Gateway Health
Provider Relations
444 Liberty Avenue
Pittsburgh, PA 15222

Provider Update

Special Edition

March 22, 2016

Re: Retrospective Authorizations for Pennsylvania Medicaid and New Cataract Removal Reimbursement Policy for Medicare

Dear Gateway Health Provider:

New Cataract Removal Reimbursement Policy for Medicare Assured

Gateway Health has developed a Reimbursement Policy developed largely in part to follow Medicare's Local Coverage Determination (LCD): Cataract Extraction (including Complex Cataract Surgery) (L35091). We know that prior authorizations can be time consuming, so Gateway Health is adopting a Reimbursement policy. The policy requires the completion and submittal of a questionnaire along with submitting specific secondary diagnosis codes demonstrating medical necessity of the procedure. For your convenience, we have posted a Questionnaire for your use. If you use a different questionnaire, it will require manual review and may delay your claim processing. In addition, it must contain all elements of our questionnaire and must be signed by the patient (our member) in accordance with the LCD and our policy.

Please take time to review our full Medicare Cataract Removal Reimbursement Policy located here: http://www.gatewayhealthplan.com/ReimbursementPolicies

This policy will be in effect for claims with dates of service March 19, 2016, and after.

Please note: At this time, this does not apply to the Medicaid Products.

Prior Authorizations Must Be Made Timely to Receive Payment

On December 1st, 2015, Medicare providers were notified that Gateway Health would no longer accept authorizations outside of the allowed timeframe. Please take time to review Gateway Health Medicare Assured's Provider manual regarding prior authorizations as provider contracts require compliance with

this process. Our manual requires you to submit authorizations in advance. In the event of an emergency, you must submit the authorization within one (1) business day.

You can find the Medicare provider manual here:
http://www.gatewayhealthplan.com/providers/provider-manual

Untimely requests for authorization will generally be handled as per the below:

- For Inpatient DRG requests, the authorization will not be accepted and the DRG is non-reimbursable whether or not the member is still in the facility.
- For Inpatient Behavioral Health paid on a per-diem basis, the prior days will not be considered for authorization and the need will be reviewed on a go forward basis from the day you call in.
- For Post-Acute and Home Health, the prior days will not be considered for authorization and the need will be reviewed on a go forward basis from the day you call in.
- For any other service that is non-emergent and not prior authorized, an authorization will not be accepted.

Effective March 19th, 2016, we will expand the enforcement of our long standing authorization procedures to our Pennsylvania Medicaid line of business in the same manner as indicated above. Please take time to review Gateway Health's Provider manual regarding prior authorizations as provider contracts require compliance with this process. Our manual requires you to submit authorizations in advance. In the event of an emergency, you must submit the authorization within two* (2) business days. To align with our Observation and Extended Assessment and Management in Facilities Medical Payment and Prior-Authorization Policy, you should call after twenty-four (24) hours of the patient presenting but earlier than two (2) business days of admitting the patient to the inpatient level of care.

*Please note, our previous communication stated one business day for Pennsylvania Medicaid.

You can find the Medicaid provider manual here:
http://www.gatewayhealthplan.com/providers/provider-manual

Failure to prior authorize entirely followed by a claim submittal will currently result in an administrative denial of your claim with no review of medical necessity. Retrospective Authorization Request Claims are denied "D170- Authorization Not Timely".

If you are submitting for an exception appeal, please make sure you supply records showing why such as a copy of the incorrect insurance information you were provided along with processing of the incorrect insurance, records that the member was incapacitated, etc.

Reminder on our recently launched Readmission Policy for DRG Based Providers

Please take time to review our full Medicare Readmission Policy for DRG Based Providers located here:
http://www.gatewayhealthplan.com/ReimbursementPolicies

We are here to help you

If you have any questions regarding this notice, please call Gateway Provider Services Department.

- Gateway's Provider Services Department hours of operation are 8:30AM-4:30PM Monday through Friday

- You can call us at:
    - 1-855-847-6381 (KY Medicare)
    - 1-855-847-6431 (NC Medicare)
    - 1-888-447-4370 (OH Medicare)
    - 1-800-685-5205 (PA Medicare)
    - 1-800-392-1145 (PA Medicaid)

Sincerely,

Gateway Health Medicare Assured[SM]