<th>Reason for Mailing</th>
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<tr>
<td>Gateway Medicaid Claims and Referral Forms</td>
<td>Gateway Health℠ Claims Processing Department</td>
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<tr>
<td></td>
<td>PO Box 830249</td>
</tr>
<tr>
<td></td>
<td>Birmingham, AL 35283-0249</td>
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<tr>
<td>Claims Reviews/Provider Appeals</td>
<td>Gateway Health℠</td>
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<td></td>
<td>Attention: Claims Review Department</td>
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<tr>
<td></td>
<td>Four Gateway Center</td>
</tr>
<tr>
<td></td>
<td>444 Liberty Avenue, Suite 2100</td>
</tr>
<tr>
<td></td>
<td>Pittsburgh, PA 15222-1222</td>
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<tr>
<td>Initial Applications for Credentialing</td>
<td>Gateway Health℠</td>
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<tr>
<td></td>
<td>Attention: Network Development Department</td>
</tr>
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<td></td>
<td>Four Gateway Center</td>
</tr>
<tr>
<td></td>
<td>444 Liberty Avenue, Suite 2100</td>
</tr>
<tr>
<td></td>
<td>Pittsburgh, PA 15222-1222</td>
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<tr>
<td>Recredentialing Applications</td>
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<td>Attention: Credentialing Department</td>
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<td>Four Gateway Center</td>
</tr>
<tr>
<td></td>
<td>444 Liberty Avenue, Suite 2100</td>
</tr>
<tr>
<td></td>
<td>Pittsburgh, PA 15222-1222</td>
</tr>
<tr>
<td>Practice Change Information</td>
<td>Gateway Health℠</td>
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<td>Attention: Provider Relations Department</td>
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<td></td>
<td>Four Gateway Center</td>
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<tr>
<td></td>
<td>444 Liberty Avenue, Suite 2100</td>
</tr>
<tr>
<td></td>
<td>Pittsburgh, PA 15222-1222</td>
</tr>
<tr>
<td>Dental Claims</td>
<td>United Concordia Dental Claims Processing Department</td>
</tr>
<tr>
<td></td>
<td>PO Box 69427</td>
</tr>
<tr>
<td></td>
<td>Harrisburg, PA 17106-9427</td>
</tr>
<tr>
<td>Vision Claims</td>
<td>Davis Vision</td>
</tr>
<tr>
<td></td>
<td>Attention: Vision Card Processing Unit</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 1525</td>
</tr>
<tr>
<td></td>
<td>Latham, NY 12110</td>
</tr>
</tbody>
</table>
Mental Health/Substance Abuse Contact Information

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

<table>
<thead>
<tr>
<th>County</th>
<th>Agency/Area</th>
<th>Telephone Number</th>
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<tbody>
<tr>
<td>Adams</td>
<td>Community Care Behavioral Health</td>
<td>1-866-738-9849</td>
</tr>
<tr>
<td>Allegheny</td>
<td>Community Care Behavioral Health</td>
<td>1-800-553-7499</td>
</tr>
<tr>
<td>Armstrong</td>
<td>Value Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-877-688-5969</td>
</tr>
<tr>
<td></td>
<td>Value Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-724-354-2746</td>
</tr>
<tr>
<td>Beaver</td>
<td>Community Care Behavioral Health</td>
<td>1-866-773-7891</td>
</tr>
<tr>
<td>Berks</td>
<td>Community Care Behavioral Health</td>
<td>1-866-729-7886</td>
</tr>
<tr>
<td>Blair</td>
<td>Community Care Behavioral Health Network of PA</td>
<td>1-866-773-7892</td>
</tr>
<tr>
<td></td>
<td>Drug &amp; Alcohol Services</td>
<td>1-814-693-3023</td>
</tr>
<tr>
<td>Bucks</td>
<td>Bucks County Behavioral Health</td>
<td>1-215-773-9313</td>
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<tr>
<td>Butler</td>
<td>Value Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-877-688-5971</td>
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<td></td>
<td>Value Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-724-284-5114</td>
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<tr>
<td>Cambria</td>
<td>Value Behavioral Health of Pennsylvania</td>
<td>1-877-404-4562</td>
</tr>
<tr>
<td>Cameron</td>
<td>Community Care BHO</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Carbon</td>
<td>Value Behavioral Health of PA</td>
<td>1-877-404-4562</td>
</tr>
<tr>
<td>Centre</td>
<td>Community Care BHO</td>
<td>1-866-878-6046</td>
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<tr>
<td>Chester</td>
<td>Magellan Behavioral Health</td>
<td>1-877-769-9784</td>
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<tr>
<td>Clarion</td>
<td>Community Care BHO</td>
<td>1-866-878-6046</td>
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<td>Clearfield</td>
<td>Community Care BHO</td>
<td>1-866-878-6046</td>
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<tr>
<td>Columbia</td>
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<td>1-866-878-6046</td>
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<tr>
<td>Crawford</td>
<td>Community Care Behavioral Health</td>
<td>1-866-404-4561</td>
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<tr>
<td>Cumberland</td>
<td>Community Care Behavioral Health Network of PA</td>
<td>1-888-722-8646</td>
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<td>Drug &amp; Alcohol Services</td>
<td>1-717-240-6300</td>
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<td>Dauphin</td>
<td>Community Care Behavioral Health Network of PA</td>
<td>1-888-722-8646</td>
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<td>Drug &amp; Alcohol Services</td>
<td>1-717-635-2254</td>
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<td>Magellan Behavioral Health</td>
<td>1-877-769-9782</td>
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<td>Community Care BHO</td>
<td>1-866-878-6046</td>
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<tr>
<td>Erie</td>
<td>Community Care Behavioral Health</td>
<td>1-855-224-1777</td>
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<td>1-877-688-5972</td>
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<td>1-724-438-3576</td>
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<td>1-877-688-5973</td>
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<td>1-724-852-5276</td>
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<td>Lackawanna</td>
<td>Community Care Behavioral Health Organization</td>
<td>1-866-668-4696</td>
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<td>1-888-722-8646</td>
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<td>1-717-299-8023</td>
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<td>County</td>
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<tr>
<td>Snyder</td>
<td>Community Care BHO</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Somerset</td>
<td>Community Behavioral Health Network of PA</td>
<td>1-866-773-7891</td>
</tr>
<tr>
<td>Susquehanna</td>
<td>Community Care Behavioral Health Organization</td>
<td>1-866-668-4696</td>
</tr>
<tr>
<td>Venango</td>
<td>Value Behavioral Health of PA</td>
<td>1-866-404-4561</td>
</tr>
<tr>
<td>Warren</td>
<td>Community Care BHO</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Washington</td>
<td>Value Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-877-688-5976</td>
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<td></td>
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<td>1-800-247-8379</td>
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<tr>
<td>Westmoreland</td>
<td>Value Behavioral Health Drug &amp; Alcohol Services</td>
<td>1-877-688-5977</td>
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<td></td>
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<td>1-800-220-1810 ext. 2</td>
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<tr>
<td>Wyoming</td>
<td>Community Care Behavioral Health Organization</td>
<td>1-866-668-4696</td>
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<tr>
<td>York</td>
<td>Community Care Behavioral Health</td>
<td>1-866-542-0299</td>
</tr>
</tbody>
</table>
Introduction

About This Manual
Gateway Health's "Gateway") success, as measured by the benefits received by the healthcare providers, members, Commonwealth of Pennsylvania and Gateway, is dependent upon strong educational processes. Understanding Gateway's policies and procedures is essential. Gateway's Provider Relations, Provider Services, Care Management, and Member Outreach staff, among others, are committed to providing accurate, up-to-date, and comprehensive information to our member and practitioner provider network through prompt and dedicated service. The Provider Policy and Procedure Manual is one way of providing participating practitioner offices and facilities with information regarding Gateway’s policies and procedures and is considered part of your contractual agreement with the health plan. This manual should be considered a general guideline and ready reference. This Manual and any updates can also be found at our website under the Medicaid Provider section: www.GatewayHealthPlan.com.

Overview of Gateway Health

Corporate Overview
Gateway Health delivers quality and affordable healthcare for its members. With more than 20 years of service to the community, Gateway strongly believes in doing things “A better way.” We don’t believe in just fulfilling members’ health insurance needs. At Gateway, we also assist our members in many aspects of their daily lives that affect their health and well-being.

Gateway understands that overall health is more than a factor of genetics and lifestyle – and that where one lives shouldn’t matter about the quality of care received. That’s why Gateway offers a variety of health plan options for beneficiaries eligible for Medicaid and Medicare. Our large network of provides access to top-notch physicians, hospitals and health providers to make sure our members have access to the care they deserve. When communities are healthier, everybody wins.

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

History
In 1992, Gateway Health Plan® was established as an alternative to Pennsylvania’s Department of Human Services’ Medical Assistance Program. For nearly two decades, members have benefited from services such as disease management, health and wellness programs and preventive care. Today, Gateway HealthSM is a top-ranked managed care organization that serves more than 300,000 members. Gateway HealthSM is a NCQA® accredited health plan. NCQA is an independent, not-for-profit organization dedicated to assessing and improving health care quality.

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

Products
Medicaid HMO Plan
Serves those who are eligible for Medical Assistance living in Pennsylvania.

Medicare Advantage Plans
Gateway Health’s Medicare Advantage plans are now available in Pennsylvania Ohio, Kentucky and North Carolina.

Dual Eligible Special Needs Plans
For Medicare beneficiaries who also qualify for Medicaid or receive assistance from the State.

- Medicare Assured® DiamondSM (HMO SNP)
- Medicare Assured® RubySM (HMO SNP)

Chronic Special Needs Plans
For Medicare beneficiaries living with diabetes, cardiovascular disorder or chronic heart failure. There are no income requirements for these plans.

- Medicare Assured® GoldSM (HMO SNP)
- Medicare Assured® PlatinumSM (HMO SNP)

Medicare Advantage Prescription Drug (MAPD) Plans
For Medicare beneficiaries living in Ohio, Kentucky and North Carolina.

- Medicare Assured® ChoiceSM (HMO)
Medicare Assured® PrimeSM (HMO)

Medicare AssuredSM Special Needs Plans* offer the following benefits in addition to all the benefits of Original Medicare including:
- $0 to low monthly premiums
- Prescription drug coverage
- Transportation
- Hearing and vision care
- Health and wellness education, such as heart disease, diabetes and asthma programs
- Health club membership

*Benefit coverage depends on plan eligibility

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 15-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 services and care for its members.

Healthcare Disparities
Gateway understands that in order to help improve the quality of life of our members, we must take into account their cultural and linguistic differences. For this reason, addressing disparities in healthcare is high on our leadership agenda. We believe a strong patient-provider relationship is the key to reducing the gap in unequal healthcare access and healthcare 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 healthcare 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.

How Does Gateway Work?

Gateway’s Practitioner/Provider 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 and hospitals treat patients in their offices and facilities 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 in no way precludes participation in any other program with which the practitioner may be affiliated.

Gateway Provider Relations Role
We are keenly aware that, to provide exceptional access and quality of healthcare 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 assure 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, and 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 Medical Assistance Consumer.” 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 of the member's care must be provided or referred by the primary care practitioner except in a true medical emergency when time does not permit a member to contact their primary care practitioner. To assure 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.*

**Department of Human Services Master Provider Index Number**

All network practitioners are required to have a Department of Human Services issued identification number and must adhere to PA Code 55, Chapter 1101. If a practitioner would like a copy of PA Code 55, contact Gateway’s Provider Services Department at 1-800-392-1145. The Office of Medical Assistance Programs (OMAP) may be contacted to obtain a Master Provider Index (MPI) Number at (717) 772-6140 from 8:00 AM to 12:00 PM, or leave a message at anytime at (717) 772-6456. Information about the Department of Human Services Office of Medical Assistance Programs may also be found on the Internet at www.DHS.state.pa.us.

**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
Introduction

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/Utilization Management Program

The Quality Improvement/Utilization Management (QI/UM) Program’s purpose is to assure the quality, safety, appropriateness, timeliness, availability, and accessibility of care and services 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 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. As a participating provider Gateway asks that you cooperate with QI activities to improve the quality of care and services members receive. This may include the collection and evaluation of data, participation in various QI initiatives and programs and allowing the plan to use and share your performance data.

Goal of the Quality Improvement/Utilization Management Program

The goal of the QI/UM Program is to ensure the provision and delivery of high quality medical and behavioral health care, pharmaceutical, and other covered health care services and quality health plan services. The QI/UM Program focuses on monitoring and evaluating the quality and appropriateness of care provided by the Gateway Health℠ 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, such as qualitative, quantitative and root/cause barrier analyses, Gateway Health℠ focuses on assessing its performance outcomes to identify opportunities for improvement in the provision and delivery of health care and health plan services, patient safety, satisfaction with care and services, and achieving optimum member health outcomes.

Of specific importance, the QI 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 and language barriers 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 healthcare resources, and financial analysis, Gateway ensures that the major population groups are represented in QI/UM activities and health management programs chosen for assessment and monitoring. This information, along with high-volume/high-cost medical and pharmaceutical/drug reports, health risk appraisal data, disease management and care management data, satisfaction survey information, and other utilization reports, is used to identify members with special needs and/or chronic conditions to develop programs and services to assist in managing their condition.

Objective of the Quality Improvement/Utilization Management Program

The objectives of the QI/UM Program are consistent with Gateway’s mission, commitment to effective use of healthcare resources, and to continuous quality improvement. To ensure that the current needs of the population are being evaluated, changes noted, programs implemented to address the needs of members, and to ensure continuous quality improvement, an annual QI/UM Work Plan is developed. 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:

- Assure processes are in place using Total Quality Management values to assess, monitor, and implement actions when opportunities are identified regarding the utilization of healthcare resources, quality of care, and access to services;
- Based on assessment of the population, develop and update guidelines that address key healthcare 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, barriers, 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 and programs, organizational policies, and the provision of healthcare. 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/Utilization Management Program**

Implementation and evaluation of the QI/UM program is embedded into Gateway’s daily operations. The QI/UM Program has available and uses appropriate internal information, systems, practitioners, and community resources to monitor and evaluate use of healthcare services, the continuous improvement process and to assure implementation of positive change.

The scope of the Program includes:
✓ Enrollment
✓ Members’ Rights and Responsibilities
✓ Network Accessibility and Availability, including those related to Special Needs
✓ Healthcare Disparities
✓ Network Credentialing/Recredentialing
✓ Medical Record Standards
✓ Member, Provider and Employee Education
✓ Member and Provider Services
✓ Claims Administration
✓ Fair, Impartial and Consistent Utilization Review
✓ Evaluating the Healthcare Needs of Members
✓ Preventive Health, Disease Management, and Care Management Services, including Complex Case Management
✓ Clinical Outcomes
✓ Oversight of Delegated Activities
✓ Patient Safety
✓ Continuous Quality Improvement using Total Quality Management Principles

To request a copy of the Quality Improvement Program, Work Plan or Annual Evaluation please contact Gateway’s Provider Services Department at 1-800-392-1145.

**Quality Improvement Manual**

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

Clinical guidelines are not meant to replace individual practitioner judgment
based upon direct patient contact. The manual consists of an introductory page,
along with the following guidelines: Adult HIV, Adult Preventive Care,
Comprehensive Diabetes Mellitus, Child Preventive, ADHD, Cardiac Medical
Management, Hypertension, Lead Screening and Follow-up Guideline,
Management of the Patient with Asthma, COPD, Major Depression in Adults in
Primary Care, Medical Record Review Procedure and standards and Routine
and High Risk Prenatal Care. To facilitate distribution of the most current version
of these guidelines, they have been added to Gateway’s web site at
are also provided. 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 412-255-4291.

**Patient Safety**

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

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

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

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

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

Institute of Medicine report: *To Err is Human: Building a Safer Health Care System*  
http://www.nap.edu/books/0309068371/html/

The Joint Commission National Patient Safety Goals  
http://jointcommission.org

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

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

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

**Reportable Conditions**

Gateway practitioners are contractually required to follow Gateway Health Quality Improvement (QI) Programs, including, but not limited to, reporting certain diseases, infections or conditions as determined by Title 28, Chapter 27, §27.21a in the Pennsylvania Code. The Reportable Conditions policy, QI-050-MD-PA, has been established to detail this requirement, and the methods by which practitioners will be notified of its necessity.

To request additional information or to obtain a copy of the Reportable Conditions policy, please contact Gateway’s Provider Services Department at 1-800-392-1145. The regulations, which include the complete list of reportable conditions, can be found via the Pennsylvania Code website at  

**Living Will Declaration**

**Advance Directives**

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

The Patient Self-Determination Act applies to hospitals, nursing facilities, providers of home healthcare or personal care services, hospice programs and health maintenance organizations that receive Medicare or Medicaid funds. The
Introduction

The primary purpose of the act is to assure that the beneficiaries of such care are made aware of advance directives and are given the opportunity to execute them if they so desire. It is also to prevent discrimination in care if the member chooses not to execute advance directives.

As a participating provider within Gateway’s network, you are responsible for determining if the member has executed an advance directive and for providing education when it is requested. You can also request a copy of a “Living Will” form from the Quality Improvement Department by calling 412-255-4291. There is no governmentally mandated form. A copy of the “Living Will” form should be maintained in the medical record. Gateway’s Medical Record Review Standards state that providers ask members age 21 and older whether they have executed advance directives and will document the response.

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

Member outreach or advance directive forms are made available through Gateway’s Member Handbook and Member Newsletter, or by visiting Gateway’s website at www.GatewayHealthPlan.com.

**Member Outreach**

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

Practitioners can refer non-adherent members for additional education regarding the importance of keeping scheduled appointments, 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 1-800-642-3550, press option 4. You can also fax the Member Outreach Form to the fax number listed on the Form.
Member

The Enrollment Process

Gateway is offered to Medical Assistance recipients within Gateway’s service area. Gateway serves Medical Assistance recipients as a voluntary alternative to the traditional fee-for-service program and as an option in the HealthChoices mandatory program.

As of January 2005, the Department of Human Services employs a Pennsylvania Enrollment Services broker in the voluntary counties just like they do for the HealthChoices (mandated program) counties. An Enrollment Specialist explains the benefits offered by Gateway and other Physical Health Managed Care Organizations (PH-MCO) and helps the recipient choose a PH-MCO that meets their needs. Potential members are encouraged to select a primary care practitioner from a list of participating practitioners. The Pennsylvania Enrollment Services contractor electronically submits all applications to the Department of Human Services to validate. The Department of Human Services then electronically notifies the Pennsylvania Enrollment Services contractor and Gateway that a recipient will be enrolled in Gateway.

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

Medical Assistance ACCESS Cards

The Department of Human Services issues a Pennsylvania ACCESS card to all eligible Medical Assistance recipients, including those recipients that choose to join Gateway. All Gateway members will have both a Department of Human Services ACCESS card and a Gateway identification card. If a patient presents an ACCESS card, the member’s eligibility can be verified through the Department of Human Services Eligibility Verification System (EVS). Practitioners must participate with the Medical Assistance Program in order to use the EVS.
To access the Department of Human Services EVS, call 1-800-766-5EVS (5387). Please have your 13-digit Master Provider Index (MPI) Number and the member’s State ID (also known as Recipient Number) from the member’s ACCESS card available when you call. Since important information is provided throughout the verification process, please listen to the entire message. If the recipient is covered by a managed care plan, such as Gateway, their eligibility with the plan is indicated immediately following the member’s demographic information (name, date of birth, etc.).

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

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

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

**Determining Eligibility Through Gateway**

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

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

2. The Gateway DIVA System
Available 24 hours a day, seven days a week at (1-800-642-3515).

To verify member eligibility at each visit, practitioners follow a few simple steps, which are listed below:

**TO VERIFY MEMBER ELIGIBILITY**

**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, then press the # key

**Press 2** to verify eligibility using the patient’s Gateway member identification number, when prompted enter the patient’s 8-digit Gateway 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 identification number

**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 touchtone 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 or the PCP assigned to the member

**Press 2** to verify whether the patient is eligible on a specific date. Enter the date using the 2-digit month, 2-digit day, and 4-digit year. Press 1 if the repeated date is correct. Press 2 if the repeated date is incorrect.

**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 (includes the spelling of the member’s first and last name)
Press 2 to receive the patient’s Primary Care Practitioner name and telephone number (includes the spelling of the provider’s name and telephone number)
Press 3 to fax information regarding the patient whose eligibility is being verified
  o You will be asked to enter the fax number for which you wish to receive the eligibility verification. You will receive a fax that looks like one of the two samples below:
  o The above verification of eligibility fax receipts will either verify coverage for Benefit Plan 400 (Adult MA) or Plan 401 (Adult GA). Each disclaimer lists applicable benefits and copays for each Benefit Plan.
Press 4 to verify eligibility for another patient/member
Press 5 to exit
Press 6 to return to the menu of automated services
Press 9 to listen to the instructions again
Press 0 to speak to a Provider Services Representative

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

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

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

Eligibility Information

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

For additional information call: 1-800-392-1145

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**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 Provider Services Department at 1-800-392-1145 for help in determining eligibility.

**Addition of Newborns**

When a member selects Gateway, the member’s effective date is usually the first or the 15th of the month. However, when the member is a newborn, the member may be added at any time during the month. Because newborn information is reported to Gateway retroactively, newborns will show up as a retrospective addition to the primary care practitioner’s next monthly panel listing. Newborns will be effective on their date of birth or the date the newborn was added to the member’s grant.

**Member Benefit**

Gateway members are eligible for all of the benefits covered under the Pennsylvania Department of Human Services (DHS) Medicaid program. Members obtain most of their healthcare services either directly from or upon referral by their primary care practitioner, except for services available on a self-referral basis. 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.

**Benefits and Special Services**

Gateway members that are age 18 or older have copayments and some members age 21 or older have service limits and copayments. Service limits do not apply for members under 21 or if member is pregnant. Copayments do not apply to members under 18 or any member who is pregnant (through the post-partum period beginning on the last day of the pregnancy and extending through the end of the month in which the 60-day period following termination of the pregnancy ends) or in a nursing home. **Members cannot be denied a service if they are unable to pay their copayment.**

The provider is required to submit in field 29 of the CMS-1500 form and field 54 of the UB-04 form the patient responsibility amount. Gateway’s system automatically deducts the copayment from the provider’s reimbursement and reflects this on the provider’s Remittance Advice. Gateway tracks the applicable copayments on each claim and through a retrospective analysis will identify members that reach the thresholds and issue member reimbursements as necessary.
Below is an excerpt from the Gateway Health Member Handbook which describes some of the services that are covered by Gateway at no cost to members:

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

### ADULT MEDICAL ASSISTANCE

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>COPAY*</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand Name RX</td>
<td>$3.00</td>
<td>Applicable to age 21 and older</td>
</tr>
<tr>
<td>Generic Drug RX</td>
<td>$1.00</td>
<td>Applicable to age 21 and older</td>
</tr>
<tr>
<td>Inpatient Hospital (General or Rehab)</td>
<td>$3/per day, up to $21/per admission</td>
<td>Applicable to age 21 and older</td>
</tr>
<tr>
<td>Outpatient Surgery (any location)</td>
<td>$3/per covered service</td>
<td>Applicable to age 21 and older</td>
</tr>
<tr>
<td>Office Visits (Not applicable to PCPs, OBs, GYNs and OB/GYNs)</td>
<td>$2/per visit</td>
<td>Applicable to age 21 and older and Federally Qualified Health Centers (FQHC)</td>
</tr>
<tr>
<td>Nuclear Medicine Services</td>
<td>$1/per covered service</td>
<td>Applicable to age 21 and older and hospital component only</td>
</tr>
<tr>
<td>Radiology Services</td>
<td>$1/per covered service</td>
<td>Applicable to age 21 and older and hospital or physician office</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>LIMIT**</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractor Outpatient Visits</td>
<td>$2/per visit</td>
<td>Applicable to age 21 and older</td>
</tr>
<tr>
<td>Podiatrist Outpatient Visits</td>
<td>$2/per visit</td>
<td>Applicable to age 21 and older</td>
</tr>
<tr>
<td>Inpatient Medical Rehabilitation</td>
<td>no limitation</td>
<td>Applicable to age 21 and older</td>
</tr>
<tr>
<td>Vision</td>
<td>Eligible for two eye Examinations per year.</td>
<td>Applicable to age 21 and older</td>
</tr>
</tbody>
</table>
| Dental                                       | Two exams, x-rays, and two cleanings per year | Limited lifetime benefits for:  
  • One partial upper denture or one full upper denture; and  
  • One partial lower denture or one full lower denture.  
  Crowns and related services; Root canals and other endodontic services; and Periodontal services. | Applicable to age 21 and older |
*Copayment do not apply to:

- Services or items provided to a terminally ill individual who is receiving hospice care.
- Services provided to individuals of any age eligible under Titles IV-B and IV-E Foster Care and Adoption Assistance.
- Services provided in emergency situations
- Family planning services and supplies
- Home health agency services
- Renal dialysis services
- Blood and blood products
- Oxygen
- Rental of Durable Medical Equipment
- Outpatient services when the MA Fee is under $2.00
- Medical exams requested by the Department
- More than one of a series of a specific allergy test provided in a 24 hour period
- Targeted case management services
- Members under 18 or any member who is pregnant (through the post-partum period beginning on the last day of the pregnancy and extending through the end of the month in which the 60-day period following termination of the pregnancy ends) or in a nursing home.
- Members covered under the MA Adult benefit category do not have a copayment for the following kinds of drugs:
  - Drugs, including immunizations, that you get in the doctor’s office
  - Anti-hypertensive agents
  - Anti-diabetic agents
  - Anti-convulsants
  - Cardiovascular preparations
  - Anti-psychotic agents, except those that are also schedule C-IV antianxiety agents
  - Anti-neoplastic agents
  - Anti-glaucoma drugs
  - Anti-Parkinson drugs
  - Drugs used only to treat HIV/AIDS

<table>
<thead>
<tr>
<th>Routine Eye Exam / Optometrist Only</th>
<th>2 visits per calendar year</th>
<th>Applicable to age 21 and older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Cessation</td>
<td>70 visits per calendar year</td>
<td>Applicable to age 21 and older</td>
</tr>
</tbody>
</table>

Introduction
The pharmacy will inform the member of any applicable copay for a prescription. Members cannot be denied a service if they are unable to pay their copay.

Members cannot be denied a service or drug if they cannot pay the co-payment. If a member cannot afford to pay the provider may bill later for co-payments not paid at the time of service.

**Benefit Limits**

**Exception for Service Limits**

Members and practitioners may request an exception for services above the service limits by calling Gateway’s Utilization Management Department at 1-800-392-1146. All exception requests are reviewed for medical necessity and can be granted if:

- The member has a serious chronic illness or other serious health condition and without the additional service their life would be in danger; or
- The member has a serious chronic illness or other serious health condition and without the additional service their health will get much worse; or
- The member would need more costly services if the exception is not granted; or
- The member would have to go into a nursing home or institution if the exception is not granted.
- Granting the exception is necessary in order to comply with state regulations.

Any exception request received prior to the service being rendered will get a response within 21 days of the date Gateway received the request. Prospective urgent exception requests will be responded to within 48 hours of the date and time Gateway received the request and requests received after the service has been rendered will be responded to within 30 days of the date that Gateway received the request.

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

Both the recipient and the provider will receive written notice of the approval or denial of the exception request. For prospective exception requests, if the provider or recipient is not notified of the decision within twenty-one (21) days of the date the request is received, the exception will be automatically granted.
Gateway denials of requests for exception are subject to the right of appeal by the Provider or recipient.

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

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

**Prescription Drug**

Gateway provides coverage for outpatient prescription drugs when the drug labeler participates in the Federal Drug Rebate Program and is included on the Gateway closed formulary. Practitioners are requested to prescribe medications included in the formulary whenever possible. Gateway’s formulary is updated on a regular basis and can be accessed online at www.GatewayHealthPlan.com. Medication additions or deletions reflect the decisions made by Gateway’s Pharmacy and Therapeutics Committee. If a formulary deletion is made that affects one of your patients, Gateway will provide you with notification within 30 days prior to the change. Additional copies of the formulary may be printed directly from our website or requested through Provider Services by calling 1-800-392-1145.

Some medications, although listed on the formulary, require prior authorization to be covered. All prior authorization and step therapy criteria can be found on Gateway’s website. If use of a formulary medication is not medically advisable for a member, you must initiate a Request for Drug Exception. 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. The exceptions process allows for a 24 hour turnaround when reviewing requests for non-formulary, prior authorization and step therapy medications. For emergently needed medications, the pharmacist may authorize up to a 5-day supply of the medication.

Prescription medications are reimbursed when the medication is prescribed for an FDA approved indication(s); prescribed for indications, dosages, and formulations that are part of nationally developed standards; prescribed for indications, dosages, and formulations that have been shown to demonstrate both efficacy and safety in a minimum of two peer reviewed journals. Any other prescription is considered experimental and therefore not covered unless specific authorization has been given by Gateway Health for an individual member based on a demonstration of medical necessity.

Select over-the-counter (OTC) pharmaceuticals are a covered benefit for all members. Members must have a written prescription for each OTC pharmaceutical/vitamin, and the prescription must be filled by a Gateway
participating pharmacy. The online formulary found at www.GatewayHealthPlan.com includes any OTC that is included in the member’s pharmacy benefit.

Prescriptions must be filled by a Gateway participating pharmacy in order to be covered by Gateway. Gateway utilizes the Argus National Network which consists of over 65,000 participating pharmacies nationwide. The member should utilize any Argus contracted Pharmacy and the claims should be billed to Gateway via the Argus Network.

Copayments are applicable for prescriptions for members age 18 or older who are not pregnant (excluding the post-partum period beginning on the last day of the pregnancy and extending through the end of the month in which the 60-day period following termination of the pregnancy ends) or in a nursing home. Please refer to the Member Benefit Packages and Copayments section of this manual for additional information regarding copayments.

Gateway contracts with Argus to develop a network of chain and independent 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 1-800-392-1147.

Specialty Pharmacy Medications

Gateway contracts with specialty pharmacy providers who are equipped to supply injectable medications to meet the unique needs of its participating Gateway providers and members. Specialty drugs are prescription medications that require special handling, administration and monitoring. These drugs are used to treat complex, chronic and often costly conditions. Gateway Health SM requires most specialty medications be authorized through a specialty pharmacy network, with the exception of infusible oncology products. Providers can obtain an infusible oncology product through a contracted specialty pharmacy, or may use a drug from the provider’s office stock and bill the product through Gateway’s medical benefit. Providers can call the Pharmacy Services Department to confirm if a pharmacy is contracted with Gateway.

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

The Specialty Pharmacy Drug List below highlights all of the specialty medications that are available through the specialty pharmacy network. Please refer to the Formulary Drug List to see which medications are included on the formulary or have additional requirements or limits on coverage such as prior authorization, step therapy or quantity limits. Products that are not on the Specialty Pharmacy Drug List can be obtained through any pharmacy.

Specialty Pharmacy Drug List:
http://www.GatewayHealthPlan.com/providers/specialty-pharmacy
Once the provider sends the referral to the specialty pharmacy, the pharmacy will outreach to the member to coordinate delivery of the medication and services needed.

If you have additional questions about obtaining a specialty medication please call Pharmacy Services at 1-800-528-6738.

**Drug Formulary**

Gateway utilizes a closed formulary. Practitioners are requested to prescribe medications included in the formulary whenever possible. Gateway’s formulary is updated on a regular basis and can be accessed online at www.GatewayHealthPlan.com. Medication additions or deletions reflect the decisions made by Gateway's Pharmacy and Therapeutics Committee. If a formulary deletion is made that affects one of your patients, Gateway will provide you with notification within 30 days prior to the change. Additional copies of the formulary may be printed directly from our formulary website or requested through Provider Services by calling 1-855-401-8243.

Some medications, although listed on the formulary, require prior authorization to be covered. All prior authorization and step therapy criteria can be found on Gateway’s website. If use of a formulary medication is not medically advisable for a member, you must initiate a Request for Drug Exception. 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. The exceptions process allows for a 24 hour turnaround when reviewing requests for non-formulary, prior authorization, and step therapy medications. For emergently needed medications, the pharmacist may authorize up to a 5-day supply of the medication. For new therapies, the pharmacist may authorize up to a 5-day supply of the medication. For medications taken on an ongoing basis, a 15-day supply of the medication will be dispensed, pending the final determination of the request.

**Drugs Covered Under Pharmacy Benefits**

Prescription Drugs are “Covered Drugs” under the Pharmacy Benefit at Participating Retail Pharmacies or Specialty Pharmacies, as applicable, when they are:

- listed in the Drug Formulary
- prescribed by a Prescriber who is a Participating Provider (unless used as part of Emergency Services or Prior Authorized by Gateway) for use by a Member
- authorized by Gateway
- not otherwise excluded or limited.

The limit is an amount normally prescribed by the practitioner, but must not exceed a 34-day supply. Prescriptions can be refilled up to 12 months from the original prescription date as authorized by the practitioner.
Exclusions

✓ Implantable drugs, including, but not limited to implantable contraceptives.
✓ Drugs which do not require a prescription by federal or state law, unless specifically designated for Coverage by Gateway. For example, but not limited to: over-the-counter drugs or over-the-counter equivalents, behind-the-counter drugs, nutraceuticals, medical foods (except when coverage is required by law), and dietary supplements.
✓ Injectable infertility drugs including, but not limited to, injectable drugs used for the primary purpose of, or in connection with, treating Infertility, fertilization and/or artificial insemination.
✓ Experimental or Investigational drugs.
✓ Drugs used for athletic performance enhancement or cosmetic purposes, including, but not limited to anabolic steroids, retinoid for aging skin, and minoxidil lotion.
✓ Drugs used for sexual performance enhancement or sexual dysfunction treatment including but not limited to Viagra, Levitra, Cialis, testosterone.
✓ Oral dental preparations and fluoride rinses, except fluoride tablets or drops.
✓ Pharmacological therapy for weight reduction.
✓ Compounded prescriptions are excluded unless all of the following apply:
  o there is no suitable commercially-available alternative available; and
  o the main active ingredient is a Covered Prescription Drug; and
  o the purpose is solely to prepare a dose form that is Medically Necessary and is documented by the Prescriber.
✓ Medications to prevent infections related to foreign travel are excluded from coverage.
✓ Medications used for the treatment or ongoing maintenance care of non-congenital transsexualism, gender dysphoria, or sexual reassignment or change.
✓ All DESI drugs, as defined by the FDA.

Drug Recalls and Drug Safety Monitoring

Gateway is dedicated to providing our physicians with access to the most up-to-date medication safety information. Drug recall and drug safety updates can occur on a daily basis due to newly published research or to the Food and Drug Administration’s (FDA) Adverse Event Reporting Program. In order to provide you with the latest information, Gateway has posted links to the FDA website to relate to providers the latest recalls and drug safety alerts that may affect their patients.
Members’ Rights and Responsibilities

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

GATEWAY HEALTH℠
MEMBERS’ RIGHTS AND RESPONSIBILITIES
STATEMENT

Member Rights

As a Gateway Member, you have the right to:

1. Get information about Gateway, the services Gateway provides, doctors and other healthcare providers giving you care, and your rights and responsibilities as a Gateway member.
2. Be treated with respect and recognition of dignity and right for privacy when receiving healthcare.
3. Work with your doctor or other healthcare provider in making decisions about your healthcare and to express preferences about future treatment decisions.
4. Openly discuss without any limitations by Gateway appropriate or medically necessary treatment choices for your condition with a doctor or other healthcare provider, including treatment options, risks of treatments, alternative therapies, and consultations or tests that may be self-administered, regardless of the cost or if it is a benefit.
5. Receive your medical and nursing care without regard to race, color, religion, sex, age, disability, national origin, or without regard to whether you have an advance directive.
6. Remain free from seclusion used as a means of coercion, discipline, convenience or retaliation.
7. Pick your own doctor from Gateway’s network of doctors.
8. Refuse care from certain doctors.
9. File a complaint or grievance about Gateway or the care it provides.
10. Make recommendations regarding Gateway’s members’ rights and responsibilities policies.
11. Request a fair hearing from the Department of Human Services.
12. Prepare a Living Will and/or Advance Directive.
13. See, or have your medical record copied, within Federal and State laws, and to request that your medical record be changed or corrected within Federal laws.
14. Have your medical records kept private and confidential.

Member Responsibilities

As a Gateway Member you have a responsibility to:

1. Give information to your doctor, other healthcare provider, or Gateway so they can provide care to you.
2. Follow the instructions and treatment plans that you agreed on with your doctor or other healthcare provider.
3. Provide consent to healthcare providers and Gateway to help them manage your care, to improve your health or for research.
4. Understand your health problems. As much as you can, take part in making a plan for treatment goals with your doctor or other healthcare providers.
5. See the doctor you picked on a regular basis.
6. Treat the people giving you medical care with the same respect and kindness you expect for yourself.

Si desea recibir una copia de esta información en español, por favor llame al número 1-800-392-1147.
Coverage Arrangements

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

In an effort to assure a consistent level of quality, Gateway has contracted with many participating hospitals and laboratory facilities for outpatient laboratory services. Gateway members are required to have all of their outpatient laboratory work completed through the appropriate contracted lab. Failure to do so could result in non-payment of services. At the time of the initial orientation, the primary care practitioner is required to select a designated laboratory based on the office’s location and the lab used most frequently.

Gateway requires participating practitioners to utilize the member’s specific designated laboratory, based on their primary care practitioner’s selection, for any and all studies required for Gateway members. The designated laboratory is listed on the member’s Gateway ID Card and on Gateway’s On-line Provider Directory located at www.GatewayHealthPlan.com. Go to PA Medicaid, and then Find A Provider, or contact Provider Services at 1-800-392-1145.

Primary Care and OB/GYN Practitioner

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

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

Contact your Provider Relations Representative for information on what tests can be performed in the primary care practitioner’s office.

Specialty Care Practitioner

Certain Specialists are permitted to perform lab work in their offices as part of the authorized office visit: Contact your Provider Relations Representative for information on what tests can be performed in the specialist’s office.

Preadmission Laboratory Testing

Gateway strongly recommends that preadmission laboratory testing be completed by the practitioner through the member’s designated laboratory. When this occurs, no referral is needed. However, if it is not possible to utilize the designated laboratory, testing can be completed at the hospital where the procedure or admission will occur. The primary care practitioner must issue a
Gateway referral to the specific Gateway participating hospital’s outpatient laboratory.

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

**Blood Lead Screening**
The Pennsylvania EPSDT Periodicity Schedule requires that all children under age 5 receive a minimum of two blood lead screenings as part of EPSDT well child screenings, regardless of the individual child’s risk factors. The tests for lead screening should be conducted by the child’s first and second birthdays. Children not previously screened, must have blood lead screenings between the ages of 3 to 6 years.

The primary care practitioner can use either their designated laboratory or Kirby Health Center Laboratory to process blood lead samples. If you choose to send blood lead samples to Kirby Health Center, you must use the sample Lead Analysis ID Form found in the *Forms and Reference Materials Section* of this Manual. The Form is only for Gateway members, and when completing the form please verify the member’s eligibility. All demographic information, including the practitioner name, member name, member address, member date of birth, Gateway Member Identification Number, and the date of service must be completed for the sample to be processed.

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

**Unusual Circumstances**
Should circumstances arise where it is impossible to follow the laboratory procedures outlined above, please contact Gateway’s Utilization Management Department at 1-800-392-1146 for assistance.
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 must maintain at least twenty (20) weekly appointment hours per marketed location.

The primary care practitioner after meeting their contract minimum may, upon ninety (90) 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.

Gateway to Practitioner Excellence GPE® Program

Gateway HealthSM pay-for-performance program was initiated in 2007 to recognize and reward physicians who are committed to providing quality healthcare. The program has undergone many enhancements since this time. In 2012, the clinical quality measures were standardized and Obstetrical Care Providers and Dentists were included; a PCP tournament methodology was introduced. In 2013, a GPE® Plus Pilot was launched to assess electronic health record capabilities and methodologies for payouts on clinical qualitative HEDIS measures such as LDL control for cardiac and diabetes. In 2014, the program underwent significant expansion:

- Inclusion of Medicare Assured practices with ≥ 50 members
- Medicaid panel size requirements expanded from 200 to 50
- Expanded set of tools (Dashboard Report) or the green report which identifies members in need of services

GPE® Program Objectives:
- Improve the member experience
- Increase physician satisfaction
- Support Primary Care Medical Home
- Supports accurate and complete coding
- Incentivize quality care
Who is eligible?
- Primary care physician practices
- Obstetrical Care Providers
- Dentists

Performance Measures
Gateway to Practitioner Excellence® focuses on data driven measures to evaluate practice performance in the areas of:

- Women’s Health; Mammography Screening
- Diabetes Management-HbA1c control <8%. HbA1c screening and LDL-C <100mg/dL
- Cardiac Management – LDL-C <100mg/dL, Controlling High Blood Pressure
- Pediatric Care-Adolescent Well Care Visits
- Obstetrical Care: Timeliness of Prenatal Care, Frequency of Prenatal Care and Postpartum Care
- Preventive Dental: Annual Pediatric Dental Visit

For a complete listing of the measures and program details, please visit our website at www.GatewayHealthPlan.com and click on the provider’s link then on Gateway to Practitioner Excellence® located on the left hand side of the web page or contact your Provider Relations Representative.

Scorecards and PCP Dashboard Reports
Scorecards and their associated payments are distributed quarterly and annually.

Scorecards
The GPE® Scorecards include two components: a quarterly scorecard and member detail.

- PCP Quarterly Scorecard: Provides a summary of the services and payments the practitioner received for that quarter, broken down by measure.

- Quarterly Scorecard Member Detail: Provides a list of all the members who received services that qualified for GPE® payment, as well as which service(s) they received and the date the service(s) were rendered.

Dashboard Reports
The GPE® PCP Scorecard is supplemented with a quarterly PCP (Primary Care Practice) Dashboard and Opportunity Report. The Dashboard Report provides primary care practices with member specific care gaps on GPE® measures as well as multiple other non-GPE® quality measures.
2015 Rewards
Gateway to Practitioner Excellence® is designed to recognize and reward practice quality. Measurement, reporting and awards are at the practice level.

The program rewards primary care practitioners with three types of payments that are in addition to base payments or any “bill above” reimbursements.

1. Quarterly Payments
2. Annual Medical Dental Payment
3. Annual Control Measures Payment

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

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

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

- Quality of care assessments and studies;
- Access and availability of service evaluation;
- Program identification and evaluation;
- Utilization pattern evaluation;
- Operational policy development and evaluation, 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 Practice, 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.

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

DHS uses the Chronic Illness & Disability Payment System (CDPS) model to assign a risk score to each Medicaid recipient who meets certain eligibility criteria. Accurate and complete reporting of diagnosis codes on encounters is essential to the CDPS model. Physicians must establish the diagnosis in the medical record and coders must use the ICD-9-CM coding rules to record each diagnosis. Chronic illnesses should be evaluated on a complete physical exam each year. Reporting complete conditions present in the member will help to assure that DHS has complete data when determining the member’s risk score.

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

Official Coding Guidelines on CDC Website
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:

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.

**Vaccines For Children**

Children under 19 years of age receiving MA are eligible for Vaccines For Children (VFC) Program. All primary care practitioners will be reimbursed for the administration of any vaccine covered under the VFC Program when a claim is received with the appropriate immunization code. Any procedures for immunizations not covered under the VFC Program, but covered by Gateway, will be reimbursed fee-for-service. Please reference the Primary Care Practitioner’s Agreement for fee schedules or contact your Provider Relations Representative for additional information.

**Oral Health Risk Assessment**

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

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

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

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

**Addition of Newborns**

When a member selects Gateway, the member’s effective date is usually the 1st or the 15th of the month. When the member is a newborn, the member may be added any time of the month. Because newborn information is reported to Gateway retroactively, newborns will show up as a retroactive addition to the...
primary care practitioner’s monthly panel listing. Newborns will be effective on their date of birth or the date the newborn was added to the member’s grant.

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

**Processing PCP Change Requests**

When a member wishes to change his or her primary care practitioner, the change is processed under the following guidelines:

- When the request is received **prior to the 25th of the current month**, the new effective date will be the first of the following month. For example, if a member’s request is received on *October 7th*, the member will be effective *November 1st* with the new primary care practitioner.
- When the request is received **on or after the 25th of the current month**, the new effective date will be the first of the subsequent month. For example, if a member’s request is received on *October 28th*, the member will be effective *December 1st* with the new primary care practitioner.
- If the member requests to change his or her primary care practitioner immediately, an exception to the above guidelines can be made if the situation warrants.

**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.

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

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

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

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

All written requests are forwarded to the Enrollment Department within 48 hours of receipt. The Enrollment Department notifies the original practitioner in writing when the transfer has been completed. If the member requests not to be transferred, the primary care practitioner will have the final determination regarding continuation of primary care services.

When the request is received prior to the 25th of the month, the new effective date will be the first of the following month. When the request is received on or after the 25th of the current month, the new effective date will be the first of the subsequent month. An exception to the above guidelines can be made if the situation warrants an immediate transfer. 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 fifteen (15) business days from receipt of the request from the Department of Human Services, its agent, the member or the member’s new primary care practitioner, without charging the member.

**Coordination of Behavioral Health and Physical Health Services**

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

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

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

Referrals are not necessary for members to receive the services of a behavioral health practitioner.

If a member requires home healthcare ordered by a BH-MCO practitioner that meets the conditions of 55 Pa. Code, Chapter 1249 (relating to Home Healthcare Services), Section 1249.52 (relating to payment conditions for various services), the services would be covered by Gateway.

Please refer to the Quick Reference Section of this Manual for a listing of Behavioral Health Managed Care Organizations or behavioral health agencies and their corresponding telephone number, county serviced, and services provided.

**Appointment Standards**

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

General Information
Gateway’s Growing Up with Gateway SM (GUWG) Program is based upon the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program for Medical Assistance eligible children under the age of 21 years. Through the EPSDT Program, children are eligible to receive regular medical, dental, vision, and hearing screens to assure that they receive all medically necessary services, without regard to Medical Assistance covered services.

Each Gateway primary care practitioner and primary care/specialist is responsible for providing the health screens for Gateway members, and reporting the results of the screens to Gateway, as well as communicating demographic information (e.g. telephone number, address, alternate address) with the GUWG staff to assist with scheduling, locating and addressing compliance issues. Gateway verifies that primary care practitioners and PCP/Specialists for special needs are able to provide EPSDT services at the time of the practitioner’s office site visit.

Primary care practitioners that treat children under the age of 21 that are unable to comply with the requirements of the EPSDT Program must make arrangements for EPSDT screens to be performed elsewhere by a Gateway participating provider. Alternative primary care practitioners and specialists should forward a copy of the completed progress report to the primary care practitioner so it can be placed in the member’s chart.

Service Delivery Requirements Under HealthChoices
Primary care practitioners are required to assure all children under the age of 21 have timely access to EPSDT services, and are responsible for assuring continued coordination of care for all members due to receive EPSDT services. Also, primary care practitioners are to arrange for medically necessary follow-up care after a screen or an encounter.

The required screens and tests are outlined later in this section. Primary care practitioners are required to follow this schedule to determine when the necessary screens and tests are to be performed. Members must receive, at a minimum, eight screens between the ages of birth and 18 months, and seventeen screens between 19 months and 21 years.

When treating SSI and SSI-related members under the age of 21, an initial assessment must be conducted at the first appointment. Written assessment must be discussed with the member’s family or custodial agency, grievance or
appeal rights must be presented by the primary care practitioner, and recommendations regarding case management must be documented.

Primary care practitioners are responsible for ongoing coordination and monitoring of care provided by other practitioners.

Currently, Gateway maintains a collaborative partnership with the Pittsburgh Public Schools Health Services department. Gateway maintains relationships with individuals who work at Health Services and calls upon those individuals when feedback is needed with respect to possible school-based interventions or ideas. Gateway’s Care Management and Quality Improvement Departments also collaborate when possible with the Allegheny County Health Department (ACHD) and some of ACHD’s initiatives with local schools or school-aged children. Gateway is also beginning to explore possible collaborations with Head Start and Early Head Start programs in order to maintain a perspective about young aged children.

An additional partnership that Gateway began cultivating in 2009 and continues with to this day is its involvement with the Appalachian Community Cancer Network (ACCN), a National Cancer Institute-funded research initiative to reduce cancer health disparities in the Appalachian region. Gateway attends ACCN seminars and participates on quarterly conference calls with all ACCN members. One particular ACCN partner is the ACTION Health HPV Programming in Appalachian PA. ACTION Health operates in the central Susquehanna River valley to provide community health outreach and education. Its HPV & Cervical Cancer Program is targeted at women aged 18 to 26 years and at parents of children aged 9 to 17 years. Because of ACTION Health’s work with over 10 parent-teacher associations (PTAs), Gateway studies the outcome data from ACTION Health’s efforts in order to increase Gateway’s own ability to understand the successes and/or challenges of a school-based intervention focused on a specific health topic.

Finally, Gateway staff participate on the Pennsylvania Immunization Coalition (PAIC), a collaborative of health care workers, school nurses, county and municipal health department staff and members of many different agencies dedicated to advancing timely and effective immunizations for residents throughout Pennsylvania.

**Growing Up with GatewaySM Unit**

Gateway’s Growing Up with GatewaySM (GUWG) staff works collaboratively with the Case Managers in coordinating medically necessary services to members. GUWG staff provides outreach via telephone and mail to members who are under 21 to provide education and assistance with scheduling appointments, transportation, and other issues that prevent access to healthcare. GUWG staff is available to outreach to members identified by the primary care practitioner.
offices who are delayed with screens and/or immunizations or who are non-adherent with appointments.

The primary care practitioner is responsible for contacting new members identified on encounter lists as not adhering to EPSDT periodicity and immunization schedules. The GUWG contact person is an EPSDT Outreach Representative who can be reached at 1-800-642-3550, Option 4.

**Claim Filing**

Gateway requires all EPSDT screens be billed on a CMS-1500.

Codes for services must be included on the form. A description of the services will not be accepted. The practitioner’s tax identification number must be included on the form to avoid problems with payment of services. Gateway does not apply coordination of benefits to EPSDT screens. Completed paper claim forms should be submitted within sixty (60) days of the date of service to: Gateway HealthSM, PO Box 830249, Birmingham, AL 35283-0249.

Please refer to the *Claims and Billing Section* of this Manual for additional information regarding submission of claims for EPSDT visits.

**Authorization**

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

Hospital admissions and some outpatient surgical procedures require authorization from the Utilization Management Department.

Following an EPSDT screen, if a developmental delay is suspected and the child is not receiving services at the time of the screening, the primary care practitioner is required to refer the child (not over five years of age) to CONNECT at 1-800-692-7288.

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

**Required Screens and Tests**

Please utilize the Gateway Guidelines for Children’s Health Maintenance for documentation needed for the medical record. Gateway has updated the Children’s Health Maintenance Schedule based on the changes by the Department of Human Services to the periodicity schedule. Please reference these updated guidelines on the Gateway website at www.GatewayHealthPlan.com or refer to your Quality Improvement Manual.
Also, refer to the Children’s Health Maintenance Schedule for frequency of testing and for further clarification.

Please complete and mail to Gateway the Member Outreach Form, located in the Forms and Reference Material Section of this Manual, for any members with abnormal findings, or who did not show up for his/her appointment, so Gateway may contact the member.

The CMS-1500 Form does not indicate findings from the clinical exam. It is the responsibility of the primary care practitioner to document these findings in the medical record.

A dental assessment at every well-child visit, through observation, should be conducted up to the age of one year. The child should be referred to a dentist when the first tooth erupts, but no later than 12 months of age and should see the dentist every six months thereafter. The dentist must check for the following and initiate treatment or refer as necessary.

**Detail of Screens and Tests**

**Family and Medical History**

It is the responsibility of each practitioner to obtain a Family and Medical History as part of the initial well-child examination. The following Family and Medical History categories must be covered by the practitioner.

Family History

1. Hereditary Disorders, including Sickle Cell Anemia
2. Hay Fever-Eczema-Asthma
3. Congenital Malformation
4. Malignancy-Leukemia
5. Convulsions-Epilepsy
6. Tuberculosis
7. Neuromuscular Disease
8. Mental Retardation
9. Mental Illness in Parent Requiring Hospitalization
10. Heart Disease
11. Details of the Pregnancy, Birth and Neonatal Period
12. Complication of Pregnancy
13. Complication of Labor and Delivery
14. Birth Weight Inappropriate for Gestational Age
15. Neonatal Illness

Medical History

1. Allergies, Asthma, Eczema, Hay Fever
2. Diabetes
3. Epilepsy or Convulsions
4. Exposure to Tuberculosis  
5. Heart Disease or Rheumatic Fever  
6. Kidney or Bladder Problems  
7. Neurologic Disorders  
8. Behavioral Disorders  
9. Orthopedic Problems  
10. Poisoning  
11. Accidents  
12. Hospitals/Operations  
13. Menstrual History  
14. Medication  

**Height**  
Height must be measured on every child at every well-child visit. Infants and small children must be measured in the recumbent position, and older children standing erect. The height should be recorded in the child’s medical record and should be compared to a table of norms for age. The child’s height percentile must be entered into the medical record. Further study or referral is indicated in a child who has deviated from his/her usual percentile rank (determined by comparison with graphed previous measurements), or in a child whose single measurement exceeds two standard deviations from the norm for his/her age (beyond the 97th or below the 3rd percentile).

**Weight**  
Weight must be measured on every child at every well-child visit. Infants should be weighed with no clothes on, small children with just underwear, and older children and adolescents with ordinary house clothes (no jackets or sweaters) and no shoes. The weight must be recorded in the child’s medical record, and should be compared to a table of norms for age. The child’s weight percentile must also be entered into the medical record. Further study or referral is indicated for a child who has deviated from his usual percentile rank (determined by comparison with graphed previous measurements), or when a child whose single measurement exceeds two standard deviations from the norm for his/her age (beyond the 97th percentile or below the 3rd percentile).

**Body Mass Index (BMI)**  
A BMI must be calculated for every child at every well-child visit. The BMI must be recorded in the child’s medical record. For children younger than 15 years of age on the date of service, the BMI must be recorded as a BMI percentile or a BMI percentile plotted on an age-growth chart. A simple BMI value is not acceptable for this age range. For adolescents 16 years and older on the date of service, BMI can be recorded as a BMI value expressed as kg/m2, as a BMI percentile or a BMI percentile plotted on an age-growth chart. The BMI value should be compared to a table of norms for age.
Head Circumference
Head circumference should be measured at every well-child visit on infants and children up to the age of two years. Measurements may be done with cloth, steel, or disposable paper tapes. The tape is applied around the head from the supraorbital ridges anteriorly, to the point posteriorly giving the maximum circumference (usually the external protuberance). Further study or referral is indicated for the same situations described in height and weight, and findings must be recorded in the child’s medical record.

Physical Growth/Nutritional Status
The child’s height, weight and body mass index are measured at each scheduled well-child exam. In addition, if the child is less than two, the head circumference is also measured. If the child’s rate of growth falls either below the lower level of normal or above the upper level of normal, nutritional counseling to the parent is required if no organic cause for the growth deviation is found. All children should receive counseling about nutrition and counseling about physical activity. Documentation about these two types of counseling should be recorded in the child’s medical record.

Blood Pressure
Blood pressure must be done at every visit for all children over the age of three years, and must be done with an appropriately sized pediatric cuff. It may also be done under the age of three years when deemed appropriate by the attending practitioner. Findings must be recorded in the child’s medical record.

Dental Screening
A dental assessment at every well-child visit, through observation, should be conducted up to the age of one year. The child should be referred to a dentist when the first tooth erupts, but no later than 12 months of age and should see the dentist every six months thereafter. The dentist must check for the following and initiate treatment or refer as necessary.
- Caries
- Fillings Present
- Missing Teeth (permanent)
- Oral Infection

Documentation and Referral
For Physicians and Providers:
1. At the time of an EPSDT screen, all PCPs must complete the following when a child is identified as needing a referral to a dental home according to the Periodicity Schedule:
   - Advise the parent or guardian that a dental referral is required according to the Periodicity Schedule.
• Notify Gateway that the child is due for a dental referral as part of a complete EPSDT screen. This notification constitutes the provider’s referral to a dental home and can be done utilizing one of the following:
  o Call in to DIVA telephone Eligibility and Referral System at 1-800-642-3515.
  o Call in to Gateway’s Care Management Department at 1-800-642-3550, Option #4.
  o Fax a Member Outreach Form to Gateway’s Care Management Department at 1-888-225-2360.

2. PCPs are encouraged to report to Gateway the most current phone number their office has on record for the member in need of a dental visit.

3. PCPs must then code the EPSDT screen claim with a “YD” code in box 10.

Vision Testing
The chart should be affixed to a light-colored wall, with adequate lighting (10-30 foot candles) and no shadows. Ordinary room lighting typically does not provide adequate lighting and the chart will need a light of its own. The 20-foot line on the chart should be set at approximately the level of the eyes of a six-year-old. Placement of the child must be exactly 20 feet. Sites that do not have a 20-foot distance at which to test should obtain a 10-foot Snellen chart rather than convert the 20-foot chart. The eye not being tested must be covered with an opaque occluder; several commercial varieties are available at minimal cost, or the practitioner may improvise one, but the hand may not be used, as it leads to inaccuracies. In older children who seem to have difficulty or in young children, bring the child up to the chart (preferably before testing) and explain the procedure.

For screening, the tester should start with the big E (20-foot line) and then proceed down rapidly line-by-line, as long as the child reads one letter per line, until the child cannot read. At this critical level, the child is tested on every letter on that line or adjacent line. Passing is reading a majority of letters in a line. It is not necessary to test for every letter on the chart. Tests for hyperopia may be done but are not required.

Referral System
Children seven years of age and over must be referred if vision in either eye is 20/30 or worse. A child may be referred if the parent complains or if the doctor discovers a medical reason. (Generally, sitting close to the television without other complaints, and with normal acuity, is not a reason for referral.) Children failing a test for hyperopia may be referred.

Children already wearing glasses must be tested with their glasses. If they pass, record the measurement; nothing further needs to be done. If they fail, refer for
re-evaluation to a Gateway participating specialist, preferably to the vision practitioner who prescribed the lenses, regardless of when they were prescribed.

If the practitioner is unable to render an eye examination in a child nine years of age or older, because of the child’s inability to read the chart or follow directions (e.g. a developmentally challenged child), refer this child to a participating ophthalmologist or optometrist.

Hearing Screening
Sweep audiometry is the most frequently used examination and must be administered to every screened child within the first month of life, and after the age of three through a hearing test.

Tuning forks and un-calibrated noisemakers are not acceptable for hearing testing.

For children under five years of age, observation should be made of the child’s reaction to noises and to voices, unless the child is sufficiently cooperative to actually do the audiometry. For audiometry, explain the procedure to the child. For small children, present it as a game. Present one tone loud enough for the child to hear, and explain that when it is heard, the child should raise his/her hand and keep it raised until the sound disappears. Once the child understands, proceed with the test. Doing one ear at a time, set the decibel level at 25, and testing at 500 Hz. Then go successively to 1,000, 4,000, and 6,000. Repeat for the other ear. The quietest room at the site must be used for testing hearing.

Referral System
Any cooperative child failing sweep audiometry at any two frequencies must be referred. If a child fails one tone, retest that tone with threshold audiometry to be certain it is not a severe single loss. To be certain of the need for referral, the practitioner must immediately retest all failed tones by threshold audiometry, or, if there is question about the child’s cooperation or ability at the time of testing, bring the child back for another sweep audiometry before referring.

Please remember that audiometers must be periodically (at least annually) calibrated for accuracy.

Developmental/Behavioral Appraisal
Since children with slow development and abnormal behavior may be able to be successfully treated if treatment is begun early, it is important to identify these problems as early as possible. Questions must be included in the history, which relate to behavior and social activity as well as development. Close observation is also needed during the entire visit for clues to deviations in those areas.
If the practitioner suspects developmental delay he/she is required to refer the child to CONNECT at 1-800-692-7288, for appropriate eligibility determination for early intervention services.

**Below Five Years of Age**
In addition to history and observation, a developmental evaluation is required. In children who are regular patients of the practitioner site, this may consist of ongoing recording in the child’s chart of developmental milestones sufficient to make a judgment on developmental progress. In absence of this, the site may elect to conduct a Denver Developmental Screening Test as its evaluation utilizing the Denver II Form.

Marked slowness in any area is cause for a referral to a participating specialist, e.g. developmental center, a MH/MR agency, a developmental specialist, a pediatric neurologist or a psychologist. If only moderate deficiencies in one or more areas are found, the practitioner must retest the child in 30-60 days.

**Social Activity/Behavior**  
Questions should be asked to determine how the child relates to his family and peers and whether any noticeable deviation in any of his/her behavior exists. The DASE test may be used as an evaluation.

**Five Years and Older**  
Since the usual developmental tests are not valid at this age, observation and history must be used to determine the child’s normality in the areas listed below. Each child should be checked and recorded appropriately. Major difficulty in any one area, or minor difficulty in two or more areas, is cause for referral to a participating mental health professional for further diagnosis.

1. Social Activity/Behavior—Does the child relate with family, teachers, and peers appropriately? Has the child had a change in behavior, specifically a loss of interest in usual and preferred activities?
2. School—Is the child’s grade level appropriate for his/her age? Has the child been held back in school? Has the child demonstrated a decrease in academic work, social function, and/or sports?
3. Peer Relationships  
4. Physical/Athletic Dexterity  
5. Sexual Maturation—Tanner Score. A full explanation of Tanner observations and scoring is found below.  
6. Speech—DASE Test if there is a problem in this area, record accordingly, refer appropriately.
Tanner Score

Knowing the normalcy of sexual development and being able to describe them with some understanding is the only way of assessing the abnormal. Using a system, such as the Tanner Score, is the only way clinically of communicating from practitioner to practitioner or measuring change from time to time. An accurate description of the sexual maturation process aids greatly in assessing height, growth patterns and prognosis, as well as future genital and reproductive development.
Standards for Genitalia Maturity Ratings for Males

<table>
<thead>
<tr>
<th>STAGE ONE</th>
<th>Preadolescence. Testes, scrotum and penis are about same size and shape as in early childhood.</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAGE TWO</td>
<td>Scrotum and testes are slightly enlarged. The skin of the scrotum is reddened and changed in texture. There is little or no enlargement of the penis at this stage.</td>
</tr>
<tr>
<td>STAGE THREE</td>
<td>Penis is slightly enlarged, at first mainly in length. Testes and scrotum are further enlarged than in STAGE TWO.</td>
</tr>
<tr>
<td>STAGE FOUR</td>
<td>Penis is further enlarged, with growth in breadth and development of glands. Testes and scrotum are further enlarged than in STAGE THREE; scrotal skin is darker than in earlier stages.</td>
</tr>
<tr>
<td>STAGE FIVE</td>
<td>Genitalia are adult in size and shape.</td>
</tr>
</tbody>
</table>

NOTE: Boys over 16 years of age who are still Tanner STAGE ONE should be referred to an appropriate specialist.

Breast Development Standards for Females

<table>
<thead>
<tr>
<th>STAGE ONE</th>
<th>Preadolescence. There is elevation of the papilla only.</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAGE TWO</td>
<td>Breast bud stage. There is elevation of the breast and the papilla as a small mound. Areola diameter is enlarged over STAGE ONE.</td>
</tr>
<tr>
<td>STAGE THREE</td>
<td>Breast and areola are both enlarged and elevated more than in STAGE TWO, but with no separation of their contours.</td>
</tr>
<tr>
<td>STAGE FOUR</td>
<td>The areola and papilla form a secondary mound projecting above the contour of the breast.</td>
</tr>
<tr>
<td>STAGE FIVE</td>
<td>Mature stage. The papilla only projects, with the areola recessed to the general contour of the breast.</td>
</tr>
</tbody>
</table>

NOTE: Girls over 15 years of age who are still Tanner STAGE ONE should be referred to an appropriate specialist.

Pubic Hair Development Standards for Males and Females

<table>
<thead>
<tr>
<th>STAGE ONE</th>
<th>Preadolescence. The vellus over the pubes is not further developed than the abdominal wall, i.e., no pubic hair.</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAGE TWO</td>
<td>There is sparse growth of long, slightly pigmented downy hair, straight, or slightly curly, chiefly at the base of the penis or along the labia.</td>
</tr>
<tr>
<td>STAGE THREE</td>
<td>The hair is considerably darker, coarser, and more curled. It spreads sparsely over the junction of the pubes.</td>
</tr>
<tr>
<td>STAGE FOUR</td>
<td>Hair is not adult in type, but the area covered is considerably smaller than in the adult. There is no spread to the medial surface of the thighs.</td>
</tr>
<tr>
<td>STAGE FIVE</td>
<td>The hair is adult in quantity and type with distribution of the horizontal (or classically “feminine”) pattern. Spread is to the medial surface of the thighs, but not up the linea alba or elsewhere above the base of the inverse triangle.</td>
</tr>
</tbody>
</table>

Structured Screening for Developmental Delays and Autism Spectrum Disorders

According to MA regulations at 55 Pa.Code § 1101.51(e) (relating to record keeping requirements and onsite access), providers must document the medical necessity for all screening services in the child’s medical record. The child’s medical record must contain documentation of all surveillance, screening, and referral activities and a copy of the completed validated developmental or autism screening tool that the provider used to conduct the screening.

There are several resources available to assist providers in educating themselves about surveillance and structured screening and in remaining up to date on validated screening tools. Providers may refer to the following resources for additional information:

Surveillance and Screening may be found on-line at: http://aappolicy.aappublications.org/cgi/reprint/pediatrics;118/1/405.pdf

The AAP Developmental Surveillance and Screening Policy Implementation Project (DPIP) may be found on-line at: http://www.medicalhomeinfo.org/screening/DPIP.html.

The 2008 Bright Futures Guidelines may be found on the AAP Bright Futures web site on-line at: http://www.brightfutures.aap.org/ or providers may order a complete copy from the AAP Bookstore, on-line at www.aap.org/bookstore.


The National AAP Policy Statement: Identification and Evaluation of Children with Autism Spectrum Disorders may be found online at: http://aappolicy.aappublications.org/cgi/reprint/pediatrics;120/5/1183.pdf.

Many validated tools have been developed that are useful in screening for particular developmental delays and ASDs. These validated screening tools reflect a broad variety of age ranges, and differences in costs, length of time involved, and methods of administering the tool. As additional research and testing are conducted, current tools may become obsolete or new tools may become available after completion of the scientific validation process. **It is the provider’s responsibility for ensuring that they continue to use tools that are validated at the time they conduct the structured screening. Providers may select a specific validated screening tool that is the most suitable tool for the provider’s practice.**

Please refer to the Forms and Reference Materials section of the manual for a listing of Validated Screening Tools for Developmental Delays and Autism Spectrum Disorders.

**Anemia Screening**

A hemoglobin or hematocrit must be done between 9-11 months of age and for females once after the onset of menses. Subsequent testing should be at the practitioner’s discretion, and based on the member’s history and presenting complaints.

All premature or low-birth weight infants must have hemoglobin or hematocrit done on their first well-visit and then repeated according to the schedule later in this section. The results of the test must be entered in the child’s medical record.

Diagnosis of anemia should be based on the doctor’s evaluation of the child and the blood test. It is strongly suggested that a child with 10 grams of hemoglobin or less (or a hematocrit of 30% or less) be further evaluated for anemia.
However, even though 10 grams may represent the lower limit of normal for most of childhood, it should be realized that in early infancy and adolescence these levels should be higher. For those practitioners who use charts to evaluate hemoglobin/hematocrit values, age is not used to determine the level of anemia, but rather values that fall two standard deviations below the mean.

<table>
<thead>
<tr>
<th>Age</th>
<th>Hbg g/dl Mean</th>
<th>Hbg g/dl –2SD</th>
<th>Hct (%) Mean</th>
<th>Hct (%) –2SD</th>
<th>Red Cell Count (10-12th liter) Mean</th>
<th>Red Cell Count (10-12th liter) –2SD</th>
<th>MCV Mean</th>
<th>MCV –2SD</th>
<th>MCH Mean</th>
<th>MCH –2SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>16.5</td>
<td>13.5</td>
<td>51</td>
<td>42</td>
<td>4.7</td>
<td>3.9</td>
<td>108</td>
<td>98</td>
<td>34</td>
<td>31</td>
</tr>
<tr>
<td>1-3 Days</td>
<td>18.5</td>
<td>14.5</td>
<td>56</td>
<td>45</td>
<td>5.3</td>
<td>4.0</td>
<td>108</td>
<td>95</td>
<td>34</td>
<td>31</td>
</tr>
<tr>
<td>1 Week</td>
<td>17.5</td>
<td>13.5</td>
<td>54</td>
<td>42</td>
<td>5.1</td>
<td>3.9</td>
<td>107</td>
<td>88</td>
<td>34</td>
<td>28</td>
</tr>
<tr>
<td>2 Weeks</td>
<td>16.5</td>
<td>12.5</td>
<td>51</td>
<td>39</td>
<td>4.9</td>
<td>3.6</td>
<td>105</td>
<td>86</td>
<td>34</td>
<td>23</td>
</tr>
<tr>
<td>1 Month</td>
<td>14.0</td>
<td>10.0</td>
<td>43</td>
<td>31</td>
<td>4.2</td>
<td>3.0</td>
<td>104</td>
<td>85</td>
<td>34</td>
<td>28</td>
</tr>
<tr>
<td>2 Months</td>
<td>11.5</td>
<td>9.0</td>
<td>35</td>
<td>28</td>
<td>3.8</td>
<td>2.7</td>
<td>96</td>
<td>77</td>
<td>30</td>
<td>26</td>
</tr>
<tr>
<td>3-6 Months</td>
<td>11.5</td>
<td>9.5</td>
<td>35</td>
<td>29</td>
<td>3.8</td>
<td>3.1</td>
<td>91</td>
<td>74</td>
<td>30</td>
<td>26</td>
</tr>
<tr>
<td>.5-2 Years</td>
<td>12.0</td>
<td>10.5</td>
<td>36</td>
<td>33</td>
<td>4.5</td>
<td>3.7</td>
<td>78</td>
<td>70</td>
<td>27</td>
<td>22</td>
</tr>
<tr>
<td>2-6 Years</td>
<td>12.5</td>
<td>11.5</td>
<td>37</td>
<td>34</td>
<td>4.6</td>
<td>3.9</td>
<td>81</td>
<td>75</td>
<td>27</td>
<td>24</td>
</tr>
<tr>
<td>6-12 Years</td>
<td>13.5</td>
<td>11.5</td>
<td>40</td>
<td>35</td>
<td>4.6</td>
<td>4.0</td>
<td>86</td>
<td>77</td>
<td>29</td>
<td>25</td>
</tr>
<tr>
<td>12-19 Years F</td>
<td>14.0</td>
<td>12.0</td>
<td>41</td>
<td>36</td>
<td>4.6</td>
<td>4.1</td>
<td>90</td>
<td>78</td>
<td>30</td>
<td>25</td>
</tr>
<tr>
<td>12-19 Years M</td>
<td>14.5</td>
<td>13.0</td>
<td>43</td>
<td>37</td>
<td>4.9</td>
<td>4.5</td>
<td>88</td>
<td>78</td>
<td>30</td>
<td>25</td>
</tr>
<tr>
<td>18-49 Years F</td>
<td>14.0</td>
<td>12.0</td>
<td>41</td>
<td>36</td>
<td>4.6</td>
<td>4.0</td>
<td>90</td>
<td>80</td>
<td>30</td>
<td>26</td>
</tr>
<tr>
<td>18-49 Years M</td>
<td>15.5</td>
<td>13.5</td>
<td>47</td>
<td>41</td>
<td>5.2</td>
<td>4.5</td>
<td>90</td>
<td>80</td>
<td>30</td>
<td>26</td>
</tr>
</tbody>
</table>

**Sickle Cell**

A sickle cell test must be performed if indicated by history and/or symptoms.

**Tuberculin Test**

Although the incidence of tuberculosis is decreasing, it now may constitute a significant health problem in some high-risk communities, especially in the lower socioeconomic groups. Early recognition of the primary conveyor will permit:

- Prompt and cost effective treatment of cases
- Earlier detection of source cases of these patients for public health purposes

Children should be screened by using a Mantoux Test or multiple puncture skin tests (Tine, Heaf, Mono-Vacc, Aplitest) commonly used by the primary care practitioner’s office. Any child with a positive tuberculin test must be further evaluated.

It is the responsibility of the primary care practitioner’s office to secure the results of the tuberculin tests 48-96 hours after it has been administered. Tuberculosis screening should be performed at the practitioner’s discretion.

**Albumin and Sugar**

Tests for urinary albumin and sugar must be done at 5 years of age. Dipsticks are acceptable. A positive test must be followed up or referred for further care.
A 1+ albumin (or trace) with no symptoms need not be referred, as it is not an unusual finding.

**Blood Lead Level Screening**

The Pennsylvania EPSDT Periodicity Schedule requires that all children under age 5 receive a minimum of two blood lead screenings as part of EPSDT well child screenings, regardless of the individual child’s risk factors. The first test for lead should be conducted during one of the screening periods between the 9-11 month and 18 month screenings, and the second test for lead should be conducted during one of the screening periods between the 24 month and 4 year screenings. Please refer to the Child Health Maintenance Schedule for further clarification.

The Center for Disease Control requires the use of a blood lead test when screening children for lead poisoning. A blood lead screening should be done by a blood lead measurement of either a venous or capillary (finger stick) blood specimen.
Environmental Investigation of Lead
Use the Gateway Member Outreach Form, found in the *Forms and Reference Materials Section* of this Manual, to notify Gateway’s GUWG staff of the need for follow-up. Gateway can also assist with issues regarding elevated blood lead levels or regarding non-compliance.

- If the screening indicates the need for the member to be referred to a specialist, a Gateway referral form must be completed.
- Blood Lead tests must go either to your designated laboratory or to Kirby Health Center. When using Kirby Health Center, blood lead samples only will be processed, and a Gateway Lead Analysis Form must be completed. Supplies for submitting to Kirby may be requested through Kirby Health Center by calling 1-888-841-6699.

Sexually Transmitted Disease Screening and Pap Tests
Tests and counseling are to be performed if sexually active. Adolescents must be questioned about sexual activity and given assistance, diagnosis, treatment and information, as the situation requires. All sexually active patients should be screened for sexually transmitted infections. All sexually active girls should have screening for cervical dysplasia as part of a pelvic examination within 3 years of onset of sexual activity or age 21 (whichever comes first).

Bacteriuria
Test for bacteriuria must be conducted on any child who has symptoms relating to possible urinary tract involvement. Routinely at every screen the simple Nitrate Test by dipstick is acceptable for bacteriuria testing. Although it is best done on a first morning specimen, it may be completed on a random specimen. A single dipstick is available to test for albumin, sugar and bacteria.

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

For HEDIS 2012, Volume 2 a new measure will be added that relates to the topic of immunizations for adolescents. HEDIS will now evaluate **Human Papillomavirus Vaccine for Female Adolescents.** This measure will assess the percentage of 13-year-old females who had three doses of the human papillomavirus (HPV) vaccine. The measure is designed to evaluate compliance with Centers for Disease Control and Prevention and Advisory Committee on Immunization Practices immunization guidelines.
Gateway follows recommended childhood immunization schedules approved by the Centers for Disease Control and Prevention’s (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics, and the American Academy of Family Physicians. To facilitate distribution of the most current version of this schedule, it has been added to Gateway’s website. A paper copy is available upon request. For a paper copy, please contact the Provider Services Department at 1-800-392-1145.
Specialty Care Practitioner

Verifying Eligibility
Due to frequent changes in a member’s eligibility, specialty care practitioners must verify eligibility prior to rendering services to assure reimbursement. This can be done by calling Gateway’s telephonic eligibility verification system - Digital Voice Assistant (DIVA). DIVA can be reached by calling 1-800-642-3515, and is available 24 hours a day, seven days a week. The Pennsylvania Medical Assistance Member Eligibility Verification System (EVS) can be reached at 1-800-766-5EVS 24 hours a day, seven days a week.

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

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

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

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

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

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

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

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

**Emergency Services**

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

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

**Specialists Functioning as Primary Care Practitioners**

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

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

<table>
<thead>
<tr>
<th>Practitioner Type</th>
<th>Requirement</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Specialist</td>
<td>Wait time for an Emergent Appointment</td>
<td>Immediately seen or referred to an emergency facility</td>
</tr>
<tr>
<td>All Specialist</td>
<td>Wait time for Urgent Care Appointment</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Specialty Types:</td>
<td>Wait time for Asymptomatic Regular/Routine Appointment</td>
<td>Within fifteen (15) business days from the date of referral</td>
</tr>
<tr>
<td>Dermatology, Dentist, Orthopedic Surgery, Otolaryngology, Pediatric Allergy &amp; Immunology, Pediatric Endocrinology, Pediatric Gastroenterology, Pediatric General Surgery, Pediatric Hematology, Pediatric Infectious Disease, Pediatric Nephrology, Pediatric Neurology, Pediatric Oncology, Pediatric Pulmonology, Pediatric Rehab Medicine, Pediatric Rheumatology, Pediatric Urology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialties not listed above</td>
<td>Wait time for Routine Appointments</td>
<td>Within 10 business days</td>
</tr>
<tr>
<td>All Specialist</td>
<td>Wait Time in the Waiting Room for routine care</td>
<td>Average office waiting time no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated Urgent Medical Condition visit or is treating a Member with a difficult medical condition need.</td>
</tr>
<tr>
<td>All Specialist</td>
<td>Wait time for first time appointment with Persons known to be HIV positive or diagnosed with AIDS</td>
<td>Within seven (7) days from the effective date of enrollment, unless member is already in active care with a PCP or specialist.</td>
</tr>
<tr>
<td>All Specialist</td>
<td>Wait time for first time appointment with member who is a Supplemental Security Income (SSI) or SSI-related consumer</td>
<td>Within forty-five (45) days of enrollment unless the Member is already in active care with a PCP or specialist.</td>
</tr>
<tr>
<td>All Specialist</td>
<td>Missed Appointment</td>
<td>Conduct outreach whenever a member misses an appointment and document in the medical record. Three attempts with at least one attempt to include a telephone call.</td>
</tr>
</tbody>
</table>
OB/GYN Services

**General Information**

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

Gateway permits its 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. Primary care practitioners who provide obstetrical services must bill in accordance with Gateway guidelines and may only provide obstetrical services to those patients assigned to their panel.

**Obstetrical Needs Assessment Form (OBNAF)**

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 (MA552), the DHS statewide form, is available at [www.DHS.state.pa.us](http://www.DHS.state.pa.us) and under the Medicaid Forms & Reference Materials section at [www.GatewayHealthPlan.com](http://www.GatewayHealthPlan.com).

The Obstetrical Needs Assessment Form should immediately be faxed or e-mailed via Gateway’s secure e-mail portal 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. The Obstetrical Needs Assessment Form is not a claim. However, the Obstetrical Needs Assessment Form must be received by Gateway in order to process the claim for the intake visit. Please submit claims on a CMS-1500 within 180 days to receive payment for the intake package.

**OB/GYN Referrals**

If an OB/GYN determines that assessment or treatment by another specialty care practitioner is necessary, the OB/GYN is required to contact the member’s primary care practitioner to request a referral to a specialist. The OB/GYN practitioner is responsible for providing written correspondence to the member’s primary care practitioner for coordination and continuity of care.
The OB/GYN cannot refer a member directly to another specialty care practitioner with the exception of participating Perinatologists.

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

**Diagnostic Testing**

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

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

Neither a referral or script is required for a screening mammogram performed at a participating hospital.

**Medical Assistance Sterilization/Hysterectomy Consent Forms**

The Department of Human Services requires that Gateway members sign a Medical Assistance Sterilization Consent Form (MA-30), or a Patient Acknowledgement Form (MA-31), thirty (30) days prior to the procedure for Hysterectomies when receiving these services. Copies of these forms can be found in the Forms and Reference Materials Section of this Manual.

**Newborns**

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

**Universal OB Access Program Follow-up Requirements**

<table>
<thead>
<tr>
<th>Item</th>
<th>OB Referral?</th>
<th>Authorization?</th>
<th>Type of PCP Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IN OFFICE SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Gynecological Exam</td>
<td>No</td>
<td>No</td>
<td>Summary Report</td>
</tr>
<tr>
<td>Other Related Gynecological Services</td>
<td>No</td>
<td>No</td>
<td>Summary Report</td>
</tr>
<tr>
<td>Suspected Pregnancy</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>Initial Intake</td>
<td>No</td>
<td>No</td>
<td>OB Risk Assessment Form</td>
</tr>
<tr>
<td>Prenatal Visits</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>Identification of New Risk Factors</td>
<td>No</td>
<td>No</td>
<td>Updated Risk Assessment</td>
</tr>
<tr>
<td>Other Related OB Services</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
</tbody>
</table>
## OB/GYN Services

<table>
<thead>
<tr>
<th>Item</th>
<th>OB Referral?</th>
<th>Authorization?</th>
<th>Type of PCP Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal Support Services</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>Fetal Non Stress Test</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
</tbody>
</table>

### OUT OF OFFICE SERVICES

<table>
<thead>
<tr>
<th>Item</th>
<th>OB Referral?</th>
<th>Authorization?</th>
<th>Type of PCP Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPU/Ambulatory Surgery Services*</td>
<td>No</td>
<td>Yes</td>
<td>Summary Report</td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>No</td>
<td>Yes</td>
<td>Summary Report</td>
</tr>
<tr>
<td>Home Healthcare/Hospice Services/IV Infusion</td>
<td>No</td>
<td>Yes</td>
<td>None</td>
</tr>
<tr>
<td>Mammogram</td>
<td>No</td>
<td>No</td>
<td>Summary Report</td>
</tr>
<tr>
<td>OB Ultrasound</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>Fetal Non Stress Test</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>STAT Laboratory Services**</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>Other Outpatient Diagnostic Tests</td>
<td>No</td>
<td>No</td>
<td>Summary Report</td>
</tr>
<tr>
<td>Delivery and Discharge Services</td>
<td>No</td>
<td>No</td>
<td>Summary Report</td>
</tr>
</tbody>
</table>

*These services can be authorized by calling Gateway’s Utilization Management Department at 1-800-392-1146. Home Health visits should be offered to all newborns.

**A referral is required only if the hospital is not the member’s designated lab. If you are unsure of the hospital’s laboratory status, please call Provider Services at 1-800-392-1145.

### Coding

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

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

The initial prenatal visit **MUST** be rendered within the first trimester and the **Obstetrical Needs Assessment Form (OBNAF)** must be completed during the visit and faxed to Gateway’s MOM Matters® department within 2-5 business days of the visit.

Procedure codes 99429-HD (First Trimester Outreach) and T1001-U9 (Initial Risk Assessment) must be reported together on the same claim form to allow the bonus payment.
The bonus payment will **NOT** be paid if both codes/modifiers referenced above are not reported on the same claim. The OBNAF is not a claim form; however, the OBNAF must be received by Gateway and documented in our claims system prior to receipt of the claim to allow the appropriate bonus and intake visit payment.

If the member’s first prenatal visit doesn’t occur within the first trimester then code 99429-HD should not be billed. However, the first visit with an obstetrical patient is considered to be the intake visit. If a patient becomes a Gateway member during the course of her pregnancy, her first visit as a Gateway member is considered to be her intake visit. At the intake visit, an OBNAF must be completed and a claim submitted with code T1001-U9 for reimbursement.

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Trimester Outreach</td>
<td>99429-HD and T1001-U9</td>
<td>1st Trimester Normal</td>
<td>99211</td>
</tr>
<tr>
<td>Initial Assessment</td>
<td>T1001</td>
<td>2nd Trimester Normal</td>
<td>99203 or 99213</td>
</tr>
<tr>
<td>1st Trimester High Risk</td>
<td>99212</td>
<td>3rd Trimester Post Partum Normal</td>
<td>99205 or 99215</td>
</tr>
<tr>
<td>2nd Trimester High Risk</td>
<td>99214</td>
<td>C-section Delivery</td>
<td>59514</td>
</tr>
<tr>
<td>3rd Trimester Post Partum High Risk</td>
<td>99215</td>
<td>Vaginal Delivery</td>
<td>59409</td>
</tr>
<tr>
<td>C-section Delivery with Post Partum</td>
<td>59515</td>
<td>Vaginal Delivery with Post Partum</td>
<td>59410</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other Maternity Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fetal Non-stress Test</td>
<td>59025</td>
<td>Fetal Biophysical Profile (Global Fee)</td>
<td>76818</td>
</tr>
<tr>
<td>Comprehensive Childbirth Preparation</td>
<td>S9436</td>
<td>Childbirth Preparation Review</td>
<td>S9437</td>
</tr>
<tr>
<td>Outreach Bonuses for 1st Trimester Recruit</td>
<td>99429</td>
<td>Nutritional Counseling</td>
<td>S9470</td>
</tr>
<tr>
<td>Smoking Cessation Counseling</td>
<td>G9016</td>
<td>Substance Abuse Problem ID and Referral</td>
<td>H0004</td>
</tr>
<tr>
<td>Genetic Risk Assessment</td>
<td>99205</td>
<td>Parenting Program</td>
<td>S9444</td>
</tr>
<tr>
<td>Outreach Visit (maximum of 3 per pregnancy)</td>
<td>H1002</td>
<td>Urgent Transport (car)</td>
<td>A0425</td>
</tr>
<tr>
<td>In-depth Psycho-social Counseling</td>
<td>H0004</td>
<td>Prenatal Exercise Series</td>
<td>S9451</td>
</tr>
<tr>
<td>Urgent Transport (Public Carrier)</td>
<td>T2003</td>
<td>Mileage Additional Allowance</td>
<td>A0425</td>
</tr>
</tbody>
</table>

**Family Planning Guidelines**

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

- The patient’s Gateway eligibility can be verified by calling 1-800-642-3515.
• Family planning patients DO NOT need a referral from their primary care practitioner under federal mandate.

• If a family planning patient becomes pregnant, she may self-refer to her OB/GYN for prenatal care. The Department of Human Services permits members to see any participating or non-participating practitioner for Family Planning Services only.

• The Sterilization Consent Form (MA-31) must be obtained from the patient thirty (30) days prior to the procedure.

• The appropriate documentation must be PREAUTHORIZED at least five (5) business days prior to the procedure by calling Adagio Health, Inc. at 1-800-532-9465.

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

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

**Appointment Standards**

Appointment standards for OB/GYN practitioners are as follows:

<table>
<thead>
<tr>
<th>Trimester</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Trimester</td>
<td>Within 10 business days of the member being identified as being pregnant</td>
</tr>
<tr>
<td>Second Trimester</td>
<td>Within 5 business days of the member being identified as being pregnant</td>
</tr>
<tr>
<td>Third Trimester</td>
<td>Within 4 business days of the member being identified as being pregnant</td>
</tr>
<tr>
<td>High-Risk Pregnancies</td>
<td>Within twenty-four 24 hours of identification of high-risk by Gateway or the maternity care provider, or immediately if an emergency exits</td>
</tr>
</tbody>
</table>

Additional standards that apply to all specialists including OB/GYNs:
## Requirement

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wait time for an Emergent Appointment</td>
<td>Immediately seen or referred to an emergency facility</td>
</tr>
<tr>
<td>Wait time for Urgent Care Appointment</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Wait time for Routine Appointments</td>
<td>Within 10 business days</td>
</tr>
<tr>
<td>Wait Time in the Waiting Room for routine care</td>
<td>Average office waiting time no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated Urgent Medical Condition visit or is treating a Member with a difficult medical condition need.</td>
</tr>
<tr>
<td>Wait time for first time appointment with Persons known to be HIV positive or diagnosed with AIDS</td>
<td>Within seven (7) days from the effective date of enrollment, unless member is already in active care with a PCP or specialist.</td>
</tr>
<tr>
<td>Wait time for first time appointment with member who is a Supplemental Security Income (SSI) or SSI-related consumer</td>
<td>Within forty-five (45) days of enrollment unless the Member is already in active care with a PCP or specialist.</td>
</tr>
<tr>
<td>Missed Appointment</td>
<td>Conduct outreach whenever a member misses an appointment and document in the medical record. Three attempts with at least one attempt to include a telephone call.</td>
</tr>
</tbody>
</table>
Policies and Procedures

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

Department of Human Services Policy Changes

In order for Gateway to meet the standards set forth by the Commonwealth of Pennsylvania Department of Human Services (DHS) standard contract, Gateway must promptly implement new policies or changes in policy at the request of the Department of Human Services.

Upon notice from DHS of program or policy changes, Gateway will assess those policies or practices that require practitioner notice. Depending upon the DHS effective date of the change, practitioners cannot always be notified prior to such alterations. Gateway is committed to notifying all appropriate practitioners, via the most appropriate medium, within 60 days of receipt of the notice of a new policy or policy change when sufficient notice is provided by DHS.

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

Practitioner Education 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 1-800-392-1145.

Practitioner Due Process

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

The Practitioner Due Process Policy will be updated in accordance with federal and state regulations. To request additional information or to obtain a copy of this policy, please contact Gateway’s Provider Services Department at 1-800-392-1145.
TITLE VI of the Civil Rights Act of 1964

Practitioners are expected to comply with Title VI of the Civil Rights Act of 1964 that prohibits race, color or national origin discrimination in programs receiving Federal funds. Practitioners are obligated to take reasonable steps to provide meaningful access to services for members with limited English proficiency, including provision of translator services as necessary for these members.

Access and Interpreters for Members with Disabilities

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

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.

Practitioners may obtain copies of documents that explain legal requirements for translation services by contacting Gateway’s Provider Services Department at 1-800-392-1145. For interpreter services, please contact a qualified medical interpretation service such as Voiance or Language Line Services. Practitioner offices can contact the AT&T Language Line at 1-800-874-9426 for assistance with Limited English Proficient (LEP) patients and the PA State Relay line at 711 or 1-800-682-8706 for patients with hearing impairments.

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

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

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

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

All practitioners and providers participating with Gateway have agreed to abide by all Gateway policies and procedures regarding member confidentiality. The performance goal for confidentiality is maintaining patient records secure 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:**
   - The Mental Health Procedures Act, 50 P.S. §§7101 et seq.
   - Patient Medical Records, 28 Pa. Code §115.27
   - Pennsylvania Drug and Alcohol Abuse Control Act
   - Pennsylvania Confidentiality of HIV-Related Information Act 35 P.S. §§ 7601 et seq.
   - Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160, 162 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. 111-5 (Feb 17, 2009) and related regulations.
   - 42 U.S.C. § 1396a(a)(7) – State plan for medical assistance
   - 42 C.F.R. § 431.300 et seq. – Medical Assistance – Safeguarding Information on Applicants and Recipients
   - 42 C.F.R. Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records
   - 73 P.S. § 2301 et seq. – Pennsylvania Breach of Personal Information Notification Act

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, medical management, appeals, case management and disease management. Further, providers will assure that PHI for TPO will be made available to the Department of Human Services, Department of Health, Department of Insurance or Business Associates of Gateway for use without member consent. All other requests for release of or access to PHI will be handled in accordance with federal and state regulations. Gateway follows the requirements of HIPAA and limits its requests to the amount of PHI that is minimally necessary to meet the treatment, payment, or operational function.**
4. The member, or a member’s representative including head of household, legal guardian, or durable power of attorney, shall have access to view and/or receive copies of the medical record upon request. There is no charge for the copied medical record if the record is sent to another practitioner or provided directly to the member. The request must allow reasonable notice and follow the specific procedures of the practitioner or provider.

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

6. Medical records must be available for all member visits for established patients.

**Fraud and Abuse**

Gateway 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 Medical Assistance 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 or 1-800-685-5235. In cooperation with the Department of Human Services, Gateway maintains a Recipient Restriction Program, which restricts members who miss-utilize medical services or pharmacy benefits. Gateway enforces and monitors these restrictions through the following process:

- Identifying Members who are over-utilizing and/or miss-utilizing medical services.
- Evaluating the degree of abuse including review of pharmacy and medical claims history, diagnoses and other documentation, as applicable.
- Proposing whether the Member should be restricted to obtaining services from a single, designated Provider for a period of five years.
- Forwarding case information and supporting documentation to Bureau of Program Integrity (BPI) at the address below, for review to determine appropriateness of restriction and to approve the action.
- Upon BPI approval, sending notification via certified mail to member of proposed restriction, including reason for restriction, effective date and length of restriction, name of designated provider(s) and option to change provider, with a copy to BPI.
- Sending notification of member's restriction to the designated provider(s) and the County Assistance Office.
Enforcing the restrictions through appropriate notifications and edits in the claims payment system.

Preparing and presenting case at a DHS Fair Hearing to support restriction action.

Monitoring subsequent utilization to ensure compliance.

Changing the selected provider per the member’s or provider’s request, within thirty (30) days from the date of the request.

Continuing a member restriction from the previous delivery system as a member enrolls with Gateway, with written notification to BPI.

Reviewing the member’s services prior to the end of the five-year period of restriction to determine if the restriction should be removed or maintained, with notification of the results of the review to BPI, member, provider(s) and CAO.

Educating members including explanations in handbooks.

Gateway members have the right to appeal a restriction by requesting a DHS Fair Hearing. Members may not file a Complaint or Grievance with the PH-MCO regarding the restriction action. A request for a DHS Fair Hearing must be in writing, signed by the Member and sent to:

Department of Human Services  
Office of Administration  
Bureau of Program Integrity  
Division of Program and Provider Compliance  
Recipient Restriction Section  
P.O. Box 2675  
Harrisburg, Pennsylvania 17105-2675

Phone number: (717) 772-4627

All practitioners and providers participating with Gateway agree to abide Gateway’s Fraud and Abuse policy FI-012-MD-ALL, which can be accessed on Gateway’s website. Fraud and Abuse policies and procedures include legal requirements determined by the Commonwealth of Pennsylvania:

- 55 PA Code §1101.75 (a) and (b) - Provider Prohibited Acts.
- 55 PA Code §1101.92 Recipient Prohibited Acts, criminal penalties & civil penalties
- 31 U.S.C. §3729 of the Federal False Claims Act
- 62 P.S. §1407 Provider prohibited acts, criminal penalties and civil remedies.
- 62 P.S. §1408 Other prohibited acts, criminal penalties and civil remedies.
- Fraud and Abuse Sanctions 55 Pa Code  
- § 1101.77. Enforcement actions by the Department  
- SEC. 1128. [42 U.S.C. 1320a-7]  
- 31 U.S.C. 3729 False Claims Act Sanctions  
- TITLE 18--CRIMES AND CRIMINAL PROCEDURE
It is Gateway’s policy to discharge any employee, terminate any practitioner or recommend any member be withdrawn from the Medical Assistance Program who, upon investigation and referral to the Department of Human Services, has been identified as being involved in fraudulent or abusive activities.

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

Some common examples of fraud and abuse are:

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

Suspected fraud and abuse may also be reported to the Department of Human Services at the following phone number:

1-866-379-8477

Additional information about Medical Assistance fraud and abuse can be found in the Fraud and Abuse section of the DHS website.

The Department of Human Services has a protocol available to practitioners/providers to voluntarily come forward and disclose overpayments and improper payments of Medical Assistance funds. Gateway and the Department of Human Services encourage practitioners and providers to utilize the Pennsylvania Medical Assistance Provider Self-Audit Protocol when concerns over payment compliance arise. The protocol, which includes options for conducting self-audit and examples of inappropriate payments that may constitute a self-audit, can be found at DHS's website or by contacting Gateway's Finance Department at 412-255-4340.

Practitioners or their representatives that have questions regarding this protocol may also contact the Department of Human Services' Bureau of Program Integrity at (717) 772-4606 for additional information.
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 HealthSM 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 Human Services.

Environmental Assessment Standards

<table>
<thead>
<tr>
<th>PHYSICAL ACCESSIBILITY AND APPEARANCE</th>
<th>Parking</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Parking Lot should have 96” wide parking spaces available for vans and cars that also have an adjacent 96” wide striped access isle.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>3. The designated parking space for handicap accessibility is the 96” accessible space closest on the path of travel to the entrance.</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Curb Ramps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. There are curb ramps where the path of travel crosses a curb.</td>
</tr>
<tr>
<td>2. There are curb ramps at least 36” wide.</td>
</tr>
<tr>
<td>3. The slope of the curb ramps is less than or equal to 1:12.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ramps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If a route has changes in level greater than ½”, a ramp is provided.</td>
</tr>
<tr>
<td>2. The slope of the ramp is no greater than 1:12 for each run of the ramp.</td>
</tr>
<tr>
<td>3. There is a level landing at the top and bottom of each run, at least as wide as the ramp and 60” in length.</td>
</tr>
<tr>
<td>4. If the ramp changes direction, there is a landing at least 60” x 60”.</td>
</tr>
<tr>
<td>5. Ramps are non-slip.</td>
</tr>
<tr>
<td>6. If the ramp rises more than 6”, or has a horizontal run longer than 72”, there are handrails on each side.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Building Entrance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. There is directional signage indicating the locations of an entrance for use by people with disabilities.</td>
</tr>
<tr>
<td>2. If there is signage, the entrance shows the International Symbol for Accessibility.</td>
</tr>
<tr>
<td>3. There are no steps or changes in level at the entrance or in route to the entrance greater than ½” high.</td>
</tr>
<tr>
<td>4. The entrance door has at least a 32” clear opening width.</td>
</tr>
<tr>
<td>5. The door handle is operable without tight grasping or twisting of the wrist.</td>
</tr>
<tr>
<td>6. There is a threshold that is at least 1/2” or less in height.</td>
</tr>
</tbody>
</table>
### 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.

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

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

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

1. All providers must maintain current and comprehensive medical records which conform to standard medical practices.
2. Patient records must be secure from public access at all times.
3. The office must have a written confidentiality policy that applies to all staff.
4. Records are documented legibly.
5. Office must have an organized filing system to insure prompt retrieval of patient records.
   - alphabetically, social security numbers
6. There must be a single chart for each patient. If family records are kept, individual records must be clearly delineated.
7. Records must identify the member on each page.
8. All medically related patient phone calls documented in the medical record.
9. Office recalls missed appointments and makes documentation in the medical record.
10. Chart Documentation:
   - Allergy or NKA visible in the same place on every record.
   - Patient medical history in each record. Is there a medical history in each patient record.
   - Treatment/progress notes in each patient record.
   - Problem List in the medical record. (PCPs and PCP Specialists Only)
   - 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 10 business days. (Within 30 Days for Medicare Assured®)
2. Waiting time to schedule a health assessment/preventive physical examination and first examination must be scheduled within three weeks. (Within 30 Days for preventive care appointment for Medicare Assured®)
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 for Medicare Assured®.
5. Waiting time to schedule an EPSDT screen for a new member assigned to the practice must be within 45 days of the effective date of enrollment. (N/A for Medicare Assured®)
6. 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.
7. Practice must have at least 20 hours of patient scheduling time per week per office.
8. There must be open appointments on the schedule for emergencies.
9. Emergency care must be seen immediately or referred to an emergency facility.
10. Practice must have physician coverage arrangements for vacations, etc.
11. Waiting time to schedule an appointment for any new patient diagnosed with HIV must be within seven days of enrollment.
12. 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 assure that all relevant medical information, including the results of the EPSDT Screens, are incorporated into the Member’s PCP medical record.

EMERGENCY CARE

1. **PCP and PCP/Specialist**—A Physician must be available 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.
Hospital Services

**Inpatient Admissions**
In order for Gateway to monitor the quality of care and utilization of services by our members, all Gateway practitioners are required to obtain an authorization number for all hospital admissions and certain outpatient surgical procedures by contacting Gateway’s Utilization Management Department at 1-800-392-1146.

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

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

**Reimbursement**
Please see the Claims and Billing Section of this Manual for information regarding claims submission.

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

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

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

Medical Necessity Reviews may be required for certain procedures. Please call Gateway’s UM Department to verify if authorization is required or refer to the Quick Reference Guide on Gateway’s website.
Emergency Room

The definition of an emergency is: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

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

- Danger of losing life or limb
- Poisoning
- Chest pain and heart attack
- Overdose of medicine or drug
- Choking
- Heavy bleeding
- Car accidents
- Possible broken bones

- Loss of speech
- Paralysis
- Breathing problems
- Seizures
- Criminal attack (mugging or rape)
- Heart attack
- Blackouts
- Vomiting blood

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

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

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

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

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

Gateway also considers the following situations emergent, and thus does not require authorization:

- ER to ER
- ER to Acute Care or Behavioral Health Facility
- Acute Care to Acute Care or Behavioral Health Facility
- Hospital-to-Hospital, when a patient is being discharged from one hospital and being admitted to another.

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

Authorization for non-emergent ambulance transportation is 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 healthcare and/or if not provided would not result in a medical or a behavioral health crisis as non-emergent. Non-emergent transportation may include the following scenarios:

- Ambulance transports from one facility to another when the member is expected to remain at the receiving facility, which may include the following:
  - Hospital to Skilled Nursing Facility (SNF)
  - SNF to Hospital (non-emergent)
  - Hospital to Rehabilitation Facility
  - Rehabilitation Facility to Hospital (non-emergent)

- Ambulance transport to home upon discharge
- Ambulance transport from home to a PCP office

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

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 wheelchair van transportation requires an authorization from Gateway’s Utilization Management Department. Members should be referred to MATP program.

**Continuity and Coordination of Care**

Specialists, Hospital & Skilled Nursing facilities must ensure compliance with the Continuity and Coordination of Care requirements, by ensuring that all discharge summaries and progress reports are reported back to the member’s PCP.
Referrals and Authorizations

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

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

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

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

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.

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

Voice Activated Referral
Gateway’s Digital Voice Assistant (DIVA) may be used by primary care practitioners and OB/GYNs to issue a referral, and by specialty care practitioner and hospitals to verify and review a referral. To use the system, call 1-800-642-3515, and please follow the prompts, or use the guide below for a quick reference.
If you are a new DIVA user, we suggest for your initial try at entering a referral that you use the detailed Referral Entry instructions printed below or in the Gateway At A Glance for Medicaid Providers. Gateway also has a DIVA video tutorial if you would prefer to watch a demonstration. For experienced users, refer to the DIVA Quick Referral Entry Guide available in the forms and reference material section of our provider website. You’ll quickly find it only takes seconds to generate a DIVA referral.

TO ENTER A REFERRAL TO A SPECIALIST OR HOSPITAL

To Issue a Referral, you will need:

- Provider ID Number (“Practice Number”)
- Member ID Number
- Specialist/Hospital Provider ID Number (“Practice Number”) for the referred provider
- Type of referral, and number of visits

The system will provide a referral number and option to fax a confirmation of the referral information to the specialist/hospital.

After dialing into DIVA at 1-800-642-3515, Press 1 to retrieve information regarding Pennsylvania Medicaid members, then Press 2 to enter a new referral. Follow the prompts below.

Provider Identification Number?
   Enter your group provider number

Member Identification Number?
   Enter the member’s 8 digit ID number (as it appears on the member’s ID card)

Specialist/Hospital Provider Identification Number?
   Enter the group provider number of the specialist/hospital to which you wish to refer the member. Finish by pressing the # key

(pause) Verification of Identification Numbers

Type of Referral
   Press 1 To enter a general referral for three visits within the next 90 days
   Press 2 To enter a referral for allergy or pain management services for nine visits within the next 90 days
   Please enter the beginning date for the referral. Referrals can be back-dated 30 calendar days. Enter the two digit month, the two digit day, and the four digit year. Press 1 if the repeated date is correct. Press 2 if the repeated date is incorrect. Press the * key to begin again

Save Referral?
   Press 1 To save the referral (wait for referral ID number)
   Press 2 To discard the referral
Additional Instructions:
Press 1 To repeat the referral number
Press 2 To enter a new referral for the same PCP
Press 3 To enter a new referral for a different PCP
Press 4 To fax a referral (see options below)
Press 5 To return to the main menu
Press 6 If you are finished
Press 9 To hear this menu again
Press 0 To be connected to a Provider Services Representative

If you chose 4:
To fax a referral, choose one of the following options:

PLEASE NOTE: The number of the specialist/hospital the referral was issued to, will be reviewed via the automated system if one is found; Please assure that this is the number that you wish to send the fax to. See additional options below for choosing the default fax or entering a new fax number.
Press 1 To send a fax to the PCP only
Press 2 To send a fax to the specialist/hospital only
Press 3 To send a fax to both the PCP and the specialist/hospital
Press 4 To return to the main menu without sending a fax
Press 9 To hear this menu again
Press # To return to the previous menu

If you chose 1, 2 or 3:
To send a fax, choose one of the following options:
Press 1 To use the fax number stored in the database
Press 2 To enter a fax number (allows you to enter any fax number)
Press # To return to the previous menu

TO VERIFY OR REVIEW A REFERRAL
If a referral is found that matches the information entered, the system will provide the following information:
- Provider ID Number
- Member ID Number
- Referral Case Number
- Effective Date and Expiration Date
- Number of Visits Approved

After dialing into DIVA at 1-800-642-3515, Press 1 to retrieve information for Pennsylvania members, then Press 3 to review an existing referral. Follow the prompts below.

Provider Type?
Press 1 If you wish to enter a PCP ID Number
Press 2 If you wish to enter a specialist/hospital ID Number
Provider Number?
Enter your group provider identification number

Member ID Number?
Enter the member’s 8-digit Gateway ID number (as it appears on the member’s ID card)

(pause) Referral Information
If there is a match, the following information will be provided:
PCP ID Number  Referral Case Number  Expiration Date
Member ID Number  Effective date  Number of Visits Approved
Specialist/Hospital ID Number

Playback Options:
Press 1 To play the referral information again
Press 2 To check for subsequent referrals
Press 3 To check for a referral using the same PCP
Press 4 To check for a referral using a different PCP or specialist
Press 5 To fax a list of reviewed referrals (see options below)
Press 6 To return to the main menu
Press 7 To exit
Press 9 To hear this menu again
Press 0 To speak with a Provider Services Representative

If you chose 5:
To fax a referral, choose one of the following options:
PLEASE NOTE: The number of the specialist/hospital the referral was issued to, will be reviewed via the automated system if one is found; Please assure that this is the number that you wish to send the fax to. See additional options below for choosing the default fax or entering a new fax number.
Press 1 To send a fax to the PCP only
Press 2 To send a fax to the specialist/hospital only
Press 3 To send a fax to both the PCP and the specialist/hospital
Press 4 To return to the main menu WITHOUT sending the fax
Press 9 To hear this menu again
Press # To return to the previous menu

If you chose 1, 2 or 3:
To send a fax, choose one of the following options:
Press 1 To use the fax number stored in the database
Press 2 To enter a fax number (allows you to enter any fax number)
Press # To return to the previous menu

Note: DIVA is only for referrals from PCPs to specialists and hospitals and for referrals from OB/GYNs to hospitals. Authorization is still required for certain services. Specialists and hospitals may only review referrals.
**You may press “0” followed by the “#” sign at any time to speak to a Provider Services Representative.

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

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

Once a participating provider is selected from Gateway’s On-Line Directory, the primary care practitioner’s office completes the following sections of the Referral Form:
1. Primary Care Information:
   - Complete the primary care practitioner Name, Practice Address, and Telephone Number.
   - Fill in the Practice’s 7-digit Gateway Provider ID Number.
2. Patient Information
   - Complete the Patient’s Name.
   - Fill in the Member’s 8-digit Gateway Member ID Number.
   - Complete the diagnosis and/or complaint field being as specific as possible. The diagnosis can be an ICD-9 (preferred) code or a written description.
3. Specialty Provider or Facility Information
   - SPECIALTY CARE PROVIDER: Complete the Specialist group name and Gateway Provider ID Number for services rendered at office site only.
   - FACILITY PROVIDER: Complete the Facility name and Gateway Facility ID Number for services rendered at outpatient facility to allow both facility and practitioner services to be covered.
4. Referral Services
   If you are referring a member for services that DO NOT REQUIRE authorization, you can check the appropriate service and specify additional information as requested on the form.
5. PCP Signature
   The paper referral form must be signed by the member’s primary care practitioner. If an office staff member completes the referral, the staff member must place their initials after the practitioner’s stamp or signature. AN UNSIGNED PAPER REFERRAL FORM IS NOT VALID.
6. Referral Date
The Referral Form must be dated. If the Referral Form is not dated, Gateway will date according to receipt date at the claim office. Payment for referral and authorized services is contingent upon the patient being an enrolled Gateway member at the time of the service.

Out-of-Plan Referrals
Occasionally, a member may need to see a healthcare provider outside of Gateway’s provider network. When the need for out-of-plan services arises, the primary care practitioner must contact Gateway’s 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 an appropriate provider in collaboration with the recommendations of the primary care practitioner. Every effort will be made to locate a healthcare provider within an accessible distance to the member.

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

Referrals for Second Surgical Opinions
Second surgical opinions may be requested by Gateway, the member, or the primary care practitioner. When requesting a second surgical opinion consultation, Gateway recommends that you issue a referral to a consulting practitioner who is in a practice other than that of the attending practitioner, or the practitioner who rendered the first opinion and possesses a different tax identification number than the attending practitioner.

Specialty Care Practitioners
When a Gateway member schedules an appointment with a specialist, the office should remind the member that a referral from the 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 through Navinet or the DIVA System by calling 1-800-642-3515 prior to providing treatment.

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.
practitioner for authorization. The primary care practitioner can then issue additional referrals based upon the recommendations of the specialty care practitioner.

Since specialists cannot refer members to other specialists, the primary care practitioner must refer the member to another specialist. If a specialist recommends that the patient should be seen by another specialty care practitioner, the specialist must contact the 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. The only exception to this is for neonatologists who may issue a referral to other participating specialists for babies discharged from the NICU who require service before seeing their primary care practitioner. Referrals should be issued under the baby’s Gateway ID Number. If the baby does not have an ID Number, the practitioner should call Gateway’s Utilization Management Department for authorization.

In unusual situations, the specialist or primary care practitioner may contact Gateway’s Utilization Management Department at 1-800-392-1146.

Renal Dialysis Services

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

If Renal Dialysis services are provided by a non-network provider, then an authorization is required; in addition to a referral from the primary care physician.

In home Renal Dialysis services require an authorization from Gateway’s Utilization Management department.

Audiology and Speech Therapy

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

Self-Referral

Members may refer themselves for the following types of care:
Dental
When a member joins Gateway, the member may self-refer to any participating United Concordia Dental dentist directly without a referral from the primary care practitioner. Should specialty dental care be needed, the dentist can refer the member to a dental specialist.

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

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

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

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

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

Standing Referrals
Gateway allows for a standing referral to a specialist for sixty (60) days or to serve as a primary care practitioner in certain pre-authorized situations. The specialist must be an existing Gateway practitioner, must be agreeable to following Gateway’s requirements for
acting as a primary care practitioner, and must receive prior authorization by Gateway’s Medical Director. Practitioners interested in obtaining more information regarding this process should contact Provider Services at 1-800-392-1145.

**Authorization Process**

The function of an authorization is to confirm the eligibility of the member, verify coverage of services, assess the medical necessity and appropriateness of care, establish the appropriate site for care, and identify those members who would benefit from care management or disease management. Gateway’s Utilization Management Department assesses the medical appropriateness of services using McKesson’s Interqual Procedure Criteria, approval criteria based on a Medical Director’s review of the latest medical literature and citations, and the Department of Human Services/HealthChoices definition of medical necessity when authorizing the delivery of healthcare services to plan members. The definition of medical necessity is:

A service or benefit is Medically Necessary if it is compensable under the MA Program and if it meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.

- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

- The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis, must be documented in writing.

The determination is based on medical information provided by the Member, the Member’s family/caretaker and the Primary Care Practitioner, as well as any other Providers, programs, agencies that have evaluated the Member.

All such determinations must be made by qualified and trained Healthcare Providers. A Healthcare Provider who makes such determinations of Medical Necessity is not considered to be providing a healthcare service under this Agreement.

**Requesting Precertification**

The Utilization Management Department is committed to assuring prompt, efficient delivery of healthcare services and to monitor quality of care provided to Gateway members. The Utilization Management Department can be contacted at 1-800-392-1146 between the hours of 8:30 AM and 4:30 PM, Monday through Friday.
When calling before or after operating hours or on holidays, practitioners are asked to leave a voicemail message and a Utilization Management Representative will return the call the next business day. For urgent or emergency situations, Gateway requires that the practitioner notify the plan within forty-eight (48) hours or two (2) business days of rendering the service.

The following services require an authorization from Gateway:

- All Hospital Admissions
- Outpatient Surgical Procedures:
  - Bariatric Surgery/Stapling
  - Blepharoplasty
  - Breast Reduction
  - Carpal Tunnel Surgery
  - Genital Reconstruction
  - Hysterectomy
  - Implants
  - Panniculectomy
  - Tubal Ligations
  - Removal of Breast Implant
  - Rhinoplasty
  - Spinal Neuro Stimulator Services
  - TMJ Surgery
  - Transplants
  - Varicose Vein
- Speech, Occupational or Physical Therapies (Members can be referred to any Gateway participating hospital for speech, occupational or physical therapy sessions)
- All services to be provided by an out-of-plan practitioner/provider (including durable medical equipment and home health)
- Durable Medical Equipment items $500.00 or greater or not covered on the MA Fee Schedule regardless of cost
- All Durable Medical Equipment rentals that are $500.00 per month or greater
- Home Healthcare
- All Non-covered Services
- Hospice
- Hearing aids, ear molds, dispensing fees as well as hearing aid repair services
- Skilled Nursing Facility Admissions
- Rehabilitation Hospital Admissions
- Chiropractic Services

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

1. Member Name
2. Member’s 8-digit Gateway ID Number
3. Diagnosis (ICD Code or precise terminology)
4. Procedure Code (CPT-4, HCPCS, or MA Coding) or billing codes for durable medical equipment requests
5. Treatment Plan
6. Date of Service
7. Name of Admitting/Treating Practitioner
8. Name of the Practitioner/Provider requesting the authorized treatment
9. NPI
10. History of the current illness and treatments
11. Any other pertinent clinical information

Authorization is the responsibility of the admitting practitioner or ordering provider and can be obtained by calling Gateway’s Utilization Management Department at 1-800-392-1146. If a service requires authorization and is being requested by a participating specialist, the specialist’s office must call Gateway to authorize the service. Hospitals may verify authorization by calling the Gateway Utilization Management Department.

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

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

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

- CT/CTA
- CCTA
- MRI/MRA
- PET Scan
- Nuclear Cardiology/MPI
- Muga Scan
- Stress Echocardiology

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

**Chiropractic Services**

Any participating practitioner may request authorization for chiropractic services by calling Gateway’s Utilization Management Department at 1-800-392-1146. All visits, including the initial visit, require authorization by Gateway and must be medically necessary. Member eligibility must be verified prior to rendering services by calling the Member Eligibility Verification Line at 1-800-642-3515. Members may self-refer for chiropractic services; however, the chiropractic office must call Gateway for authorization including the initial evaluation.

Gateway will authorize one chiropractic evaluation per course of treatment. All course of treatments are subject to medical necessity determination based on Gateway’s criteria guidelines. All Chiropractic services requested for children under the age of 13 are referred to Gateway’s Medical Director for review. Only one visit per day can be authorized.

Participating chiropractors may not render radiological services in the office. X-rays may only be done at a Gateway participating facility, and no authorization will be given for these services to be done in a chiropractic office setting. Members requiring radiological services (including CT or MRI) or other diagnostic testing should be referred back to their primary care practitioner.

**Durable Medical Equipment**

Gateway members are eligible to receive any covered and medically necessary durable medical equipment needed. When ordering durable medical equipment, these procedures are followed:

- If the cost of a single item or multiple quantities of a single item is $500.00 or greater as reimbursed by Medical Assistance, the ordering practitioner/provider must obtain authorization from the Utilization Management Department. A referral from the primary care practitioner is not required, but a written prescription and Gateway authorization are necessary to obtain the item.
- Rental equipment must be authorized if the monthly rental cost is $500.00 or greater.
- Covered items under $500.00 can be obtained from a participating durable medical equipment provider with a prescription from the ordering practitioner/provider. A referral from the primary care practitioner and Gateway authorization is not required. Provider Services can direct practitioners to a contracted vendor to supply durable medical equipment. Durable Medical Equipment vendors are also listed in the Gateway Specialty Care Practitioner Directory. A written prescription is required to obtain the item.
- Any item not covered by Medical Assistance, regardless of price, requires authorization by the Utilization Management Department.
• Regardless of price, when a miscellaneous code is requested, an authorization from Gateway’s UM Department is required.
• Due to frequent interruptions of Pennsylvania Medical Assistance coverage, Gateway strongly recommends that all providers verify eligibility if the need for an item or service extends beyond the calendar month in which the authorization was given.
• All medical supplies including wound care, ostomy, enteral products, diapers, and incontinence products must be obtained through a contracted durable medical equipment vendor as opposed to a participating pharmacy.
• Oral enterals must be obtained through a participating durable medical equipment provider. Based on the cost of the product ordered, an authorization from Gateway’s Utilization Management Department may be necessary if the product is $500.00 or greater. Please do not direct members to retail pharmacies such as Giant Eagle, Rite Aid, etc. for these services.
• Gateway will accept the request for durable medical equipment directly from the durable medical equipment supplier. If the practitioner is requesting the authorization, please contact a participating durable medical equipment provider to receive the appropriate billing code(s) before calling Gateway’s Utilization Management Department. Please call Gateway’s Provider Services Department at 1-800-392-1145 if you need an updated list of participating providers.
• Services provided by non-participating durable medical equipment providers requires an authorization from the Gateway Utilization Management Department.
• Incontinence items will be covered by Gateway without requesting an Explanation of Benefits from any other plan; however, if the billed charge is $500.00 or greater, and/or a miscellaneous code is used to request the supply, a Utilization Management authorization will be required according to plan guidelines. Any services provided by non-participating providers always require an authorization.

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

1. Patient Name, Gateway ID Number, Prior Authorization Number (If Applicable)
2. Durable Medical Equipment Vendor/Provider NPI number
3. Ordering Practitioner/Provider, including NPI number
4. Diagnosis
5. Name of Requested Equipment, MA Fee Schedule Code, Cost
6. Is this a Purchase or a Rental Request?
7. Amount of Items Requested—Over What Period of Time (if requesting rental)
8. Clinical Information to Support the Request

To request a precertification for durable medical equipment, please call Gateway’s Utilization Management Department at 1-800-392-1146.
Skilled Nursing Facility
Should a member be in need of admission to a nursing facility, the primary care practitioner, attending practitioner, hospital Utilization Review Department, or the nursing facility should contact the Gateway Utilization Management Department at 1-800-392-1146 for new requests. Gateway will coordinate the necessary arrangements between the primary care practitioner and the nursing facility to provide the member with continuity and coordination of care.

At the time the Skilled Nursing Facility services are approved, the Gateway Utilization Management reviewer will provide the name, phone and fax number of the Primary Care Physician in order to fax any discharge instructions to ensure coordination of discharge services.

Outpatient Therapy Services
All Outpatient Therapy services including physical therapy, occupational therapy, speech therapy, cardiac and pulmonary rehab require an authorization from Gateway’s Utilization Management Department. The Outpatient Therapist or the ordering provider of the therapy must contact Gateway’s Utilization Management Department to request a precertification by contacting 1-800-392-1146. The therapy provider will be asked to fax the current progress notes, plan of treatment, and goals, which support the medical necessity of the therapy services.

Acute Inpatient Rehabilitation Facility
Should a member be in need of admission to an Acute Inpatient Rehabilitation Facility, the primary care practitioner, attending practitioner, hospital Utilization Review Department, or the rehabilitation facility should contact the Gateway Utilization Management Department at 1-800-392-1146 for new requests. For ongoing reviews, contact your assigned reviewer.

Home Healthcare
Gateway encourages the use of home-based services as an alternative to hospitalization when medically appropriate in order to:
- Allow for timely and appropriate discharge from the hospital.
- Avoid unnecessary admissions of members who could effectively be treated at home.
- Permit members to receive care in greater comfort due to familiar surroundings.

Home-based services may include, but are not limited to the following type of services:
- Skilled Nursing
- Speech Therapy
- Hospice
- Home Health Aid
- Physical Therapy
- Infant Care (after initial two postpartum visits)
- Occupational Therapy
- High-Risk Pregnancy
- Social Services

Gateway’s Utilization Management Department coordinates medically necessary non-private duty home healthcare needs with the ordering practitioner and the home healthcare
provider. Please call Gateway's Utilization Management Department at 1-800-392-1146. Authorization is required for all home-based services. Gateway will accept the request for home health request directly from the home health provider.

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

**Private Duty Nursing Services**
Gateway's Care Management Department coordinates medically necessary private duty nursing services with the ordering practitioner and the home healthcare provider. The Care Management Department can be reached at 1-800-642-3550 option 1 and then option 1 again. The Care Management Department can be contacted between the hours of 8:30 AM and 4:30 PM, Monday through Friday.

Should a member be in need of private duty services, the member's primary care practitioner or a specialist rendering care to the member may submit a letter of medical necessity to Gateway's Care Management Department.

The following information will provide assistance to physicians when ordering private duty services:

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

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

**Hospice Services**
Should a member be in need of hospice services including: Home Hospice, Inpatient Hospice, Continuous Care, and Respite, the primary care practitioner, attending physician, or hospice agency should contact Gateway's Utilization Management department. Gateway will coordinate the necessary arrangements between the primary care practitioner and the hospice provider in order to assure continuity and coordination of care.
Due to frequent interruptions of Pennsylvania Medical Assistance coverage, Gateway strongly recommends verification of eligibility if the need for an item or service extends beyond the calendar month in which the authorization was given.

**Pharmacy Services**

Gateway allows access to all non-formulary drugs, other than those excluded by the Department of Human Services’ Fee-For-Service program, through the exception review process. If changing to a formulary medication is not medically advisable for a member, a practitioner must initiate a Request for Medicaid Drug Exception by faxing the Request for Medicaid Drug Exception Form, found in the Forms and Reference Materials Section of this manual, to 1-888-245-2049. Practitioners should assure that all information on the form is available when calling. The Medicaid Drug Exception Form can also be found in Gateway’s Drug Formulary or on Gateway’s website. The form may be photocopied. You can also request a copy of the form by calling 1-800-528-6738.

All requests for exception will receive a response within 24 hours. In the event a decision has not been made in 24 hours, Gateway will authorize a temporary supply of the nonformulary medication. For new therapies, the pharmacist may authorize up to a 5-day supply of the medication. For medications taken on an ongoing basis, a 15-day supply of the medication will be dispensed, pending the final determination of the request.

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

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

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

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

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

Claims

General Information
Procedures for Gateway are as follows:

- Beginning July 6, 2011 all drug-specific claim information reported to Gateway using the 837P format MUST be reported with a HCPCS code, such as a J-Code, AND an NDC code. Claims submitted without both the appropriate HCPCS Code and NDC will be rejected by Emdeon. Effective July 1, 2013, this will also apply to 837I as well.

- Submit claims for all services provided including capitated services.

- Payment for CPT and HCPCS codes are covered to the extent that they are recognized by Medical Assistance or allowed per medical review determination by Gateway. Correct coding (procedure, diagnosis, HCPCS) must be submitted for each service rendered. Gateway utilizes CMS place of service codes to process
claims, and they are the only place of service codes that are accepted. Gateway will add new codes to the respective fee schedules effective the first of the month upon receipt of notification from the Department of Human Services.

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

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

- Correct/current practitioner information, including Gateway Provider ID Number, must be entered on all claims. The format is 5 or 7 digits.

- Correct/current member information, including Gateway Member ID Number, must be entered on all claims. The format is 6 or 8 digits.

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

- Timely filing criteria for initial bills are 180 days from the date of service. Corrected claims or requests for review are considered if information is received within the 90-day follow-up period from the date on the remittance advice.

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

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

- Any reimbursement or coding changes made by the Department of Human Services to its current inpatient and outpatient fee schedules shall be implemented by Gateway the month the Department of Human Services notifies Gateway of such change. There will be no adjustments made to previously processed claims due to any retroactive change implemented by the Department of Human Services.

**Timely Filing**
Practitioners must submit a complete original, initial CMS-1500 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, or a UB-04 Forms. No other billing forms will be accepted. Paper
claims that are not received on original forms with red ink may delay final processing as original forms are required for every claim submission.

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

Practitioners must bill within 60 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 180 days from the date of the corresponding remittance advice. All claims submitted after the 180-day period for initial claims or after the 180-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. Claims status inquiries can be researched via Navinet or by calling Gateway Provider Services Department at 1-800-392-1145 to inquire whether the claim was received and/or processed.

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

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

- Faster Claims Submission and Processing
- Reduced Paperwork
- Increased Claims Accuracy
- Time and Cost Savings

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

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

**Requirements for Submitting Claims to Gateway through Emdeon and RelayHealth**
To submit claims to Gateway please note the Pennsylvania Payer ID Number is 25169. Gateway has a health plan specific edit through Emdeon and RelayHealth for electronic claims that differ from the standard electronic submission format criteria. The edit requires:
• A Gateway assigned 8-digit member identification number, the member number field allows 6, 8, or 12 digits to be entered. For practitioners who do not know the member’s Gateway identification number it is acceptable to submit the member’s Recipient Number on electronic claims.

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

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

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

Gateway will accept electronic claims for services that would be submitted on a standard CMS-1500 (08-05) or a UB-04 Form. However, the following cannot be submitted as attachments along with electronic claims at this time:

- Claims with EOBs
- Services billed by report
- The PCP Referral Form (paper version)
- The OB/GYN Referral Form (Paper version)

**Electronic Remittance Advice**

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

The Companion Documents, which are located in the *Forms and Reference Materials* Section of this Manual, provide information about the 835 Claim Remittance Advice Transaction that is specific to Gateway and Gateway’s trading partners. Companion
Documents are intended to supplement the HIPAA Implementation Guides. Rules for format, content, and field values can be found in the Implementation Guides available on the Washington Publishing Company’s website at www.wpc-edi.com.

Due to the evolving nature of HIPAA regulations, these documents are subject to change. Substantial effort has been taken to minimize conflicts or errors.

There is a distinct data variation between the current Gateway Claims Remittance Advice and the 835 Transaction. The difference occurs in the code sets that tell claim submitters the results of each claim’s adjudication. Few Gateway and HIPAA Adjustment Reason Codes have solid, unambiguous matches at the same level of detail. A crosswalk has been created in attempt to ease the code set transition and can be located on Gateway’s website at www.GatewayHealthPlan.com and going to “For Providers” and then “Electronic Claims”. These documents can also be found in the Forms and Reference Materials Section of this Manual.

Claims Review Process
Gateway will review any claim that a practitioner feels was denied or paid incorrectly. The request may be conveyed in writing, or verbally through Gateway’s Provider Services Department if the inquiry relates to an administrative issue. Please forward all 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 180-day timely filing limit, or the 60-day limit for EPSDT services, will not qualify for review. All follow-up review requests must be received within 180 calendar days of the initial remittance advice.

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

This form, together with all supporting materials relevant to the claim(s) reversal request being made including but not limited to EOB from other insurance carriers and your refund check should be mailed to:

PNC BANK  
c/o GATEWAY HEALTH PAYMENTS/REFUNDS  
Lock Box #645171  
500 1st Avenue  
Pittsburgh, PA 15219

Administrative Claims Review
Claims that need to be reviewed based upon administrative, policy, or processing issues can be discussed with a Provider Services Representative via a phone call to Gateway at 1-800-392-1145. For inquiries received in the mail, Claims Review Representatives
evaluate whether the documentation attached to the claim is sufficient to allow it to be reconsidered. Inquiries received in the mail 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 responded to via a letter. All review requests must be received within 180 days of the initial remittance advice.

**Medical Claims Review**

Claims rejected for services that did not have medical records attached or the appropriate referrals or authorizations are subject to a Medical Management Review. All claim records should be sent to Gateway. When submitting a written request for a claim review, please provide:

- A copy of the Gateway Remittance Advice
- The member’s name and Gateway Identification Number
- The reason the review is requested and include as much supporting documentation as possible to allow for a complete and comprehensive review
- Date(s) of service in question
- A copy of the medical record for the service(s) in question (if applicable)

In the event that the claim cannot be reprocessed administratively, a medical necessity review is undertaken. The records will be reviewed by a Medical Review Nurse. If the medical review nurse cannot approve the services, a Gateway Medical Director makes the final decision to approve or deny the claim. A final decision is made within 30 days from receipt of the inquiry. If the Medical Director does not approve the services, a denial letter is sent to the practitioner. If the practitioner is not satisfied with the results of the medical necessity review, a First Level Appeal can be requested.

Claims inquiries for administrative/medical review should be mailed to: Attention: Claims Review Department, Gateway HealthSM, Four Gateway Center 444 Liberty Avenue, Suite 2100, Pittsburgh, PA 15222-1222.

**Coordination of Benefits**

Some Gateway recipients have other insurance coverage. Gateway, like the Pennsylvania Medical Assistance Program, is the payer of last resort on claims for services provided to members with other insurance coverage. Gateway may not delay or deny payment of claims unless the probable existence of third party liability is established at the time the claim is submitted. *(Note: Effective with claims processed on or after July 1, 2009, Gateway will process and pay EPSDT and prenatal visits as primary even when our records indicate Gateway is secondary and a primary plan exists. If an explanation of benefits (EOB) is attached to the EPSDT or prenatal claim, then coordination of benefits will be applied. We will continue to coordinate benefits and require the primary explanation of benefits when submitting the delivery claim.)*

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

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

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

When Gateway receives a letter from the primary carrier indicating that the member no longer has coverage, Gateway will use the letter to investigate the situation and verify if the coverage is cancelled and if there is a new plan covering the member. If Gateway’s investigation confirms that the member no longer has primary coverage, Gateway will submit an electronic request to the State to update the system. Gateway will update our system immediately and reprocess claims finalized within the 120 day period prior to the date of the onset of the investigation.

Gateway members cannot be billed for any co-payments and/or co-insurance, as regulated by the Department of Human Services.

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

**Primary Care Services**

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

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

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

Since April 2010 Gateway has reimbursed those Primary Care Physicians (PCPs) properly certified for the application of topical fluoride varnish a fee-for-service payment for rendering this service. Only those PCPs who received a certificate for completing the online training module titled "Oral Health Risk Assessment" qualified for the fee-for-service reimbursement. Gateway has been notified that the “Oral Health Risk Assessment” training module has been discontinued and replaced with the Society of Teachers of Family Medicine’s “Smiles for Life” continuing medical education (CME) course. (Refer to MA Bulletin 09-12-27, 31-12-27). If you’ve already completed the "Oral Health Risk Assessment" on-line training recertification through the “Smiles for Life” is not required.
Physicians interested in providing topical fluoride varnish in the office for their Gateway PA Medicaid patients under the age of five and receive the $18.00 reimbursement must submit a copy of the training certificate to:

Gateway HealthSM
Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222
Attn: Provider Relations Department
Or
Fax to 1-855-451-6680, Attn: Provider Relations Department

At the top of the certificate, please include your 13-digit MA provider identification number and/or Gateway Individual Provider Number. PCPs will not be reimbursed for providing the topical fluoride varnish before we have a copy of the training certificate on file. Your practice will receive written notification confirming receipt of your certificate and provide a date when you may begin billing procedure code D1206 and receive reimbursement.

**Specialty/Fee-For-Service Providers**

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

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

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

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

<table>
<thead>
<tr>
<th>Practitioner Charges</th>
<th>$1,500.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Carrier Allowable</td>
<td>$1,000.00</td>
</tr>
<tr>
<td>Primary Payment (80% of Allowable)</td>
<td>$800.00</td>
</tr>
<tr>
<td>Patient Responsibility Under Primary Plan</td>
<td>$200.00</td>
</tr>
<tr>
<td>Gateway Allowable if Primary</td>
<td>$850.00</td>
</tr>
</tbody>
</table>
Medicare

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

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

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

<table>
<thead>
<tr>
<th>Example A</th>
<th>Example B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Practitioner Charges</strong></td>
<td><strong>Practitioner Charges</strong></td>
</tr>
<tr>
<td></td>
<td>$1,500.00</td>
</tr>
<tr>
<td><strong>Deductible is Satisfied</strong></td>
<td><strong>Deductible is Satisfied</strong></td>
</tr>
<tr>
<td></td>
<td>-</td>
</tr>
<tr>
<td><strong>Medicare Allowable</strong></td>
<td><strong>Medicare Allowable</strong></td>
</tr>
<tr>
<td></td>
<td>$1,000.00</td>
</tr>
<tr>
<td><strong>Medicare Payment (80% of Allowable)</strong></td>
<td><strong>Medicare Payment (80% of Allowable)</strong></td>
</tr>
<tr>
<td></td>
<td>$800.00</td>
</tr>
<tr>
<td><strong>Gateway Allowable if Primary</strong></td>
<td><strong>Gateway Allowable if Primary</strong></td>
</tr>
<tr>
<td></td>
<td>$600.00</td>
</tr>
<tr>
<td><strong>Gateway compares the Medicare Payment to the Gateway Allowable</strong></td>
<td><strong>Gateway compares the Medicare Payment to the Gateway Allowable</strong></td>
</tr>
<tr>
<td></td>
<td>$800.00 vs. $600.00</td>
</tr>
<tr>
<td><strong>Gateway does not issue payment</strong></td>
<td><strong>Gateway issues Payment for the Difference</strong></td>
</tr>
<tr>
<td></td>
<td>$0.00</td>
</tr>
</tbody>
</table>

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

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

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

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

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

1. Submit medical records to the review committee of the primary insurance plan. Please allow adequate time for the review to be completed prior to the onset of services that you want Gateway to consider for primary coverage. Upon receipt of the letter from the primary plan, please forward to a Gateway Claims Reviewer at Gateway HealthSM Four Gateway Center 444 Liberty Avenue, Suite 2100 Pittsburgh, PA 15222-1222. Faxed correspondence will not be accepted. Letters must be received by Gateway within one month of the date on the denial letter. (See examples #1 and #2 on the next page). Gateway’s review will be completed within three weeks of receipt.

2. Following the review, Gateway will send written documentation advising the provider if the letter was accepted. If the denial letter is not accepted, EOBs must be submitted with each claim to Gateway.

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

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

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

Example #1

Examples #2
Primary insurance review letter dated March 5, 2004. Gateway receives letter June 5, 2004. Gateway determination – Gateway will require EOBs since nursing services exception letter was not received in 30 days.

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

Autism Act Claims Processing Procedures for Physical Therapy (PT), Speech Therapy (ST) and/or Occupational Therapy (OT)

These procedures are effective July 1, 2009 for members under age 21 and the following criteria applies:

- Precertification/Authorization through Gateway’s Utilization Management (UM) Department is required
- Gateway will require a primary plan EOB
  - If primary plan $36,000 annual payment limit has expired, EOB must include applicable denial
  - If primary plan is self-funded plan, EOB must include wording on the EOB

- An alternate letter process rather than an EOB will be required annually to request exemption and will apply to this procedure as follows:
  - If Gateway is notified that the other insurance company is a self-funded plan and is exempt from the Autism Act, Gateway will require a letter from the insurance company. The letter will be evaluated for approval or denial. Letters should be sent directly to Gateway’s Claims Quality Review Department rather than the PO Box and should include the following wording:
    - Based on the Autism Insurance Act 62, the member is covered under XXXXX (Name of Company) and this is a self-funded plan.
Subrogation
According to Gateway’s agreement with the Department of Human Services, if a member is injured or becomes ill through the act of a third party, medical expenses may be covered by casualty insurance liability insurance or litigation. Any correspondence or inquiry forwarded to Gateway by an attorney, practitioner of service, insurance carrier, etc. relating to a personal injury accident or trauma-related medical service, or which in any way indicates that there is, or may be, legal involvement, will be handled by Gateway’s Legal Department and will be forwarded to the Department of Human Services’ Third Party Liability Department.

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

However, if the auto/casualty Explanation of Benefits is submitted after Gateway has already paid as primary, claims cannot be adjusted, as Gateway must comply with criteria set by the Department of Human Services.

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

A cover letter identifying the date and description of the injury, requested dates of services for billing statements and release of information signed by the member should be forwarded to the following address: Attention: Legal/Regulatory Affairs, Gateway HealthSM, Four Gateway Center, 444 Liberty Avenue, Suite 2100, Pittsburgh, PA 15222-1222.

Claim Coding Software
Gateway uses a fully automated coding review product that programmatically evaluates claim payments to verify the clinical accuracy of professional claims in accordance with clinical editing criteria. This coding program contains complete sets of rules that correspond to CPT-4, HCPCS, ICD-9, AMA, and CMS guidelines as well as industry standards, medical policy and literature and academic affiliations. The program used at Gateway is designed to assure data integrity for ongoing data analysis and reviews procedures across dates of service and across providers at the claim, practitioner and practitioner-specialty level.
Billing

Billing Procedures

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

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

1. Patient name;
2. Patient medical plan identifier;
3. Date of service for each covered service;
4. Description of covered services rendered using valid coding and abbreviated description;
5. ICD-9 surgical diagnosis code (as applicable);
6. Name of practitioner/provider and plan identifier;
7. Provider tax identification number;
8. Valid CMS place of service code;
9. Billed charge amount for each covered service;
10. Primary carrier EOB when patient has other insurance;
11. All applicable ICD-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. DRG code for inpatient hospital claims.

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

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

A claim without valid, legible information in all mandatory categories is subject to rejection/denial. To assure reimbursement to the correct payee, the Gateway practitioner number must be included on every claim.
To comply with encounter data reporting, primary care practitioners and specialty care practitioners must submit claims under the individual practitioner identification number rather than the practice or group identification number. CMS submissions for anesthesiology, pathology, radiology, and emergency room practitioner groups must also include the individual practitioner identification number. Any claim billed on a CMS form must include the individual practitioner identification number (box 31 on the CMS Form). Please note that it is extremely important to promptly notify Gateway of any change that involves adding practitioners to any group practice, as failure to do so may result in a denial of service. Gateway will process claims utilizing individual practitioner numbers even if the individual practitioner number is not included on the claim. The only exception to the individual practitioner number requirement applies to UB charges for practitioner services when a remittance advice is issued to a hospital facility.

All claims must have complete and accurate ICD-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 is: Gateway HealthSM, Claims Processing Department, P.O Box 830249, Birmingham, AL 35283-0249.

Any questions concerning billing procedures or claim payments can be directed to Gateway’s Provider Services Department at 1-800-392-1145.

**EPSDT Services**

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

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

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

• Gateway uses fully automated coding review software. The software programatically evaluates claim payments in accordance with CPT-4, HCPCS, ICD-9, AMA and CMS guidelines as well as industry standards, medical policy and literature and academic affiliations.

CMS-1500 PAPER FORMAT REQUIREMENTS

• All EPSDT screening services must be reported with the age-appropriate evaluation and management code (99381-99385, 99391-99395, 99431 and 99435) along with the EP modifier.

• The EP modifier must follow the evaluation and management code in the first line of Block 24D on the claim form. Use CPT Modifier (52 or 90) plus CPT code when applicable.

• Diagnosis codes V20.0, V20.1 or V20.2 must be noted in Box 21 and should be used except when billing for newborns in an inpatient setting (POS 21). V30.00 is primary with V20.0, V20.1 or V20.2 as secondary.

• Report visit code ‘03’ in box 24(h) of the CMS-1500 when providing EPSDT screening service.

• Report 2-character EPSDT referral code for referrals made or needed as a result of the screen in box 10(d) on the CMS-1500. Codes for referrals made or needed as a result of the screen are:
  
  YO – Other  
  YV – Vision  
  YH – Hearing  
  YB – Behavioral  
  YM – Medical  
  YD – Dental  

CMS-1500 EDI FORMAT REQUIREMENTS

• All EPSDT screening services must be reported with the age-appropriate evaluation and management code (99381-99385, 99391-99395, 99431 and 99435) along with the EP modifier.

• The EP modifier must follow the evaluation and management code in the first position on the claim form. Use CPT Modifier (52 or 90) plus CPT code when applicable.

• Diagnosis codes V200, V201 or V202 must be noted in Box 21 and should be used except when billing for newborns in an inpatient setting (POS 21). V3000 is primary with V200, V201 or V202 as secondary.

• Populate the SV111 of the 2400 loop with a “yes” for an EPSDT claim (this is a mandatory federal requirement).
Populate the Data Element CLM12 in the 2300 Claim Information Loop with “01” (meaning EPSDT).

Populate NTE01 of the NTE segment with “ADD”. This means that additional information is available in ‘field’ NTE02 (see below).

Populate NTE02 of the NTE segment of the 2300 Claim Information Loop with appropriate referral codes:

- YO – Other
- YV – Vision
- YH – Hearing
- YB – Behavioral
- YM – Medical
- YD – Dental

Obstetrical Care Services

The first visit with an obstetrical patient is considered the intake visit, or if a patient becomes a Gateway member during the course of her pregnancy, her first visit as a Gateway member is considered to be her intake visit. At the intake visit, an Obstetrical Needs Assessment Form (OBNAF) must be completed. A copy of the OBNAF 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. The fax number can be found on the front page of the OBNAF. The OBNAF is not a claim, however, the OBNAF must be received by Gateway in order to process the claim for the intake visit. Submit claims on a CMS-1500 within 180 days to receive payment for the intake package. The intake package code is T1001-U9.

Obstetric practitioners are reimbursed on a per visit basis. All visits and dates of service must be included on the CMS-1500 Form and identified with appropriate maternity codes for appropriate reimbursement. Delivery charges are to be coded with CPT Codes. The date billed for a Delivery Code, in CPT code format, must be the actual date of service. Gateway’s payment allowance for the delivery includes all postpartum visits.

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

Surgical Procedure Services

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

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

Anesthesia Services
Gateway processes anesthesia services based on anesthesia procedure codes only.

- All services must be billed in minutes. Fractions of a minute should be rounded to whole minutes (30 seconds or greater: round up; less than 30 seconds: round down). For billing purposes, the number of minutes of anesthesia time will be placed in space 24G on the CMS-1500 for providers who bill in paper format.
- Physical status modifiers, P1-P6, will not allow any additional payment.
- Gateway will not accept pricing modifier AA.
- The claim should include ONLY the primary anesthesia code except when there is an add-on code that should be reported along with the primary anesthesia service.
- If you provide pain management services, continue to bill with surgical codes.
- If you provide medical procedures such as Swan Ganz, Laryngoscopy Indirect with Biopsy, Venipuncture Cutdown, Placement of Catheter or Central Vein, then continue to bill with the medical procedure code.
- When billing OB anesthesia codes 01960, 01961, 01962, 01963 and 01967, you do not need to add an additional hour for patient consultation. The Department of Human Services has already added 4 to the relative value unit for these codes.
- When billing anesthesia for all obstetrical procedures, use the anesthesia procedure codes as defined in the Anesthesia section of the CPT4 manual.

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

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

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Practitioner Name, Address, Phone Number</td>
<td>Required</td>
</tr>
<tr>
<td>2</td>
<td>Unlabeled Field</td>
<td>Not Required</td>
</tr>
<tr>
<td>3</td>
<td>Patient Control Number</td>
<td>Required</td>
</tr>
<tr>
<td>4</td>
<td>Type of Bill</td>
<td>Required</td>
</tr>
<tr>
<td>5</td>
<td>Federal Tax Number</td>
<td>Required</td>
</tr>
<tr>
<td>6</td>
<td>Statement Covers Period</td>
<td>Required</td>
</tr>
<tr>
<td>7</td>
<td>Covered Days</td>
<td>Required, if Inpatient</td>
</tr>
<tr>
<td>8</td>
<td>Non-covered Days</td>
<td>Required, if Inpatient</td>
</tr>
<tr>
<td>9</td>
<td>Coinsurance Days</td>
<td>Required, if inpatient</td>
</tr>
<tr>
<td>10</td>
<td>Lifetime Reserve Days</td>
<td>Not Required</td>
</tr>
<tr>
<td>11</td>
<td>Unlabeled Field</td>
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</tr>
<tr>
<td>12</td>
<td>Patient Name</td>
<td>Required</td>
</tr>
<tr>
<td>13</td>
<td>Patient Address</td>
<td>Required</td>
</tr>
<tr>
<td>14</td>
<td>Patient Birth Date</td>
<td>Required</td>
</tr>
<tr>
<td>15</td>
<td>Patient Sex</td>
<td>Required</td>
</tr>
<tr>
<td>16</td>
<td>Patient Marital Status</td>
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</tr>
<tr>
<td>17</td>
<td>Admission/Start of Care Date</td>
<td>Required, if Inpatient</td>
</tr>
<tr>
<td>18</td>
<td>Admission Hour</td>
<td>Required, if Inpatient</td>
</tr>
<tr>
<td>19</td>
<td>Admission Type</td>
<td>Required, if Inpatient</td>
</tr>
<tr>
<td>20</td>
<td>Source or Admission</td>
<td>Required, if inpatient</td>
</tr>
<tr>
<td>21</td>
<td>Discharge Hour</td>
<td>Required</td>
</tr>
<tr>
<td>22</td>
<td>Patient Status</td>
<td>Required</td>
</tr>
<tr>
<td>23</td>
<td>Medical Record Number</td>
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</tr>
<tr>
<td>24-30</td>
<td>Condition Codes</td>
<td>Minimum of One Required, If Applicable</td>
</tr>
<tr>
<td>31</td>
<td>Unlabeled Field</td>
<td>Not Required</td>
</tr>
<tr>
<td>32-35</td>
<td>Occurrence Codes and Dates</td>
<td>Minimum of One Required, If Applicable</td>
</tr>
<tr>
<td>36</td>
<td>Occurrence Span Codes and Dates</td>
<td>Minimum of One Required, If Applicable</td>
</tr>
<tr>
<td>37</td>
<td>Internal Control Number</td>
<td>Not Required</td>
</tr>
<tr>
<td>38</td>
<td>Responsible Party Name and Address</td>
<td>Not Required</td>
</tr>
<tr>
<td>39-41</td>
<td>Value Codes and Amounts</td>
<td>Required for DRG Reimbursement, Value Code Record Type 41 must be entered as ZZ and DRG Code must be entered in Value Amount Field</td>
</tr>
<tr>
<td>42</td>
<td>Revenue Codes</td>
<td>Required</td>
</tr>
<tr>
<td>43</td>
<td>Descriptions</td>
<td>Required</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/Rates</td>
<td>Required, if Outpatient</td>
</tr>
<tr>
<td>45</td>
<td>Service Dates</td>
<td>Required, if Outpatient</td>
</tr>
<tr>
<td>46</td>
<td>Service Units</td>
<td>Required</td>
</tr>
<tr>
<td>47</td>
<td>Total Charges</td>
<td>Required</td>
</tr>
<tr>
<td>48</td>
<td>Non-covered Charges</td>
<td>Required, if Applicable</td>
</tr>
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</tr>
<tr>
<td>50</td>
<td>Payer Identification</td>
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</tr>
<tr>
<td>51</td>
<td>Practitioner Number</td>
<td>Gateway HealthSM Practitioner Identification Number Required</td>
</tr>
<tr>
<td>52</td>
<td>Release of Information Certification Indicator</td>
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</tr>
<tr>
<td>53</td>
<td>Assignment of Benefits</td>
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</tr>
<tr>
<td>54</td>
<td>Prior Payments</td>
<td>Required, if Applicable</td>
</tr>
<tr>
<td>55</td>
<td>Estimated Amount Due</td>
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</tr>
<tr>
<td>56</td>
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</tr>
<tr>
<td>57</td>
<td>Unlabeled Field</td>
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</tr>
<tr>
<td>58</td>
<td>Insured’s Name</td>
<td>Required</td>
</tr>
<tr>
<td>59</td>
<td>Patient Relationship to Insured</td>
<td>Not Required</td>
</tr>
<tr>
<td>60</td>
<td>Certificate-Social Security Number-Health Insurance Claim-Identification Number</td>
<td>Gateway Member Identification Number Required (10-digit MA Recipient Number acceptable for electronic claims)</td>
</tr>
<tr>
<td>61</td>
<td>Group Name</td>
<td>Required</td>
</tr>
<tr>
<td>62</td>
<td>Insurance Group Number</td>
<td>Not Required</td>
</tr>
<tr>
<td>63</td>
<td>Treatment Authorization Code</td>
<td>Required, if Applicable</td>
</tr>
<tr>
<td>64</td>
<td>Employment Status Codes</td>
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</tr>
<tr>
<td>65</td>
<td>Employer Name</td>
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<tr>
<td>66</td>
<td>Employer Location</td>
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<tr>
<td>67</td>
<td>Principal Diagnosis Code</td>
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</tr>
<tr>
<td>68-75</td>
<td>Other Diagnosis Codes</td>
<td>Required, if Applicable</td>
</tr>
<tr>
<td>76</td>
<td>Admitting Diagnosis Code</td>
<td>Required, if Applicable</td>
</tr>
<tr>
<td>77</td>
<td>E Code</td>
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<tr>
<td>78</td>
<td>Unlabeled Field</td>
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<tr>
<td>79</td>
<td>Procedure Code Method Used</td>
<td>Not Required</td>
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<tr>
<td>80</td>
<td>Principal Procedure Code and Date</td>
<td>Required, if inpatient only</td>
</tr>
<tr>
<td>81</td>
<td>Other Procedure Codes and Date</td>
<td>Required, if inpatient only</td>
</tr>
<tr>
<td>82</td>
<td>Gateway Individual Provider ID Number</td>
<td>Required</td>
</tr>
<tr>
<td>83</td>
<td>Other Practitioner Identification</td>
<td>Required</td>
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<tr>
<td>84</td>
<td>Remarks</td>
<td>Not Required</td>
</tr>
<tr>
<td>85</td>
<td>Provider Representative</td>
<td>Required</td>
</tr>
<tr>
<td>86</td>
<td>Date</td>
<td>Required</td>
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</tbody>
</table>
CMS 1500 Data Elements for Submission of Claims for Paper Claims
EDI Requirements Must be Followed for Electronic Claims Submissions

<table>
<thead>
<tr>
<th>Field #</th>
<th>Description</th>
<th>Requirements</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Insurance Type</td>
<td>Required</td>
</tr>
<tr>
<td>1a</td>
<td>Insured Identification Number</td>
<td>Gateway HealthSM Member Identification Number Required (10-digit MA Recipient Number acceptable for Electronic Claims)</td>
</tr>
<tr>
<td>2</td>
<td>Patient’s Name</td>
<td>Required</td>
</tr>
<tr>
<td>3</td>
<td>Patient’s Birth Date</td>
<td>Required</td>
</tr>
<tr>
<td>4</td>
<td>Insured’s Name</td>
<td>Required</td>
</tr>
<tr>
<td>5</td>
<td>Patient’s Address</td>
<td>Required</td>
</tr>
<tr>
<td>6</td>
<td>Patient Relationship to Insured</td>
<td>Required</td>
</tr>
<tr>
<td>7</td>
<td>Insured’s Address</td>
<td>Required</td>
</tr>
<tr>
<td>8</td>
<td>Patient Status</td>
<td>Required</td>
</tr>
<tr>
<td>9</td>
<td>Other Insured’s Name</td>
<td>Required, If Applicable</td>
</tr>
<tr>
<td>9a</td>
<td>Other Insured’s Policy or Group Number</td>
<td>Required, If Applicable</td>
</tr>
<tr>
<td>9b</td>
<td>Other Insured’s Date of Birth, Sex</td>
<td>Required, If Applicable</td>
</tr>
<tr>
<td>9c</td>
<td>Employer’s Name or School Name</td>
<td>Required, If Applicable</td>
</tr>
<tr>
<td>9d</td>
<td>Insurance Plan Name or Program Name</td>
<td>Required, If Applicable</td>
</tr>
<tr>
<td>10</td>
<td>Is Patient Condition Related to:</td>
<td>Required, If Applicable</td>
</tr>
<tr>
<td>10a</td>
<td>a. Employment</td>
<td></td>
</tr>
<tr>
<td>10b</td>
<td>b. Auto accident</td>
<td></td>
</tr>
<tr>
<td>10c</td>
<td>c. Other accident</td>
<td></td>
</tr>
<tr>
<td>10d</td>
<td>Reserved for Local Use</td>
<td>Not Required (see instructions for EPSDT claims instructions)</td>
</tr>
<tr>
<td>11</td>
<td>Insured’s Policy Group or FECA Number</td>
<td>Required</td>
</tr>
<tr>
<td>11a</td>
<td>Insured’s Date of Birth, Sex</td>
<td>Required, If Applicable</td>
</tr>
<tr>
<td>11b</td>
<td>Employer’s Name or School Name</td>
<td>Required, If Applicable</td>
</tr>
<tr>
<td>11c</td>
<td>Insurance Plan Name or Program Name</td>
<td>Required, If Applicable</td>
</tr>
<tr>
<td>11d</td>
<td>Is There Another Health Benefit Plan?</td>
<td>Required, If Applicable</td>
</tr>
<tr>
<td>12</td>
<td>Patient or Authorized Person’s Signature</td>
<td>Required</td>
</tr>
<tr>
<td>13</td>
<td>Insured’s or Authorized Person’s Signature</td>
<td>Required</td>
</tr>
<tr>
<td>14</td>
<td>Date of Current Illness OR Injury OR Pregnancy</td>
<td>Required, If Applicable</td>
</tr>
<tr>
<td>15</td>
<td>If Patient has had Same or Similar Illness, Give First Date</td>
<td>Not Required</td>
</tr>
<tr>
<td>16</td>
<td>Dates Patient Unable to Work in Current Occupation</td>
<td>Required, If Applicable</td>
</tr>
<tr>
<td>17</td>
<td>Name of Referring Practitioner or Other Source</td>
<td>Required</td>
</tr>
<tr>
<td>17a</td>
<td>Identification Number of Referring Practitioner</td>
<td>Not Required</td>
</tr>
<tr>
<td>18</td>
<td>Hospitalization Dates Related to Current Services</td>
<td>Required, If Applicable</td>
</tr>
<tr>
<td>19</td>
<td>Reserved for Local Use</td>
<td>Not Required</td>
</tr>
<tr>
<td>20</td>
<td>Outside Lab</td>
<td>Not Required</td>
</tr>
<tr>
<td>21</td>
<td>Diagnosis or Nature of Illness or Injury</td>
<td>Required</td>
</tr>
<tr>
<td>22</td>
<td>Medical Resubmission Code</td>
<td>Not Required</td>
</tr>
<tr>
<td>23</td>
<td>Prior Authorization Number</td>
<td>Not Required</td>
</tr>
<tr>
<td>24a</td>
<td>Date(s) of Service</td>
<td>Required</td>
</tr>
<tr>
<td>24b</td>
<td>Place of Service</td>
<td>Required</td>
</tr>
<tr>
<td>24c</td>
<td>Type of Service</td>
<td>Not Required</td>
</tr>
<tr>
<td>24d</td>
<td>Procedures, Services, or Supplies</td>
<td>Required</td>
</tr>
<tr>
<td>24e</td>
<td>CPT/HCPCS/Modifier</td>
<td>Required</td>
</tr>
<tr>
<td>24f</td>
<td>Diagnosis Code</td>
<td>Required</td>
</tr>
<tr>
<td>24g</td>
<td>Charges</td>
<td>Required</td>
</tr>
<tr>
<td>24h</td>
<td>EPSDT Family Plan</td>
<td>Not Required (see instructions for EPSDT claims submissions)</td>
</tr>
<tr>
<td>25</td>
<td>EMP#</td>
<td>Not Required</td>
</tr>
<tr>
<td>25a</td>
<td>COB</td>
<td>Not Required for Gateway Primary Claims</td>
</tr>
<tr>
<td>25b</td>
<td>Reserved for Local Use</td>
<td>Not Required</td>
</tr>
<tr>
<td>25c</td>
<td>Federal Tax Identification Number</td>
<td>Required</td>
</tr>
<tr>
<td>26</td>
<td>Patient Account Number</td>
<td>Not Required, but Gateway includes payment information when present to assist with reconciliation in provider records</td>
</tr>
<tr>
<td>27</td>
<td>Accept Assignment</td>
<td>Not Required</td>
</tr>
<tr>
<td>28</td>
<td>Total Charge</td>
<td>Required</td>
</tr>
<tr>
<td>29</td>
<td>Amount Paid</td>
<td>Not Required</td>
</tr>
<tr>
<td>30</td>
<td>Balance Due</td>
<td>Not Required</td>
</tr>
<tr>
<td>31</td>
<td>Signature of Practitioner or Supplier including degrees or credentials</td>
<td>Gateway Individual Practitioner Name and Date Required</td>
</tr>
<tr>
<td>32</td>
<td>Name and Address of Facility Where Services were Rendered</td>
<td>Name and Address Required</td>
</tr>
<tr>
<td>33</td>
<td>Practitioner’s, Supplier’s Billing Name, Address, Zip Code and Phone Number</td>
<td>Gateway Vendor Name, Address, and Number Required</td>
</tr>
</tbody>
</table>
**Member Complaint Process**

Gateway provides a two-level internal complaint process for its members. Members may file complaints with Gateway regarding issues such as quality of care, quality of service and non-covered benefits. A provider may file a complaint on the member’s behalf, but must be officially appointed as the member’s representative to do so. Gateway will require that documentation is submitted to demonstrate said appointment prior to initiating complaint proceedings.

For first level complaints, the filing limit varies depending upon the issue of the complaint. The complaint must be filed within forty-five (45) days of the following events: plan failure to decide a complaint or grievance within specified timeframes, plan failure to meet timeframes for providing a service or item; dispute of a non-covered benefit denial; dispute of a denial for payment because the service was provided without an authorization by a non-par provider after the service has been rendered; dispute of payment for a service that was denied because it is not a covered benefit but has already been provided. There is no filing limit for any other type of complaint. First level complaints are resolved within thirty (30) days of receipt. As part of the complaint process, the Member has the opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The Member will be given at least seven (7) days advance written notice of the review date, time, and location. If the Member cannot appear in person at the review, the Member has the option of participating with the first level complaint review committee by telephone or videoconference. If the Member chooses not to participate in the first level Complaint review, the meeting will be conducted with the same protocols as if the Member was present. Gateway will be flexible when scheduling the review to facilitate the Member’s attendance. A letter explaining the outcome is mailed to the member, member’s appointed representative (if applicable), and prescribing PCP (if applicable) within five (5) business days from the date of the first level complaint review committee’s decision.

If a member or member’s representative is not satisfied with the outcome of a first level complaint, a second level complaint may be filed within forty-five (45) days from the date of receipt of the notice from the first level complaint committee. Second level complaints are reviewed within forty-five (45) days of receipt. As part of the complaint process, the Member has the opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The Member will be given at least fifteen (15) days advance written notice of the review date, time, and location. If the Member cannot appear in person at the review, the Member has the option of participating with the first level Complaint review committee by telephone or videoconference. If the Member chooses not to participate in the second level Complaint review, the meeting will be conducted with the same protocols as if the Member was present. Gateway will be flexible when scheduling the review to facilitate the Member’s attendance. A letter explaining the outcome is mailed to the member, member’s appointed representative (if applicable), and prescribing PCP (if applicable) within five (5) business days from the date of the second level complaint review committee’s decision.
If a member is receiving a service or item that is being reduced or terminated, and a complaint is filed within ten (10) days of the date on the denial notice, Gateway will continue to cover those services during the complaint process.

**External Complaint Review**
If a member or member’s representative is not satisfied upon the exhaustion of the internal complaint review process, an external complaint may be filed with the Department of Health or Department of Insurance. Members must ask for an external review within 15 days of the date they receive the 2nd level complaint decision letter. These options and instructions are included in any notice from the Gateway Second Level Complaint Committee.

**Expedited Complaint**
If a member or member’s representative believes that the usual timeframes for review of a complaint would endanger the member’s life, health or ability to regain maximum function, an expedited complaint review may be requested. Whether the member or the provider files such a request, or dentist a physician or dentist must submit written certification of emergent need. Please refer to the *Forms and Reference Materials Section* of this manual for the Certification of Need for Expedited Appeal Form that may be used for this purpose. Gateway will call you with our decision within 48 hours of when we receive the letter from your doctor explaining how the usual timeframe for deciding your complaint will harm your health or within 3 business days of your request for an expedited (faster) complaint review, whichever is sooner.

More information on the member complaint process can be found on our website, www.GatewayHealthPlan.com.

**Expedited External Complaint Review**
If a member or member’s representative is not satisfied upon the exhaustion of the internal expedited complaint review process, the Member, or the Member’s representative, with proof of the Member’s written authorization for the representative to be involved and/or act on the Member’s behalf, may file a request for an expedited external Complaint review with Gateway within two (2) Business Days from the date the Member receives Gateway’s expedited Complaint decision.

In addition, the Member may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of Gateway’s expedited complaint decision (see “DHS Fair Hearing” below).
Member Grievances

Member Grievances: The First Level

A grievance is defined as a request to have Gateway reconsider a decision based solely upon the medical necessity and appropriateness of a healthcare service. The member, member’s representative, or provider with member’s written consent may file a grievance with Gateway.

Grievances may be filed to request the review of the following types of decisions:

- Denial, in whole or in part, of payment for a service if based upon lack of medical necessity;
- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension or termination of a previously authorized service;
- Denial of the requested service but approval of an alternative service.

The member must file a grievance within forty-five (45) days of the utilization management decision or from the date of receipt of notice about the utilization management decision. Member grievances can be submitted orally by contacting Gateway’s Member Service Department at 1-800-347-1147, by fax at 412-255-4503, or in writing by sending to:

Gateway HealthSM, Inc.
Attn: Member Appeals
Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222

If any grievance is filed within ten (10) days of the date of the decision notice (or receipt of the decision notice) and the member had already been receiving services, the member will continue to receive the service during the grievance process. (Members are afforded a similar right under the member complaint process when the appellant disputes a decision to discontinue, reduce or change a service because it is not or is no longer a covered benefit.)

Gateway will send written confirmation of receipt of the grievance to the member, the member’s representative and the provider. The notice will include the following information:

- The classification of the matter under review as a grievance. The member, representative or provider may question the classification by contacting the Pennsylvania Department of Health;
- The member’s right to appoint a representative to act on his or her behalf at any point during the process;
The member or member’s representative right to right to review information related to the grievance upon request and submit additional information to be considered by the plan;

The member or member’s representative right to request the aid of a Gateway staff member who has not been involved in the matter under review to help with the grievance process.

The First Level Grievance Committee will conduct the review. The members of the Committee will not have been involved in any prior decision related to the grievance. The Committee will include a licensed physician or an approved, licensed psychologist of the same or similar specialty who would typically manage or consult on the healthcare service in question. Gateway will provide to the member, representative or provider access to all information relating to the matter under grievance review and will provide a copy of all material that is available as it pertains to the grievance. The member, representative or provider may specify the remedy or corrective action being sought.

Upon request, Gateway will provide at no charge to the member the assistance of a staff member who has not participated in any decision-making on the decision under review.

Gateway will commence its review, arrive at its decision, and issue a written decision notice within thirty (30) days of receiving the grievance. The member may request a fourteen (14) day extension if needed. As part of the grievance process, the Member has the opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The Member will be given at least seven (7) days advance written notice of the review date, time, and location. If the Member cannot appear in person at the review, the Member has the option of participating with the first level grievance review committee by telephone or videoconference. If the Member chooses not to participate in the first level grievance review, the meeting will be conducted with the same protocols as if the Member was present. Gateway will be flexible when scheduling the review to facilitate the Member’s attendance. A letter explaining the outcome is mailed to the member, member’s appointed representative (if applicable), and prescribing PCP (if applicable) within five (5) business days from the date of the first level grievance review committee’s decision. The written decision notice will include the basis for the decision and the procedures for the appellant to request a second level review, including the following:

- A statement of the issue reviewed by the First Level Committee;
- The reasons for the decision;
- References to the provisions on which the decision is based and how to obtain these documents, if used;
- An explanation of the scientific or clinical judgment for the decision;
- An explanation of how to request a second level review, which must be filed within forty-five (45) days of receipt of the first level decisions.

**Member Grievances: The Second Level**

Within five (5) business days of receiving a request for a second level grievance review, Gateway will send the member an explanation of the procedures followed during the
second level grievance. This notice will include that the member may contact Gateway Member Services to request the aid of a staff member who has not participated in any previous decision making regarding the issue under dispute. As part of the grievance process, the Member has the opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The Member will be given at least fifteen (15) days advance written notice of the review date, time, and location. If the Member cannot appear in person at the review, the Member has the option of participating with the first level grievance review committee by telephone or videoconference. If the Member chooses not to participate in the second level grievance review, the meeting will be conducted with the same protocols as if the Member was present. Gateway will be flexible when scheduling the review to facilitate the Member’s attendance.

If any grievance is filed within ten (10) days of the date of the decision notice (or receipt of the decision notice) the member will continue to receive the service during the grievance process. (Members are afforded a similar right under the member complaint process when the appellant disputes a decision to discontinue, reduce or change a service because it is not or is no longer a covered benefit.)

The Second Level Grievance Committee will be comprised of three (3) or more individuals who did not previously participate in the decision to deny coverage or payment for the issue in dispute. The Committee will include a licensed physician or an approved, licensed psychologist in the same or similar specialty that would typically provide or consult on the healthcare service in question. The second level grievance process allows the member, representative and/or provider to be present at the second level review and to present a case.

Gateway will make reasonable accommodation to facilitate the participation of the member, representative, and/or healthcare provider by conference call or in person. Gateway will take into account the member’s access to transportation and any known disabilities or language barriers. If the member, representative or healthcare provider cannot appear in person, Gateway will allow the opportunity to communicate with the Committee by telephone or other appropriate means.

Attendance at the Second Level Grievance Committee meeting will be limited to the following:

- Members of the review committee;
- Appropriate plan representatives;
- The member, member’s representative, including any legal representative and/or any attendee necessary for the member to participate in or understand the proceedings;
- The healthcare provider, and
- Applicable witnesses.

The Committee members may not discuss the case to be reviewed prior to the Second Level Committee meeting. A Gateway attorney may attend the meeting to represent the
interests of the Committee, but may not argue Gateway’s position or represent Gateway or its staff. The Committee may question the member, the member’s representatives and the healthcare provider. The Committee will base its decision based solely upon the materials and testimony presented at the review. The proceedings will be recorded electronically and then transcribed. The transcription will be included as a part of the permanent record to be forwarded upon request for an external review.

Gateway will complete the second level grievance review, arrive at its decision, and issue a decision notice within forty-five (45) days of its receipt. The member may request a fourteen (14) day extension if needed. A letter explaining the outcome is mailed to the member, member’s appointed representative (if applicable), and prescribing PCP (if applicable) within five (5) business days from the date of the second level grievance review committee’s decision and will include the following information:

- A statement of the issue under review by the Second Level Grievance Committee;
- The reason for the decision;
- References to the provisions on which the decision was based and how to obtain these documents, if used;
- An explanation of the scientific or clinical judgment for the decision.
- Instructions regarding further appeal rights (when applicable)

**Expedited Grievances (Internal)**

The member, member’s representative, or healthcare provider with written consent of the member can file an Expedited Grievance with Gateway. Members may call Member Services at 1-800-392-1147. The Expedited Grievance process is provided for use in instances when the member’s life, health or ability to regain maximum function would be placed in jeopardy by the delay occasioned by the standard review process. The member’s physician must provide written certification of the need to expedite the process. The certification must include the clinical rationale and facts to support the physician’s opinion.

If any grievance is filed within ten (10) days of the date of the decision notice (or receipt of the decision notice) the member will continue to receive the service during the grievance process. (Members are afforded a similar right under the member complaint process when the appellant disputes a decision to discontinue, reduce or change a service because it is not or is no longer a covered benefit.) The member, member’s representative, and/or healthcare providers may participate in the hearing by telephone.

The expedited grievance will be committed to writing and will be reviewed by the committee under the same requirements as the Second Level Grievance process previously described with the following exceptions:

- Gateway will call the member and the provider involved in the expedite with our decision within 48 hours of when we receive the provider certification explaining how the usual timeframe for deciding the grievance would harm the member’s health or within 3 business days of a request for an expedited faster grievance
review, whichever is sooner. If the member, member’s representative, or appealing provider does not attend the hearing, all information presented at the hearing is read into the record, including any report obtained from a physician of same or similar specialty. A copy of the report is available upon request.

- It is the responsibility of the member, the member’s representative or the appealing provider to submit information to Gateway within the time constraints of the expedited grievance process.

A written notice will follow that explains the rationale for the decision, including any clinical rationale and the procedure for obtaining an Expedited External Grievance or Expedited Department of Human Services (DHS) Fair Hearing.

**Expedited Grievances (External)**

A member or the Member’s representative, with proof of the Member’s written authorization for the representative to be involved and/or act on the Member’s behalf, may file a request for an expedited external grievance review with Gateway within two (2) business days from the date the Member receives Gateway’s expedited grievance decision. DOH will then assign a Certified Review Entity (CRE) within one (1) business day of receiving the request. The CRE will have two (2) business days following receipt of the case file to make its decision. The CRE will inform all parties involved of its decision in writing.

In addition, the Member may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of Gateway’s expedited grievance decision (see “DHS Fair Hearing” below).

If any grievance is filed within ten (10) days of the date of the decision notice (or receipt of the decision notice) the member will continue to receive the service during the grievance process. (Members are afforded a similar right under the member complaint process when the appellant disputes a decision to discontinue, reduce or change a service because it is not or is no longer a covered benefit.)

**External Grievances (Standard)**

Pursuant to Pennsylvania Act 68, a member, member’s representative or provider with the written consent of the member, may file an External Grievance following the denial of a Second Level Grievance. The member has fifteen (15) calendar days from receipt of the Second Level Grievance decision notice to request an External Grievance. Gateway will notify DOH that an External Grievance has been requested within five (5) business days of receiving such a request. DOH will inform all parties of the name, address and phone number of the CRE assigned within two (2) business days.

If any grievance is filed within ten (10) days of the date of the decision notice (or receipt of the decision notice) the member will continue to receive the service during the grievance process. (Members are afforded a similar right under the member complaint process when the appellant disputes a decision to discontinue, reduce or change a service because it is not or is no longer a covered benefit.)
Within fifteen (15) days of the request for an external review, Gateway will forward a copy of the case file to the CRE. A listing of all documents provided will also be provided to the member or filing provider. The CRE will inform all parties (including DOH) in writing of its decision within sixty (60) days of receipt of the request. Immediately upon notice from the CRE, Gateway will authorize a healthcare service and pay any claims determined to be medically necessary and appropriate by the CRE.

**DHS Fair Hearing**

At any time during the complaint or grievance process and for the period of up to thirty (30) days following any Gateway decision notice, a member may request a Fair Hearing with the Pennsylvania Department of Human Services (DHS). The request must be filed in writing to the Department of Human Services at the following address:

Department of Human Services  
OMAP – HealthChoices Program  
Complaint, Grievance and Fair Hearings  
P.O. Box 2675  
Harrisburg, PA 17105-2675

The request must include a copy of the written notice of decision that is the subject of the request.

If the request for a fair hearing is filed by a healthcare provider on behalf of a member, the request must include the member’s written consent to do so. The request must be submitted within thirty (30) calendar days of any Gateway decision notice. The Department of Human Services will not consider provider appeals for payment regarding managed care organization decisions.

If the request for fair hearing is filed within ten (10) days of the date of the decision notice (or receipt of the decision notice) the member will continue to receive the service during the grievance process. (Members are afforded a similar right under the member complaint process when the appellant disputes a decision to discontinue, reduce or change a service because it is not or is no longer a covered benefit.)

The party requesting the fair hearing is expected to be available for participation in the hearing either in person or by telephone. Failure to appear for the hearing will result in dismissal of the case. An Administrative Law Judge (ALJ) assigned to the case acts as the hearing officer and will make a determination as to whether the health plan’s decision to deny services was correct based on the evidence and testimony provided by all parties at the hearing. Fair Hearing decisions are typically issued within sixty (60) to ninety (90) calendar days from the date the request was filed.

If the decision is in favor of the member, Gateway will immediately authorize the service(s) or process the claim(s) for payment. If the decision is in favor of the plan, the member or
authorized representative will be given the opportunity to request a Reconsideration by the Secretary of the Department of Human Services.

If the provider believes that the member’s life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the standard DHS Fair Hearing process, an expedited Fair Hearing may be requested. In order to do this, the provider must submit written certification with respect to the expedited need for review to DHS. This certification should be faxed to DHS at 717-772-6328. The provider may also call DHS at 1-800-798-2339 to ask for an expedited Fair Hearing. If written certification is not submitted, the provider may testify at the hearing to explain the need for an expedited fair hearing. A member who files a request for an expedited Fair Hearing must continue to receive the disputed service/item at the previously authorized level pending resolution of the DHS Fair hearing, if the request for an expedited Fair hearing is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

The Bureau of Hearings and Appeals will contact the provider and/or member to schedule the expedited fair hearing. The expedited fair hearing will be held by telephone within three (3) business days of the receipt of the request. If the provider does not send a written statement and does not testify at the fair hearing, the fair hearing decision will not be expedited. Another hearing will be scheduled, and the time frame for the fair hearing decision will be based on the date the hearing request was received. If the provider submits a written statement or testifies at the hearing, the decision will be made within three (3) business days after the fair hearing was held.

**Provider Initiated Member Grievances**

Pursuant to Pennsylvania Act 68, with the written consent of the member, a provider may file an appeal on the member’s behalf. Providers may request the member’s written consent to appeal prior to treatment, but it cannot be a requirement for treatment to be provided. The regulatory requirements for providers to pursue a grievance as well as the timeframes for member notice of a provider to pursue or discontinue pursuit of a grievance must be included in the consent. In this situation, the rights afforded the member under the Act 68 grievance process is transferred to the provider. It is important to note that the member may rescind consent at any time. The Act 68 process applies to Medicaid members only.

Please note that providers who initiate the Act 68 grievance process may not make use of the provider appeal process, as previously outlined, to request a review for the same matter.

**Provider Responsibilities When Initiating Member Appeals**

Medicaid members may not be billed or balance billed for covered services at any time. The member’s consent is automatically rescinded if the provider fails to pursue the grievance and the member may continue the grievance at that point in the process.

The member has the right to ask any person (family, friend, relative, attorney, provider, etc.) to act as a representative during the grievance process. This person is referred to as
the “member’s representative.” If the representative is a healthcare provider, the provider must secure and provide to Gateway the member’s written consent to do so. If the member is a minor or legally incompetent, the provider must submit written consent of the parent, guardian, or legally appointed representative in order to pursue a grievance.

An acceptable consent document must contain all of the following components:

- The member’s name;
- The member’s address;
- The member’s identification number;
- If the member is a minor or legally incompetent, the name, address and relationship to the member of the person who consents for the member;
- The name, address and identification number of the provider to whom the member or representative is granting consent;
- The name and address of the plan to whom the member or representative is providing consent;
- An explanation of the specific service for which coverage was provided and/or denied to which the consent applies.

The following statements must also be included in the consent document:

- The member or the member’s representative may not submit a grievance concerning the services listed in this consent form unless the member or the member’s legal representative rescinds consent in writing. The member or the member’s legal representative has the right to rescind consent at any time during the grievance process.
- The consent of the member or the member’s legal representative is automatically rescinded if the provider fails to file a grievance or fails to continue to prosecute the grievance through the second level review process.
- The member or the member’s legal representative, if the member is a minor or is legally incompetent, has read, or has been read this consent form, and has had it explained to his or her satisfaction. The member or the member’s legal representative understands the information in the member’s consent form.

The document must also contain the dated signature of the member or the member’s legal representative if the member is a minor or is legally incompetent as well as the dated signature of a witness. The member may rescind the consent at any time during the grievance process. If consent is rescinded, the member may continue the process at the point in the process at which consent was rescinded. The member may not file a separate grievance. A member who has already filed a grievance may choose to authorize a provider to pursue the grievance process at any point during the grievance process. A member’s representative carries all the rights conferred upon the member by the Act 68 grievance process.
Provider Initiated Member Grievances: The First Level

A grievance is defined as a request to have Gateway reconsider a decision based solely upon the medical necessity and appropriateness of a healthcare service. The member, member’s representative, or provider with member’s written consent (referred to as “appellant” in this section) may file a grievance with Gateway

Grievances may be filed to request the review of the following types of decisions:

- Denial, in whole or in part, of payment for a service if based upon lack of medical necessity;
- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension or termination of a previously authorized service;
- Denial of the requested service but approval of an alternative service.

The appellant must file a grievance within forty-five (45) days of the utilization management decision or from the date of receipt of notice about the utilization management decision.

If any grievance is filed within ten (10) days of the date of the decision notice (or receipt of the decision notice) the member will continue to receive the service during the grievance process. (Members are afforded a similar right under the member complaint process when the appellant disputes a decision to discontinue, reduce or change a service because it is not or is no longer a covered benefit.)

Providers who have obtained the member’s consent to file a grievance have a period of ten (10) days from receipt of any denial notice to notify the member or legal representative of its intent to discontinue pursuit of a grievance.

Gateway will send written confirmation of receipt of the grievance to the member, the member’s representative and the provider. The notice will include the following information:

- The classification of the matter under review as a grievance. The member, representative or provider may question the classification by contacting the Pennsylvania Department of Health;
- The member may appoint a representative to act on his or her behalf at any point during the process;
- The member, representative, or provider that filed on the member’s behalf, may review information related to the grievance upon request and submit additional information to be considered by the plan;
- The member or representative may request the aid of a Gateway staff member who has not been involved in the matter under review.
The First Level Grievance Committee will conduct the review. The members of the Committee will not have been involved in any prior decision related to the grievance. The Committee will include a licensed physician or an approved, licensed psychologist of the same or similar specialty who would typically manage or consult on the healthcare service in question. Gateway will provide to the member, representative or provider access to all information relating to the matter under grievance review and will provide a copy of all material that is available as it pertains to the grievance. The member, representative or provider may specify the remedy or corrective action being sought.

Upon request, Gateway will provide at no charge to the member the assistance of a staff member who has not participated in any decision-making on the decision under review.

Gateway will commence its review, arrive at its decision, and issue a written decision notice within thirty (30) days of receiving the grievance. The appellant may request a fourteen (14) day extension if needed. The written decision notice will include the basis for the decision and the procedures for the appellant to request a second level review, including the following:

- A statement of the issue reviewed by the First Level Committee;
- The reasons for the decision;
- References to the provisions on which the decision is based and how to obtain these documents, if used;
- An explanation of the scientific or clinical judgment for the decision;
- An explanation of how to request a second level review, which must be filed within forty-five (45) days of receipt of the first level decisions.

Provider Initiated Member Grievances: The Second Level

Within five (5) business days of receiving a request for a second level grievance review, Gateway will send the appellant an explanation of the procedures followed during the second level grievance. This notice will include that the member may contact Gateway Member Services to request the aid of a staff member who has not participated in any previous decision making regarding the issue under dispute as well as notice of the right to appear before the review committee and that Gateway will provide fifteen (15) days’ notice of the date and time scheduled for the review.

If any grievance is filed within ten (10) days of the date of the decision notice (or receipt of the decision notice) the member will continue to receive the service during the grievance process. (Members are afforded a similar right under the member complaint process when the appellant disputes a decision to discontinue, reduce or change a service because it is not or is no longer a covered benefit.)

The Second Level Grievance Committee will be comprised of three (3) or more individuals who did not previously participate in the decision to deny coverage or payment for the issue in dispute. The Committee will include a licensed physician or an approved, licensed psychologist in the same or similar specialty that would typically provide or consult on the healthcare service in question. The second level grievance process allows the member,
representative and/or provider to be present at the second level review and to present a case.

Gateway will make reasonable accommodation to facilitate the participation of the member, representative, and/or healthcare provider by conference call or in person. Gateway will take into account the member’s access to transportation and any known disabilities or language barriers. If the member, representative or filing healthcare provider cannot appear in person, Gateway will allow the opportunity to communicate with the Committee by telephone or other appropriate means.

Attendance at the Second Level Grievance Committee meeting will be limited to the following:

- Members of the review committee;
- Appropriate plan representatives;
- The member, member’s representative, including any legal representative and/or any attendee necessary for the member to participate in or understand the proceedings;
- The healthcare provider who filed the grievance with the member’s consent, and
- Applicable witnesses.

The Committee members may not discuss the case to be reviewed prior to the Second Level Committee meeting. A Gateway attorney may attend the meeting to represent the interests of the Committee, but may not argue Gateway’s position or represent Gateway or its staff. The Committee may question the member, the member’s representatives and the healthcare provider. The Committee will base its decision based solely upon the materials and testimony presented at the review. The proceedings will be recorded electronically and then transcribed. The transcription will be included as a part of the permanent record to be forwarded upon request for an external review.

Gateway will complete the second level grievance review, arrive at its decision, and issue a decision notice within forty-five (45) days of its receipt. The appellant may request a fourteen (14) day extension if needed.

Gateway’s written notice will be provided to the member, representative and healthcare providers and will include the following information:

- A statement of the issue under review by the Second Level Grievance Committee;
- The reason for the decision;
- References to the provisions on which the decision was based and how to obtain these documents, if used;
- An explanation of the scientific or clinical judgment for the decision.
Expedited Grievances (Internal)
The member, member’s representative, or healthcare provider with written consent of the member can file an Expedited Grievance with Gateway. Members may call Member Services at 1-800-392-1147. Providers may call Provider Services at 1-800-392-1145. The Expedited Grievance process is provided for use in instances when the member’s life, health or ability to regain maximum function would be placed in jeopardy by the delay occasioned by the standard review process. The member’s physician must provide written certification of the need to expedite the process. The certification must include the clinical rationale and facts to support the physician’s opinion.

If any grievance is filed within ten (10) days of the date of the decision notice (or receipt of the decision notice) the member will continue to receive the service during the grievance process. (Members are afforded a similar right under the member complaint process when the appellant disputes a decision to discontinue, reduce or change a service because it is not or is no longer a covered benefit.) The member, member’s representative, and/or healthcare providers may participate in the hearing by telephone.

The expedited grievance will be committed to writing and will be reviewed by the committee under the same requirements as the Second Level Grievance process previously described with the following exceptions:

- The review and decision is completed within forty-eight (48) hours.
- If the member, member’s representative, or appealing provider does not attend the hearing, all information presented at the hearing is read into the record, including any report obtained from a physician of same or similar specialty. A copy of the report is available upon request.
- It is the responsibility of the member, the member’s representative or the appealing provider to submit information to Gateway within the time constraints of the expedited grievance process.

Following the hearing, Gateway will telephone the member, member’s representative and provider with its decision. A written notice will follow that explains the rationale for the decision, including any clinical rationale and the procedure for obtaining an Expedited External Grievance or Expedited Department of Human Services (DHS) Fair Hearing.

Expedited Grievances (External)
For Expedited External Grievance reviews, Gateway is required to notify the Pennsylvania Department of Health (DOH) within twenty-four (24) hours of receipt of such a request made by a member, member’s representative or provider with member’s written consent. DOH will assign a Certified Review Entity (CRE) within one (1) business day of receiving the request. The CRE will have two (2) business days following receipt of the case file to make its decision. The CRE will inform all parties involved of its decision in writing.

If any grievance is filed within ten (10) days of the date of the decision notice (or receipt of the decision notice) the member will continue to receive the service during the grievance process. (Members are afforded a similar right under the member complaint process when
the appellant disputes a decision to discontinue, reduce or change a service because it is not or is no longer a covered benefit.)

If the provider requests the External Grievance, both Gateway and the provider must establish escrow accounts in the amount of one-half of the estimated cost of the review. If the CRE’s decision is in favor of the member, in whole or in part, Gateway will be responsible for the fee charged by the reviewer, regardless of who filed the grievance. If the decision is wholly in favor of Gateway, and the healthcare provider filed the grievance on the member’s behalf, the provider is responsible for payment to the CRE.

**External Grievances (Standard)**
Pursuant to Pennsylvania Act 68, a member, member’s representative or provider with the written consent of the member, may file an External Grievance following the denial of a Second Level Grievance. The member, member’s representative or healthcare provider with written consent (referred to as “appellant” in this section), has fifteen (15) calendar days from receipt of the Second Level Grievance decision notice to request an External Grievance. If the provider files the request for an External Grievance, the provider shall forward a copy of the member’s written consent that authorizes the filing of an External Grievance. Gateway will notify DOH that an External Grievance has been requested within five (5) business days of receiving such a request. If the provider requests the External Grievance, both Gateway and the provider must establish escrow accounts in the amount of one-half of the estimated cost of the review. DOH will inform all parties of the name, address and phone number of the CRE assigned within two (2) business days.

If any grievance is filed within ten (10) days of the date of the decision notice (or receipt of the decision notice) the member will continue to receive the service during the grievance process. (Members are afforded a similar right under the member complaint process when the appellant disputes a decision to discontinue, reduce or change a service because it is not or is no longer a covered benefit.)

Within fifteen (15) days of the request for an external review, Gateway will forward a copy of the case file to the CRE. A listing of all documents provided will also be provided to the member or filing provider. The CRE will inform all parties (including DOH) in writing of its decision within sixty (60) days of receipt of the request. Immediately upon notice from the CRE, Gateway will authorize a healthcare service and pay any claims determined to be medically necessary and appropriate by the CRE. If the decision in an external grievance review is against the healthcare provider in full, the healthcare provider shall pay the fee charged by the CRE. If the decision is in full or in part in favor of the member, regardless of who filed the external grievance, Gateway will pay the fee charged by the CRE.

**DHS Fair Hearing**
At any time during the complaint or grievance process and for the period of up to thirty (30) days following any Gateway decision notice, a member may request a Fair Hearing with the Pennsylvania Department of Human Services (DHS). The request must be filed in writing to the Department of Human Services at the following address:
The request must include a copy of the written notice of decision that is the subject of the request.

If the request for a fair hearing is filed by a healthcare provider on behalf of a member, the request must include the member’s written consent to do so. The request must be submitted within thirty (30) calendar days of any Gateway decision notice. The Department of Human Services will not consider provider appeals for payment regarding managed care organization decisions.

If the request for fair hearing is filed within ten (10) days of the date of the decision notice (or receipt of the decision notice) the member will continue to receive the service during the grievance process. (Members are afforded a similar right under the member complaint process when the appellant disputes a decision to discontinue, reduce or change a service because it is not or is no longer a covered benefit.)

The party requesting the fair hearing is expected to be available for participation in the hearing either in person or by telephone. Failure to appear for the hearing will result in dismissal of the case. An Administrative Law Judge (ALJ) assigned to the case acts as the hearing officer and will make a determination as to whether the health plan’s decision to deny services was correct based on the evidence and testimony provided by all parties at the hearing. Fair Hearing decisions are typically issued within sixty (60) to ninety (90) calendar days from the date the request was filed.

If the decision is in favor of the member, Gateway will immediately authorize the service(s) or process the claim(s) for payment. If the decision is in favor of the plan, the member or authorized representative will be given the opportunity to request a Reconsideration by the Secretary of the Department of Human Services.

If the provider believes that the member’s life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the standard DHS Fair Hearing process, an expedited Fair Hearing may be requested. In order to do this, the provider must submit written certification with respect to the expedited need for review to DHS. This certification should be faxed to DHS at 717-772-6328. The provider may also call DHS at 1-800-798-2339 to ask for an expedited Fair Hearing. If written certification is not submitted, the provider may testify at the hearing to explain the need for an expedited fair hearing. A member who files a request for an expedited Fair Hearing must continue to receive the disputed service/item at the previously authorized level pending resolution of the DHS Fair hearing, if the request for an expedited Fair hearing is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.
The Bureau of Hearings and Appeals will contact the provider and/or member to schedule the expedited fair hearing. The expedited fair hearing will be held by telephone within three (3) business days of the receipt of the request. If the provider does not send a written statement and does not testify at the fair hearing, the fair hearing decision will not be expedited. Another hearing will be scheduled, and the time frame for the fair hearing decision will be based on the date the hearing request was received. If the provider submits a written statement or testifies at the hearing, the decision will be made within three (3) business days after the fair hearing was held.

Requests for Additional Information for Member Appeals

During any of the appeal processes outlined above, Gateway may send you a request for additional information based on the issue of the appeal that is being reviewed. Additional information can be faxed to Gateway at 412-255-4503 or mailed to the following address:

Gateway HealthSM, Inc.
Attn: Member Appeals
Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222
Care Management

Gateway to Lifestyle Management<sup>SM</sup>

Gateway to Lifestyle Management<sup>SM</sup> (GTLM) provides patient education and self-empowerment for medication, diet and lab adherence, to reduce inpatient and emergency room utilization.

The program will provide the following member benefits and support:

- Welcome letter provides members with information about their condition/disease and about the GTLM program. The brochure includes information about how members can reach a care manager.
- Member newsletters provide the members with educational information about their condition.
- Gateway Website provides educational material and has links to the Pennsylvania Quit Line to assist members with smoking cessation.
- General educational materials may be mailed such as flu or pneumonia reminders.
- Pre-Queue condition specific messages (a recorded message heard when a member calls), provides members with health tips.
- IVR campaigns (interactive voice response) provide members with tips to help manage their condition.
- Text message programs may be offered to certain member populations.

Telephonic Management: Case Managers proactively reach out to higher-risk members to:

- Assess overall well-being
- Determine the member’s understanding of their condition(s)
- Assess behavioral, economic, environmental, social, spiritual and medical needs
- Discuss lifestyle management issues including but not limited to diet, nutrition, meal planning, weight management, exercise and smoking cessation
- Refer members to a health educator, home health visits, behavioral health or any other discipline if indicated
- Communicate with member’s care team as needed
- Perform medication reconciliation to assess compliance and understanding; assess for polypharmacy and multiple prescribers
- Review claims for laboratory testing and follow up with member for results
- Provide pillboxes if needed

- Provider benefits and support:
  - Decrease inpatient and emergency room utilization
  - Increase appropriate lab testing and medication adherence
✓ Emphasize the importance of making and keeping appointments and provide coaching on how to make the best use of the time with the physician/health care team
✓ Encourage adherence to obtain flu and pneumonia immunizations.
✓ Provide education to assist your patients in understanding their condition and life style implications, and motivating them to take a proactive role in managing their health
✓ Provide feedback via the Physician Dashboard which identifies your patients enrolled in the GTLM programs and highlights testing they may need to manage their condition

We would like to work with you to make a positive impact on your patient’s health! For more information or to refer a patient to any of the GTLM programs call 1-800-642-3550.

Asthma Program
The Gateway to Lifestyle ManagementSM Asthma Program emphasizes patient education self-management, and medication adherence. The goal of this program is to reduce inpatient utilization and emergency room visits in our asthma population.

Gateway members age 2 years and older are eligible for the program. The program encourages an active lifestyle while minimizing or preventing asthma exacerbations. Members are automatically enrolled once they are identified with asthma, but are able to opt-out if they choose.

The program will help your patient:
- Identify their asthma triggers
- Recognize early symptoms requiring medical attention
- Understand the difference between a rescue inhaler and a controller medication
- Understand and prevent potential risks of uncontrolled asthma

For more information or to refer a patient to the Asthma Program call 1-800-642-3550 and press option 3.

Diabetes Program
The Gateway to Lifestyle ManagementSM Diabetes Program emphasizes education and personal responsibility for diabetes management to reduce the need for hospitalizations, ER visits and to prevent diabetic complications. All adult and pediatric Gateway members with Type 1 or Type 2 diabetes are eligible for this program. Members are automatically enrolled once they are identified with diabetes but are able to opt-out if they choose.

The program will help your patient:
- Learn how to keep blood sugars under control to help prevent diabetic complications
- Understand what tests/labs are needed to manage diabetes
Know what is normal and what is not
Understand when to call the doctor

Gateway works with Neighborhood Diabetes, a DME company who offers in-home visits for adult members with diabetes. Visits include:
- Glucometer education and choice of glucometer products
- Basic diabetic information
- Random blood sugar is drawn and when indicated, an A1C is obtained
- Lab results are communicated to providers

For more information or to refer a patient to the Diabetes Program, call 1-800-642-3550.

Cardiac Program
The Gateway to Lifestyle Management℠ Cardiac Program emphasizes patient education, and support to help members with cardiac conditions take an active role in their well-being by adopting a heart healthy lifestyle; by taking medications as prescribed and by understanding how to avoid sudden flare ups of their condition.

All adult Gateway members, age 21 or older, with a diagnosis of HF, MI, or CAD are eligible for the program. Members are automatically enrolled once they are identified with one of these cardiac conditions but are able to opt out if they choose.

The program will help your patient:
- Learn the meaning of specific cardiac symptoms to prevent further cardiac damage
- Understand the importance of lab tests for cholesterol and medications
- Understand how other conditions play a part in worsening a cardiac condition
- Understand when to call the physician and the key words to tell the office

For more information or to refer a patient to the Cardiac Program, call 1-800-642-3550 and press option 3.

COPD Program
The Gateway to Lifestyle Management℠ COPD Program emphasizes patient education self-management, and medication adherence. The program promotes lifestyle modification and safety to reduce inpatient utilization, emergency room visits and preventable flare-ups.

Gateway members 21 years of age and older with a diagnosis of COPD are eligible for this program. Members are automatically enrolled once they are identified with COPD but are able to opt-out if they choose.

The program will help your patient:
• Understand the importance of medication adherence as well as proper use of their inhalers
• Identify and avoid COPD triggers to help prevent an exacerbation and recognize when they should call their physician
• Understand the role of supplemental oxygen and/or the benefits of a pulmonary rehabilitation program
• Understand the importance of lifestyle modifications including smoking cessation

For more information or to refer a patient to the COPD Program, call 1-800-642-3550.

**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 and pre-term deliveries; and to decrease the need for NICU admissions. This is a population-based program directed toward improving outcomes for all pregnant members. Specific interventions are designed to identify and prospectively intervene with members at high risk for adverse pregnancy outcomes.

All Gateway members identified as pregnant are eligible for this program. Pregnant members are automatically enrolled but are able to opt-out if they choose.

The program will help your patient:
• Identify signs and symptoms of preterm labor or complications with the pregnancy
• Understand lifestyle modifications to maintain a healthy pregnancy
• Recognize how co-existing medical conditions can impact the pregnancy
• Understand the importance of post-partum follow-up

For more information or to refer a patient to the MOM Matters® Prenatal Program call 1-800-642-3550.

**Special Needs Unit Care Management**

**General Information**

The goal of the Special Needs Unit (SNU) Care Management is to intervene in medically or socially complex cases that may benefit from increased coordination of services to optimize health and prevent disease. The SNU is staffed by individuals with medical or social service backgrounds in the following areas: oncology, medically complex children, HIV/AIDS, substance abuse, mental health, physical rehabilitation and mental retardation.

A SNU Case Manager is available at 1-800-642-3550, Monday through Friday from 8:00 AM to 5:00 PM to assist with coordination of the member’s healthcare needs.

The responsibilities of the SNU include:
• Liaison with various healthcare practitioners, community social service agencies, advocacy groups and other agencies that the Medical Assistance population may interface with;
• Case management of children with medically complex special needs;
• Coordination of services between primary care, specialty, ancillary, and behavioral health practitioners within and outside the network;
• Facilitation of dispute resolution including informing members of the complaint, grievance and appeal mechanism that is available to the member. Facilitation of members’ access to city, county and Commonwealth social agencies for those members with complicated ongoing social service needs that affect their ability to access and use medical services.

Criteria for Referrals to the Special Needs Unit Care Management Team
The following problems and/or diagnoses are examples of appropriate referrals to the SNU:
• Children with Special Healthcare Needs (i.e., Cerebral Palsy)
• HIV/AIDS
• Mental Health or Substance Abuse Issues
• Mental Retardation/Developmental Disabilities
• Social Issues (homelessness, domestic violence, and substitute care)

Complex Case Management
Gateway HealthSM provides a Complex Case Management program for eligible members. A Case Manager can help members better understand their health condition and benefits and can also help to coordinate health care services. A Case Manager can tell members about community organizations and resources that may meet their needs.

Eligible members may include:

• Members with multiple medical conditions
• Members with a complex medical history
• Members that need assistance to become more self-reliant in managing their health care

Please contact the Care Management department to make a referral to the Complex Case Management program at 1-800-642-3550.
Gateway will review the request for enrollment and make the final decision for inclusion in the program.

Chronic Care Management
Gateway’s Chronic Care Team provides care management services for members with chronic illnesses not noted above. Case Managers focus on active condition monitoring, lifestyle management, preventive health, care coordination and community resource
referrals. To refer a member or discuss care coordination issues, contact the Medicaid Chronic Care Team at 1-800-642-3550.
Credentialing

Purpose of Credentialing
Credentialing is the process of performing a background investigation, as well as validation of a practitioner and provider’s credentials and qualifications. The credentialing and recredentialing processes also encompass a complete review of, to include but not limited to, malpractice histories, quality of care concerns and licensure status. Gateway prides itself on the integrity and quality of the composition of the practitioner and provider networks.

Who is Credentialled?
Practitioners: Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic (DC), Doctor of Dental Medicine (DMD), Doctor of Dental Surgery (DDS), Doctor of Optometry (OD), Doctorate of Psychology (Ph.D), and Doctorate of Philosophy (Ph.D). (This listing is subject to change.)

Extenders: Physician Assistant (PA), Certified Nurse Practitioner (CRNP), Certified Nurse Midwife (CNM), a Clinical Nurse Specialist (CNS) and a Certified Nurse Practitioner (CNP). (This listing is subject to change.)

Facility and Ancillary Service Providers: Hospitals, Nursing Homes, Skilled Nursing Facilities, Home Health, Rehabilitation Facilities, Ambulatory Surgical Centers, Portable X-ray Suppliers, End Stage Renal Disease Facilities, Clinical Laboratories, Outpatient Physical Therapy and Speech Therapy providers, Rural Health Clinics, and Federally Qualified Health Centers. (This listing is subject to change.)

Credentialing Standards
Gateway has established credentialing and recredentialing policies and procedures that meet CMS, DOH, DHS, and NCQA standards.

All information must be current and up-to-date to begin the credentialing process. Therefore, it is important to submit all applications and attachments in a timely manner with the most current information available.

In addition, extenders are required to submit a copy of their collaborative/written agreement with a Gateway participating supervising practitioner. This agreement would include the extender’s responsibilities and must be signed and dated by both the extender and the Gateway participating supervising practitioner. Any time there is a change in the extender’s supervising physician, the extender will be required to submit to Gateway, a current copy of his/her new collaborative/written agreement as indicated in his/her approval letter. Where applicable, the submittal of the collaborative/written agreement to Gateway must include a copy of the letter of approval from the State and if applicable, a DEA is required.
Gateway’s standards include, but are not limited to, the following:

- A current, unrestricted license
- Fully completed and signed application, which includes an active individual Master Provider Index (MPI) number and National Provider Identifier (NPI) number
- Curriculum Vitae and/or Work History to include month and year
- Copy of current, unencumbered DEA certificate, if applicable
- Current hospital admitting privileges for PCPs or appropriate coverage arrangement
- Acceptable malpractice history as subject to decision by Gateway Medical Directors
- Practitioners must maintain professional liability coverage as required by the state in which he/she practices or as outlined in the practitioner contractual agreement. For those self-insured a statement on letterhead indicating the providers are insured by a self-indemnification policy needs submitted.
- Active participation in the Medicare and/or Medical Assistance Programs; free of sanctions
- Foreign graduates must submit an ECFMG certificate
- Other items as deemed appropriate

The credentialing/recredentialing process involves primary sourced verification of practitioner credentials.

Gateway’s Credentialing Department will notify practitioners, in writing, within forty-five (45) calendar days of receiving any information obtained during the credentialing or recredentialing process that varies substantially from the information provided by the practitioner. Practitioners have the right to correct erroneous information submitted by another party or to correct his or her own information submitted incorrectly. Applicants have ten (10) calendar days from the date of Gateway’s notification to submit written corrections and supporting documentation to Gateway’s Credentialing Department. A credentialing decision will not be rendered until the ten (10) calendar days have expired.

Practitioners, upon request, have the right to be informed of the status of their credentialing or recredentialing application. Practitioners also have the right to review any information submitted in support of their credentialing applications except for National Practitioner Data Bank (NPDB) and/or Healthcare Integrity Practitioner Data Bank (HIPDB) reports, letters of recommendation, and information that is peer review protected. A practitioner must submit a written request to review their credentialing information. All appropriate credentialing information will be sent by Certified Mail, overnight mail or carrier to the practitioner within (10) business days from the date that the Credentialing Department received the request.

All practitioners must be recredentialled at least every three (3) years in order to continue participation with Gateway. This helps to assure Gateway’s continued
compliance with National Committee for Quality Assurance (NCQA), Department of Human Services (DHS), Center for Medicare Services (CMS), and Department of Health (DOH) regulations, as well as to uphold the integrity and quality of the networks. Extensions of this timeframe will only be considered in the event the practitioner is on maternity leave, military leave or sabbatical. Otherwise extensions cannot be granted.

Gateway is committed to protecting the confidentiality of all practitioner information obtained by the Credentialing Department as outlined in Gateway Health PlusSM Confidentiality of Practitioner/Provider Credentialing Information Policy and Procedure.

**Ongoing Performance Monitoring**

Gateway’s Credentialing Department conducts ongoing monitoring of sanctions, licensure disciplinary actions and member complaints.

Sanction information is reviewed by utilizing the Office of Inspector General’s (OIG) report, the Medicare Opt Out Listing (CMS), the 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 terminated. In all instances, the information is reported to the QI/UM Committee.

Monitoring of Member Complaints is conducted on a quarterly basis. The Gateway Credentialing Department reviews a practitioner complaint report, which reveals member complaints, filed against practitioners regarding: attitude of provider, provider treatment, quality issues of physician, and any complaints regarding adverse events. If the outcome of the complaint investigation substantiates the complaint, it is documented. Depending upon the number, severity and trends of the substantiated complaint(s), the practitioner’s file may be sent to the Medical Director for review and recommendation, sent to Quality Improvement/Utilization Management Committee for review and decision and/or immediately 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 on an approved sabbatical. However, it is the practitioner or their office’s responsibility to notify Gateway in writing that the practitioner has been called to active duty or beginning the said leave, as well as provide an expected return date. The letter should also include the practitioner who will be covering during his or her leave. The Gateway Credentialing Department will not terminate the practitioner if they are called to active duty, on maternity leave or on an approved sabbatical if appropriate coverage is in place. Practitioner/practitioner’s office should notify Gateway of practitioners return, as soon as possible, but not exceeding ten (10) business days from the practitioners return to the office. The Gateway Credentialing Department will determine, based upon the length of time, if the practitioner will have to complete a recredentialing application. If the practitioner requires recredentialing, the application must be completed within sixty (60) calendar days of the practitioner resuming practice.

Denial and Termination
In accordance with Gateway’s business practices, the inclusion of a practitioner in the Gateway Practitioner/Provider Network is within the sole discretion of Gateway.

Gateway conducts credentialing in a non-discriminating manner and does not make credentialing decisions based on an applicant’s type of procedures performed, type of patients, or a practitioner’s specialty, marital status, race, color, religion, ethnic/national origin, gender, age, sexual orientation or disability. Gateway understands and abides by the Federal Regulation of the Americans with Disabilities Act whereby no individual with a disability shall on the sole basis of the disability be excluded from participation.

If a practitioner meets Gateway’s credentialing criteria, a Gateway Medical Director may approve the credentialing applicant. If a practitioner does not meet Gateway’s baseline credentialing criteria, the QI/UM Committee will make a final determination on participation or continued participation. If a practitioner fails to submit information and/or documentation within requested time frames, processing of the practitioner application may be discontinued or terminated. All requests for recredentialing updates must be completed and returned in a timely manner. Failure to do so could result in denial or termination of participation.

Denial and termination decisions that are made based on quality concerns can be appealed and are handled according to Gateway’s Due Process Policy and Procedure. If necessary, the information is reported to the National Practitioner Data Bank and Bureau of Quality Management and Provider Integrity in compliance with the current 45 CFR Part 60 and the Health Care Quality Improvement Act, as well as State licensing boards.

Practitioners who want to request a review of a termination, other than for quality of care concerns, must submit a written request for the review along with any supporting
documentation to Gateway within thirty (30) calendar days of the date of the certified notification.

**Delegated Credentialing**

Delegation is the formal process by which Gateway has given other entities the authority to perform credentialing functions on the behalf of Gateway. Gateway may delegate certain activities to a credentialing verification organization (CVO), Independent Practitioner Association (IPA), hospital, medical group, or other organizations that employ and/or contract with practitioners. Organizations must demonstrate that there is a credentialing program in place and the ability to maintain a program that continuously meets Gateway’s program requirements. The delegated entity has authority to conduct specific activities on behalf of Gateway. Gateway has ultimate accountability for the quality of work performed and retains the right to approve, suspend, or terminate the practitioners and site. Any further sub delegation shall occur only with the approval of Gateway and shall be monitored and reported back to Gateway.
FORMS AND REFERENCE MATERIALS