

GATEWAY Health Plan
Medicare Assured[®]
Provider Manual
Behavioral Health Care
2011

Gateway Health Plan *Medicare Assured*[®] Provider Manual 2011

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PRODUCT DESCRIPTION

Summary of the Gateway Health Plan *Medicare Assured*[®]

Gateway Health Plan *Medicare Assured*[®] is a Medicare-approved Special Needs Plan for persons who are eligible for both Medicare (Parts A and B) and Medical Assistance (full and QMB). Gateway Health Plan *Medicare Assured*[®] covers all the benefits of Original Medicare and Prescription Drug benefits.

Gateway Health Plan *Medicare Assured*[®] has contracted with Community Behavioral HealthCare Network of Pennsylvania (CBHNP) to manage Gateway Health Plan *Medicare Assured*[®]'s behavioral health services in twenty-seven (27) counties. Counties served are:

Adams	Dauphin	Mercer
Allegheny	Erie	Northampton
Armstrong	Fayette	Northumberland
Beaver	Indiana	Perry
Berks	Lancaster	Schuylkill
Blair	Lackawanna	Somerset
Butler	Lawrence	Washington
Cambria	Lebanon	Westmoreland
Cumberland	Lehigh	York

Summary of Responsibilities of CBHNP and Contracted Providers

Gateway Health Plan[®] has retained the responsibility for the claims processing and payment process. This will assure accuracy of cumulative totals and administration of benefit periods.

CBHNP will perform the following administrative services:

- Build and maintain a network of behavioral health providers in the service area as now designated and as it may be expanded during the course of business.
- Credential and re-credential all network providers.
- Provide Medical Management and Utilization Management Services (Care Management).
- Provide Crisis Intervention hotline and referral services (Member Services).
- Perform Quality Improvement Activities

Contracted Providers will perform the following:

- Provide medically necessary Medicare Part A and B covered behavioral health services to Members.
- Request authorization and follow utilization management protocols as required in this Provider Manual and written notices. CBHNP will provide thirty (30) days notice of any changes in authorization protocols.
- Submit claims for services provided in standard formats with service specific encounter data to Gateway Health Plan[®] according to timeframes specified in the Provider Agreement.
- Abide by all applicable Medicare rules for service delivery, contracting and service provisions.

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- Assist in audits, Quality Improvement activities, investigating Member appeals, claims processing and other managed care operations functions by providing records timely, within the requirements of Medicare, HIPAA and the Mental Health Procedures Act.

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GENERAL INFORMATION

Gateway Health Plan *Medicare Assured*[®] has contracted with Community Behavioral Healthcare Network of Pennsylvania (CBHNP) to be its delegate for Medicare Parts A and B behavioral health services.

CBHNP is responsible to develop and maintain a network of appropriately credentialed, Medicare participating behavioral health providers who agree to provide Medicare Covered Behavioral Health Services to Members. Members of the Gateway Health Plan *Medicare Assured*[®] will be directed to Providers that participate in the CBHNP network. Although CBHNP may assist a *Medicare Assured*[®] Provider regarding administrative services or interpretation of the Participating Provider Gateway Health Plan[®] Agreement, CBHNP is not an insurer, guarantor or underwriter of the financial responsibility of Gateway Health Plan *Medicare Assured*[®] to pay for Covered Behavioral Health Services or the delivery of Covered Behavioral Health Services by Gateway Health Plan *Medicare Assured*[®] providers.

CBHNP Clinical Care Managers are licensed, experienced clinicians with advanced training in mental health/chemical dependency conditions so that they may appropriately assess needs, monitor services, and enable our network providers to provide treatment services in a managed care delivery model.

CBHNP Clinical Care Managers and Member Services Specialists are available 24-hours a day, seven days a week, to address your needs as well as the needs of our Members. Member Services Specialist staff can be reached at **1-866-755-7299**.

CBHNP together with its providers set the standards for progressive, high quality care that is also cost effective. We are happy that you have chosen to be part of our team. Please do not hesitate to phone us if you need assistance or have recommendations for improvement. CBHNP Provider Relations staff can be reached by calling 1-888-700-7370.

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Chapter I **INFORMATION PAGE**

Mailing Address for Claims:

Gateway Health Plan[®]
P.O. Box 69359
Harrisburg, PA 17106-9359

Telephone Numbers

Gateway Health Plan [®] Provider Services Department Available Monday – Friday 8:30 a.m. to 4:30 p.m.	800-685-5205
Member Services / Care Management Available 24 hours a day, 7 days a week	866-755-7299
CBHNP Provider Relations	888-700-7370
Pharmacy	800-685-5215

FAX Numbers

Member Services / Care Management FAX	717-540-1146
CBHNP Provider Relations FAX	717-671-6522

Website Address

Gateway	www.gatewayhealthplan.com
CBHNP	www.cbhnp.org

Authorization Request Forms, Provider Info's, Provider Newsletters, information about how to access Medical Necessity Criteria and more are available on the website.

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Chapter II Member Eligibility

The Enrollment/Disenrollment Process

Gateway Health Plan *Medicare Assured*[®] is a Health Maintenance Organization "HMO" for people with Medicare Part A, Medicare Part B and Medicaid. Most Medicare plans have certain times of the year, called election or special election periods, when a person can apply or disenroll. Gateway Health Plan *Medicare Assured*[®] is a Special Needs Plan (SNP), which must allow the applicant to enroll or disenroll at any time during the year.

Members can enroll into our plan by using these methods: calling Gateway Health Plan[®]; a paper enrollment form; calling 1-800-MEDICARE; or enrolling on-line using www.medicare.gov or the Gateway Health Plan[®] website at www.gatewayhealthplan.com and clicking on the link for *Medicare Assured*[®].

Members can disenroll from Gateway Health Plan *Medicare Assured*[®] by calling Gateway Health Plan[®]; completing a paper disenrollment form; sending a letter/fax to Gateway Health Plan *Medicare Assured*[®] writing a letter to Social Security or Railroad Retirement Board; or by calling 1-800-MEDICARE. Members may also disenroll from Gateway Health Plan *Medicare Assured*[®] by simply enrolling in another Medicare Plan. Members that enroll and disenroll are made effective the first day of the calendar month.

Member ID Cards

Each Gateway Health Plan *Medicare Assured*[®] member receives an ID card. The card is issued once, unless cards are requested or reissued due to a change. ID Cards are good for as long as the person is a member of Gateway Health Plan *Medicare Assured*[®]. (See sample ID cards below).

Front:



Back:



Determining Eligibility through Gateway Health Plan *Medicare Assured*[®]

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

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1. Gateway Health Plan *Medicare Assured*[®] Identification Card

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

2. Gateway Health Plan[®] Digital Voice Assistant (DIVA)

- The Gateway Health Plan[®] DIVA System (1-800-642-3515) is available 24 hours a day, 7 days a week. To verify member eligibility at each visit, providers follow a few simple steps, which are listed below:

Member Identification Number

- Press 1 to verify eligibility using the patient's social security number, when prompted enter the patient's 9-digit social security number
- Press 2 to verify eligibility using the patient's Gateway Health Plan *Medicare Assured*[®] member identification number, when prompted enter the patient's 8-digit Gateway Health Plan *Medicare Assured*[®] identification number
- Press 3 to verify eligibility using the patient's Medical Assistance recipient identification number, when prompted enter the patient's Medical Assistance recipient 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 touch tone phone. For example: To enter an A, B, or C, press the 2 key. For Q, press the 7 key. For Z, press the 9 key.)
- Press 0 to speak to a Provider Services Representative
- Press 9 to repeat the menu

Verification of Date

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

Additional Instructions:

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

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Chapter III **PROVIDER RELATIONS SERVICES**

Credentialing/Re-credentialing

Gateway Health Plan[®] has delegated to CBHNP responsibility for credentialing and re-credentialing providers of behavioral health services for Gateway Health Plan *Medicare Assured*[®].

CBHNP has an established network of behavioral health providers for Gateway Health Plan *Medicare Assured*[®] that is capable of offering the full scope of care and service resources within established standards of access and choice. All network providers are credentialed and re-credentialed to provide clinical care and services. Gateway Health Plan[®] has formally assigned responsibility for the credentialing and re-credentialing review function to the CBHNP Credentialing Committee. The Credentialing Committee, part of the Provider Network Operations Department, performs the review of behavioral health provider credentials, for credentialing and re-credentialing activities. The Credentialing Committee reviews information and makes recommendations for approval or disapproval of each entity.

The following types of provider organizations, facilities and individual behavioral health providers fall under the scope of authority of the credentialing/re-credentialing process:

- Board Eligible or Board Certified Psychiatrists
- Licensed Psychologists
- Licensed Clinical Social Workers
- Physician Assistants
- Certified Registered Nurse Practitioners
- Hospital/Inpatient Facilities
- Community Mental Health Centers
- Substance Abuse Treatment Organizations

Individual Provider Application

In order to be credentialed for the Gateway Health Plan *Medicare Assured*[®], CBHNP requires each individual behavioral health practitioner to have an active Medicare number. The practitioner must complete a credentialing application. Practitioners interested in joining the Gateway Health Plan *Medicare Assured*[®] network must contact CBHNP Network Development or Credentialing staff and provide a representative with your name, address, date of birth and Medicare number. Before receiving the credentialing application, the provider will receive a Gateway Health Plan *Medicare Assured*[®] provider agreement. The provider must submit the signed agreement to CBHNP. After CBHNP receives the signed agreement, CBHNP credentialing staff will forward the information listed above to our primary source verification provider (Med Advantage CVO). CVO will forward a credentialing application to you for completion. You must complete the application and provide evidence such as copies of diplomas, licenses, insurance riders, documentation of privileges, etc. You may contact CBHNP Credentialing at 1-888-700-7370.

Following the primary source verification processes, the Credentialing Committee makes a determination regarding network participation.

With the exception of information obtained from NPDB and peer references, you have the right to review, if you desire, information received by CBHNP that supported the credentialing decision. Additionally, it is

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your right to correct any erroneous information that varies substantially from that which you reported and to be made aware of the status of your credentialing/re-credentialing application, upon request.

Professional Provider Organization and Facility Application Process

Other than Hospitals and Partial Hospitalization Programs, facility and professional provider organizations do not need to complete a Facility Application or be credentialed. These facilities and provider organizations must have all of their Medicare approved practitioners credentialed. The facility or provider organization must complete a Provider Payee Form, Provider Assignment Form and Provider Acceptance form in order to receive payment for those practitioners under that facility or group. To participate in the Gateway Health Plan *Medicare Assured*[®], you must have approval from Original Medicare to provide the service. For example, Medicare may have approved you for outpatient mental health services but not for partial hospitalization. Even though you carry a valid license from DPW for partial hospitalization services, you would not be permitted to bill for *Medicare Assured*[®] Members through Gateway Health Plan[®] until you have approval from Medicare for partial hospitalization services.

You may request an application from the Centers for Medicare and Medicaid Services (CMS) website at www.cms.hhs.gov. Once in the website, in the search box, enter 855i for individual application, 855b for group or clinic application or 855a for facility application. You may call CBHNP Provider Relations at 1-888-700-7370 to request assistance.

With the exception of information obtained from NPDB and peer references, you have the right to review, if you desire, information received by CBHNP that supported the credentialing decision. Additionally, it is your right to correct any erroneous information that varies substantially from that which you reported and to be made aware of the status of your credentialing/re-credentialing application, upon request.

Credentialing Site Visit

Initial site visits will be required for any potential high volume Provider (licensed organization) or potential high volume independent practitioner. Outpatient services (individual, family and group therapy, medication management and psychiatric evaluations) are considered to be high volume services. Outpatient is typically the gateway to higher levels of care and captures the largest segment of unique Members served. In order to be identified as a potential high volume provider who would require a site visit, the provider/practitioner will indicate that they have existing capacity to serve more than 200 Members. The initial site visit to the office of potential high-volume behavioral healthcare providers and practitioners will occur prior to the credentialing decision. The office site visit includes evaluation of the facility for accessibility, appearance, adequacy of waiting and treatment rooms, appointment availability, and appropriate treatment record keeping practices.

The minimum score for initial and re-credentialing visits is 80%. The Provider Relations Representative will assist the Provider to the extent practical and appropriate relative to improvement. The Provider Relations Representative will provide a report with recommendations for improvement to the Provider, and if a score below 80% is received, will re-visit the site within six (6) months to assess progress. Assistance will be documented in the provider file and will include dates and assistance that was provided. This will continue until the Provider meets standards or declines further participation in the process.

Initial site visits will be required for any non-accredited Provider Organization using the same criteria as indicated above with the following exception. CMS or State review or certification does not serve as

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accreditation of an organization. However, in the case of non-accredited organization; NCQA permits that CBHNP may substitute a CMS or State review in lieu of the required site visit. State licensing tools have been reviewed and are acceptable to meet CBHNP's standards. CBHNP will obtain the report directly from the organization. Should the organization have not obtained full licensure, CBHNP will conduct a site visit.

The application and site visit report are reviewed by the CBHNP Credentialing Committee for an approval or disapproval determination regarding the organization /facility's CBHNP network participation.

Re-credentialing

Re-credentialing involves the periodic review and re-verification of clinical credentials of CBHNP network providers. The Provider Network Operations Department maintains an active file of all CBHNP credentialing decisions. A tickler system ensures each professional provider organization, facility, and individual behavioral health provider is re-credentialed as scheduled. As part of this process, CBHNP periodically reviews provider information from the National Practitioner's Data Bank.

At a minimum the re-credentialing process occurs every three years. The re-credentialing process includes an up-to-date re-examination of all the materials and a review of the following:

- Member complaints and grievances
- Results of quality indicators monitoring and evaluating activities
- Care Management provider profiles, as available
- Utilization Management provider profiles, as available
- Member satisfaction surveys, as available
- Re-verification of licensure standing
- Re-verification of hospital privileges
- Review of incident reports

Adding a New Site or Service

When a high volume provider relocates or opens a new site CBHNP must evaluate the new site. Providers are contractually bound to report changes that affect referrals. CBHNP must review the new site as soon as possible but before the provider's re-credentialing date. Providers who are adding a new service should complete Part II of the initial credentialing application and submit it with required attachments to the attention of the Provider Relations Representative. The Provider Relations Representative will notify you if a site visit is necessary.

Policies for Suspension, Reduction of Privileges and Termination

Progressive Discipline Policy

CBHNP retains the right and responsibility to credential and recommend for approval all new professional provider organizations, facilities, and individual behavioral health providers.

Professional provider organizations, facilities, and individual behavioral health providers may have their provider status reduced, suspended, or terminated for failure to perform according to the clinical, quality, or other administrative criteria of the provider agreement. Recommendations to adjust individual privileges

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and/or the Gateway Health Plan *Medicare Assured*[®] Plan network status of a qualified provider organization or facility are rendered on behalf of the organization by the CBHNP Credentialing Committee.

The Credentialing Committee assumes responsibility for notification of any changes in the Gateway Health Plan *Medicare Assured*[®] network status to the affected professional provider organizations, facilities and/or individual behavioral health providers. Notification is given fourteen (14) days prior to the effective date of reduction, suspension, termination or change in status. This provision for advanced notification is set aside in the event that any activities by the professional provider organizations, facilities and/or individual behavioral health providers place Members receiving care and/or services in danger, or if there is evidence of fraud or criminal activity.

The written notice to the professional provider organizations, facilities and/or individual behavioral health providers states the circumstances warranting the adjustment and, at the discretion of the CBHNP Credentialing Committee, specifies a reasonable period within which the professional provider organizations, facilities and/or individual behavioral health providers may remedy the failure to perform according to standards. The professional providers are advised of the right to appeal the decision.

Reporting of Serious Quality Deficiencies to Appropriate Authorities

In any case in which the adjustment of qualified provider status of any professional provider organizations, facilities and/or individual behavioral health providers is based upon ethical, criminal, or other serious quality performance concerns, CBHNP follows established guidelines of reporting to the appropriate authorities. The guidelines are set forth by the corporate office of the organization.

Provider Appeal Process

The professional provider organizations, facilities and/or individual behavioral health provider may appeal the decision to reduce, suspend, or terminate clinical privileges or change provider status by formally requesting such a review at any time before the effective date of adjustment. The right to appeal and procedures to follow is included in the notification of the original decision. The steps to the appeal process are as follows:

- The professional provider organization, facility and/or individual behavioral health provider must formally file an appeal in writing with the CBHNP Executive Director and/or the CBHNP Director of Quality Improvement (QI). The request for appeal is logged, and the issue is tracked until resolution.
- Written acknowledgement of the request to appeal is sent within 72 hours of receipt of the appeal by the CBHNP Executive Director and/or the CBHNP Director of QI.
- The initial level in the network status change appeal process is reviewed by the CBHNP Medical Director. The CBHNP Medical Director makes a determination within ten (10) days.
- The CBHNP Executive Director and/or Director of Quality Improvement sends “Notification of disposition of appeal” to the professional provider organization, facility and/or individual behavioral health provider.
- If the provider is dissatisfied with the decision, a second and final level appeal may be requested. The request is made in writing to the CBHNP Chief Executive Officer.
 - The provider appeal is presented to a representative panel of peer advisors with no previous involvement in the decision to change the provider’s network status. The provider is given advance written notice of the panel’s meeting, including the date; time and place the disputed matter will be considered.

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- The provider is afforded the opportunity to present supporting statements and documentation. The panel renders a decision within fifteen (15) days of the meeting, and advises the professional provider organization, facility and/or individual behavioral health provider of the final decision in writing.
- The provider contract contains a provision for arbitration of any disputes that cannot be resolved through the internal appeal process. The parties agree not to bring any judicial action against the other until all administrative remedies have been exhausted.

Contracting and Rate Notices

Gateway Health Plan *Medicare Assured*[®] uses a standard Provider Agreement that has been approved by Gateway Health Plan[®] and CBHNP. CMS approved the agreement to assure that it includes all required language per Gateway Health Plan *Medicare Assured*[®] as well as rules and regulations around managed care services.

Gateway Health Plan *Medicare Assured*[®] payment structure mirrors Original Medicare. Providers will use the same procedure codes and rates established by Original Medicare. Gateway Health Plan[®] will reimburse services at 100% of the Medicare Physician Fee Schedule based on the place of service code and rendering practitioner's type less any deductible and/or coinsurance amounts. The Gateway Medicare Specialist Fee Schedule shall be implemented and updated in accordance with the release and implementation of updates by the Center for Medicare and Medicaid Services.

As a network Provider, you will occasionally receive a "Rate Notice" which is an official amendment to the Provider Agreement. Providers will have 30 days notice of rate changes. Providers who do not accept the terms of the Rate Notice may terminate the Agreement upon 30 days written notice.

Inpatient services are not addressed on the fee schedule, rather they are negotiated rates. Providers of inpatient services may request rate increases at any time. Gateway Health Plan *Medicare Assured*[®] will consider the request and respond accordingly. **Please know that rate adjustments will never be made retroactively at any time.**

Your Provider Agreement automatically renews each year. An amendment to the agreement will be generated only if new services are added due to new CMS changes. Rate Notices are used to document rate or per diem changes to existing services.

Provider Data Updates

It is critical that Providers notify their Provider Relations Representative immediately if anything has changed which will affect our ability to refer Members to your organization or practice. Further notification must be provided in writing to avoid any miscommunication. CBHNP has created a form called "Provider Data Update Form." Providers are welcome to use the form however; that specific format is not required. Information can be faxed to Provider Relations at 717-671-6522.

Regular reporting will benefit the Provider, in that they will be updated appropriately in the Provider Directory.

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Provider Profiling

CBHNP recognizes that its Quality Improvement Program is dependent on the quality of service rendered by network providers. To this end, it will monitor providers using specific outcome measures.

The CBHNP Credentialing Committee establishes indicators and performance standards, reviews and trends results, and recommends corrective action when necessary. Network providers that consistently fail to meet standards will be placed on probationary status pending corrective action, and are in jeopardy of contract termination. Provider Indicators and Standards Provider Profiling Reporting) are integrated into the re-credentialing decision process.

Provider Profile Reporting

On a monthly basis, the Provider Relations Department produces reports of select performance indicators for each provider who is undergoing re-credentialing during that particular month.

Performance will be compared against following standards:

1. 90% of the Members responding to provider surveys conducted by CBHNP will report positive experiences.
2. No negative trends or single serious, substantiated complaints are identified for any single provider based on the Provider Complaint database system.
3. Additional measures may be designated by the Credentialing Committee or Quality Improvement Committee and included for review by providers, Members, family Members, and Counties.

Individual Outcome Measures

The CBHNP Credentialing Committee will meet to credential and re-credential Providers on a monthly basis. Provider Relations will report outcome measures for those providers who are undergoing re-credentialing during that particular month. This report gives a detailed review that allows the Credentialing Committee to further refine the Provider Profile Methodology as well as provide consistent and frequent feedback to the provider regarding performance. The Credentialing Committee will determine the need for follow-up site visits and specific performance indicators for providers based on available data from performance measures collected. Follow-up areas may include, but are not limited to:

- **Access to Care** - Providers will be expected to offer/schedule appointments and/or admission consistent with Gateway Health Plan[®] access standards for Emergent, Urgent, and Routine care.
- **Medical Record Completeness and Accuracy** - Gateway Health Plan *Medicare Assured*[®] will conduct medical record reviews, either using redacted charts or with properly signed Release of Information forms, to review documentation for completeness of information, accuracy, appropriate signatures, current treatment plan and supporting documentation, and discharge planning.
- **Level of Care Consistency** - The diagnosis, treatment plan and documentation must be consistent, and must reflect that the level of care delivered was appropriate to treatment needs presented by the Member.
- **Accreditation, Certification, and Licensure**- Each provider must meet qualifications/licensure requirements as designated by CMS, Gateway Health Plan *Medicare Assured*[®] and CBHNP.
- **Compliance with Gateway Health Plan *Medicare Assured*[®] requirements** – Providers are rated on standards that measure compliance with administrative requirements of Gateway Health Plan *Medicare Assured*[®]. This includes requests for authorizations for admission and continuation of

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care; claims and encounter data submissions; coordination of care; aftercare planning and follow-up.

Complaints against Providers

All complaints against network providers, subsequent appeals, and resolution of such activities are entered into the complaint and grievance database system by the Quality Improvement Department. The database will be queried monthly for information regarding Providers who are ready for re-credentialing. Complaint and Grievance information will be used in the re-credentialing decision.

Actions

The Credentialing Committee may make one or more of the following recommendations to the CBHNP Quality Improvement Committee and JAC (Joint Administrative Committee), based on the provider not reaching acceptable levels of performance:

1. No action
2. Probationary status with a specified period for continued observation
3. Corrective Action Plan, documentation, and monitoring required
4. Suspension
5. Termination of the provider from the network

All Providers must be actively enrolled and in good standing with the Medicare Program and not be included on the:

List of Excluded Individuals/Entities; <http://oig.hhs.gov/fraud/exclusions.asp>,
Or the Medicare “Opt-Out” List; <http://www.hgsa.com/bene/optout.html>.

Provider Staff Credentialing

Licensed provider organizations have a responsibility to verify the credentials of their staff. Prior to credentialing any organizational Provider, CBHNP verifies that there is an acceptable process in place for provider staff credentialing. Providers must verify and maintain documentation to verify the following:

- 1) Primary source verification that the Practitioner’s license is in good standing (for PA State Licensed Practitioners, search <http://licensepa.state.pa.us/>).
- 2) Verification that there are no sanctions on a practitioner’s license. (for PA State Licensed Practitioners, search <http://licensepa.state.pa.us/>).
- 3) Primary source verification of the highest level of education for all employees. Note that for Board Certified Psychiatrists, primary source verification of Board Certification is acceptable to meet this requirement.
- 4) Verification that the employee has not been terminated, suspended, precluded or excluded from the Medicare and/or Medical Assistance Program. (See <http://www.dpw.state.pa.us/PartnersProviders/MedicalAssistance/DoingBusiness/FraudAbuse/003673510.aspx> OR <http://exclusions.oig.hhs.gov/>)

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- 5) A resume that shows continuous employment for the past five years. Any breaks in employment must be explained in writing.
- 6) For licensed practitioners, a query to the National Practitioners Databank (NPDB).
- 7) Verification of the DEA certificate for psychiatrists.

These elements will be reviewed at credentialing and re-credentialing site visits. Providers are encouraged to review NCQA Standards for more information. Please see NCQA's website at <http://www.ncqa.org>

Provider Appeals of Payment Denial

Clinical Care Managers are not permitted to backdate any request for authorization. Such requests must be submitted through the provider payment denial appeal process. The process for appeal requests is outlined below.

Providers are expected to follow all prior authorization requirements as defined in the Provider Manual and Provider Infos. This policy is intended to address claims denial only. Any denial that occurs after the service has been rendered is subject to review under the provider appeal process or reconsideration, but not both types of reviews. For services not yet provided, the Gateway Health Plan[®] reconsideration policy and procedure will apply.

Reversal of payment denials should be regarded as an exception and will not be routinely approved without compelling evidence that the Provider did not follow protocol due to legitimate special circumstances as determined by CBHNP. CBHNP will evaluate all requests and take into consideration factors that caused the procedural error as well as remedies in place to prevent future occurrences.

CBHNP will be responsible for all first and second level internal review appeals. The provider must initiate the formal Provider Payment Denials Appeal process through a written appeal request. All requests must go to:

Gateway Health Plan[®]
Attention: Medicare Complaint Administrator
U.S. Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219-2704

Claims appeals are subject to the Member Reconsideration/Appeal process outlined in Chapter VIII. Members may request reconsideration of prior authorization denials or of claim payment denials. Providers may address claim payment denials via the Provider Appeal Process.

Providers requesting review of a payment denial will be instructed to send a letter stating the following:

- Plan Name (Gateway Health Plan *Medicare Assured*[®])
- Member name
- Members Gateway Health Plan *Medicare Assured*[®] ID Number
- Documentation of Members seen/dates services provided and billable amount(s)
- The service that was delivered
- Reason for the delay or failure to get authorization
- Explanation of circumstances

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- Steps taken to correct and prevent future occurrences
- Desired action from CBHNP
- Documentation relevant to the request (i.e.... Eligibility slips verifying that Eligibility was checked and wrongly indicated enrollment status, fax confirmation page, etc....)
- **ALL** relevant information should be included with your appeal.

Appropriate reasons for approval (reversal of the non-authorization decision) include but are not limited to:

1. Documentation of eligibility verification issues beyond the control of the provider.
2. Documentation of processing errors by CBHNP or Gateway Health Plan[®].
3. Documentation of continued stay review issues beyond the control of the provider.
4. Unavoidable delays caused by another provider.
5. Any other reason as decided by the review committee.

Reasons to uphold a non-authorization decision include but are not limited to:

1. Failure in authorization management by the provider.
2. Submission of the request for review beyond 90 days of the initial notice or service delivery date.
3. Failure to check eligibility prior to service delivery.
4. Failure in claims or billing management by provider.
5. This was a MNC denial when services have already been provided.
6. Any other reason as decided by the review committee.

A decision will be made within 30 days of receipt of the documentation and a written decision will be mailed within 5 days of the decision but must also be mailed within 30 days of receipt of the appeal request. If the request is approved and the claim is in the Gateway Health Plan[®] claims processing system, CBHNP will contact Gateway Health Plan[®] to adjudicate the claim. The approval letter serves as authorization and you should retain it in your records.

Second Level Review

A provider may request a second level internal review. The provider must request the second level review in writing and the request must be received at Gateway within 30 days of the date of the first level internal review decision letter. All second level appeal requests must set forth the specific reason why the provider feels that the first level decision was in error.

A second level determination will be completed within 45 days of receiving the payment denial appeal. The provider may elect to participate in the review by telephone or in person to present information. The provider's written appeal request must indicate the provider's intention to participate in these proceedings.

You should direct questions on this process to CBHNP Provider Relations at 1-888-700-7370.

All relevant information must be submitted with the appeal, as the decision of the Second Level Committee review is final.

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Chapter IV

PROVIDER RESPONSIBILITIES

Compliance with Law and Regulation

Per the participating provider agreement, Providers must comply with all applicable Rules, Regulations and Requirements of CMS and any other applicable entity.

Members Rights and Responsibilities

The member's rights and responsibilities are listed in the Gateway Health Plan *Medicare Assured*[®] Evidence of Coverage (EOC). This information is available on the internet at www.gatewayhealthplan.com. Members also receive a copy of the EOC from Gateway Health Plan *Medicare Assured*[®] every year.

Compliance with the Americans with Disabilities Act

Gateway Health Plan *Medicare Assured*[®] Network Providers have a responsibility to remove "non-physical" barriers to service and to make available at the request of its clients the following:

- Assisted listening devices
- Large print or Braille forms
- Sign language services
- Telecommunications devices for the deaf

Section 504 of the Rehabilitation Act of 1973 (Section 504) and Titles II and III of the Americans with Disabilities Act of 1990 (ADA) set forth requirements for Providers in serving persons who are deaf and hard of hearing or have other disabilities. This manual strives to alert Providers to their responsibilities.

Providers should consult their legal counsel with questions or concerns.

A person with a disability cannot be denied or excluded from services or treated differently. Auxiliary aids and services must be available at no additional cost to ensure effective communication.

Section 504 at 45 CFR Part 84 of the Rehabilitation Act of 1973 prohibits discrimination applying to service availability, accessibility, delivery, employment and the administrative activities and responsibilities of organizations receiving Federal financial assistance. Relative to Health Care and Human Services settings, a recipient of Federal financial assistance may not, on the basis of disability:

- ✓ Deny qualified individuals the opportunity to participate in or benefit from federally funded programs, services, or other benefits.
- ✓ Deny access to programs, services, benefits or opportunities to participate as a result of physical barriers.

The ADA states that Public Entities must:

- ✓ Provide services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

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- ✓ Make reasonable modifications in their policies, practices and procedures to avoid discrimination on the basis of disability, unless they can demonstrate that a modification would fundamentally alter the nature of their service, program or activity.
- ✓ Ensure that individuals with disabilities are not excluded from services, programs and activities because buildings are inaccessible
- ✓ Provide auxiliary aids to individuals with disabilities, at no additional cost, where necessary to ensure effective communication with individuals with hearing, vision or speech impairments. Auxiliary aids include but are not limited to qualified interpreters, assistive listening headsets, television captioning and decoders, telecommunications devices for the deaf (TDD's), videotext displays, readers, taped texts, brailled materials and large print materials.

The material presented above comes from the OCR Fact Sheet U.S. Department of Health and Human Services Office for Civil Rights Washington DC 20201. Copies can be obtained by calling: 1-800-368-1019 (voice); 1-800-537-7697 (TDD); or e-mail ocr@os.dhhs.gov

Suggestions:

- ✓ All Provider staff should be aware of Members' rights as well as the Provider's responsibilities as defined in Titles II and III of the ADA of 1990, Section 504 of the Rehabilitation Act of 1973, Mental Health Procedures Act of 1966 and the Drug and Alcohol Abuse Control Act of 1972. Contact the Pennsylvania Office for the Deaf and Hard of Hearing for additional information on resources that may assist you. It is suggested that you use the Pennsylvania ODHH Main Office number to speak with the Administrative Assistant to reach your regional representative.
- ✓ Awareness of language and communication barriers at the beginning of treatment is critical in order to support success in treatment. A good initial assessment should include questions about communication methods.
- ✓ Modes of communication could consist of Computer Assisted Real-time Transcription (CART), Assistive Listening Devices (ALD), Qualified Sign Language Interpreter, PC, and writing. Ask the Member what is their preferred method of communication. Do not assume that all Members who are deaf or hard of hearing read lips.
- ✓ When using writing as a method of communication accommodation, be aware of the vocabulary level of the individual.
- ✓ Make connections with specialized services so they are readily available when you need them. Have Agreements in place before the need presents (i.e..... interpreters). Be proactive and budget for this expense.

Use of an Interpreter

- ✓ The interpreters' role is to facilitate communication and serve as a source of cultural information when necessary. An interpreter must never offer an opinion about a subject he/she is not an expert in.

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- ✓ Never use a family Member, as objectivity may be affected, the Member may be inhibited and not comfortable to speak freely, the Member's right to confidentiality is breached and it becomes impossible for a clinician to get a true, uncompromised picture of the Member's skills.
- ✓ Don't assume that a staff person who knows sign language is qualified to interpret.
- ✓ Always use certified interpreters with experience or training.
- ✓ Encourage pre-and post-session meetings between the practitioner and the interpreter. Allow for longer sessions when an interpreter is used.

Resources for Consumers and Providers

Disability Law Project

(215) 238-8070 (Voice)

(215) 789-2498 (TDD)

(215) 772-3126 (Fax)

Pennsylvania Protection & Advocacy

800-692-7443 (Voice)

877-375-7139 (TDD)

Pennsylvania Assistive Technology Lending Library

800-204-7424 (Voice)

800-750-7428 (TTY)

Pennsylvania TTY/Assistive Communications

800 670-7303 (Voice) or 717-236-2400 (Voice)

800-440-0374 (TTY)

717-236-5733 (TTY)

717-236-5733 (Fax)

Pennsylvania Office for the Deaf and Hard of Hearing

800-233-3008 (Voice/TTY)

717-783-4912 (Voice/TTY)

717-783-4913 (Fax)

National Association for the Deaf

301-587-1788 (Voice)

301-587-1789 (TTY)

301-587-1791 (Fax)

American Society for Deaf Children

703-739-1049 (Voice)

703-739-0874(TTY)

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Self for Hard of Hearing People

301-657-2248 (Voice)

301-657-2249 (TTY)

301-913-9413 (Fax)

National Institute on Deafness and other Communication Disorders Clearing House

800-657-2248 (Voice)

800-241-1055 (TTY)

301-907-8830 (Fax)

Gateway Health Plan[®]/CBHNP Member Services Department will assist Members with a request for special needs and Gateway Health Plan *Medicare Assured*[®] Provider Relations Department will assist the Provider in meeting this goal when applicable.

Cultural/Ethnic/Racial Sensitivity

All Providers are expected to be aware of and sensitive to their organization's cultural competency, creating an environment whereby the developmental, cultural and linguistic needs of Members are taken into consideration. Providers must have policies and procedures to assure that requests be initiated by non-English speaking Members, and that the organization staff is equipped to handle the requests appropriately. Gateway Health Plan[®] may monitor this area during provider profiling, site visits, or other activities.

Confidentiality

Gateway Health Plan *Medicare Assured*[®] Providers will ensure that Members personal and clinical information are kept secure and confidential, and that access will be limited to authorized persons only as identified by Member signed releases.

Providers are required to abide by all state and federal laws and regulations in regards to Member confidentiality, including HIPAA.

Release of Information Forms

Gateway Health Plan *Medicare Assured*[®] Providers will coordinate care with the Member's PCP, other behavioral health care providers, etc., as needed. A signed release form must be documented and kept on file. A Provider may use his/her own release forms for this purpose as long as they meet all requirements of statute and law.

To guarantee Member confidentiality, Gateway Health Plan[®] and CBHNP complies with federal and state regulations governing the release of client information (disclosure of confidential information) and record retention. Gateway Health Plan[®] and CBHNP maintain strict policies concerning internal security, review processes, disposal of confidential documents and distribution of statistical information. Gateway Health Plan[®] and CBHNP also require all Providers to adhere to strict confidentiality measures including:

- Password protection of on-line Member information.
- Written consent from Member/guardian is required before disclosure of any information, except as allowed by law, (e.g., emergency treatment, under court-order, etc.). Drug and Alcohol services require Member consent regardless of age.

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- Members, 14 years and older, receiving mental health services shall control the release of their medical record. Any release of information forms needed shall be signed by the Member, when the Member is 14 years or older. Drug and Alcohol services require Member consent regardless of age.
- Members who are under the age of 14 years or who are incapacitated, except for Members in drug and alcohol treatment, may not sign their own release of information forms. In these cases the parent or guardian shall sign the release of information forms.
- Members of any age receiving drug and alcohol services shall control the release of their medical records, in accordance with state and federal laws.
- Gateway Health Plan *Medicare Assured*[®] Providers have the responsibility to make sure the release of information form is explained and understood by the Member/guardian prior to being signed.
- A copy of the signed release of information form will be filed in the Member's medical record and a signed copy given to the Member/guardian.
- Gateway Health Plan *Medicare Assured*[®] Providers may release information when the Member's condition is life threatening and it is impossible to obtain the Member's/guardian's consent. All such occurrences must be thoroughly documented in the Member's record.
- Verbal disclosure about a Member can only be made if the Member/guardian has a signed release of information form specifying the information to be released.
- Any documents released or exchanged between Gateway Health Plan[®], CBHNP and a Gateway Health Plan *Medicare Assured*[®] Provider must include a statement regarding the confidentiality of the information exchanged.
- Any Gateway Health Plan *Medicare Assured*[®] Provider violating any of the confidentiality policies and procedures will be subject to disciplinary action.
- Release of information forms should be signed by the Member/guardian during the first session and retained in the Member's chart. If the Member/guardian refuses to allow the release of information, this must be clearly documented in the Member's chart.

Providers may use their own consent form to release information in accordance with the federal and state laws that govern confidentiality for mental health, e.g. Federal Regulations 42 CFR, part 2; Pennsylvania stature D&A Control Act & State Regulations, 28 PA Code Subsection 255.5, PA Code Title 55, Subsection 5100.33-39, 5200.41, 5210.56, 5221.52; Health Care Financing Administration, 42 CFR Chapter IV, 10-1-93.

Appointment Availability

Providers are required to maintain hours sufficient to meet the demand of the practice. If a provider site cannot meet the Member's need within the specified timelines for emergent, urgent, or routine care, as indicated below, Providers must inform the Member that they can contact Gateway Health Plan *Medicare Assured*[®] Member Services Department to obtain additional Provider options. The Member has the right to choose to wait for the next available appointment; however this must be clearly documented in the Member's medical record.

Access Standards

The required Provider responses time for emergent, urgent and routine services as follows:

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Life Threatening Emergencies

Providers must ensure that Gateway Health Plan *Medicare Assured*[®] Members receive an appointment within **one hour** of the request for services.

Definition of Life Threatening Emergency: A situation requiring immediate care to a Member to prevent death, serious injury or deformity of the Member.

Non-Life Threatening Emergencies

Provider must ensure that Gateway Health Plan *Medicare Assured*[®] Members receive an appointment within **six hours** of the request for services.

Definition of Non-Life Threatening Emergency: A behavioral health condition where the Member may suffer significant physical or emotional deterioration resulting in hospitalization or partial hospitalization unless an intervention is made within **six hours**.

Urgent

Providers must ensure that Gateway Health Plan *Medicare Assured*[®] Members receive an appointment within **twenty-four (24) hours** of the request for services.

Definition of Urgent: The diagnosis and treatment of medical conditions that are serious or acute but pose no immediate threat to life and health, but which require medical attention within **24 hours**.

Routine

Providers must ensure that Gateway Health Plan *Medicare Assured*[®] Members receive an appointment within **10 business days** of the request for services.

Definition of Routine: Routine services are those services not deemed emergent or urgent.

Critical Incident Reporting

The following information on Critical Incident Reports is **targeted for implementation** in the **near future**. It is being provided here to assist you with any planning for implementation of this future requirement.

Gateway Health Plan *Medicare Assured*[®] providers are expected and required to develop written policies and procedures for an incident management process, take strong measures to prevent the occurrence of critical incidents, investigate and report on those that occur, and to take reasonable corrective action to prevent reoccurrence.

All Gateway Health Plan *Medicare Assured*[®] providers will be required to report critical incidents within 24 hours of the time at which the provider becomes aware of the occurrence.

The following incidents must be reported immediately:

1. Death of a Member.

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2. Suicide attempt.
3. Medication error.
4. Any event requiring the services of the fire department, or law enforcement agency.
5. Abuse or alleged abuse involving a Member.
6. Any injury or illness (non-psychiatric) of a Member requiring medical treatment more intensive than first aid.
7. A Member who is out of contact with staff for more than 24 hours without prior arrangement, or a Member who is in immediate jeopardy because he/she is missing for any period of time.
8. Any fire, disaster, flood, earthquake, tornado, explosion, or unusual occurrence that necessitates the temporary shelter in place or relocation of residents.
9. Seclusion or restraint.
10. Other incident identified by Providers as Critical, Adverse or Unusual.

Some definitions:

Medication Error:

Any missed medication, incorrect medication or incorrect dosage, where a Member requires treatment greater than first aid for adverse effects of the medication.

Abuse:

Any act of alleged or suspected abuse, neglect of a consumer which could include physical, verbal, psychological or sexual abuse, exploitation, neglect and misuse of a Member's funds.

Injury or Illness of a Member:

Any injury or illness where the Member requires medical treatment more intensive than first aid. First aid includes assessing a condition, cleaning an injury, applying topical medications, applying a band aid, etc. Treatment beyond first aid includes but is not limited to lifesaving interventions such as CPR or use of the Heimlich maneuver, wound closure by a medical professional, casting or otherwise immobilizing a limb. Evaluation/assessment of an injury by emergency personnel in response to a "911" call is reportable even if the individual is not transported to an emergency room. This incident type includes:

- Diseases reportable to the Department of Health, defined as any disease reportable on the Pennsylvania Department of Health List of Reportable Diseases. Report is only required when disease is initially diagnosed.
- Emergency Room Visits are defined as the use of a hospital emergency room. This includes situations that are clearly "emergencies" as well as those when an individual is directed to an emergency room in lieu of a visit to a primary care physician (PCP) or as a result of a visit to the PCP. The use of an emergency room by an individual's PCP, in place of a physician's office is not reportable.
- Hospitalization, defined as an inpatient admission to an acute care facility for the purposes of treatment. Scheduled treatment of medical conditions on an outpatient basis is not reportable.

Restraint:

Any chemical, mechanical, or manual technique used for the purpose of restricting movement. A chemical restraint is a medication used to control acute or episodic behavior that is not the standard treatment for the Member's medical or psychiatric condition, and is intended to significantly lower the individual's level of consciousness and restricts the movement of a Member. A medication ordered by a physician as part of the ongoing individualized treatment plan for treating the symptoms of mental, emotional, or behavioral disorders is not a chemical restraint. A mechanical restraint is a device used to control acute or episodic behavior that restricts movement or function of a Member or portion of a Member's body. Examples of

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mechanical restraints are handcuffs that are locked around the wrists, elbow restraints, foot restraints, cloth harnesses applied to any portion of the body, and blanket wraps. Mechanical restraints do not include measures to promote body positioning to protect the Member and others from injury, or to prevent the worsening of a physical condition. Devices also used for medical treatment such as helmets for prevention of injury during seizure activity, mitts, and muffs to prevent self-injury are not considered restraints. A manual restraint is a physical hands-on technique that restricts the movement or function of a Member's body or portion of a Member's body. Prompting, escorting, or guiding a Member who does not resist assisting in the activities of daily living is not a manual restraint.

Seclusion:

Restriction of a Member in a locked room, and isolating the person from any personal contact. The term "locked room" includes any type of door locking device such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door closed, preventing the individual from leaving the room. Seclusion does not include the use of a time-out room. Locking an individual in a bedroom during sleeping hours is considered seclusion.

Time-out Room:

An unlocked room used to remove an individual from the individual's immediate environment to reduce stimulation and assist the individual to regain self-control. Use of a time-out room constitutes a potential alternative to the use of seclusion and restraint.

Medical Records Standards

The Quality Improvement Program provides guidelines for medical record documentation for Gateway Health Plan *Medicare Assured*[®] Providers. These guidelines are consistent with the standards of national accrediting organizations. Gateway Health Plan *Medicare Assured*[®] Medical Records standards for behavioral health providers are as follows:

Accessibility and Availability of Medical Records

Provider contracts include provisions to permit Gateway Health Plan[®] and CBHNP Quality Improvement staff, and appropriate/required agencies access to the medical records of Gateway Health Plan *Medicare Assured*[®] Members. Records may be reviewed to monitor quality, medical necessity, coordination of care, and continuing care planning.

Gateway Health Plan *Medicare Assured*[®] Providers are contractually obligated to maintaining medical record documentation of each encounter with Gateway Health Plan *Medicare Assured*[®] Members.

Recordkeeping

Standards are established for organization, content, and readability of the Gateway Health Plan *Medicare Assured*[®] Member's medical records. The Member medical record documentation may be either paper based or electronic. Documentation must be current, detailed, organized, comprehensive, and legible, promote effective care, and facilitate quality review. Providers must adhere to all applicable federal and state confidentiality regulations for treatment records. By provider contract, treatment records must be made available for review by Gateway Health Plan[®], CBHNP and appropriate/required agencies for quality improvement purposes. Data elements for Member medical records include:

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- The Member's name and/or client number on each page of paper documentation and on every entry of electronic records.
- The Member's identifying information and demographics to include:
 - Name
 - Age and Date of Birth (DOB)
 - Address and County of residence
 - Home, work telephone number and/or method of contact
 - Employer or school
 - Marital status
 - Legal status
 - Parent/Guardian Name (for children and non-adjudicated adolescents)
- Name and contact information of Primary Care Physician (PCP)
- All entries are dated; author of documentation is identified by name, title, credential and signature (paper) or key identifier (electronic).
- Written documentation is legible to someone other than writer or affiliated staff colleagues. Legibility is determined through review by CBHNP Staff.
- Allergies to include medication allergies and adverse reactions. Absence of allergies is noted as "no known allergies – NKA".
- Risk factors/Risk assessments
- Past Medical History/Treatment History to include:
 - Significant Health Events – accidents, operations, hospitalizations
 - Developmental History (for children and adolescents)
 - History of past behavioral health interventions/treatment to include dates and duration of services and level of care
 - DSM-IV diagnoses for all axes I through V
- Medication Information to include medication name, frequency, dosage, effectiveness of treatment regime and any known side effects for:
 - Past medications for physical conditions
 - Past psychotropic medications
 - All current medications
 - Evidence that current medication has been consistently provided as prescribed and reevaluated as necessary; changes in medication, dosage and reason for change
- Past history and current use of alcohol/drugs to include kind, type, frequency and amount
- Consultations, Referrals and Specialists' Reports to include laboratory results and review psychological evaluations, summaries and review as applicable
- Record of all emergency care, how directed and emergencies' surveys
- Discharge summaries
- Individualized Treatment Plan to include:
 - Goals and objectives
 - Discharge criteria to move to lesser level of care
 - Therapeutic interventions/modalities
 - Client's response to treatment/client progress towards goal achievement
 - Documentation of evidence and results of any behavioral health screening
 - Documentation of all treatment/interventions provided and results of treatment/interventions
 - Documentation of team Members involved in the multi-disciplinary team of Gateway Health Plan *Medicare Assured*[®] Member needing specialty care
- Documentation of behavioral health and medical surgical integration to include:
 - Screening for behavioral health conditions which may be affecting physical health
 - Screening for physical health conditions which may be affecting behavioral health

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- Screening and referral to Gateway Health Plan *Medicare Assured*[®] Primary Care physician when appropriate
- Documentation of Gateway Health Plan *Medicare Assured*[®] Primary Care Physician referral to Gateway Health Plan *Medicare Assured*[®] Provider.
- Quarterly summary of the Gateway Health Plan *Medicare Assured*[®] Member's progress in behavioral health treatment, prepared by the Gateway Health Plan *Medicare Assured*[®] Provider(s) for the Gateway Health Plan *Medicare Assured*[®] Member's Primary Care Physician. Summary is prepared more frequently when clinically appropriate.
- Documentation that behavioral health professionals are included in the primary and specialty care service teams when a Gateway Health Plan *Medicare Assured*[®] Member with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder.
- Documentation of GAF scores at initiation of treatment and delineated treatment intervals through episode of care/illness but at a minimum at termination of treatment for all Gateway Health Plan *Medicare Assured*[®] Members.
- Documentation of reason for termination of treatment.
- Documentation of date(s) of family, therapy/intervention/visits for any Gateway Health Plan *Medicare Assured*[®] Member under the age of 18.

Communication Requirements and Continuity of Care

- The treating Gateway Health Plan *Medicare Assured*[®] Provider is required to make and maintain contact with the Gateway Health Plan *Medicare Assured*[®] Member's PCP when clinically appropriate and to provide, at a minimum, quarterly treatment summaries to the PCP.
- The treating Gateway Health Plan *Medicare Assured*[®] Provider is required to make and maintain contact with other service Providers who are also treating the Member.
- When indicated, the Gateway Health Plan *Medicare Assured*[®] Provider refers the Member to the PCP for assessment, evaluation, treatment, and further referral as needed. In those situations in which the Gateway Health Plan *Medicare Assured*[®] Member does not know/have a PCP, the Gateway Health Plan *Medicare Assured*[®] Provider refers the Member to Gateway Health Plan[®] Member Services.
- Providers facilitate coordination and continuity of care among the multi-providers treating a Gateway Health Plan *Medicare Assured*[®] Member and communicate regularly with Gateway Health Plan[®].
- Providers must communicate admission and discharge of a Gateway Health Plan *Medicare Assured*[®] Member into Inpatient or Partial Hospitalization even if there is a primary insurer.

Referral for Medically Necessary Behavioral Health Services

Gateway Health Plan *Medicare Assured*[®] through CBHNP coordinates medically necessary behavioral health services for Members through the Care Manager. The Care Manager is responsible during the assessment, screening, and referral process to determine whether the Member may be in need of behavioral health services and to facilitate an appropriate referral to a behavioral health provider based on Medical Necessity Criteria. The Care Manager will collaborate with physical health services on a case-by-case basis when a Member's physical health care needs impact behavioral health treatment. Providers should contact a Clinical Care Manager to facilitate referral as necessary for behavioral health treatment.

Gateway Health Plan *Medicare Assured*[®] together with CBHNP facilitates orientation and education for Gateway Health Plan *Medicare Assured*[®] Providers to increase Providers' awareness of the Member's needs

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for medically necessary medical-surgical, specialty, secondary, and tertiary services and to establish the referral process and procedures.

Provision of Emergency Care

Gateway Health Plan *Medicare Assured*[®] ensures the provision of emergency services to Gateway Health Plan *Medicare Assured*[®] Members. Gateway Plan *Medicare Assured*[®] ensures that Members know where and how to obtain medically necessary care in emergency situations. “Emergency Services” means covered inpatient or outpatient Covered Behavioral Health Services that are (1) furnished by a provider who is qualified to furnish those services under Title XIX of the Social Security Act and (2) needed to evaluate or stabilize an Emergency Medical Condition.

Broken/Missed Appointments and AMA Discharge

CBHNP has tasked its contracted network Providers with following up on a CBHNP Member’s chronic broken and/or missed appointments. Providers are expected to contact CBHNP if a Member’s treatment is compromised or there is a risk of termination of services due to non-compliance.

When a Member leaves routine care, this is typically not an area of concern. There are two types of terminations, however, which do necessitate further follow-up: “no shows” and discharges against medical advice (AMA). These terminations are often considered treatment “drop outs” and could be a liability/danger.

The following methods are used for handling “no shows” to appointments based on the nature of care:

- For all “no shows” and AMAs, document this fact in the medical record.
- For Members who are AMA or fail to keep a scheduled appointment for emergency or urgent care:
 - Call the Member at least three times to attempt to make contact.
 - If no contact has been made, document in writing to the Member that they have terminated care AMA.
 - Whether telephonically or in writing, offer the Member treatment alternatives.
 - Ensure that there is Member safety, or initiate emergency procedures.
- For Members who “no show” for initial routine care, the Provider will send a letter requesting that the Member contact their Provider if they wish further services.
- Providers are required to make contact by phone or letter for individuals who miss on-going routine treatment appointments, depending on clinical circumstances.
- If there is a referring party for a “no show” Member, that party will be notified in writing, if permissible.

Continued Stay Review

Gateway Health Plan *Medicare Assured*[®] and CBHNP have the responsibility to review treatment received by Members in order to assure that the appropriate services are delivered based on established medical necessity criteria. Continued stay reviews are utilized to discuss specifics of Member care with the Provider so that appropriate decisions can be made. The Provider must give accurate and complete information. Specific review information is found in Chapter V, Clinical Handbook.

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Determination of Medical Necessity

The CMS definition of medically necessary specifically states that a service must be medically necessary to be covered. “Medical Necessity” and “Medically Necessary” means that it must be reasonable and necessary for the purpose of diagnosing or treating illness or injury to improve the functioning of a malformed body member. It refers to services or supplies that: are proper and needed for the diagnosis or treatment of the member's medical condition; are used for the diagnosis, direct care, and treatment of the member's medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of the member or the doctor. The Medical Necessity Criteria that will be used for Gateway Health Plan *Medicare Assured*[®] is ASAM PPC-2R (Second Edition Revised) for Substance Abuse. Mental health inpatient and partial hospitalization will use McKesson’s InterQual Proprietary Criteria.

Discharge Planning

While basic requirements for Providers are provided in regulation and licensing standards, discharge planning is an essential part of treatment and is expected to begin upon admission. Gateway Health Plan *Medicare Assured*[®] and CBHNP expects that the discharging Provider will assure that continuity of care is maintained and that appointments are scheduled in new levels of care as appropriate, according to regulations, licensing requirements and quality standards. Discharging inpatient Providers are expected to assure that follow-up appointments are in place. Members should not be asked to take responsibility for this activity. Gateway Health Plan *Medicare Assured*[®] and CBHNP have identified critical elements that must be addressed in discharge plans and outlines expectations in Chapter V, Clinical Handbook.

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Chapter V CLINICAL HANDBOOK

Definitions

MSS – Member Services Staff
CCM – Clinical Care Manager
MNC – Medical Necessity Criteria
ICM – Intensive Case Management/Manager
POC – Plan of Care
SA – Substance Abuse
MH – Mental Health
CI – Crisis Intervention
ASAM – American Society of Addiction Medicine
PHP – Partial Hospitalization Program

Non-Incentive Statement

Gateway Health Plan *Medicare Assured*[®] and CBHNP do not provide incentives to employees who conduct utilization management activities for approving, denying, limiting or discontinuing medically necessary services.

Member Services (MSS)

Member Services is a great resource for Providers. It is available 7 days a week/24 hours a day/365 days a year. When calling MSS please be prepared to provide the following information so that we can best serve you.

When you call Member Services Staff, they will ask:

- The caller's name
- Facility/Agency they are calling from, if applicable
- The purpose of the call
- Member name
- Member social security number
- If requesting to speak with a CCM, indicate the reason for this request as MSS may be able to assist you.

It is imperative that callers provide the information needed in order for the MSS to appropriately meet your needs as well as the needs of our Members.

Member Services Staff can assist with questions about:

Authorizations

Questions regarding status of approval, authorization numbers, etc. Authorization questions will be forwarded to the appropriate CBHNP staff.

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Eligibility Questions

MSS should not be contacted routinely to check Member eligibility. However, if you come across a situation where you are unsure if the person is a Gateway Health Plan *Medicare Assured*[®] Member or not after properly checking the available eligibility verification resource, we can assist. Providers are expected to check eligibility prior to initiation of service and periodically through the course of treatment.

Locating Providers

MSS can help Members/family Members find outpatient providers that are conveniently located near the Member home or work.

Inpatient Referral and Emergency Intake

MSS is the first point of contact for Providers and families during times of crisis. MSS will ask for information about the emergency and pass the information to the CCM as appropriate. Please provide all possible information to the MSS.

Authorization Procedures by Level of Care

Utilization management for the Gateway Health Plan *Medicare Assured*[®] has been delegated to CBHNP for Behavioral Health Services. CBHNP is responsible to authorize services and conduct pre-certification and concurrent review for services that require prior authorization and register outpatient treatment sessions.

Mental Health Outpatient Treatment Registration

Gateway Health Plan *Medicare Assured*[®] does not require par (in-network) providers to complete the Mental Health Outpatient Treatment Registration Form. However, psychological testing, neuropsychological testing and outpatient ECT must be pre-certified using a separate form.

The Outpatient Treatment Registration form is required for all outpatient non-par providers. Remember in order to be eligible for Gateway Health Plan *Medicare Assured*[®], the par and non-par providers must have a Medicare number. If the provider does not have a Medicare number, the provider will get an administrative denial of their request. Eligible non-par providers must do the following:

a. **Initial Request**

MH outpatient services should be requested within 10 business days from the time a Provider sees a Member using the Outpatient Treatment Request form for MH services (i.e. individual, family, group therapy; psychiatric evaluations and medication management).

The provider will receive a phone call to enter the network. If the provider agrees to be credentialed, the service will be authorized for 90 days.

If the provider does not wish to enter the network, the provider will be asked for a clinical reason why the member cannot go to an in-network provider. If clinical appropriate, the provider will be given a 90 day authorization in order to transition the member to an in-network provider. Any

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services provided after the 90 day period will be denied and the provider may not seek reimbursement from the Member.

b. **Ongoing Services/ Reauthorization Requests**

Only those non-par providers that choose to enter the network will receive continuation authorizations provided that their credentialing application is in process with CBHNP. Reauthorizations will be limited to an additional 90 day period. Reauthorization should be requested using the Outpatient Treatment Request form for MH services, which is the same form used for initial authorization requests. Providers may submit a reauthorization request up to two weeks prior to the requested authorization start date or up to ten (10) business days after the requested start date of the authorization.

All current authorization request forms are available at our website, www.cbhnp.org. Please print and copy these forms.

SA Outpatient Treatment Registration

Gateway Health Plan *Medicare Assured*[®] does not require par (in-network) providers to complete the Substance Abuse Outpatient Treatment Registration Form. However, psychological testing, neuropsychological testing and outpatient ECT must be pre-certified using a separate form.

The Outpatient Treatment Registration form is required for all outpatient non-par providers. Remember in order to be eligible for Gateway Health Plan *Medicare Assured*[®], par and non-par providers must have a Medicare number. If the provider does not have a Medicare number, the provider will get an administrative denial of their request. Eligible non-par providers must do the following:

a. **Initial Request**

SA outpatient services should be requested within 10 business days from the time a Provider sees a Member using the Outpatient Treatment Request form for SA services (i.e. individual, family, group therapy; psychiatric evaluations and medication management).

The provider will receive a phone call to enter the network. If the provider agrees to be credentialed, the service will be authorized for 90 days.

If the provider does not wish to enter the network, the provider will be asked for a clinical reason why the member cannot go to an in-network provider. If clinical appropriate, the provider will be given a 90 day authorization in order to transition the member to an in-network provider. Any services provided after the 90 day period will be denied and the provider may not seek reimbursement from the Member.

b. **Ongoing Services**

Only those non-par providers that choose to enter the network will receive continuation authorizations provided that their credentialing application is in process with CBHNP. Continued authorization is based on Member meeting American Society of Addiction Medicine (ASAM) criteria. Reauthorizations will be limited to an additional 90 day period. Reauthorization should be requested using the Outpatient Treatment Request form for SA services, which is the same form used for initial authorization requests. Providers may submit a reauthorization request up to two

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weeks prior to the requested authorization start date or up to ten (10) business days after the requested start date of the authorization.

All current authorization request forms are available at our website, www.cbhnp.org. Please print and copy these forms.

MH Partial Hospitalization

More specific information needed for pre-certification and continued stay reviews is discussed later in this chapter.

a. Initial Request

Must be pre-certified by contacting CBHNP by phone prior to initiating services. Approval is based on Member meeting MNC.

b. Ongoing Services

Continued authorization is based on Member meeting MNC, which is discussed during the live continued stay review conducted over the phone with a CBHNP Care Manager.

If a Member has a primary insurance, Gateway Health Plan *Medicare Assured*[®] through CBHNP **will require** pre-certification.

MH Inpatient

More specific information needed for pre-certification and continued stay review is discussed later in this chapter.

a. Initial Request

Must be pre-certified by contacting a CBHNP Care Manager by phone prior to initiating services.

b. Ongoing Services

Continued authorizations are based on Member meeting MNC received during a live continued stay review with a CBHNP Care Manager.

If a Member has a primary insurance, Gateway Health Plan *Medicare Assured*[®] **will require** pre-certification. A CBHNP Care Manager must be notified upon admission and discharge.

SA Hospital Based Detoxification and Rehabilitation

a. Initial Request

Must be pre-certified by contacting CBHNP by phone prior to initiating services.

b. Ongoing Services

Continued authorizations are based on Member meeting ASAM criteria received during a live continued stay review with a CBHNP Care Manager

If a Member has a primary insurance, Gateway Health Plan *Medicare Assured*[®] **will require** pre-certification. A CBHNP Care Manager must be notified upon admission and discharge.

Discharge Planning

Discharge planning should begin as soon as the Member enters treatment. Providers should be developing treatment goals and discharge criteria that involve the Member and family, as appropriate, in this process. There must be an understanding of the Member's needs and goals in order to successfully complete treatment

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at the current level of care. While the Member is in active treatment, the Provider, in cooperation with Gateway Health Plan *Medicare Assured*[®] and CBHNP, will discuss how to affect a successful discharge. For inpatient treatment, this may involve the inpatient Provider working with the targeted case manager. Discharge planning will be discussed at every continued stay review for inpatient and partial hospitalization.

Gateway Health Plan *Medicare Assured*[®] through CBHNP will conduct live discharge reviews with all network Providers for inpatient and PHP. The following information must be included in the **discharge review** with the CBHNP Critical Care Manager.

- Date of discharge
- Axis I- Axis V Diagnosis information (confirm and review changes)
- Discharge plan (level of care, date, time and location of step down appointment)
- Risk/Safety Status:
 - Present active SI or attempts
 - Present violent ideation or behavior
 - Present psychotic symptoms posing risk to self/others
 - Present suspected/confirmed harm to Member by others
- ***Were risk/safety issues communicated to Provider/next LOC?*
- Member's clinical symptoms/presentation and relevant situational information since the last continued stay review.
- Next level of care, date of aftercare appointment
- Family involvement in treatment and outcome

Discharge plans are critical in documenting progress and planning for ongoing services. **Discharge plans must be provided within 2 weeks after discharge from any Gateway Health Plan *Medicare Assured*[®] funded service.** Documents may be submitted via U.S. Mail or Fax. *The discharge plan is considered part of the service purchased from you, therefore, in accordance with the Provider Agreement, lack of receipt of the discharge plan by Gateway Health Plan *Medicare Assured*[®] may delay payment for services rendered. This becomes especially important when the discharge summary recommends other levels of care.*

Outpatient Discharge

Gateway Health Plan *Medicare Assured*[®] through CBHNP should also be notified when a Member discontinues outpatient services within the same timeframe. The discharge plan must include:

- Specific information about where the follow-up services will be provided, including the Provider address.
- Background information
- Presenting problems
- All five (5) Axes Diagnoses and clinical indicators supporting discharge treatment recommendations.

The discharge plan is also expected to reflect use or development of natural supports. CBHNP strongly advocates for the development of natural supports.

AMA and Discharge Plans

If a Member leaves treatment against medical advice and there are no grounds for commitment, Gateway Health Plan *Medicare Assured*[®] and CBHNP requires that the Provider notifies the CBHNP CCM in a timely fashion so that outreach efforts by CBHNP, if authorized, can be initiated quickly.

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Medical Necessity Denial

An MNC denial is defined as a determination made by a CBHNP Medical Director or Physician Advisor on behalf of Gateway Health Plan *Medicare Assured*[®] in response to a Provider or Member request for approval to provide a service of a specific amount, duration and scope which:

- disapproves the request completely, or;
- approves provision of the requested service(s), but for a greater or lesser amount, scope or duration than requested, or;
- disapproves provision of the requested service(s), but approves provision of an alternative service(s), or;
- reduces, suspends, or terminates a previously authorized service.

Notice of Denial of Medical Coverage are printed and reviewed by the CBHNP Care Manager for accuracy prior to mailing.

Denial notices follow the format approved by Medicare. Advanced notice will be given to the Member for filing a complaint or grievance if the Member disagrees with the decision. For continued stay inpatient denials, the inpatient facility is contacted by telephone and the notice is sent via regular mail, consistent with HIPAA guidelines, rather than mailed to the inpatient facility. The notice is then to be hand-delivered to the Member by that facility.

For any denial, if the practitioner would like to discuss this case with a physician reviewer or appropriate behavioral health reviewer, please call CBHNP at 1-866-755-7299, reference the denial notice, and request to speak to the assigned Care Manager. The assigned Care Manager will assist the Provider in arranging a time to discuss the case with an appropriate reviewer. It is not guaranteed that this will be the original reviewer of the case, and this is not intended to be an additional complaint or grievance level. The intent of this discussion is for clarification of any Provider issues related to the denial or denial notice. Please refer to Chapter VIII of this Provider Manual for a full discussion of Appeals and Grievance Procedures.

Community Integration

Whenever possible, Members should receive services in community-based programs and in the least restrictive environment.

Improvement of Quality of Life

Beyond maintenance of baseline functioning, services should help Members define, choose, and achieve the most constructive and satisfying lifestyle possible. Gateway Health Plan *Medicare Assured*[®] will promote this philosophy, develop appropriate resources, and monitor the quality standards to ensure the recovery emphasis.

Outcome Focus

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Systems of care and Provider services are guided by defined outcomes, measurable goals, and research-supported best practice approaches to treatment. Gateway Health Plan *Medicare Assured*[®] has developed and monitors standards of care, providing research and training on outcomes-proven treatment technologies. The development of outcomes that include a focused assessment of how well treatment addresses the needs of priority and special needs populations is critical.

Cultural Competence

Providers must strive to eliminate barriers to treatment caused by failures to understand or address issues of cultural differences. Gateway Health Plan *Medicare Assured*[®] stresses the importance of providing clinical assessment, which addresses the developmental, cultural and linguistic needs of Members. Gateway Health Plan *Medicare Assured*[®] does not make assumptions regarding cultural preferences but asks Members directly which type of provider they would prefer. Gateway Health Plan *Medicare Assured*[®] through CBHNP contracts with community treatment centers that are capable of addressing cultural, linguistic, and developmental needs to provide direct assessments and ongoing care.

Clinical Practice Guidelines

Gateway Health Plan *Medicare Assured*[®] Provider Advisory Committee (PAC) adopts Clinical Practice Guidelines for various levels of care. These guidelines are intended to act as a reference for best practice. While adverse action may not be taken with Providers when not followed, it does serve to identify expectations when providing services to Members. The PAC has set a goal of adopting several Clinical Best Practice Guidelines to serve as a framework for future quality improvement initiatives. The PAC includes representation from our Provider network as well as county representation from our five counties. PAC meets quarterly to consider proposals for new services and to consider adoption of clinical practice guidelines. The committee has focused on the most common diagnoses with Major Depression, ADHD, Drug & Alcohol Disorders and Schizophrenia as the initial areas of interest. So far the committee has adopted 4 clinical practice guidelines:

1. Major Depression. Adopted the American Psychiatric Association Practice Guideline for the Treatment of patients with Major Depression (2nd. Ed. April, 2002). Available on-line at: http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm
2. Substance Use Disorders. Adopted the American Psychiatric Association Practice Guideline For The Treatment Of Patients With Substance Use Disorders: Alcohol, Cocaine, Opioids (1995). Available on-line at: http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm
3. Bipolar Disorders. Adopted the American Psychiatric Association Practice Guidelines for the Treatment of Patients with Bipolar Disorder (Revision 2002). Available online from APA at www.psych.org/psych_pract/treatg/pg/bipolar_revisebook_index.cfm
4. Schizophrenia. Adopted the American Psychiatric Association Practice Guidelines for the treatment of Patients with Schizophrenia Second Edition (2004) Available on-line at http://www.psych.org/psych_pract/treatg/pg/SchizPG-Complete-Feb04.pdf

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CBHNP MH Inpatient and Partial Hospitalization Initial Assessment, Continued Stay Review and Discharge Information

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Initial Assessment – Pre-certification for Inpatient/Partial Hospitalization

Information on physical health plan and any other primary insurance.

Presenting Problem: Clinical information/symptoms. Why Member needs requested level of treatment.

Risk Assessment: Information related to harm to self, self-injurious behaviors, harm to others and harm to Member by others. This would include current as well as past risk issues.

Drug/Alcohol Use/Abuse: Substance and amount.

Medications: Name of medication, dose and frequency.

Treatment: Level of care, facility/provider, month/year for current and past treatment.

Axis I through Axis V

Natural Supports: Examples include: Boy/Girl Scouts, clubs, 4H, YMCA, YWCA, friends, church, volunteer time, community events, educational/self-improvement, hobbies, vocational training, school, recreational activities, support groups, employment.

Structured Supports: MH Case Manager, MR Case Manager, CYS Case Manager, legal issues, work and school.

Emergency contact information

Can the Member return home following treatment (if applicable?)

Medical necessity criteria

Continued Stay Review

Axis I- Axis V Diagnosis information: Upon admission. Changes to be reported at time of review.

Medication/Dose/Frequency: Upon admission. Changes to be reported at time of review.

Ancillary services with contact information: Upon admission. Changes to be reported at time of review.

Natural supports: Upon admission. Changes to be reported at time of review. The goal is to increase natural supports.

Risk/Safety status: Asked at each review.

- Present active SI or attempts
 - Present violent ideation or behavior
 - Present psychotic symptoms posing risk to self/others
 - Present suspected/confirmed harm to Member by others

Treatment goals: The following information is required for each goal. Each goal is addressed in its entirety before discussion of the next goal. Completed at each review.

Identify goal

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Identify method for above goal
Detail progress, lack of progress on goal
Identify any changes in goal and/or method based on Member progress

Recent significant changes: Reserved for relevant clinical information NOT related to treatment goals.

Discharge Plans: Discharge planning should be discussed at each review.

Family Involvement: Family involvement in treatment, number of family sessions and outcome.

Discharge Information

Discharges will need to be completed live with a CBHNP Clinical Care Manager in the same manner as continued stay reviews are conducted. Your CBHNP Clinical Care Manager will let you know when your facility is expected to do the live discharge call. At this point it will no longer be acceptable to call and leave a voicemail message with discharge information.

The discharge reviews should be scheduled with the CBHNP Clinical Care Manager and should occur prior to the actual discharge.

The following is the information needed at the time of the discharge review:

Date of discharge

Axis I- Axis V Diagnosis information: Confirm diagnosis at discharge and discuss changes from last continued stay review.

Discharge plan: Level of care, date, time and location (including the site address of the provider office, phone number and the name of who will be seeing the Member for the aftercare appointment). Members should be discharged with a scheduled aftercare appointment.

Risk/Safety Status:

- Present active SI or attempts
 - Present violent ideation or behavior
 - Present psychotic symptoms posing risk to self/others
 - Present suspected/confirmed harm to Member by others
- **Were risk/safety issues communicated to provider/next LOC?

Member's clinical symptoms: Presentation and relevant situational information since the last continued stay review.

Family involvement: Family involvement in treatment, number of family sessions and outcome.

CBHNP must be notified of inpatient stays and discharge plans even if the Member has other primary insurance. If a Gateway Health Plan *Medicare Assured*[®] Member has a primary insurance, we will still require pre-cert.

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Excluded Services

The following exclusions are not covered and therefore not paid for by Gateway Health Plan *Medicare Assured*[®]:

1. Services that aren't covered under the Original Medicare Plan.
2. Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by Gateway Health Plan *Medicare Assured*[®] as a covered service.
3. Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare. However, certain services may be covered under a Medicare-approved clinical research study. Gateway will follow CMS guidance with regard to payment for clinical trial items and services. Experimental procedures and items are those items and procedures determined by Gateway Health Plan *Medicare Assured*[®] and the Original Medicare Plan to not be generally accepted by the medical community.[®]
4. Surgical treatment of morbid obesity *unless* medically necessary and covered under the Original Medicare plan.
5. Private room in a hospital, *unless* medically necessary.
6. Private duty nurses.
7. Personal convenience items, such as a telephone or television in the Member's room at a hospital or Skilled Nursing Facility.
8. Nursing care on a full-time basis in the Member's home.
9. Custodial care unless it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
10. Homemaker services.
11. Charges imposed by immediate relatives or members of the Member's household.
12. Meals delivered to the Member's home.
13. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
14. Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as the unaffected breast, to produce a symmetrical appearance.
15. Chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine) and is limited according to Medicare guidelines.
16. Routine foot care is generally not covered under the Plan and is limited according to Medicare guidelines.

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17. Orthopedic shoes unless they are part of a leg brace and are included in the cost of the leg brace. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
18. Supportive devices for the feet. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
19. Radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
20. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hypogasmia.
21. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
22. Acupuncture.
23. Naturopath services.
24. Counseling or referral services that Gateway Health Plan *Medicare Assured*[®] objects to based on moral or religious grounds. In the case of Gateway Health Plan *Medicare Assured*[®], we won't give counseling or referral services related to contraceptive services, female sterilization services, male sterilization services and abortion services. To the extent these services are covered by Medicare, they will be covered through an alternative process.
25. Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under Gateway Health Plan *Medicare Assured*[®], we will reimburse veterans for the difference. Members are still responsible for Gateway Health Plan *Medicare Assured*[®] cost-sharing amount.
26. Any of the services listed above that aren't covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.
27. Effective January 1, 2008 limited dental care will be offered Pennsylvania Gateway Health Plan *Medicare Assured*[®] members. Refer members to their Evidence of Coverage (EOC).

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

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Chapter VI CLAIMS HANDBOOK

This section provides an overview of the claims process for Gateway Health Plan *Medicare Assured*[®]. The Gateway Health Plan *Medicare Assured*[®] claims payment process is designed to ensure prompt and accurate payment for services provided to Members in the Gateway Health Plan *Medicare Assured*[®].

Completing & Submitting Claims Forms

Gateway Health Plan *Medicare Assured*[®] will accept the two existing claims forms, the UB-04 for inpatient or other services billed with a procedure code for inpatient (124) (126) (128) and the CMS-1500 for all services billed with a procedure code (outpatient mental health and D&A services).

Providers of inpatient services will use a UB-04 claim form. Providers of Ambulatory Services will use the CMS 1500 for billing. UB-04 claims forms will not be accepted for billing ambulatory MH services. **All invoices must be received within 365 days of the date of service to be considered for payment.**

Electronic Billing

Contact the Gateway Health Plan *Medicare Assured*[®] Provider Services Center for additional information about electronic claims submission. Gateway Health Plan *Medicare Assured*[®] accepts electronic claims through Emdeon and RelayHealth. To submit claims to Gateway Health Plan *Medicare Assured*[®] please note the Payer ID Number is 60550.

Gateway Health Plan *Medicare Assured*[®] can accept claims electronically through our association with Emdeon and RelayHealth. Gateway Health Plan[®] 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

Gateway Health Plan[®] electronic claims through Emdeon and RelayHealth must be forwarded to Gateway Health Plan[®] in the HIPAA compliant format only.

Requirements for Submitting Claims to Gateway Health Plan[®] through Emdeon and RelayHealth

To submit claims to Gateway Health Plan *Medicare Assured*[®] please note the Payer ID Number is 60550. Gateway Health Plan[®] has a health plan specific edit through Emdeon and RelayHealth for electronic claims that differs from the standard electronic submission format criteria. The edits requires:

- A Gateway Health Plan *Medicare Assured*[®] assigned 8-digit Member identification number; the Member number field allows 8 or 12 digits to be entered. For providers who do not know the Member's Gateway Health Plan *Medicare Assured*[®] identification number it is acceptable to submit the Member's HIC Number on electronic claims.

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

- Emdeon -- Provider Daily Statistics (RO22)
- Emdeon -- Daily Acceptance Report by Provider (RO26)
- Emdeon -- Unprocessed Claim Report (RO59)

- RelayHealth – Claims Acknowledgement Report (CPI 651.01)
- RelayHealth – Exclusion Claims Report (CPI 652.01)
- RelayHealth – Claims Status Report (CPA 425.02)

If you are not submitting claims electronically, please contact either your Gateway Health Plan *Medicare Assured*[®] Provider Relations Representative or an 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 (phone numbers are current as of October 2008). Gateway Health Plan[®] will accept electronic claims for services that would be submitted on a standard CMS-1500 or a UB-04 Form. However, the following cannot be submitted as attachments along with electronic claims at this time:

- Claims with EOBs

Paper Claim Submission

Paper claims should be mailed to:

Gateway Health Plan[®]
P.O. Box 69359
Harrisburg, PA 17106-9359

CMS 1500 Form and UB-04

Each claim form must indicate the Member's diagnosis using all applicable ICD-9-CM diagnosis codes and the procedures that you performed. Current procedure codes found with your agreement will be used for billing. Reimbursement will be based on the Gateway Health Plan *Medicare Assured*[®] rate schedule provided through the contracting process.

Billing Procedures

A "clean claim" as used in this section means a claim that has no defect, impropriety, lack of any required substantiating documentation, including the substantiating documentation needed to meet the requirements

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for encounter data, or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirement for equivalent claims under Medicare. In addition, a claim shall be considered "clean" if the appropriate authorization has been obtained in compliance with Gateway Health Plan *Medicare Assured*[®] 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 Health Plan[®]-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. (For informational purposes only)

Gateway Health Plan[®] processes behavioral health expenses upon receipt of a correctly completed CMS-1500 Form or UB-04. A description of each of the required fields for each form is identified later in this section. Paper claim forms must be submitted on original forms printed with red ink. A claim without valid, legible information in all mandatory categories is subject to rejection/denial. To ensure reimbursement to the correct payee, the Gateway Health Plan *Medicare Assured*[®] provider number must be included on every paper claim. For electronic claims submissions, Gateway Health Plan[®] will require providers to use their NPI number(s). Any claim billed on a CMS-1500 Form must include the individual practitioner name in box 31 on the form. Please note that it is extremely important to promptly notify CBHNP of any change that involves adding practitioners to any group practice, as failure to do so may result in a denial of service. All claims must have complete and accurate ICD-9-CM diagnosis codes for claims consideration. If the diagnosis code requires, but does not include the fourth or fifth digit classification, the claim will be denied. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. By signing a claim for services, the practitioner certifies that the services shown on the claim were medically indicated and necessary for the health of the patient and were personally furnished by the practitioner or an employee under the practitioner's direction. The practitioner certifies that the information contained in the claim is true, accurate and complete. Any questions concerning billing procedures or claim payments can be directed to Gateway Health Plan *Medicare Assured*[®] Provider Services Department at 1-800-685-5205.

Claim Payment Disagreements

All claims payments will include a Remittance Advice (RA). The RA provides you with a detailed explanation of the amount of each claim paid and the reason for any amount of the claim that was denied. If you have questions about a denial or disagree with a claim payment for any reason, contact Provider Services at 1-800-685-5205. A Gateway Health Plan *Medicare Assured*[®] Provider Services Representative can help to facilitate a review of the claim in question. Please be prepared to provide the authorization number, provider/facility name, the Member's name and ID number.

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If the claim is denied as a result of a Provider error that can be corrected, the Provider Services Representative will assist you to understand the required corrections so that you can re-submit the invoice.

If after reviewing the denial with the Gateway Health Plan[®] Provider Services Representative you continue to believe that a claim was denied in error, you have the right to request a formal review. Gateway Health Plan[®] will review any claim that a provider feels was denied or paid incorrectly. The request may be conveyed in writing or verbally through Gateway Health Plan[®]'s Provider Services Department if the inquiry relates to an administrative issue. Please forward hard copy information via mail to the Claims Review Department along with all of the appropriate documentation, i.e. the actual claim, medical records, and notations regarding telephone conversations, in order to expedite the review process. Initial claims that are not received within the timely filing limit will not qualify for review. All follow-up review requests must be received within 120 calendar days of the initial remittance advice.

Administrative Claims Review

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

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

Claims inquiries for administrative reviews should be mailed to:

Gateway Health Plan[®]
Attention: Claims Review Department
US Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219-2704.

Claim Re-submission

Resubmission of Corrected Claims

Corrected claims may be resubmitted when the Provider finds that they billed for an incorrect number of units. In cases where the resubmission serves to correct a claim that has already been paid, the claim must be clearly identified as a "resubmitted corrected claim" and resubmitted within 120 days of the remittance notice date relative to the original claim submission.

If no payment has been made for a claim because the claim was returned to you as incomplete or with a code error, the claim must be clearly identified as a "resubmitted corrected claim" and resubmitted within 120 days of the return date.

Resubmission for COB Request and Third Party Liability (TPL)

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When you receive a denial requesting Coordination of Benefits (COB) information, you should resubmit the claim with the primary carriers EOB's.

When submitting claims to Gateway Health Plan *Medicare Assured*[®] as a secondary payer, the EOB (Explanation of Benefits) from the primary insurer must be attached to the claim. **Claims with attached EOB must be submitted within 180 days of your notification of payment or denial by the other insurance company.**

Expectations for Gateway Health Plan *Medicare Assured*[®] Response to Claims Submission

Gateway Health Plan *Medicare Assured*[®] will pay all "clean" claims (claims that are accurate and complete) within forty-five (45) days. Our goal is to provide payment as quickly as possible and to pay most claims within thirty (30) days of receipt of a clean claim. **If you have not heard from Gateway Health Plan[®] within 30 days after you sent the claim in, please contact Provider Services at 1-800-685-5205 to inquire as to the status of the claim.** If Gateway Health Plan[®] indicates the claim was not received, Providers will be asked to resubmit the claim immediately. It is imperative that Providers closely monitor their claims submissions to identify potential issues quickly.

Checking on the Status of a Claim

You may check the status of a claim during normal business hours by calling Provider Services at 1-800-685-5205. To make an inquiry, you will need to provide the provider/facility name, Member's name and identification number, the procedure code(s) and the date(s) of service for which you are billing. **Again, if you have not heard from Gateway Health Plan *Medicare Assured*[®] on a claim within 30 days of the date you believe it was submitted, contact Gateway Health Plan[®] immediately as this may indicate that the claim was not received. If Gateway Health Plan[®] indicates the claim was not received, Providers will be asked to resubmit the claim immediately.**

Claims Appeals

Claims appeals are subject to the Member Reconsideration/Appeal process outlined in Chapter VIII. Members may request reconsideration of prior authorization denials or of claim payment denials. Providers may address claim payment denials via the Provider Appeal Process.

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CMS-1500 (08-05) Data Elements for Submission of Paper Claims Forms EDI requirements must be followed for Electronic claims submissions

Field #	Description	Requirements
1	Insurance Type	Required
1a	Insured Identification Number	Gateway Health Plan [®] Member Identification Number
2	Patient's Name	Required
3	Patient's Birth Date	Required
4	Insured's Name	Required
5	Patient's Address	Required
6	Patient Relationship to Insured	Required
7	Insured's Address	Required
8	Patient Status	Required
9	Other Insured's Name	Required, If Applicable
9a	Other Insured's Policy or Group Number	Required, If Applicable
9b	Other Insured's Date of Birth, Sex	Required, If Applicable
9c	Employer's Name or School Name	Required, If Applicable
9d	Insurance Plan Name or Program Name	Required, If Applicable
10	Is Patient Condition Related to: a. Employment b. Auto accident c. Other accident	Required, If Applicable
10d	Reserved for Local Use	Not Required
11	Insured's Policy Group or FECA Number	Required
11a	Insured's Date of Birth, Sex	Required, If Applicable
11b	Employer's Name or School Name	Required, If Applicable
11c	Insurance Plan Name or Program Name	Required, If Applicable
11d	Is There Another Health Benefit Plan?	Required, If Applicable
12	Patient or Authorized Person's Signature	Required
13	Insured's or Authorized Person's Signature	Required
14	Date of Current: Illness OR Injury OR Pregnancy	Required, If Applicable
15	If Patient has had Same or Similar Illness, Give First Date	Not Required
16	Dates Patient Unable to Work in Current Occupation	Required, If Applicable
17	Name of Referring Practitioner or Other Source	Required, If Applicable
17a, b	Identification Number of Referring Practitioner	Not Required
18	Hospitalization Dates Related to Current Services	Required, If Applicable
19	Reserved for Local Use	May be Required in Specific Circumstances (Consult CMS Criteria)
20	Outside Lab	Not Required
21	Diagnosis or Nature of Illness or Injury	Required
22	Medical Resubmission Code	Not Required
23	Prior Authorization Number	Not Required
24a	Date(s) of Service	Required
24b	Place of Service	Required
24c	EMG	Not Required
24d	Procedures, Services, or Supplies CPT/HCPCS/Modifier	Required
24e	Diagnosis Code Pointer	Required
24f	Charges	Required
24g	Days or Units	Required
24h	EPSDT Family Plan	Not Required

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Field #	Description	Requirements
24i	ID Qualifier	Not Required
24j	Rendering Provider ID	Required, If Applicable
25	Federal Tax Identification Number	Required
26	Patient Account Number	Not Required, but used as identifier on remit for claim processing
27	Accept Assignment	Not Required
28	Total Charge	Required
29	Amount Paid	Not Required
30	Balance Due	Not Required
31	Signature of Practitioner or Supplier including degrees or credentials	Gateway Health Plan <i>Medicare Assured</i> [®] Individual Practitioner Name and Date Required
32	Service Facility Location Information	Facility Name and Address where Services were Rendered Required
33	Billing Provider Info and Phone #	Gateway Health Plan <i>Medicare Assured</i> [®] Vendor (Payee) Name, Address, and Phone Number Required. NPI and Gateway Legacy Number should be entered.

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Hospital Services

Hospital claims are submitted to Gateway Health Plan *Medicare Assured*[®] on a UB-04. To assure that claims are processed for the correct Member, the Member's 8-digit Gateway Health Plan *Medicare Assured*[®] identification number must be used on all claims. To aid in the recording of payment, patient account numbers recorded on the claim form by the practitioner are indicated in the *Patient ID* field on the Gateway Health Plan[®] remittance advice.

UB-04 Data Elements for Submission of Paper Claims Forms EDI requirements must be followed for Electronic claims submissions

Field	Description	Requirements
1	Provider Name, Address, City, State, Zip, Telephone, Fax, Country Code	Required
2	Pay to Name, Address, City, State, Zip	Required If Different from Billing Provider in Field 1
3a	Patient Control Number	Required
3b	Medical Record Number	Not Required
4	Type of Bill	Required – If 4 Digits Submitted, the Lead 0 will be Ignored
5	Federal Tax Number	Required
6	Statement Covers Period	Required
7	Unlabeled Field	Not Used
8a	Patient Name	Required
9	Patient Address	Required
10	Birth date	Required
11	Patient Sex	Required
12	Admission Date	Required for Inpatient and Home Health
13	Admission Hour	Not Required
14	Type of Admission/Visit	Required, If Inpatient
15	Source of Admission	Required
16	Discharge Hour	Not Required
17	Patient Status	Required
18-28	Condition Codes	May be Required in Specific Circumstances (Consult CMS Criteria)
29	Accident State	Not Used
30	Unlabeled Field	Not Used
31-34	Occurrence Codes and Dates	May be Required in Specific Circumstances (Consult CMS Criteria)
35-36	Occurrence Span Codes and Dates	Required, If Inpatient
37	Unlabeled Field	Not Used
38	Responsible Party Name and Address	Not Required
39-41	Value Codes and Amounts	Required, If Inpatient
42	Revenue Codes	Required
43	Revenue Descriptions	Required
44	HCPCS/Rates/HIPPS Codes	Required, If Outpatient
45	Service Dates	Required, If Outpatient
46	Service Units	Required
47	Total Charges	Required
48	Non-covered Charges	Required, If Applicable
49	Unlabeled Field	Not Used
50	Payer Identification	Required
51	Health Plan ID	Not Required
52	Release of Information Certification Indicator	Required
53	Assignment of Benefits	Not Used
54	Prior Payments	Required, If Applicable
55	Estimated Amount Due from Patient	Not Required
56	National Provider ID	Required – NPI Number
57	Other Provider ID	Gateway Health Plan [®] Practitioner Identification Number should be entered on paper claims only- legacy number

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Field	Description	Requirements
		reported as secondary identifier to NPI on electronic claims
58	Insured's Name	Required, If Applicable
59	Patient Relationship to Insured	Required, If Applicable
60	Certificate-Social Security Number-Health Insurance Claim-Identification Number	Gateway Health Plan <i>Medicare Assured</i> [®] Member Identification Number Required
61	Insurance Group Name	Required, If Applicable
62	Insurance Group Number	Required, If Applicable
63	Treatment Authorization Code	Required, If Applicable
64	Document Control Number	Not Required
65	Employer Name	Required, If Applicable
66	Diagnosis and Procedure Code Qualifier	Required
67	Principal Diagnosis Code	Required (Coding for Present on Admission data required)
67A-67Q	Other Diagnosis Codes	Required (Coding for Present on Admission data required)
68	Unlabeled Field	Not Used
69	Admitting Diagnosis Code	Required
70A-70C	Patient Reason for Visit	Not Required
71	Prospective Payment System (PPS) Code	Required for DRG Code – If 4 Digits Submitted, the Lead 0 will be Ignored
72	External Cause of Injury Codes	Not Used
73	Unlabeled Field	Not Used
74	Principal Procedure Code and Date	Required, If Applicable
74A-74E	Other Procedure Codes and Date	Required, If Applicable
75	Unlabeled Field	Not Used
76	Attending Provider Name and Identifiers (Including NPI)	May be Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send
77	Operating Provider Name and Identifiers (Including NPI)	May be Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send
78-79	Other Provider Name and Identifiers (Including NPI)	May be Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send
80	Remarks	May be Required in Specific Circumstances (Consult CMS Criteria)
81	Code – Code Field	Optional (Consult CMS Criteria)

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Chapter VII Quality Improvement

Gateway Health Plan *Medicare Assured*[®] has delegated certain Quality Improvement (QI) activities to CBHNP, but retains the ultimate accountability for all activities and functions performed by CBHNP. Gateway Health Plan[®] has assessed and approved the Quality Improvement Program that CBHNP has in place to oversee the Behavioral Health Managed Care services it provides. Some of the major areas delegated to CBHNP include, but are not limited to the following: Behavioral Health Practitioner and Provider Contracting; Access and Availability of Behavioral Health Practitioners and Behavioral Health Services; Clinical Practice Guidelines for Behavioral Health Conditions; and Investigation and Resolution of Quality of Care Concerns. Activities of the Gateway Health Plan *Medicare Assured*[®] Quality Improvement Program are summarized below.

Purpose of the Quality Improvement/Utilization Management Program

The Quality Improvement /Utilization Management (QI/UM) Program's purpose is to ensure the quality, appropriateness, timeliness, availability and accessibility of care and service provided to Gateway Health Plan *Medicare Assured*[®] Members. A complete review and assessment of care, demographic/household, and community data, along with current scientific evidence is key in understanding Members and developing programs to meet the Member's needs. The development of behavioral health programs must be done with the aid of partners including Members, practitioners, community agencies, regulators, CBHNP and Gateway Health Plan *Medicare Assured*[®] staff, not only to meet the current needs of the Members, but also to begin to address the future needs of the Members. Necessary to the success of these programs is the development of meaningful data and measurement to assess the improvements in the quality of care and to identify where opportunities may exist.

Goal of the Quality Improvement/Utilization Management Program

The QI/UM Program will focus on reviewing mental health and substance abuse services and improving the quality of care and service by monitoring and evaluating the correctness of care provided by Gateway Health Plan *Medicare Assured*[®] providers. Quality Improvement methods will be used to measure and improve care and service, Member satisfaction, and performance. The Program will attempt to improve Members' compliance with behavioral health guidelines and those interventions and treatments that are important to the success of managing behavioral health conditions and substance abuse behaviors. Also, the QI/UM Program will aim to improve patient safety by educating Members and practitioners in regard to safe practices, and by assessing and identifying opportunities to improve patient safety throughout the practitioner/provider network.

Objective of the Quality Improvement/Utilization Management Program

The objectives of the QI/UM Program are similar to Gateway Health Plan *Medicare Assured*[®] mission; committing to effective use of health care resources, and to continuous quality improvement. To ensure that the current needs of the population are being reviewed, changes noted, programs implemented to address the needs of Members, and to ensure continuous quality improvement, an annual QI/UM Work Plan is developed. The QI/UM Program will be assessed on an annual basis to determine the status of all activities and identify opportunities that meet the QI/UM Program objectives.

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Objectives are as follows:

- Implement a QI/UM Work Plan that identifies and assures completion of planned activities for each year:
- Ensure processes are in place using Total Quality Management values to assess, monitor, and implement actions when opportunities are identified regarding the utilization of behavioral health care resources, quality of care, and access to services;
- Based on assessment of the population, develop and update guidelines that address key behavioral health care needs, which are based on scientific evidence and recommendations from expert and professional organizations and associations;
- Conduct studies to measure the quality of care provided, including established guideline studies, evaluate improvements made, barriers, opportunities and develop actions to address those opportunities;
- Evaluate the utilization and quality performance of behavioral health providers to assure Gateway Health Plan *Medicare Assured*[®] standards are met and to identify both opportunities and best practices. In a group effort with practitioners, identify barriers, opportunities and implement interventions as needed;
- Conduct satisfaction surveys to determine Member and provider satisfaction with behavioral health services, organizational policies, and the provision of care. Review results for barriers, opportunities and implement 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 Health Plan *Medicare Assured*[®] daily operations. The QI/UM Program has available and will use appropriate internal information, systems, practitioners, and community resources to monitor and evaluate use of behavioral health care services, the continuous improvement process and to assure implementation of positive change.

The scope of the Program includes:

- Marketing and Enrollment
- Members' Rights and Responsibilities
- Network Accessibility and Availability
- Network Credentialing /Re-credentialing
- Medical Record Standards
- Confidentiality
- Member, Provider and Employee Education
- Member and Provider Services and Satisfaction
- Claims Administration
- Fair, Impartial and Consistent Utilization Review
- Evaluating the Health Care Needs of Members
- Behavioral Health Services
- Clinical Outcomes
- Oversight of Delegated Activities
- Patient Safety
- Continuous Quality Improvement using Total Quality Management Principles

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To request a copy of the Quality Improvement Program, Work Plan or Annual Evaluation, please contact the Gateway Health Plan[®] Provider Services Department at 1-800-685-5205.

Quality Improvement Manual

The Quality Improvement Manual is designed as a resource to assist practitioners in caring for Gateway Health Plan *Medicare Assured*[®] 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 Health Plan *Medicare Assured*[®] Members. The use of guidelines permits Gateway Health Plan[®] to measure the impact of the guidelines on outcomes of care and may reduce inter-practitioner variation in diagnosis and treatment.

Clinical guidelines are not meant to replace individual practitioner judgment based upon direct patient contact. The manual consists of an introductory page, along with behavioral health guidelines approved by Gateway Health Plan *Medicare Assured*[®]'s QI/UM Committee. To facilitate distribution of the most current version of these guidelines, they have been added to Gateway Health Plan *Medicare Assured*[®] web site at www.gatewayhealthplan.com. A paper copy of the Quality Improvement Manual and individual guidelines are available upon request. For a paper copy, please contact the Quality Improvement Department at 412-255-1144.

Patient Safety

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

There are ways practitioners can develop a Patient Safety Culture in their practice. Clear communication is key to safe care. Working in collaboration with Members of the multidisciplinary care team, hospitals, other patient care facilities and including the patient as an important Member of the 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 other practitioners and send documentation to other providers, as necessary, to assure continuity and coordination of care. When calling in orders over the telephone, have the person on the other end repeat the information back to you.

Collaborate with hospitals and treatment facilities, and support their safety culture. Bring patient safety issues to the committees you attend. Report errors or "close calls" to your practice or facility's risk management department. Offer to participate in multidisciplinary work groups dedicated to error reduction. Ask Gateway Health Plan *Medicare Assured*[®] Quality Improvement Department how you can support compliance with their safety initiatives.

Gateway Health Plan *Medicare Assured*[®] also works to ensure patient safety by monitoring and addressing quality of care issues identified through pharmacy utilization data, continuity and coordination of care standards, sentinel/adverse event data, Behavioral Health Program follow-up, and Member complaints.

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

Institute of Medicine report: To Err is Human-Building a Safer Health Care System

<http://www.nap.edu/books/0309068371/html/>

JCAHO National Patient Safety Goals

<http://www.jcaho.com/accredited+organizations/patient+safety/npsg.asp> 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>

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Chapter VIII **Appeals and Grievances**

Introduction

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

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

What are Appeals and Grievances?

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

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

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

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

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

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Generally, grievances should be filed directly with Gateway, but for matters related to quality of care, members also have the opportunity to file such complaints with a Quality Improvement Organization (QIO). THE QIO in Pennsylvania is Quality Insights of Pennsylvania. QIO reviews are discussed on page 67.

Acting as an Appointed Representative

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

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

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

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

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

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

Appeals Regarding Hospital Discharge

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

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

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

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

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

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

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

Quality Improvement Organization (QIO) Review

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

The notice will provide the name and phone number of the appropriate QIO agency. If the member receives the termination notice two days before coverage is scheduled to end, the member must contact the QIO no

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later than noon of the day the notice is received. If the notice is received more than two (2) days prior to the scheduled end in coverage, the QIO must be contacted no later than noon of the day before the scheduled termination of coverage.

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

After reviewing all the information, the QIO will decide whether it is medically appropriate for coverage to be terminated on the date that has been set for you. The QIO will make this decision within one full day after it receives the information necessary to make a decision. If the QIO decides in favor of the member, Gateway will continue to cover the stay for as long as medically necessary. If the QIO decides that our decision to terminate coverage was medically appropriate, the member will be responsible for paying the SNF, HHA or CORF charges after the termination date that appears on the advance notice. Neither Original Medicare nor Gateway will pay for these services. If the member agrees to discontinue receiving services on or before the date given on the notice, there will be no financial liability.

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

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

Appeals for Coverage of Other *MEDICAL SERVICES*

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

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

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

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

Information may also be provided as follows:

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

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

For a decision about payment for care already received, the appeal must be finalized by Gateway within sixty (60) days, which includes payment for the services or forwarding the appeal to the Independent Review Entity (IRE) for review. For a standard review about medical care not yet provided, Gateway must finalize the appeal within thirty (30) days or sooner if the member's health condition warrants. For expedited appeals regarding medical care, Gateway has up to seventy-two (72) hours to make a decision, but will make it sooner if the member's life, health, or ability to regain maximum function requires it. If we do not issue a decision within seventy-two (72) hours or by the end of the extended time period, the appeal will be automatically forwarded to the IRE for review.

If the member requests an extension, or if we find that some information is needed that would be beneficial to the member in this review, an extension of up to fourteen (14) calendar days may be granted. The fourteen (14) day extension is also an option with expedited appeal. If we do not issue a decision within thirty (30) calendar days (or by the end of the extended time period), the appeal is automatically forwarded to the Independent Review Entity (IRE) for review. The IRE has a contract with CMS and is not part of Gateway.

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

IRE Review

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

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

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Administrative Law Judge Review

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

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

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

Medicare Appeals Council

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

Federal Court

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

Appeals for Coverage of Part D *DRUGS*

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

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

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

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

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

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

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

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

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

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

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

For an expedited appeal regarding Part D drugs that have not been provided, Gateway has up to seventy-two (72) hours to issue a decision and authorize the requested medication. If the member's health condition

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requires it, the decision will be issued sooner. If an expedited appeal was requested and Gateway does not comply with the seventy-two (72) hour timeframe, the case will automatically be forwarded to the IRE for review.

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

Independent Review Entity (IRE)

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

The IRE will issue its decision in writing, explaining the reasons for the decision. If the decision is in the member's favor and the member has already paid for the medication, Gateway will reimburse the member within thirty (30) calendar days of the IRE's decision. We will also send the IRE confirmation that we have honored their decision. If the decision is in the member's favor and the member has not yet received the drug, Gateway will authorize the medication within seventy-two (72) hours of receiving the decision notice. Confirmation will be sent to the IRE in this situation as well. If an expedited IRE review was conducted, Gateway will authorize the medication within twenty-four (24) hours of receiving the IRE's decision notice.

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

Administrative Law Judge (ALJ) Review

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

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

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

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

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

Medicare Appeals Council

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

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

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

Federal Court

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

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

Amount in Controversy, Federal Minimum Requirements for Filing

Appeal Level	Calendar Year 2007	Calendar Year 2008	Calendar Year 2009	Calendar Year 2010	Calendar Year 2011
ALJ Hearing	\$110	\$120	\$120	\$130	\$130

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Judicial Review	\$1,130	\$1,180	\$1,220	\$1,260	\$1,300
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Member Grievances

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

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

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

Members also have the opportunity to file expedited grievances under certain conditions. See page (104).

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

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

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

First Level Grievance

The member or his or her authorized representative will have the opportunity to submit any information, documentation or evidence regarding the grievance. The First Level Grievance Committee will review all of this information in making their decision. The Committee will send a written response as quickly as the case requires based on the member's health status, but no later than thirty (30) calendar days after receiving the

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grievance. We may extend the timeframe by up to fourteen (14) calendar days if you request the extension or if we justify a need for additional information and the delay is in your best interest.

Second Level Grievance

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

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

Expedited Grievances

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

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

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

When an expedited grievance is filed, an Expedited Grievance Hearing is immediately scheduled to occur within twenty-four (24) hours of receiving the request. As with Second Level Grievances, the member or appointed representative may participate in this hearing, but participation is not required. All affected parties will be notified of the decision by telephone within twenty-four (24) hours of filing the Expedited Grievance, and a letter explaining the decision will follow within three (3) days.

Quality Improvement Organization Review

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

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How to File a Quality of Care Complaint with the QIO

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

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

There is no filing limit for quality of care grievances.

Provider Appeals

Any provider may file a formal provider appeal to request the review of any post-service denial. This process is intended to afford providers with the opportunity to address issues regarding payment only. Appeals for services that have not yet been provided must follow the Member Reconsideration or Re-determination processes. The formal Provider Appeal Process must be initiated by the provider through a written request for an appeal. The written request for an appeal, along with all supporting documentation, must be received by Gateway within ninety (90) calendar days of the date of the denial notice. All written appeals must be sent to:

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

First Level Appeal (The Informal Dispute Resolution Process)

The Gateway Provider Appeal Committee will resolve all First Level Appeals as soon as possible after receipt of all necessary information, but no less than thirty (30) calendar days from the date received. The Appeal Committee will be comprised of two (2) or more Gateway staff members who were not involved in the initial review. The First Level Appeal Committee will inform the provider of its decision in a written decision notice.

Second Level Appeal (The Informal Dispute Resolution Process)

If the provider is not in agreement with the first level appeal decision, the provider may request a Second Level Appeal. The provider must submit a written request for a Second Level Appeal to Gateway within thirty (30) calendar days of the date of the First Level Appeal decision letter. The Appeal Committee will be comprised of two (2) or more staff members who were not involved in any previous level of review. The provider will have the opportunity to participate in person or by telephone conference call in the second level appeal review. The provider must notify the Complaints Administrator in writing of the intent to participate.

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The Complaints Administrator will provide written notice of the hearing date at least fifteen (15) days in advance.

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

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Chapter IX

SUSPECTED/SUBSTANTIATED FRAUD AND ABUSE

CBHNP and Gateway Health Plan *Medicare Assured*[®] seek to ensure the integrity of the Medicare by investigating any suspected fraud and abuse. Provider fraud and abuse can include:

- Physical/verbal abuse to a Member
- Denial of care
- Confidentiality violations
- Fraudulent billing
- Provider staff misrepresenting credentials
- Any Provider action that places a Member in jeopardy
- Any Provider action that violates Federal, State or other applicable regulations

CBHNP and Gateway Health Plan *Medicare Assured*[®] provides a toll free access line 24 hours a day, 7 days a week to ensure the immediacy of Provider reporting of suspected fraud and abuse.

Investigating instances of fraud, abuse and waste in Medicare is the responsibility of the Office of the Inspector General (OIG).

To report fraud, waste or abuse in Medicare

Call OIG Fraud and Abuse Hotline at 1-800-447-8477. For the hearing and speech impaired, TTY is available at 1-800-377-3950.

Some common examples of fraud and abuse are:

- Incorrect reporting of diagnoses or procedures to maximize payments.
- Billing for services not furnished. This includes billing Medicare for appointments that the Member failed to keep.
- Altering claim forms, electronic claim records, medical documentation, etc. to obtain a higher payment amount.
- Billing more than once for the same service
- Billing for separate services that should be combined into one billing code
- Falsifying records
- Performing inappropriate or unnecessary services
- Misrepresentation of dates and descriptions of services rendered or the identity of the beneficiary or the individual who rendered the service.
- Physical, mental, emotional and sexual abuse by provider or staff employed by a provider.
- Providing substandard care not consistent with current standards of practice.
- Offering free services, equipment or supplies in exchange for a Member's ID Number.
- Giving or accepting something of value in return for providing medical services.
- Over-utilizing or abusing the use of medical services.

The complete Medicare Program Integrity Manual is located at www.cms.hhs.gov/Manuals. You want to refer to Publication 100-08 Chapter 4.

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Chapter X PROVIDER COMPLAINTS

CBHNP is an organization of providers and, as such, promises to make every effort towards a cooperative and collaborative relationship with providers. CBHNP personnel are professionals who recognize the importance of good customer service. We also understand that there will be occasions where differences or complaints arise in the course of business. Therefore, CBHNP encourages providers to make complaints.

Complaints should be directed to the Complaints and Grievances (C&G) Department. You can access the C&G Department by calling Member Services at 1-888-722-8646. The Complaints & Grievances staff will obtain information from you and can explain the process that will be followed. Complaints can also be submitted to CBHNP in writing to:

CBHNP
Complaints and Grievances Department
P.O. Box 6600
Harrisburg, PA 17112.

CBHNP will respond to all CBHNP contracted provider complaints.

In addition, CBHNP tracks all provider complaints in a database for analysis to identify trends that need to be addressed by CBHNP for improving our performance. This type of analysis is also reviewed by the Quality Improvement Committee.

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Chapter XI

PROVIDER INFO'S

Provider Info's should be maintained with the Gateway Health Plan *Medicare Assured*[®] Provider Manual to serve as procedure updates and clarifications. The information contained in Provider Info's should be shared with Provider staff to clarify Gateway Health Plan *Medicare Assured*[®] and CBHNP expectations and procedures. Provider Info's are available at the website, www.cbhnp.org or by calling Provider Relations at 1-888-700-7370.

Provider Info's are organized into categories so you can easily determine what items are relevant to your organization or practice. The following categories will be used. CBHNP will number the documents according to the structure outlined below for easy reference.

Categories:

- a. AD – Administrative Updates (Includes administrative procedures or expectations pertaining to all levels of care. EXCLUDES authorization procedures)
- b. D&A – Drug and Alcohol all LOC Updates (includes authorization procedures)
- c. MH – Mental Health all LOC Updates (includes authorization procedures)

Example:

AD03 – 001

Category is AD (Administrative Update); Year issued is 2003; 001 indicates it is the first publication of the year.

As information changes, we will rescind previous Info's containing outdated information. Please remember to maintain the Provider Info's with your Provider Manual and distribute the information widely among staff responsible for carrying out the activities.

A summary of Provider Info's distributed during the year will be available by February of each following year. Policies and procedures may also be distributed from time to time.

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Chapter XII FREQUENTLY ASKED QUESTIONS

Provider Enrollment and Related Questions

HOW CAN I BECOME A GATEWAY HEALTH PLAN MEDICARE ASSURED[®] NETWORK PROVIDER?

All Providers go through the credentialing process which begins by completing a Provider application. Providers may obtain an application package by contacting Provider Relations at 888-700-7370. All Providers must be approved to bill Medicare.

HOW DO I OBTAIN A MEDICARE NUMBER?

You must complete Form CMS 855b (for facilities and group practices) or CMS 855i (for physicians and non physician practitioners). These forms may be found at www.cms.hhs.gov. In the “Search Now” block enter the appropriate form number.

HOW DO I ENROLL WITH THE PENNSYLVANIA MEDICAL ASSISTANCE PROGRAM?

Since the Gateway Health Plan *Medicare Assured*[®] is a Plan for the dually eligible (i.e. Members have both Medicare and Medical Assistance), providers should also obtain a Medical Assistance PROMISE Number. You may visit DPW’s website at www.dpw.state.pa.us or call them at (717) 772-6456 24 hours per day, 7 days per week. To check the status of your application to be a Medical Assistance Provider call (717) 772-6140 Monday through Friday 8:30 – 12:00 or 1:00 – 5:00 pm.

WHAT IF I CANNOT ACCEPT ANY NEW REFERRALS OR OTHER CHANGES OCCUR THAT AFFECTS MY ABILITY TO SEE MEMBERS?

It is important that you tell your Provider Relations Representative any new information that affects referrals so Providers and Members will not be inconvenienced. Please be sure to notify us of phone number and address changes as well. CBHNP will need the information in written form via fax (717-671-6522) or mail. A “Provider Data Update Form” may be used and is available on the website. Temporary inability to accept referrals will not jeopardize network status.

WHO DO I NOTIFY WHEN A SITE MOVES OR A PRACTITIONER LEAVES/STARTS EMPLOYMENT?

This information should be reported to your Provider Relations Representative in writing using the “Provider Data Update Form.” Updated information prevents inconvenience for Members as well as Providers.

If you are structured as a group practice, each new practitioner must complete an Individual Application for Enrollment which is available on the website. If you are credentialed as an organization it is not necessary to complete the Individual Application for Enrollment for new hires however, you must let us know if you have a new prescribing practitioner. Failure to notify Gateway Health Plan *Medicare Assured*[®] through CBHNP of new prescribing psychiatrists may lead to problems when Members get prescriptions filled.

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Clinical Operations and Authorization Questions

HOW DO I REQUEST AUTHORIZATION?

All services except psychiatric evaluation, medication management, and family, individual and, group therapies, which are outpatient services, require prior authorization through CBHNP.

Psychological Testing

Psychological testing should not be requested using the outpatient request forms. Psychological testing requests require prior authorization. The form is available on the Gateway Health Plan[®] website, CBHNP website or from a Provider Relations Representative. You must complete the form and fax it to CBHNP at 1-717-540-1146.

Neuropsychological Testing

Neuropsychological testing should not be requested using the outpatient request forms. Neuropsychological testing requests require prior authorization. A copy of this form will be available on the Gateway Health Plan[®] website, CBHNP website or from a Provider Relations Representative. You must complete the form and fax to CBHNP at 1-717-540-1146.

ECT

Requests for ECT should not be submitted on the OP Request form. These requests should be made by calling CBHNP at 1-866-755-7299 and request to speak with a Clinical Care Manager.

Current authorization request forms as well as instructions for completing the form can be found on the website. Inpatient hospitalization and partial hospitalization authorizations require a phone call to CBHNP. You will have access to a live person 24 hours per day, 7 days per week if you have questions or need to discuss a case.

HOW DO I KNOW WHO IS THE ASSIGNED CLINICAL CARE MANAGER?

Member Services Specialists can provide this information via phone inquires.

WHY DO MEMBER SERVICES STAFF ASK SO MANY QUESTIONS FOR EVERY CALL?

Our Member Services Specialists need to obtain as much information as possible from callers in order to determine how to handle each call. They are responsible for completing an initial assessment for each incoming call.

WHAT DO I DO IF A MEMBER WANTS TO GO TO A DIFFERENT PROVIDER?

As a Provider, you would be responsible for providing the Member with other provider options and/or referring the Member to Gateway Health Plan[®] if they require additional information or experience any problems with transferring providers.

WHAT IF I DO NOT AGREE WITH A PROVIDER PAYMENT DENIAL APPEAL?

If your payment denial appeal was denied due to administrative or procedural errors, you may request that Gateway Health Plan[®] through CBHNP reconsider the decision through a Second Level Review.

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A provider may request a second level internal review. The provider must request the second level review in writing and within 30 days of the date of the first level internal review decision letter. All second level appeal requests must set forth the specific reason why the provider feels that the first level decision was in error.

A second level determination will be completed within 45 days of receiving the payment denial appeal. The provider may elect to participate in the review by telephone or in person to present information.

Providers requesting review of Provider Payment Denial Appeals will be instructed to send a letter to Gateway Health Plan[®] stating the following:

1. Plan Name (Gateway Health Plan *Medicare Assured*[®])
2. Member name
3. date(s) of service
4. type of service that was delivered
5. Reason for delay or failure to get authorization
6. Explanation of circumstances
7. Steps taken to correct and prevent future occurrences
8. Documentation of Members seen/dates services provided and billable amount(s)
9. Desired action from CBHNP
10. Documentation relevant to the request (i.e., Medical Record for review, fax confirmation page to show outpatient request was submitted, etc...)

Appropriate reasons for approval (reversal of the administrative denial decision) include but are not limited to:

- documentation of eligibility verification issues beyond the control of the Provider
- documentation of processing errors by CBHNP
- documentation of continued stay review issues beyond the control of the Provider
- unavoidable delays caused by another provider
- timely notification and resolution of the issue
- any other reason as decided by the review committee.

Reasons for upholding of an administrative denial include but are not limited to:

- failure in authorization management by the Provider
- submission of the request for review beyond the latter of 30 days of the initial notice or service delivery date
- failure to check eligibility prior to service delivery
- failure in claims or billing management by Provider
- this was a MNC denial when services have already been provided
- any other reason as decided by the review committee.

A decision will be made within 30 days of receipt of the documentation and a written decision will be mailed within 5 days of the decision. If the request is approved and the claim is in the Gateway Health Plan[®] claims processing system, CBHNP will contact Gateway Health Plan[®] to adjudicate the claim. The approval letter serves as authorization and you should retain it in your records.

Gateway Health Plan[®] will make a decision about your request and communicate that decision within 30 days of receipt of the appeal.

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HOW WILL I KNOW ABOUT CHANGES IN AUTHORIZATION PROCESSES AND OTHER PROCEDURES AT CBHNP?

CBHNP will share this information with Providers through Provider News briefs and Provider Info's. Provider Info's should be regarded as supplements and clarifications to the Gateway Health Plan *Medicare Assured*[®] Provider Manual. All such communication can be found on the website and are available for download.

WHAT DO I DO IF A MEMBER NEEDS EMERGENCY SERVICES?

Gateway Health Plan *Medicare Assured*[®] expects the Provider to take immediate action to ensure the safety of the Member and others. Gateway Health Plan *Medicare Assured*[®] should be contacted for service authorization at 1-866-755-7299 after the situation is stabilized.

Incidents/behaviors should be considered emergencies when a Member is a direct threat to self and/or others and is in need of a higher level of care due to safety.

The Lead Clinician or Outpatient Therapist should be consulted first for an acute exacerbation of target behaviors that do not result in risk to self and/or others but still require immediate interventions for stabilization. This should be part of treatment plan and may include but not be limited to Lead Clinician's direct interventions in the home.

The Lead Clinician should contact the Member's assigned Clinical Care Manager within one business day to discuss the case. A team meeting may need to be convened to discuss any changes to current treatment interventions.

Claims and Eligibility Questions

HOW DO I SUBMIT A CLAIM FOR PAYMENT?

Claims must be submitted within 365 days of the date of service.

Depending on the service you provided, one of two (2) claim forms may be used. The CMS 1500 is used for ambulatory services or services billed with a procedure code. The UB-04 should be used for inpatient or other services that are billed with a procedure code (00124) (00126). Forms can be obtained at most office supply stores, as they are standard in the industry. Claims may be submitted to the following address:

Gateway Health Plan[®]
Claims Processing Department
P.O. Box 11-560
Albany, NY 12211- 0560

WHEN WILL I GET PAID?

A minimum of ninety percent (90%) of all clean claims are paid within 30 days. All clean claims are paid within 45 days. A clean claim includes all of the information necessary to process your claim. Necessary information is listed in Chapter VI of the Gateway Health Plan *Medicare Assured*[®] Provider Manual.

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WHAT IF I HAVE A QUESTION ABOUT MY CLAIM?

Call Gateway Health Plan *Medicare Assured*[®] Provider Services Department to check on a status of a claim. They are available Monday through Friday from 8:30 a.m. to 4:30 p.m. The phone number is 800-685-5205.

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APPENDIX

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB no. 0938-0950

APPOINTMENT OF REPRESENTATIVE

NAME OF BENEFICIARY	MEDICARE NUMBER
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SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the beneficiary:

I appoint this individual: _____ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF BENEFICIARY		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This form should be filled out if the representative waives a fee for such representation. (Note that providers or suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished the items or services at issue **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

SIGNATURE	DATE
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SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers that furnished the items or services at issue must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, and could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for furnished items or services at issue involving 1879(a)(2) of the Act.

SIGNATURE	DATE
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CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Department of Health and Human Services (DHHS) at the Administrative Law Judge (ALJ) or Medicare Appeals Council (MAC) level is required by law to obtain approval of the fee in accordance with 42 CFR §405.910(f). A claim that has been remanded by a court to the Secretary for further administrative proceedings is considered to be before the Secretary after the remand by the court.

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with DHHS. Where a representative has rendered services in a claim before DHHS, the regulations require that the amount of the fee to be charged, if any, for services performed before the Secretary of DHHS be specified. If any fee is to be charged for such services, a petition for approval of that amount must be submitted.

An approval of a fee is not required where the appellant is a provider or supplier or where the fee is for services (1) rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed office and the court has approved the fee in question; (2) in representing the beneficiary before the federal district court of above, or (3) in representing the beneficiary in appeals below the ALJ level. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

AUTHORIZATION OF FEE

The requirement for the approval of fees ensures that representative will receive fair value for the services performed before DHHS on behalf of a claimant while at the same time giving a measure of security to the beneficiaries. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

CONFLICT OF INTEREST


Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Form CMS-1696 (07/05) EF (07/05)

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**Gateway Health Plan *Medicare Assured*[®]
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 <p>GATEWAY Health Plan <i>Medicare Assured[®] HMO</i></p>	<p>Waiver of Liability Statement</p>
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Gateway Health Plan- ID

Member's Name

Provider Name

Dates of Service

I waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

Signature

Date

Printed Name

Gateway Health Plan *Medicare Assured[®] HMO* is a Medicare approved Special Needs Plan for individuals who have both Medicare and Medical Assistance

H5932_270A

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SPECIAL NEEDS PLAN (SNP) MODEL OF CARE

Overview

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

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

SNP Model of Care Elements

1. Staff Structure and Care Management Roles

- There are three essential care management roles within Gateway’s Model of Care:
 - **Administrative Roles** – These roles involve the day-to-day operations of the plan such as processing enrollments, paying claims, and handling appeals and grievances.
 - **Service Delivery Roles** – These roles involve providing care to the beneficiary, including such things as Advocating, Informing and Educating Beneficiaries, Identifying and Facilitating Access to Community Resources, and ensuring that the member receives the care he/she needs.
 - **Oversight Roles** – These include oversight of both Administrative and Clinical functions. Some examples include Monitoring Model of Care Compliance, Assuring Statutory and Regulatory Compliance, and Evaluating the Model of Care Effectiveness; And, Monitoring the Interdisciplinary Care Team (see below), Assuring Timely and Appropriate Delivery of Services and Assuring Seamless Transitions and Timely Follow-up to care, and Conducting Chart Reviews

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

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

3. Health Risk Assessment (HRA)

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

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4. Interdisciplinary Care Team (ICT)

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

5. Individualized Care Plan (ICP)

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

6. Communication Network

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

7. Performance and Health Outcomes

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

8. Measurable Goals.

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

9. Model of Care Training

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

How the Model of Care Works for a Member

- Shortly after a member enrolls with *Medicare Assured*[®], the member is given a Health Risk Assessment. The assessment is mailed to the member as part of the member's new member packet. The member is asked to complete and return the form. If the form is not returned within a specified period of time, Care Management outreaches to that member by telephone.
- The completed Health Risk Assessment is reviewed, and based on that review; the member is assigned to an Interdisciplinary Care Team (ICT).
- The ICT develops the member's Individualized Care Plan (ICP). Input is gathered from the primary care physician (PCP) whenever applicable.

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- The ICP is communicated to the member, the member's primary care physician (PCP), and other ICT members as appropriate; normally by mail.
- The member receives care as indicated on his/her ICP.
- At least annually, the member receives another health assessment to determine if the needs of the member have changed.

Other Important Information about Gateway's Model of Care

- Gateway recognizes that member's care needs are varied and are subject to change. Policies and procedures have been put in place to allow members to receive the level of care management needed for their particular circumstance.
- Members may be referred for Care Management in a variety of ways:
 - Providers may call 1-800-685-5212, option 1
 - Members may self-refer by calling 1-800-685-5212, option 1.
 - Gateway employee via an internal process.
- Oversight of the Model of Care Plan is handled by the Medicare Administration Department. Specific questions with regard to the Model of Care Plan should be addressed with your Gateway Provider Representative.