



Provider Manual



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Section 1 Forward

1.1 Gateway Health Alliance Background

Gateway Health Alliance (Gateway) is a managed care company dedicated to partnering with area employers in order to provide them with affordable, well managed health insurance. Gateway is organized as a free-standing corporation, operating separately from the hospitals, physician practices, pharmacies, mental health facilities and other providers. The offices are presently located at 1500 Fulton Heights, Danville, Virginia 24540.

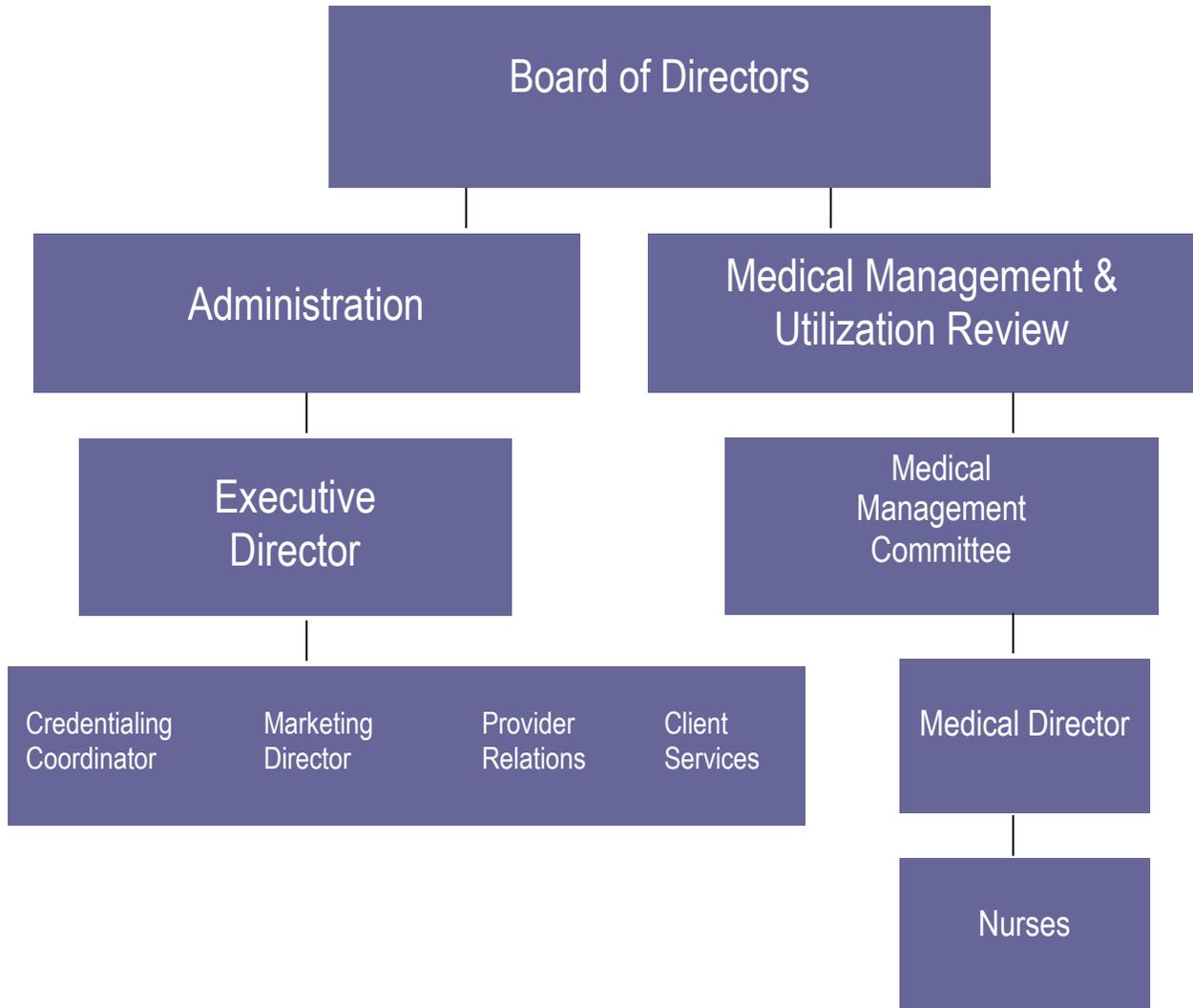
Leadership

Gateway Health Alliance is directed by a 12-person Board of Directors, selected by the hospital and physician members.

An organizational diagram for Gateway Health Alliance's management is listed on the next page.

1.2 Organizational Chart

Gateway Health Alliance



1.3 Business Purpose

Business Purpose

- Integrate health care providers in the Piedmont area of Virginia and Central North Carolina into a managed care delivery system.
- Form health care partnerships with area employers aimed at fostering collaborative strategies for reducing health care benefit costs and assuring cost-effective, quality care.
- Reduce health care costs for area employers operating in the region by emphasizing wellness and avoiding costly health care treatments.
- Become a market leader by providing data and leadership to maximize value for area employers.

Business Volume

Today, more than 70 employers now offer health plan benefits through Gateway to nearly 30,000 employees and their family members across the country.

Measures of Success

Our success is due in large part to the way that Gateway has facilitated significant change over the years in how health care is provided and paid for on behalf of Gateway client employers. Each Gateway Client Employer has different goals and needs. Accordingly, Gateway has facilitated a variety of health benefit plan strategies to achieve employers' goals in terms of cost, access to providers, employees' preferences and administrative requirements. Gateway's greatest source of pride is that goals have been achieved and the predictable problems associated with change have been addressed through our working Gateway Employer partnerships.

Access to Services

All Gateway Health Plan members have access to any Gateway Product (Wellness or otherwise) purchased by their employer through Gateway.

Health Literacy

All information provided to Gateway Health Plan members by Gateway Health has been literacy tested and is delivered in plain language.

1.4 Mission Statement

Mission, Vision and Values Statement

Mission

We manage health plans for businesses. Our commitment revolves around meeting the needs of employers who pay for care, employees who receive care, and providers who deliver care. We focus on the delivery of high quality, cost-effective health care through:

- Network coordination
- Disease management and wellness programs
- Accurate and timely claims processing and data reporting

Vision

Gateway Health Alliance is the premier provider of effective, proactive management of self-funded employer health plans. We continually research and analyze industry trends and best practices while providing client-centered service that exceeds expectations.

Values

- Gateway values integrity above all. We will put the best interests of the client first.
- Gateway believes in quality service the first time. We put forth our best efforts in every endeavor.
- Gateway believes in informed decisions. In a complex industry, open and honest communication is key to success and growth, for us as well as our employer clients.
- Gateway believes in healthy living. Taking control of health care costs begins with the individual. We lead by example.

Section 2

Administrative Services

2.1 Participating Providers

Participating providers include those physicians, hospitals, skilled nursing facilities, urgent care centers, pharmacies or other duly licensed institutions or health professionals that have a contract with Gateway. In order for a member in an HMO plan to be eligible for covered services, participating providers must be utilized unless non-participating providers are specifically authorized by Gateway before services are rendered. POS and PPO products allow the member to receive covered services from non-participating providers usually at a reduced level of coverage.

You should be aware that the various payors, *Directory of Health Care Providers* is subject to change. You should verify the participation status of a provider with the applicable payor, plan or Gateway before referring a patient.

Primary Care Physicians

Primary Care Physicians (PCPs) are those physicians who accept the responsibility of providing and/or coordinating the health care needs of any Gateway member who chooses that physician. This applies only to benefit plans that require the member to select a PCP. **It is important that all primary care providers ensure 24-hour coverage and accessibility for members. Referring patients directly to the Emergency Room when you are unavailable is *not acceptable*** and is a violation of the Physician Agreement.

Primary Care Physicians fall within the following types of medical specialties:

- Internal Medicine
- Family Practice
- General Practice
- Pediatrics
- Osteopaths
- OB/GYN, depending on the payor

OB/GYN Physicians

Often, payor benefit plans which require the selection of a PCP also allow female members, age 13 or older, to select an OB/GYN Physician. Even in plans where a member does not select a specific OB/GYN physician, the member may go directly to an OB/GYN physician for covered services.

Specialty Care Physicians

A specialty care physician is a physician who provides care to covered members within the scope of a specific medical specialty.

Hospitals/Ancillary Providers

Gateway Health Alliance maintains contracts with hospitals and ancillary providers within the service area to fulfill the health care needs of all members.

Please note: Each participating provider may not be a participating provider for all products or services. Please call Gateway to verify participation status. In addition, watch the Gateway Health Alliance Newsletter for important messages and updates. Physicians have the option to opt out of certain products. Please consult your Agreement for further details.

2.2 Physician/Member Relationships

Gateway Health Alliance requires all participating providers to discuss treatment options with members who are their patients. This allows a member to make an informed decision about course of treatment with knowledge of both the possible benefit limitations and treatment options.

2.3 Gateway Provider Newsletter

Gateway regularly publishes a provider newsletter. This is one of the main sources of communication to participating providers. The Gateway Newsletter may include Provider Manual Amendments and is part of the provider's contract. The newsletter is intended to explain Amendments and keep participating providers abreast of issues, including but not limited to, Gateway programs, policy and procedure changes/updates, network changes, changes in the Schedule of Allowances, billing information and general topics of interest. These notices should be added to this Manual. The newsletter clarifies changes to Gateway policies and procedures that amend the provider's agreement with Gateway.

To ensure proper receipt of the newsletter, please contact Gateway Health Alliance's Provider Relations Department immediately if your address changes.

2.4 On-Call Providers

As a participating physician, you are responsible for providing access for members twenty-four (24) hours a day, seven (7) days a week. Referring patients directly to the Emergency Room when you are unavailable is *not acceptable* and is a violation of the Physician Agreement. When a physician is taking calls for you, he or she is responsible for coordinating any necessary care for those patients in your absence.

On-call physicians who are not affiliated with your practice, but participate with the applicable plan, may bill the plan. These physicians should indicate on the claim that they were on call for you.

On-call non-participating physicians may bill a plan as well and will be reimbursed at the participating fee schedule for the given product or region. **Be sure to inform non-participating physicians who are on call for you that they may not bill patients for any amount other than the applicable co-payment.** Should the member's coverage have a deductible and/or coinsurance, the physician can bill the member once the member's liability is reflected on the provider remittance. In order to reimburse your on-call physician, you must provide the information regarding your on-call physician in advance. Otherwise, the claims could be denied or delayed awaiting this information. To facilitate claims processing, please notify Gateway Health Alliance's Provider Relations Department of the current on-call information for your practice.

2.5 Copayment/Coinsurance/Deductible Collection

Each plan's member ID card has information regarding applicable co-payments or coinsurance for office visits, prescriptions, and outpatient and inpatient services. Schedules of Benefits vary among groups. **Therefore, it is important to reference the Member ID card for the correct co-payment, coinsurance and deductible amount.** Co-payments for office visits should be collected by the physician office. All other co-payments or coinsurance are to be collected by the appropriate provider upon receipt of the explanation of benefits.

An office visit co-payment should be collected in the following circumstances:

- A member receives service(s) from a physician's office and the charge billed is a CPT procedure code indicating an office visit (E & M code).
- A member is given an allergy shot(s). If the charge for the shot(s) is less than the co-payment, collect the charge for the shot(s) only. Collect only one co-payment per visit, regardless of the number of shots.
- A member has a visit for physical therapy, whether performed at the office of a participating physician, a participating hospital outpatient department, and a participating freestanding physical therapy provider or at home.
- A member has a visit for a procedure(s) that does not require an office visit charge, but does require the attention of the physician or trained personnel (e.g., in-office surgery, joint injection, testing, casting).

A co-payment should **not** be collected when:

- A member is in the physician's office for laboratory testing, X-rays or a therapeutic injection only, excluding allergy shots, unless an E & M code is covered or allowed for payment.
- A member has a visit for follow-up care that is included in the global fee for a procedure or situation.
- A member receives care and the charges are for supplies only.
- A member is in a physician's office for chemotherapy administration.

EXAMPLE OF CARD

Gateway Health Questions? 704.944.6268 www.primarypc.com

<p>Member</p> <p>JOHN DOE ID: 000000001</p> <p>Group #: 099 Employer: PRIMARY PHYSICIANCARE -SP PLAN</p> <p>Dependents TOMMY DOE KATHY DOE</p>	<p>Medical Plan</p> <p>Coverage: Family</p> <p>Gateway Health ①</p> <p>\$25 COPAY PCP, DEDUCTIBLE: \$750 PHYSICIANS: 75% PPO, 50% NON-PPO HOSPITALS: 75% PPO, 50% NON-PPO VISION BENEFIT: \$200 PER FAMILY</p> <p>Pharmacy Plan</p> <p>RX BIN: 003858 RX PCN: A4 RX GRP: PPHA</p> <p>EXPRESS SCRIPTS www.express-scripts.com Member Srv: 800.889.0350 Pharmacists: 800.824.0898</p>
<p>Medical Claim Submission</p> <p>EDI: Payer ID # [REDACTED]</p> <p>Mail: [REDACTED]</p>	<p>Eligibility</p> <p>[REDACTED]</p> <p>This card does not guarantee coverage or payment.</p> <p>Utilization</p> <p>Pre-certification must be obtained for all hospital admissions and outpatient surgeries performed outside the physician's office or for other services as specified in the member's plan.</p> <p>[REDACTED]</p> <p>Failure to comply may result in a reduction of benefits. Pre-certification does not guarantee payment.</p>

2.6 No-Show Appointments

If your office has an established policy on prior notification of canceled appointments that includes a charge for no-shows, you may charge Gateway members should they violate this policy. Please note that this must be an established policy communicated to and applied to all patients. Gateway members may not be charged for a canceled appointment at a rate greater than would be charged to a non-Gateway member.

2.7 Non-Covered Services

As stated in your Provider Agreement with Gateway, you may not bill the member for services that are not covered unless you notify the member before the service and the member indicates in writing their willingness to pay out-of-pocket. You also must require that the member execute a form to the effect that the services are not a covered benefit.

2.8 Dismissal of Patients from a Practice

It is recommended that your practice have an established policy for dismissing patients from the practice. Gateway members should be seen and treated in the same manner as any other patients you see. Services or appointments cannot be refused in emergency or urgent care situations unless you have provided a member with at least 30 days notice and requested that they select another physician. In the event of a member dismissal from your practice, the member should be notified in writing. It is recommended that the practice submit a copy of the dismissal notification letter sent to the member to Gateway or the applicable Plan. If requested, Gateway or the applicable Plan can assist the member in selecting a new physician. This policy is to be used for special situations with specific patients only where just cause exists for dismissing the patient.

2.9 Termination And Restrictions

Participating providers may terminate their participation with Gateway. Practices wishing to terminate must notify Gateway in writing within an appropriate notice period. Please refer to your Provider Agreement for complete guidelines.

Participating PCP's who wish to restrict their practice in any way also must restrict their practice to all carriers and must give Gateway written advance notification as stated in your Provider Agreement. The Provider Agreement has provisions regarding the necessary timing.

Section 3

Authorizations

(for Gateway/Healthgram Members)

3.1 Overview – Various Payor Plans

Each Payor/Plan that contracts with Gateway may develop and manage its own Preauthorization and Medical Management Program.

3.2 Medical Management For Gateway/Healthgram Members

Typically an authorization (prior approval) is required for inpatient and outpatient hospital admissions, certain medical, surgical or diagnostic procedures, durable medical equipment, home care hospice and care by nonparticipating providers. The Healthgram/Gateway Authorization List is periodically updated by Gateway. Please make sure an authorization for applicable services is issued prior to members receiving the services unless it is an emergency. If you are unsure about a particular procedure for more information, contact Gateway Utilization Review at 434-799-0702, out of area 1-877-846-8930.

The physician ordering the care must contact Gateway to obtain authorization, if required. Specific medical information is required to determine medical necessity and the availability of benefits. The initial service authorized must be provided within 30 days from the date the authorization is given. In order to allow sufficient time for the authorization process, please contact Gateway a minimum of two (2) working days prior to when the service is needed for elective, scheduled procedures or diagnostic testing.

The clinical information provided and the plan of treatment will be evaluated and completed by the Preauthorization Nurse within two (2) working days of receipt of all necessary information to make a determination for elective procedures or testing. For urgent or emergent procedures or testing, the determination will be made within 24 hours upon receipt of all clinical information. If the 24-hour deadline falls on a weekend or holiday, authorization will be given on the next working day. Evaluation using Gateway approved criteria will be performed and a decision will be made on the requests. For concurrent review, the Case Manager will review the information the next working day after notification.

The authorization number should be given to the patient and specialty care office. The authorization number should be included on the specialist's claim form when submitting the claim. Specialty care physicians are expected to forward appropriate reports of consultations or treatments, and/or plans for future evaluation and treatment to the member's Medical Management Department.

If a member is admitted to the hospital in an emergency, Gateway must be notified within 48 hours or by the end of the next working day if the 48 hour deadline falls on a weekend or legal holiday. Earlier notification greatly facilitates the utilization review process, and lets Gateway determine during the stay whether or not the stay meets criteria for coverage. Notification may be given via fax or telephone.

Unless the patient has received prior authorization from Gateway for out-of-network care, or is a member of a plan with out-of-network benefits, all care must be received within the contracted provider network in order for services to be eligible for coverage. Should you refer a member for care outside of the network without an authorization, you may be held responsible for the charge(s) of the service(s) rendered. **Please note that each participating provider may not be a participating provider for all products or services. Please call Gateway to verify participation status.** In addition, watch the newsletter for important messages. Members who have out-of-network benefits may receive care from non-participating providers without an authorization for consults at reduced levels of coverage.

Gateway is assisted by a computer-based medical review system with appropriateness criteria for frequently performed inpatient and outpatient procedures. A Gateway Nurse Reviewer uses the medical review system to ask the provider questions about the member's symptoms, other indications, and what types of treatment and / or tests have already been utilized. This information will be compared with the medical review system's indications for appropriateness. If the

indicators are present, the procedure will be authorized. If appropriateness indicators are not present, the case will be referred to the Medical Director, who can discuss this case with the member's attending physician.

Providers may be held responsible for the cost of service(s) when prior authorization is required but not obtained. In most cases, the member may not be billed for the applicable service(s).

(SEE PRE-AUTHORIZATION LISTING ON NEXT PAGE)

3.2 Services Requiring Preauthorization/Notification

Gateway Health Alliance / Halifax PHO / Healthgram

- | | |
|---|--|
| <ul style="list-style-type: none"> ■ Angioplasty ■ Cardiac Catheterization ■ Cardiac/Pulmonary Rehabilitation ■ Dialysis ■ Durable Medical Equipment (>\$200) ■ Endoscopies
(Bronchoscopy, Colonoscopy) ■ Sigmoidoscopy (In Hospital) ■ Home Health Care/Services/Hospice ■ Inpatient Hospital Care ■ Inpatient Mental Health ■ Inpatient Rehabilitation ■ Non-Emergent Ambulance Transportation –
<small>Non reimbursable except hospital to hospital or with
appropriate letter of medical necessity</small> | <ul style="list-style-type: none"> ■ Oncology/Chemotherapy/Radiation Therapy ■ Outpatient Pain Management Services ■ Outpatient Surgery (Hospital or Freestanding
surgical center) ■ PET Scans ■ Pregnancy/Maternity Care
(at time of diagnosis of pregnancy) ■ Skilled Nursing Facility Admissions ■ Sleep Apnea Studies ■ Transplants including Evaluations ■ Any services performed by a non-participating
provider that cannot be performed by a
network provider |
|---|--|

Services NOT Requiring Preauthorization/Notification

- | | |
|---|--|
| <ul style="list-style-type: none"> ■ Allergy Testing ■ Amniocenteses ■ Arteriogram ■ Bone Scans ■ CT Scans ■ Dental Procedures ■ DME less than \$200 ■ EEG/EKG ■ Holter Monitors ■ Lithotripsy ■ Lumbar Puncture | <ul style="list-style-type: none"> ■ Mammograms ■ MRI/MRA ■ Muga Scan ■ Myelograms ■ Nerve Conduction Studies ■ Office Visits ■ Outpatient Blood Transfusions ■ Stress Tests ■ TEE (Trans Esophageal Electrocardiogram) ■ Ultrasound |
|---|--|

Preauthorization / Notification Phone (434)799-0702

(Out of area 877-846-8930)

*****48 Hour Advance Notice Is Required for Preauthorization of Services*****

(Please note that covered benefits may vary by Employer)

EXCEPTIONS TO PREAUTHORIZATION LIST – EFFECTIVE JULY 1, 2005

HALIFAX REGIONAL HEALTH SYSTEM

- Physical, Occupational or Speech Therapy – DOES require Preauthorization

DANVILLE REGIONAL MEDICAL CENTER

- Alternative Behavioral Health Treatment (intensive outpatient, partial hospitalization and residential treatment) DOES require Preauthorization

3.3 Gateway/Healthgram Guidelines For Inpatient Authorization

Gateway must be informed prior to a Healthgram patient's non-emergency hospitalization. Before calling Gateway, please be prepared to provide the information contained in the list below, which will reveal the severity of illness and/or intensity of service. This information will be used to determine whether or not the care meets criteria for coverage as an inpatient stay.

- General information such as the member's name and ID number, the admitting physician and the Primary Care Physician.
- Severity of illness including a history of the current illness and the diagnosis(es), description of symptoms (frequency/severity), physical findings and outpatient treatment attempted (if applicable). Gateway may request lab results (if applicable), X-ray findings and other significant medical information.
- Plan of treatment such as the medication (IV or IM), invasive procedures, tests monitoring/observation, consultation (if needed during admission, has it been schedule?), other services (i.e. respiratory treatments, therapies, wound care), activity level (if relevant to treatment Plan) and diet (if relevant).
- Anticipated duration of inpatient hospital stay.
- Alternative treatment available such as IV therapy, skilled nursing, physical therapy, or DME
- Discharge plans.

Hospitalization and the continued stay can be authorized only when the severity of the patient's illness and /or the intensity of the required services meet the established criteria for acute inpatient care. For inpatient stays, Gateway reviews each patient's chart on a daily basis and coordinates the length of stay with the admitting physician. Gateway nurse reviewers are available to work with you and the hospital staff to coordinate the care a member may need following discharge from the hospital. Continued stay review can be performed telephonically.

Concurrent review is performed prior to the expiration of the assigned length of stay. If the nurse reviewer needs information in addition to that in the patient's chart, he or she will contact your office. If the member does not appear to meet criteria for an inpatient stay, the nurse reviewer will discuss alternative care that can be arranged. The Medical Director will be involved in the final decision when a denial appears necessary. The physician and the member will be notified if medical criteria are not met and benefits are no longer available for coverage of additional inpatient days.

Coverage will not be authorized for services that a member receives from a non-participating physician, hospital or other provider, if member's benefit plan requires prior authorization and/or use of participating providers. In such benefit plans, authorizations to non-participating providers are approved only when medically necessary and when Gateway does not have a participating provider who can provide the needed service. Gateway has the right to determine where the covered services can be provided when a participating provider cannot provide the service. **Only those visits made after approval is given will be covered.**

Gateway must be notified of an emergency admission within 48 hours or by the end of the next working day if the 48-hour deadline falls on a weekend or non-working day. However, earlier notification greatly facilitates the utilization review process, and allows Gateway to determine during the stay whether or not medical criteria for coverage are met.

If you are unsure about the necessity of an authorization number please call Gateway at 434-799-0702, out of area 1-877-846-8930.

3.4 DME (Durable Medical Equipment)

Gateway providers are required to obtain prior authorization for members for the rental or purchase of durable medical equipment. For authorization, please contact Gateway at 434-799-0702, out of area 1-877-846-8930. A nurse reviewer will contact Gateway's provider of DME with the authorization, services authorized and member name and ID number. The DME provider and the nurse reviewer will work with the provider and patient to arrange for delivery of the needed equipment.

Most Gateway members have a benefit limit for DME and partial coverage for non-implanted prosthetic devices. To verify a member's benefit, call Healthgram at 1-800-446-5439.

Please Note: DME benefits may vary among employer groups. For detailed information, members should check their coverage documents and call Healthgram or the applicable Plan.

3.5 Respiratory Equipment And Oxygen

Gateway/Healthgram members are required to obtain prior authorization for the rental or purchase of respiratory equipment and oxygen. Please contact Medical Management at 434-799-0702, out of area 1-877-846-8930. A nurse reviewer will contact Gateway's provider of respiratory equipment and oxygen with the authorization, services authorized, and member name and ID number. The respiratory equipment and oxygen provider and the nurse reviewer will work with you and your patient to arrange for delivery of the needed equipment.

Most benefit plans do not have a benefit limit on respiratory equipment and oxygen. To verify a member's benefits, please reference the member's identification card for their plan benefits customer service telephone number.

3.6 Rehabilitative Therapy

Therapy provided on an inpatient or outpatient basis is covered for a limited time period of treatment, per condition, if improvement can be expected within this time period. In most benefit plans, the maximum benefit is 90 consecutive days from initial treatment of the condition. Typically, *speech therapy is not covered when treatment is due to developmental delay or failure to progress in a school setting.*

Early Intervention Services

In coordination with Federal guidelines, Virginia law guarantees that, all children up to the age of three can undergo a free evaluation under the Individuals with Disabilities Education Act. Children certified for Part C services are entitled to the following coverage for Early Intervention Services of:

- Speech & Language Therapy
- Occupational Therapy
- Physical Therapy
- Assistive Technology Services & Devices

MAXIMUM BENEFIT PAYABLE PER YEAR IS SUBJECT TO THE PLAN DESIGN.

Gateway has contracted with specific facilities to provide these services for our members. Please consult a current *Directory of Health Care Providers* for the names of these facilities. Please note that the *Directory of Health Care Providers* is subject to change. To verify the current participation status of a provider, please call Gateway Health Alliance at 434-799-3838.

3.7 Mental Health And Substance Abuse

Care must be obtained through the contracted manager of psychiatric care listed in the *Directory of Health Care Providers* and on the member's ID Card. Most members have limited benefits for the diagnosis and treatment of certain psychiatric, mental health, substance abuse and conditions. Members have the option to self-refer by contacting the manager of psychiatric care directly.

3.8 Emergency Room Visits

An authorization is required for emergency treatment received in an out-of-network facility's emergency room. However, patients are instructed to contact their primary care physician for medical advice prior to seeking care, if possible. Follow-up visits to the emergency room are not covered under any circumstance. If you personally take a call from a member after hours and advise him or her to go to the emergency room, please contact Medical Management at 434-799-0702, out of area 1-877-846-8930 (choose option #1) on the next working day to inform us of your action.

3.9 Out-Of-Plan Authorization

(HMO Plan, In-Network POS, Certain Self-funded Plans or PPO Products)

In certain cases for HMO, Point-of-Service (POS), certain self-funded plans or PPO members seeking in-network benefits, Gateway will pre-authorize services rendered by nonparticipating physicians or facilities. Such requested out-of-plan services are approved only when the member's medical needs require specialized or unique services which Gateway considers unavailable within the existing network.

While final treatment decisions remain the responsibility of the physician and patient, coverage (as described above) is only extended if treatment options are not available in-network. Your cooperation in explaining this process fully to patients is appreciated when discussing treatment options.

Gateway must be notified in writing and an authorization assigned before care is rendered, except in emergency cases. Please allow two (2) working days for the evaluation of an Out-of-Plan Authorization Request. A second opinion from a participating specialist may be required. The provider and member will be notified of the approval or denial of out-of-plan care.

If an HMO member sees a nonparticipating physician or is admitted to a nonparticipating hospital in an emergency situation, then Gateway will work with the PCP and the attending physician to have the member's care transferred to participating providers as soon as medically possible.

In the course of an out-of-plan evaluation, any services, tests, or procedures which can be provided within the network must be performed by participating providers in order to obtain coverage as described above. The referring physician is asked to monitor the care of out-of-plan providers and assist in Case Management by helping coordinate lab, X-ray, etc. through participating facilities.

3.10 OB/GYN Treatment

Female members, age 13 or older, may receive obstetrical/gynecological care directly from participating physicians. Some benefit plans which require the selection of a Primary Care Physician also allow female members to choose an OB/GYN physician in addition to or in place of their PCP. If care is received from an OB/GYN physician other than the one chosen, a higher co-payment may apply. OB/GYNs performing annual exams should bill with the appropriate preventive medicine CPT code.

3.11 Referrals For Gateway/Healthgram Members

Certain self-funded benefit plans in which Gateway/ Healthgram administer the benefits may require either fax or telephonic referrals. Communication will occur with Providers notifying them of these certain plans which may require the PCP to obtain a referral prior to sending a Member to a Specialist. (See copy of the referral form under Section-Forms)

Section 4

Reimbursement & Claims

(For Gateway/Healthgram Members)

4.1 Various Payor Plans

Each Payor/Plan that contracts with Gateway may develop and manage its own Preauthorization and Medical Management Program.

4.2 Medical Supplies

Applicable Durable Medical Equipment (DME) over \$200 must be authorized by the Medical Management Department at 434-799-0702, out of area 1-877-846-8930.

Covered supplies should be billed with a valid HCPC code. CPT code 99070 should only be used when a valid HCPC code is not available. If 99070 is used, information must be provided to identify the supply being billed, and only covered items will be reimbursed.

For example: when billing with 99070 for a brace, the word “brace” under the item category is not sufficient. The brace manufacturer and other identifying characteristics should also be provided to indicate which brace is being billed, for example “Innovative Sports Brace Model AB600/Right Leg”.

Payment for covered supplies depends on the type of supply and the type of provider billing the supply. Where a HCPC code exists for a supply and there is a nationally recognized resource to obtain fee for a supply, generally the most reasonable price noted in the national resource is used. For supplies that are not assigned a HCPC, Gateway/ Primary PhysicanCare shall use proprietary claims payment guidelines which may include payment at a percentage of charges. Supplies are not generally reimbursed for capitated orthopedic providers and certain ancillary providers where supplies are considered incidental to the services provided. Durable medical equipment is not included in this section as it is discussed in section 3.4.

Medicare and CPT guidelines are used to determine coverage of supplies during chemotherapy administration or in-office procedures.

Covered supplies vary by payor. Providers may call the applicable payor if there are questions related to supplies.

Charges for non-covered supplies will be denied as non-covered services.

Supplies (e.g., bandages, suture removal kits) billed within the surgical global period used in follow-up care will be denied as included in the global fee and should not be billed to the member. This policy does not apply to braces or slings.

4.3 Immunizations And Injectables

Healthgram reimburses immunizations and injectables based on a percentage of AWP (Average Wholesale Price). These rates are updated quarterly.

4.4 Non-Covered Services

Gateway/ Healthgram employer benefits are described in detail in the *Evidence of Coverage, Plan Document, Certificate of Coverage* or *Certificate of Insurance* which each subscriber receives at time of enrollment. Benefits and the member's payment responsibility may vary among employer groups. Members are advised that their *Evidence of Coverage, Plan Document, Certificate of Coverage* or *Certificate of Insurance* and Healthgram should be their sources of information regarding coverage status. If you have questions about the coverage for a certain service, please reference the member's identification card for their health benefits customer service telephone number. Be sure to have the member's ID number handy so you can get accurate information.

4.5 Compensation

Healthgram /Gateway Physician Allowances

Physician allowances are set by CPT code. Please include any applicable modifiers to ensure proper payment. Physicians must submit claims to Healthgram for covered services rendered to Gateway/ Healthgram members in order to receive reimbursement. Claims submitted to Healthgram should include your usual fee for services rendered by CPT code. Proper coding remains the responsibility of the billing provider. Fees charged for services provided to Gateway/ Healthgram members should be the same as those charged to non-Gateway/ Healthgram members for the same services.

Members are not responsible for charges in excess of the negotiated rate for participating providers. Patients are, however, responsible for all copays, deductibles, coinsurance and non covered charges.

Physician Allowances for Other Payors

Physician reimbursements for payors other than Healthgram may vary.

4.6 Claims Filing Procedure

Submit charges on an HCFA 1500 Health Insurance Claim form (or UB92 if applicable) directly to the Claims Department of applicable payor as directed. Electronic submission of claims is available through Healthgram's NEIC/Envoy number 56144. Please contact their Network Management Department prior to sending your first batch of electronic claims.

Use a separate claim form for each provider.

- Use a separate claim form for each member.
- Please submit one claim for all services provided in the same day. Payor reserve the right to retract claims paid where split billing (using two claim forms for the same date of service) is used.
- Submit original form to Payor; keep a copy for your files.

Submit a complete and correct claim form.

- When applicable, write other insurance information on the claim form. When Payor is secondary, please attach the primary carrier's Explanation of Benefits (EOB) to the claim.
- Include primary diagnosis and pertinent secondary diagnosis information.
- Include the complete provider number and member number including the two-digit suffix.
- Include Employer Name, if applicable

Please note: Any special circumstances, please include office notes with claims submitted for services that require special consideration.

Remember to include:

1. Authorization Number for hospitalization, outpatient hospital services and other services or procedures requiring authorization as stated in this manual or in accordance with the coverage documents for that benefit plan.
2. Authorization Number (when required by the benefit plan) for services performed by out-of-network providers.
3. CPT Procedure Code – unlisted codes must be accompanied by description of service, test, or procedure before payment will be considered.
4. ICD-9 Diagnosis Code, (four or more digits must be used).
5. Referring Provider, if required.

The accuracy and completeness of claims is necessary to help ensure correct payment in a timely manner.

4.7 Timely Filing Policy

Timely filing requirements vary by employer or payor. If you have questions, contact applicable payor or call Gateway Provider Relations at 434-799-3838 at extension 3010 or 3006.

4.8 Remittance

It is the responsibility of the Provider to verify remittances. If the Provider wishes to appeal a payment, the Provider must contact the Payor.

The following is an explanation of the remittance advice you will receive for medical services rendered.

Schedule of Payment

For most Employer Groups, checks are scheduled to run on a weekly basis. Checks are usually received by provider offices within 10 -15 working days after a check run.

Method of Payment

- Payments are made to the provider. The check sum includes payment for all services processed for that practice during the payment cycle.
- Should a remittance include denied charges or payments requiring adjustment, an explanation of the denial or adjustment code will be given on the last page of the voucher.

Correction of Payment

- If you receive an underpayment, please contact the Payor and the correction will be made on a future remittance/check.
- If you receive an overpayment, the Payor will correct the error by subtracting the overpayment from a future remittance/check and reissue the correct payment. Please notify the Payor so that they can make the appropriate adjustments. PLEASE DO NOT RETURN A CHECK TO THE APPLICABLE PAYOR UNLESS IT IS SPECIFICALLY REQUESTED.

Out-of-Pocket Maximums

Most co-payments, deductibles and coinsurance are applied to the member's out-of-pocket maximum stop / loss limit, but it varies by Plan. The actual amount of the maximum varies among benefit plans. When a member meets his or her out-of-pocket maximum, an EOB message will appear on the remit and co-payments should not be collected for the remainder of the benefit or plan year. Payors are required by Virginia regulation to ensure that any co-payments the member pays after reaching the maximum are promptly refunded. As a participating provider, you are required by Gateway Health Alliance to promptly refund co-payments to the member when you are notified by a Payor that the member has met his or her maximum. The Member is instructed to present his/her letter from the Plan stating that he/she has reached the out-of-pocket maximum on all subsequent provider visits for the remainder of the benefit or plan year.

4.9 Status of Claims

You may call the applicable payor to check the status of claims.

Gateway Health Alliance recommends that claims status inquiries not be made unless it has been at least 45 days since the date of submission.

It is the responsibility of the Provider to maintain an updated record of their account receivables. Gateway recommends that you check your account receivables monthly to determine if there are any outstanding claims. The Provider should contact the applicable Payor to determine the status of the claim. Payors will not be responsible for claims that were never received and the date of service exceeds the timely filing limit.

For Providers who submit claims electronically, reports are provided to Provider after each submission detailing the claims that were sent and received. It is the Provider's responsibility to track this list to ensure that claims were received by the Payor. Payors will not be responsible for claims that were never received when the date of service exceeds the timely filing limit and an EDI report showing acceptance of the claim is not present.

4.10 Coordination of Benefits

Medicare

1. Typically, an employer's health plan is primary to Medicare for active employees age 65 and over and their spouses age 65 and over when the group employs 20 or more individuals. The employer's health plan is also primary to Medicare for active employees that are disabled or their disabled spouse when the group employs 100 or more individuals.
2. If the services being charged are not covered by the plan, then Medicare becomes the Payor for these services.
3. If Medicare eligibility is based on End Stage Renal Disease, Medicare is not primary during the first 30 months of treatment while the member fulfills Medicare eligibility requirements. After these requirements have been met, Medicare becomes primary for treatment of End Stage Renal Disease.

Group and Individual Coverage with HEALTHGRAM and Other Payors

When a member is covered by more than one health insurance policy, coordination of benefits is necessary to prevent the duplication of benefits. The National Association of Insurance Commissioners (NAIC) provides guidelines for insurance companies to follow in order to determine the order in which benefits are to be paid.

When Healthgram is determined to be the primary plan, it will pay claims first without regard to any other coverage up to applicable benefit maximums.

When a Gateway Payor is determined to be the secondary plan, it will take into account benefits to be paid by the primary plan in determining payment for a covered service. Aggregate payment, from all sources, for a service shall not exceed the Payor allowable amount for the service. Only one co-payment will apply if the member is covered by two of the Payor policies. If the payment is a percentage payment, the COB covered amount is still subject to the member's plan deductible and is payable at the applicable plan percentage. When a member's policy has been flagged as having other coverage primary to this plan, all claims should be submitted with a copy of the primary carrier's Explanation of Benefits (EOB) statement in order to calculate secondary benefits.

Information about other coverage of any member must be furnished promptly and the Gateway Payor should be notified promptly of any coverage changes. When a Payor receives a claim indicating there is other coverage in effect, the claim may be pending to confirm other coverage information, or requesting an EOB in order to determine covered benefits. It is important to let each Payor know about other coverage changes so that claim payments will not be delayed.

Gateway's Payor partners generally use a set of nationally accepted rules governing COB. These rules establishing the order of benefits determination between this plan and any other Plan(s) covering the member are summarized below.

Birthday Rule

When children are covered by both natural parents on two health insurance policies, the parent whose birthday comes first in the year is primary. The year of birth does not matter, only the month within the calendar year.

Active versus retired

If a person is employed with two groups, associations, or companies and is actively employed with one, but retired (or laid off) from the other, then the policy covering the person as an active employee is primary.

Custody rule

If a child is covered by each biological parent on two health insurance policies and the parents are divorced or legally separated, the policy of the parent with custody is primary. If there is a divorce decree which places financial responsibility for the health care of dependent children, then the decree will override this custody rule.

Dependent versus non-dependent

A group plan which covers an individual as a subscriber is always primary to the plan which covers that individual as a dependent.

Individual versus group

A group plan is always primary to an individual plan.

Medicaid and Champus (Tri-Care)

These are governmental plans that are always secondary if there is any other coverage in force.

Oldest effective date

If a member is covered by two policies as a subscriber, the policy with the oldest effective date is primary.

Medicare

This is the primary carrier for many physically challenged and elderly individuals. Medicare is governed by its own set of guidelines. Most policies sold by Gateway's partners that cover Medicare eligible members only pay benefits as secondary.

Please assist members by advising them of and following prior authorization procedures, even if their plan is the secondary carrier.

Worker's Compensation

If a member becomes ill or is injured on the job, his/her employer will be responsible for payment of claims incurred as a result of the work related illness or injury. Authorization procedures should be followed in the event that the claim is denied by Worker's Compensation. For that same reason, members seeking services they believe to be work-related should receive care whenever possible and if applicable to the member's plan, from providers who are in both the Worker's Compensation and Gateway networks.

Subrogation

The subrogation process allows Payors to withhold payment of a claim in the event of an accident in which a third party was involved. If a third party is responsible, the third party is held responsible for payment of applicable charges.

Filing Claims for Coordination of Benefits/Subrogation

1. Always submit a claim to the primary carrier first.
2. If a Payor has information indicating another insurance as primary, the claim will be denied with a code which states that an Explanation of Benefits (EOB) is required before payments can be made.
3. When submitting a claim to secondary carriers, always include a complete EOB from the primary carrier.
4. Be aware of the timely filing limitation when a member has two carriers.

COB Payments

When a Gateway Payor is primary, the payment shall not exceed the established maximum allowable fee. The participating physician writes off the disallowed amount and the secondary carrier should be billed for any co-payments, deductible, coinsurance or other amounts which are the member's responsibility.

When the plan is secondary, the primary carrier must be billed first. Bill the Payor after the primary carrier has made its consideration. If the primary carrier reimbursement is equal to or greater than the established maximum allowable fee, Payor will not be responsible for any payment as a secondary carrier. **IMPORTANT:** You must include with the claim the primary carrier's EOB. If the EOB is not included, the claim will be pended requesting the other carrier's EOB. Even when the plan is the secondary carrier, preauthorization requirements still apply.

Gateway Payors periodically requests information form the members regarding other insurance coverage. Claims submitted for members who have not completed a COB questionnaire may be pended until the questionnaire is received.

4.11 Provider Reimbursement-Fee Schedule

Gateway's Payor fee schedules vary by region and are subject to change. Please note that the existence of a fee for a CPT code does not guarantee payment for a CPT code as described in Section 4: *Reimbursement and Claims*. Gateway shall reply to written requests from providers for specific allowances within 30 working days of receipt. Requests should be limited to frequently billed services offered by the provider.

4.12 Reimbursement Determinations by Gateway

This section is designed to provide some specific information about the types of rules applied to claims billed by providers to Healthgram /Gateway.

The Healthgram /Gateway schedule of allowances represents the maximum reimbursement amount for each covered service that corresponds to any given medical service code. The basis of determining valid medical service codes are from Current Procedural Terminology (CPT), HCFA Common Procedural Coding System (HCPCS), or National Drug Codes (NDC). For covered services represented by a single code, the maximum reimbursement amount is the allowance amount determined by Healthgram /Gateway or the provider's usual charge for the service, whichever is less. In many cases, these allowances are based upon measures of relative value such as Average Wholesale Price (AWP), the Federal Resource Based Relative Value Scale (RBRVS), American Society of Anesthesiologists (ASA) units and Medicare's laboratory and Durable Medical Equipment (DME) rates.

Age/Sex Restrictions

Some services are allowed for only one sex (e.g., provider should not submit CPT 58150 for a hysterectomy for a male patient). Some services are allowed only for certain age ranges (e.g. provider should not submit CPT 43831 for a gastrostomy, neonatal for feeding for a 45-year-old patient).

Experimental / Investigational Supplies / Drugs / Services

A health product service, supply or drug is deemed experimental/investigational by Healthgram /Gateway according to the following criteria following coverage eligibility criteria:

- Any drug not approved for use by the Food and Drug Administration (FDA); any drug that is classified as IND (investigational new drug) by the FDA; any drug requiring pre-authorization that is proposed for off-label prescribing.
- Any health product or service that is subject to Investigation Report Board (IRB) review or approval.
- Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, or III as set forth by FDA regulations.
- Any health product or service that is considered not to have demonstrated value based on clinical evidence reported by peer-review medical literature and by generally recognized academic experts.

A drug, device, procedure, or other service will be experimental or investigational if Healthgram / Gateway makes such a determination based upon the criteria noted, unless otherwise noted in the *Certificate of Insurance*, *Certificate of Coverage* or *Plan Document*. Experimental or investigational services are non-covered.

Global Processing

For some medical services (in most instances surgical services), Healthgram /Gateway will impose surgery processing rules, wherein some services (in most instances evaluation and management services) are incidental to other services (in most instances procedural services) when provided within a defined time period and in conjunction with the procedural service. Healthgram /Gateway follow HCFA conventions regarding global designations and time periods for major and minor surgery.

History Edits

These edits apply to once-in-a-lifetime procedures, such as an appendectomy. These edits also apply to items such as drugs or supplies that may have monthly limits. History edits may also apply to certain codes, which denote services for a specified time period such as weekly or monthly radiology or renal dialysis.

Incidental Claims Processing

An incidental procedure is one that is performed at the same time as a more complex primary procedure that does not require significant, additional physician resources and / or is clinically integral to the performance of the primary procedure. When multiple medical service codes are billed in conjunction, some codes may be considered incidental to other codes and may not be considered toward the total allowance for the aggregation of billed codes. A code which is a subset of another code based on an objective interpretation of CPT verbiage will be considered incidental to the latter code. Codes which are "components" of "comprehensive" codes based on the Health Care Financing Administration's Correct Coding Initiative will be considered incidental to the latter. In addition, Gateway may also consider a code incidental to another if the incremental value of the former is less than one-fourth of its usual value when provided in combination with the latter. In many instances, this occurs when the lesser services do not pertain to different routes of access, different organ systems, different pathological processes, or to multiple trauma.

Laboratory Services

Laboratory services provided by an outside or reference lab that is not the applicable contracted laboratory provider for each respective Service Area will not be reimbursed to the provider of service. In this instance, the provider may not bill the Member / patient or Payor for the laboratory service(s). Payor will allow a handling fee (CPT Code 99000) for laboratory tests sent out to the applicable contracted laboratory provider for each respective Service Area. There will be no handling fee reimbursement made to the provider when a laboratory service is performed in the provider's office and another laboratory service is sent to the applicable contracted laboratory provider for the same patient on the same date of service. The reimbursement for the handling fee will be based on the current allowance for CPT Code 99000.

Medical Necessity

Medical necessity is defined as the use of services or supplies as provided by a hospital, skilled nursing facility, physician or other provider required to identify or treat a member's illness or injury and which, as determined by Gateway, are: (1) consistent with the symptoms or diagnosis and treatment of the member's condition, disease, ailment or injury; (2) appropriate with regard to standards of good medical practice; (3) not solely for the convenience of the member, his/her participating physician, hospital or other health care provider; and (4) the most appropriate supply or level of service which can safely be provided to the member. When specifically applied to an inpatient admission, it further means that the member's medical symptoms or condition requires that the diagnosis or treatment cannot be safely provided to the member in an outpatient setting. Services listed in the schedule of benefits are covered only if they are medically necessary.

Modifiers

Healthgram /Gateway accepts most standard modifiers, however some may require clinical review. If you have a question about the resulting payment from a modifier being applied to a specific medical service code, please call Provider Relations at 434-799-3838.

Multiple Surgeries/Procedures

When two or more different medical service codes are provided to the same patient (usually by the same provider on the same date of service), for covered surgical services provided in a single operative session, reimbursement would be made at the full Allowance amount for the highest paying procedure, plus half of the usual Allowance amount for the second medical service code, and one-fourth of the usual Allowance amount(s) for each subsequent procedure. All multiple surgery/procedural services are pended and sent to a Medical Claims Review Unit for review and determination of reimbursement.

Non-Covered Services/Supplies/Drugs

Certain services and supplies are non-covered and / or specifically excluded by Gateway's customer contracts. Examples of these non-covered services for most Gateway contracts include, but are not necessarily limited to, genetic counseling and services for weight loss. Different Gateway products may have a different list of exclusions. The most common exclusions for Gateway's HMO, Point-of-Service, and Preferred Provider Organization products follow. The lists are labeled by product. This list may be reduced or expanded for self-funded groups. In addition to those items specifically listed as a non-covered service in a customer contract, any service which is not medically necessary will be considered non-covered.

Participating providers licensed to render rehabilitative services may not be considered participating for any or all of these services. To determine participation, please contact Customer Service.

Preauthorization

Some services may be non-covered, or only partially covered if they are not preauthorized through the Gateway Medical Management Department. You may contact the Medical Management Department at 434-799-0702, out of area 1-877-846-8930.

Rebundling Claims Processing

Procedure unbundling occurs when two or more procedures are used to describe a service when a single, more comprehensive procedure exists that more accurately describes the complete service performed by the provider. For some combinations of medical service codes, Healthgram /Gateway will allow the allowance amount for a totally different service code while disallowing the billed medical service codes. Healthgram refers to this as rebundling processing. Medical service codes to which billed services combine are usually a superset of the billed codes. An example would be a set of laboratory codes that are all contained within a single panel or multi-channel test. Less frequently, Healthgram will combine billed codes into a code which is not a superset of the billed codes, but does represent the value of the combined medical services billed.

Reimbursement Regarding Secondary and Subsequent Procedures

Multiple units of the same medical service code may be subject to limits and /or to partial payments for secondary and subsequent units of service. For some medical service codes which may be provided multiple times to a single patient on a single day, Healthgram allows a partial payment (typically one-half or one-fourth) of the usual allowance amount for secondary and subsequent units of service. For some such medical service codes, Healthgram establishes a maximum total allowance (limit), notwithstanding the number of units provided.

Screening and Preventive Services

Screening and preventive services are provided in the absence of signs or symptoms of illness, injury or pregnancy. Some Gateway contracts do not cover all screening and preventive services. In addition, the majority of Gateway contracts have an annual limit on screening and preventive services.

Section 5

Drug Formulary

5.1 Client And Payor Formularies

Each Payor/Plan that contracts with Gateway may develop and manage its own Drug Formulary and Medical Management Program. For specific Plan information, lists and contact numbers, please contact the applicable payor.

Section 6

Laboratories

6.1 Laboratory Services

Each Payor/Plan that contracts with Gateway may develop and manage its own laboratory services. It is Gateway's policy that laboratory services should be provided by a preferred vendor. When a participating provider sends lab to a vendor that Gateway has not contracted with to perform lab services, the provider is accountable for the charges.

6.2 Healthgram /Gateway

No non-participating reference laboratory will be paid by Healthgram for routine lab work. Emergency laboratory procedures performed will be considered individually for payment.

A provider may bill one handling charge, CPT Code 99000, per patient visit when the lab specimens are sent to a reference participating laboratory. Please note that this handling charge will not be paid if there is lab work for the same visit which is done at the physician office.

If a member needs lab work that is not available through a participating Lab, please call the Medical Management Department at 434-799-0702, out of area 1-877-846-8930.

Surgical Pathology

Surgical Pathology specimens may be sent to any participating Gateway pathologist or to a participating reference lab. One handling charge, CPT code 99000, per patient per visit will be paid.

Handling Laboratory Specimens

You may handle laboratory specimens and/or charges in any of the following ways:

1. Physicians should draw the specimen in their office and send it out to a participating reference Lab. Exceptions are listed below:
 - One handling charge CPT code 99000, per patient per visit may be billed whenever lab specimens are sent to LabCare. This is not applicable if the physician is reimbursed for lab work done from the same patient visit.
2. You may direct the patient to a drawing station to have the specimen drawn and tested. You should provide patients with a test order form before directing them to a service center / drawing station.

Section 7

Plan Options

7.1 Types of Benefit Plans

Network Access, PPO and Point-of-Service products are available to both large and small companies with as few as two employees. The amount of benefits provided and premium required depends upon the product and benefit plan selected. The product descriptions are only summaries of benefits, exclusions and limitations and are not contracts. The complete benefits, limitations, exclusions and procedural requirements of a plan can be found in the coverage documents for each product or by contacting the Specific Payor.

Gateway arranges the provider network for benefit plans funded by employer groups and payors. **In all plans, the employer or payor, not Gateway has the ultimate payment responsibility to the provider.**

Product Options

Gateway providers have the ability to opt-out of any managed care plan. In the event a provider wishes to opt-out of a plan, notice must be given pursuant to the provider's agreement.

Section 8

Physician Participation Information

8.1 General Guidelines

Provider Contract

A provider/ancillary group must complete an application, sign a Physician Agreement and be fully credentialed in order to be approved for participation and treat any Gateway members. Once the Provider Agreements have been executed, an original copy will be returned to the provider for his / her records.

Physician / Patient Relationships

Physicians will be solely responsible for the treatment and medical care provided to a member, and the maintenance of their relationship with a member. Gateway network Payors/Providers will not exercise control or direction over, nor will be liable for, the manner or method by which the physician provides professional services under the Physician Agreement. Physicians can and must freely communicate with members regarding appropriate treatment alternatives and/or the treatment options available to them, including alternative medications, regardless of benefit coverage limitations. Payors is entitled to deny payment for physician services to a member which it determines are not covered services. A coverage denial does not absolve physicians of his/her professional responsibility to provide appropriate medical care to members.

Committee Activity

Provider input is an important element of the management structure of Gateway. The Medical Management Committee will allow our participating providers a voice in the policy and procedure-making process. If you have an issue to bring before this committee, please contact Gateway at (434) 799-3838.

Recredentialing

Gateway recredentials providers every three years. At this time, we verify that the physician has a current medical license, sufficient medical malpractice coverage, hospital privileges, and board certification. Medical malpractice claims filed during the last three years are reviewed. Quality Improvement issues, Utilization Management issues, and member complaints are also considered during this process. Decisions about recredentialing are made by Gateway's Medical Management Committee.

8.2 Gateway's Access And Availability Standards

Indicator	Standard
Physician Availability Routine history, physical exam, & preventive health appointment offered	6 weeks
Routine primary care (chronic or ongoing problems) Appointment offered	1 week
Maternity appointments	First trimester – 14 calendar days; Second trimester – 7 calendar days; third trimester – 3 business days High-risk pregnancy – 3 business days (or immediately if an emergency exists)
Semi-urgent complaint (sore throat, fever) Appointment offered	2 days
Urgent complaint appointment offered	Same day
Emergency appointment offered	Immediately
24-hour availability	24 hours a day; 7 days a week
Waiting room time	30 minutes
Number of patients per hour	No more than 6 patients per hour
Behavioral Health Routine appointment offered	10 working days
Urgent visit offered	Same day
Crisis / Emergency	Same day
Post hospital follow-up	1-5 working days
Consultant Routine consultant appointments for an evaluation (unless otherwise specified by the physician appointment offered)	3 weeks
Coverage PCP's – Urban areas PCP's – Rural areas Specialist – Urban areas Specialist – Rural Areas Hospitals – Urban areas Hospitals - Rural areas	40 miles radius 70 miles radius 40 miles radius 70 miles radius 40 miles radius 70 miles radius
Ratios of Coverage-Provider to members PCP OB/GYN Pediatric Specialist	1 to 120 1 to 240 1 to 360 1 to 2000

8.3 Malpractice Insurance Program

In any verdict returned against a health care provider in an action for malpractice where the act or acts of malpractice occurred on or after August 1, 1999, which is tried by a jury or in any judgment entered against a health care provider in such an action which is tried without a jury, the total amount recoverable for any injury to, or death of, a patient shall not exceed \$1.5 million. Prior to that date, the maximum amount recoverable per claim cannot exceed \$1 million.

The maximum recovery limit of \$1.5 million shall increase on July 1, 2000 and each July 1 thereafter by \$50,000 per year; however the annual increase on July 1, 2007, and the annual increase on July 1, 2008, shall be \$75,000 per year. Each annual increase shall apply to the act or acts of malpractice occurring on or after the effective date of the increase. The July 1, 2008 increase shall be the final annual increase. This applies to all health care providers. Certificate of Insurance on file should reflect these yearly increases.

8.4 Office Survey And Medical Record Review

To ensure and evaluate the accessibility of services and the quality of care, Gateway performs on-site reviews of physician offices. There are two aspects of the review, a survey addressing office policies and procedures and a medical record review.

The office survey is completed by a Gateway reviewer and the office manager or physician in the practice. It surveys the office policies and procedures in place such as those to schedule appointments, handle emergencies, and ensure patient confidentiality. Prior to the medical record review, a list of names is sent to the practice for medical records to be pulled for the Gateway reviewer(s) to check for documentation and coding accuracy.

Gateway considers these reviews educational and will work with the office to improve areas in which the office is weak. After a review, the office receives a written report. Information, including sample problem lists, is available to those practices that request follow-up. Offices will be revisited as determined by the results of the review. Generally an office is revisited in one, two or three years.

More information about the office survey and medical record review, including Gateway's required standards, may be obtained by calling Provider Relations at 434-799- 3838.

8.5 Member's Rights And Responsibilities

Gateway is committed to treating members in a manner that respects their rights as members.

Members of Gateway Health Alliance have the right to:

- Be provided with information about Gateway's partner services, benefits, their rights and responsibilities, and participating providers.
- Participate with their physician in decisions made regarding their health care and access to their applicable patient advocate group.
- Be treated with respect and recognition of their dignity and need for privacy and confidentiality.
- Voice complaints and appeals about the organization or the care provided by participating providers and to have a clear, documented method for addressing any grievances; and
- Discuss appropriate or medically necessary treatment options for medical conditions, regardless of the cost or benefit coverage.
- Obtain information on the types of provider payment arrangements used to compensate providers for the health care services rendered to members.

Gateway members have the responsibility for cooperating with providers of health care services by:

- Providing information needed by health care professionals;
- Informing office staff of their coverage and notifying office staff if they terminate enrollment; and
- Following instructions and guidelines given by health care providers.

Gateway members have the responsibility of knowing their health benefits, as well as any procedures required for seeking care, such as:

- For members, staying within the network. It is their responsibility to seek care from a participating provider, unless a medical emergency makes that impossible.
- Always obtaining any required referral or authorization as described in the member's coverage document; unless referrals are not required under their benefit plan;
- For plans requiring a primary care physician selection, notifying the Payor to request a change in primary care physician prior to seeking care from that physician as described in their coverage document;
- Checking with their employer regarding dependent eligibility and notifying the Payor within 31 days of any change;
- Making sure family members are aware of the correct procedures for obtaining benefits;
- For HMO, certain POS members and certain self-funded members, understanding the role of their primary care physician in the coordination of their overall health care.
- Obtaining a Gateway authorization or approval prior to continuation of their care if the member or a covered family member is receiving health care from a non-participating provider when they enroll. This applies to POS members and certain self-funded members only if they want the services to be eligible for payment at the in-network level of benefits. HMO, certain POS members and certain self-funded members should consult with their PCP or OB/GYN physician who will call Gateway to obtain the authorization.
- Accessing mental health and substance abuse services as described in their coverage document, if applicable.
- Verifying the current participation status of any provider prior to receiving services for their specific benefit plan.
- Promptly notify the Payor of any telephone number or address changes.

8.6 Key Contract Terms

(Excerpt from Gateway Health Alliance Provider Participation Agreement)

Termination

Termination by The Provider: The Provider may terminate this Agreement at any time, with or without cause, upon ninety (90) days prior written notice to Gateway.

Termination by Gateway:

- (a) Gateway may terminate this Agreement at any time, without cause, upon ninety (90) days' prior written notice to the Provider.
- (b) Gateway may terminate this Agreement "for cause" upon thirty days written notice. "For cause" shall include, but not be limited to, any of the following:
 - (i) Any breach of this Agreement;
 - (ii) A decision by the Provider to "opt out" of more than three consecutive Managed Care Agreements presented by Gateway.
- (c) Gateway may terminate this Agreement immediately upon the occurrence of any of the following events:
 - (i) The suspension, revocation or significant limitation of the Provider's license to practice

- medicine in the Commonwealth of Virginia, or in any other state or jurisdiction;
- (ii) The suspension, revocation, restriction, or limitation of the Provider's medical staff privileges at a Participating Facility;
 - (iii) The inability of the practitioner to procure or maintain professional liability insurance in accordance with Section 3.5 above;
 - (iv) The refusal or failure of the Provider to comply fully with the requirements of the Utilization Review, Quality Assurance, Case Management or Credentialing programs established by Gateway, Complaint and Appeals Procedure of any MCHIP, or any other programs that are operated pursuant to any Managed Care Agreement executed by Gateway; or
 - (v) The refusal or failure of Provider to treat any Subscriber in accordance with the terms of a Managed Care Agreement.

Opt-In And Opt-Out Process

Opt-Out Form: The notice provided by the Provider to Gateway on a form approved for that purpose by Gateway, notifying it that the Provider intends to opt out of a given Managed Care Agreement.

Authority to Negotiate Managed Care Agreements:

- (a) Subject to Subsection (b) of this Section, the Provider hereby expressly provides Gateway with the authority to negotiate and execute Managed Care Agreements on his/her behalf. Provider expressly agrees to be bound by the terms and conditions of all Managed Care Agreements entered into by Gateway unless Provider has "opted out" in accordance with the provisions of Section 2.3(b). The Provider also may negotiate and execute contracts with third-party payers or purchasers of health care services independently or as a participant in another network. The Provider may not, however, negotiate or execute contracts independently or as a participant in another network with any party after the Provider has received from Gateway pursuant to Section 4.4 an executed Managed Care Agreement between Gateway and that party.
- (b) The Provider may choose to "opt-out" of any Managed Care Agreement executed by Gateway that the Provider determines is not in his/her best interests. To reject a Managed Care Agreement, the Provider shall deliver an Opt Out Form to Gateway within ten (10) days of receipt from Gateway of the information set forth in Section 4.4 of this Agreement. In the event that the Provider does not reject a Managed Care Agreement within ten (10) days of receipt pursuant to this subsection 2.3(b) and Section 4.4, (s) he will be deemed to have accepted such agreement, and the Agreement will be deemed to be incorporated by reference into, and made a part of, this Agreement, without the necessity of amending this Agreement, and the Provider will be bound by its terms and conditions. Once the Provider has become bound by a Managed Care Agreement, (s) he shall remain bound by it until the earlier of termination of this Agreement pursuant to Article 5 hereunder, or termination of the

Managed Care Agreement pursuant to its terms. However, in any event, the Provider shall be required to comply with Section 5.5 of this Agreement, relating to the effect of expiration or termination. In the event that the Provider rejects any Managed Care Agreement pursuant to this subsection 2.3(b), (s) he shall remain bound by the prohibition on negotiation and execution of contracts contained in subsection 2.3(a).

- (c) The Provider expressly acknowledges that the Managed Care Agreements negotiated by Gateway may compensate the Provider on a fee-for-service, discounted fee-for-service, withhold, capitation or other at-risk basis, and that Gateway may enter into withhold, capitation or other at-risk Managed Care Agreements which, unless opted out of by the Provider as set forth in Section 2.3(b) and Section 4.4, will require the Provider to accept financial risk. However, Gateway only shall enter into at-risk agreements with Health Maintenance Organizations licensed to do business in Virginia, or other entities that are licensed or otherwise permitted by the Virginia Bureau of Insurance, to enter into at-risk agreements with Gateway.

Billing

Billing and Collection: Subject to Section 3.9, the Provider shall be responsible for billing and collecting for all Medical Services (s) he provides to Subscribers pursuant to any Managed Care Agreement.

- (a) Provider hereby agrees that in no event, including, but not limited to nonpayment by applicable MCHIP or Gateway, MCHIP or Gateway insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against subscribers or persons other than applicable MCHIP or Gateway for services provided pursuant to this agreement. This provision shall not prohibit collection of any applicable copayments or deductibles billed in accordance with the terms of MCHIP's subscriber agreement (*Evidence of Coverage*).
- (b) Provider further agrees that (1) this Provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of MCHIP's subscribers and that (2) this provision supersedes any oral or written Agreement to the contrary now existing or hereafter entered into between Provider and the subscriber or persons acting on the subscriber's behalf.

Dues

Payments to Gateway: In consideration for the services to be provided by Gateway pursuant to this Agreement, the Provider has paid to Gateway a participation fee. The Provider agrees to pay any additional sums or annual participation dues as determined by Gateway.

Why we have Dues through the PHO

- The assessment of dues is a decision made annually by the Board of Directors. This board is made up of physicians and hospital representatives. They pay dues, as well.
- Dues have decreased steadily over the years. They are approximately 25% of what they once were. Occasionally, when we have a successful year, dues have been waived or refunded. Again, this is a board decision.
- Dues are necessary to support the PHO. When going competing against large national insurance companies who have almost unlimited resources, it is important for the provider community to have a local alternative in the PHO.
- If the PHO goes away, the big insurers will have an even more monopolistic hold on the market.
- Those big carriers retain provider discounts and have Wall Street shareholders that fund them. Our support is local.

Section 9

Complaint Process

9.1 Complaint Process

The Medical Management Committee (MMC) shall oversee Utilization Management, Quality Improvement, and the Credentialing Committee. The Medical Director, the Executive Director, and other staff and participating providers will participate as deemed appropriate. The Medical Director or designee shall serve as chairperson of the MMC.

The MMC will review cases in which the practitioner's care of a patient or a practitioner's patterns involving patient care do not meet GHA's standards.

The Chairperson of the MMC shall coordinate the MMC process and determine the committee meeting schedule. The meeting may be conducted by conference call. The Medical Director and appropriate staff compile information on each case to be presented to the MMC.

The Chairperson or Medical Director of the MMC will notify the practitioner by mail that a case involving the practitioner will be considered by the MMC. The provider will be given two weeks from the date of the letter to submit any additional information in writing to the Committee.

The MMC will review all information provided and make a determination. Sanctions may include:

- Referral to individual or group committee in the same specialty.
- Education and discussion of problem with peers.
- Suspension of new patient assignment or referrals.
- Probation period with or without payment during which time there will be ongoing review.
- Termination of contract with cause.

The Chairperson or Medical Director of the MMC will notify the provider by mail of the decision by the MMC within five (5) working days of the decision. The notification will include the action of the committee, the rationale, and the practitioner's right to appeal.

Section 10

Appeal/Hearing Guidelines

10.1 Appeal/Hearing Guidelines Regarding Terminations

The following actions shall entitle a practitioner to a hearing before the Gateway Medical Management Committee:

- In any instance where the corrective action will be required to be reported to the National Practitioner Data Bank;
- In any instance where the practitioner's contract with Gateway is terminated for cause under the terms of the contract; or
- In any instance where the Executive Director or the Medical Director deems it would be in the best interest of the member or the plan that the practitioner be entitled to a hearing.

If the practitioner falls within one of the categories defined above, the Medical Management Committee shall notify the practitioner in writing of the basis for its decision to terminate. The notification will include the following:

- The action that has been proposed to be taken against the practitioner;
- The reasons for the actions, e.g., the practitioner's quality of delivering medical services is below reasonable standards of quality or safety of care consistent with prevailing standards of medical practice or medical ethics;
- That the practitioner may request a hearing on the proposed action within thirty (30) calendar days of his/her receipt of the notice; and
- The rights of the practitioner at the hearing.

If the practitioner requests a hearing, the Medical Management Committee shall schedule the hearing date. The practitioner will be notified in writing via certified mail of the time, place and date of the hearing. The date of the hearing shall not be more than 30 calendar days after the date of notice. The notice must also include a list of witnesses, if any, expected to testify on behalf of the plan.

If the practitioner does not request a hearing within thirty (30) calendar days of his or her receipt of the action notice, he or she will waive the right to have a hearing regarding the proposed notice.

The Gateway Medical Management Committee shall consist of the Medical Director and two network practitioners, who have had no involvement in the matter under consideration. The Medical Director shall function as the chairperson.

At the hearing, the practitioner affected by the proposed action shall have the right to:

- Be represented by an attorney or other person of the practitioner's choice;
- Have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with the preparation of the material;
- Call, examine and cross examine witnesses;
- Present evidence that is determined to be relevant by the Gateway Medical Management Committee; and
- Submit a written statement at the close of the hearing.

10.2 Hearing Process

Prior to evidence or testimony, the Chairperson shall announce the purpose of the appeals hearing and the procedure that will be followed for the presentation of evidence.

Presentation of Evidence by Gateway Health Alliance

Gateway Health Alliance will present the oral testimony and submit the documentary evidence upon which it relies in support of its determination to terminate the practitioner. The practitioner and/or the practitioner's counsel will have the

opportunity following the submission of such evidence to question any witness(es) who gave testimony on behalf of Gateway Medical Management Committee.

Presentation of Evidence by Practitioner

After the completion of Gateway Medical Management Committee's submission of evidence, the practitioner shall present any evidence he/she deems necessary to rebut or explain the situation or events described by Gateway as contributing to the termination decision. Such evidence may be witness testimony or documentary evidence. Gateway Medical Management Committee shall have the opportunity to question any witness questioned by the practitioner.

Rebuttal

In the event the practitioner raises factual matters during the course of his/her presentation of evidence and/or questioning of Gateway Medical Management Committee's witnesses, Gateway may present any additional witnesses or submit additional documents to rebut the practitioner's submission of such evidence. The practitioner has a right to question any additional witnesses that are then presented by Gateway Medical Management Committee.

Summary Statements

Upon completion of Gateway Medical Management Committee's and the practitioner's submission of their testimony and evidence, Gateway and the practitioner shall make a brief closing statement summarizing their positions.

Examination by the Gateway Medical Management Committee

Throughout the course of the hearing, the Gateway Medical Management Committee may question any witness giving oral testimony for Gateway.

10.3 Evidentiary Standards

The oral testimony and documentary evidence provided by Gateway and the practitioner shall be reasonably related to the specific issues or matters that are the subject matter of the termination decision and as raised by the appeal. The Gateway Medical Management Committee has the right to refuse to consider testimony or evidence that is not relevant to this hearing. In the event a party objects to the presentation of any evidence, the grounds shall be stated for such objection, and the Gateway Medical Management Committee shall determine whether or not such evidence shall be admitted. The Gateway Medical Management Committee shall determine the relative weight to be given to any evidence submitted to its review.

10.4 Gateway Medical Management Committee Decision

Standard Review – Upon completion of the hearing, the Gateway Medical Management Committee shall make a final written recommendation within fourteen (14) calendar days of the hearing date.

Majority Vote – Subsequent to the hearing, the Gateway Medical Management Committee shall convene and privately discuss the evidence presented at the hearing. The Gateway Medical Management Committee shall have the ability to uphold, reject, or modify the recommended action, and its decision will be based solely on the evidence provided at the hearing.

The Gateway Medical Management Committee's decision shall be by the affirmative vote of the majority of its members. The Panel shall prepare a written decision identifying the evidence relied upon and its reasons for its decision. A copy of the written decision shall be provided to the practitioner and Gateway. The action of the Gateway Medical Management Committee will be final.

10.5 Effective Determination

In the event the Gateway Medical Management Committee's decision is to uphold termination, the participation status of the practitioner shall cease within sixty (60) calendar days following the date of the Gateway Medical Management Committee's decision. The practitioner shall not submit claims to Gateway Health Alliance for services provided to

members after the effective date of termination. Practitioner must give prompt, individual written notice of termination to all current patients whom the termination will affect. Practitioner must inform all members initially seeking Physicians services of the termination. The practitioner shall be entitled to payment for past services rendered to Gateway Health members prior to the effective date of the practitioner's termination.

In the event that Gateway Medical Management Committee's decision is not to terminate the practitioner, the practitioner shall continue as a participating practitioner with Gateway Health Alliance.

10.6 Administrative Appeal Guidelines Regarding Claim Denial

Administrative appeals are those appeals that do not require review for medical necessity. These include, but are not limited to, appeals for claim denials due to no authorization of certain covered services or the performance of services considered to be non-covered. A provider may file an administrative appeal with Gateway within ninety (90) days of the date the provider received written notification of the denial. (Please note that members have their own appeal process as outlined in their coverage documents. See Members' Rights and Responsibilities below.)

When a provider requests an administrative appeal, he/she will receive written acknowledgement of receipt of the appeal within five (5) working days. Within thirty (30) working days of the receipt of the appeal, the Gateway Medical Management Committee will convene to decide whether to uphold the initial denial or overturn the denial. The decision letter will be sent to the provider within five (5) working days.

If the provider wishes to make a second appeal, he/she must request the second administrative appeal in writing within thirty (30) calendar days of the date that the Gateway Medical Management Committee issued its decision. The provider will receive written acknowledgement of receipt of the appeal within five (5) working days. Within thirty (30) working days of receipt of the appeal, the Gateway Board of Directors will convene to decide whether to uphold the Medical Management Committee's decision or to overturn it. The provider has the right to attend the hearing or have representation, either in person or by telephone. The decision letter will be sent to the provider within five (5) working days.

This is the final level of appeal through Gateway Health Alliance.

MEMBERS' RIGHTS AND RESPONSIBILITIES

Policy Statement

The Member Bill of Rights and Responsibilities assures that all members are treated in a manner consistent with GHA's mission, goals and objectives and assures that members are aware of their obligations and responsibilities upon joining the Plan and throughout their membership with the Plan.

Members have the Right:

1. To be treated in a manner reflecting respect for his/her privacy and dignity as a person.
2. To be informed regarding his/her diagnosis, treatment and prognosis in terms he/she can reasonably be expected to understand.
3. To receive sufficient information to enable him/her to give informed consent prior to the initiation of any procedure and/pr treatment.
4. To participate with practitioners in decision making and to refuse treatment to the extent permitted by the law, and to be made aware of the potential medical consequences of such action.
5. To a candid discussion of appropriate or medically necessary treatment option for his/her conditions, regardless of cost or benefit coverage.
6. To expect that all communications and records pertaining to his/her health care will be treated as confidential. Any data shared with employers is not member identifiable unless specific consent has been obtained. No records will be released without his/her written authorization to protect access to his/her medical information. In the case of a minor, release of information is allowed only by the authorization of the legal guardian or court order.
7. To select his/her own primary care physicians and to expect the physician to provide or arrange

- for, and coordinate, all care the member requires.
8. To express a complaint or appeal about the Plan or the care provided and to expect a response to that complaint or appeal within a reasonable period of time.
 9. To reasonable access to necessary medical services.
 10. To be informed of the Plan's policies and procedures regarding services, benefits, practitioners and providers, and member right and responsibilities, and to be notified of any significant changes in those policies and procedures.
 11. To discuss his/her medical record with the physician, and to receive upon request a summary copy of that record (at a nominal charge) as required under State Law. The Plan's staff can only release records with the member/patient's physician's approval and signed consent.
 12. To obtain from the Plan a certificate of credible coverage which shows prior, continuous coverage. With this certificate, the member may be able to receive coverage under the next health plan with either no waiting period for preexisting conditions or a reduced waiting period.
 13. To make recommendations regarding member rights and responsibilities.

Section 11

Utilization Management

Appeal Process

11.1 Utilization Management

Utilization Management is a system for reviewing the necessity appropriateness and efficiency of hospital, medical or health care resources rendered or proposed to be rendered to a patient for the purpose of determining whether such services should be covered. This includes prospective, concurrent and retrospective medical necessity determination review related to the appropriateness of the site at which services were or are to be delivered. It is typically performed prospectively or concurrently, i.e., before or while services are being rendered.

Admission Review

Using approved medical guidelines and any modification made by GHA, admission review will be done by GHA Utilization Management personnel within one working day of admission to assure that each admission is medically necessary.

Concurrent Review/Discharge Planning

UM shall authorize all inpatient care in accordance with the GHA Medical Management Plan. Upon notification of an admission, GHA UM personnel will assign a length of stay estimate in accordance with medically approved guidelines and bring this to the attention of involved physicians. GHA will facilitate discharge planning, including early coordination with outpatient services, in conjunction with the attending physician. GHA will initiate a case management evaluation if circumstances warrant. GHA will coordinate authorization of inpatient care with the GHA claims system and will record all necessary utilization management data. GHA will review each hospitalized patient's status and documentation daily to maintain appropriate length of stay authorization and keep the attending physician informed.

Authorization Decision

The GHA Nurse Case Manager shall issue or decline to issue an authorization number within two (2) working days of a request for authorization or immediately if the request is for an authorization to continue a hospital stay already commenced.

Completion of Authorization Process

If an authorization number is issued, the treating provider may receive a Referral/Authorization Form and authorization number.

Authorization Procedures

When any provider determines that medically necessary non-routine services are appropriate to be provided, the treating provider, or his/her office staff, shall seek authorization from the GHA office. (See services requesting pre-authorization list), Authorization shall be issued as follows:

Pre-Authorization

The treating provider, or his/her designee, must fax, 434-799-4397, a Referral/Authorization Form or phone, 434-799-0702, the necessary information to the GHA Nurse Case Manager during regular business hours, 8:30 am - 5:00 pm EST, Monday thru Friday, holidays excluded. The required authorization information includes:

- a. Date of authorization request
- b. Member name and ID number
- c. Treating provider name

- d. Name of the facility at which non-routine services will be provided
- e. Type of authorization
 - i. Referral (required for out of network only)
 - ii. Hospital admission
 - iii. Outpatient diagnostic/services
 - iv. Outpatient surgery
- f. Diagnosis by ICD-9 code with brief history
- g. Reason for treatment (clinical indications, pertinent lab and test data)

Retroactive Authorizations

Authorizations requested after the service has already been rendered may not be permitted. Payment of covered services requiring authorization will be governed by the member's benefit plan and may be reimbursed at a reduced benefit level or not at all.

11.2 Appeals (Non-Clinical)

When a provider receives an adverse benefit determination, the claimant has 180 days (or according to health plan) following receipt of the notification in which to appeal the decision. This first level of appeal will normally be reviewed by the Claim Supervisor or when applicable, a medical professional employed by the Claims Supervisor. A provider may submit written comments, documents, records, and other information relating to the claim. A copy of that authorization must accompany the appeal. An assignment of benefits to a provider does not constitute an authorization to appeal, i.e. in order to qualify as an authorized representative of the claimant a separate authorization must be obtained from the provider.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

1. Was relied upon in making the benefit determination
2. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination
3. Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
4. Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. If the applicable medical professional determines that the adverse benefit determination was correct, the provider will receive a written statement and a full explanation for the decision. The provider then has the right to appeal directly to the Plan Sponsor or to the Trustees of the Plan (if any) for a final review. This must be done in writing by the provider, addressed to the medical professional's adverse benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

Medical Management Appeal Procedures

Appeals Process

All GHA utilization management decisions may be appealed by physicians or patients to the Medical Director and if necessary the MMC. GHA utilization management decisions are recommendations with regard to medical necessity. Benefit determination and coverage are determined by the employer contract. Physicians will continue to be responsible for making treatment decisions in consultation with their members.

When a member, his/her representative or treating provider is dissatisfied with a decision not to authorize non-routine services, such member, and their representative or treating provider, may appeal such an adverse decision pursuant to the following Medical Management Appeal Procedures.

As defined in the Medical Management Plan, the attending physician contacts GHA to request pre-certification or authorization as appropriate. Initial contact with GHA is with a utilization review nurse. The utilization review nurse reviews the attending physician's request and may approve the attending physician's request according to UR criteria or if the utilization review nurse is unable to approve the attending physician's request, the utilization review nurse notifies the Medical Director and the procedure for a potential initial adverse determination is followed.

Notification of an Adverse Decision

Written notification of an adverse decision is made to the patient, the attending physician or provider and the provider facility. The letter is tailored as appropriate for the type of care being reviewed, the type of review being performed, the reason for the adverse decision, the criteria utilized in decision process, and any alternatives related to length of stay or treatment settings that would be approved by GHA. The adverse decision notification letter also contains a description of the appeal process including the option of an expedited appeal process if an expedited appeal process is appropriate, such as when an adverse decision is made in relation to on going inpatient or outpatient treatment. The written notification also contains the time limits for appealing, GHA's address, GHA's toll free telephone number, 1-877-846-8930, and GHA's fax number, 434-799-4397.

Section 12

Case Management And Wellness Programs

12.1 Case Management

Case Management is a program whereby a case management nurse monitors patients, explores, discusses and recommends coordinated and/or alternate types of appropriate medically necessary care. The case manager consults with the patient, the family and the attending physician in order to develop a plan of care for approval by the patient's attending physician and the patient.

Case Management may be needed in any of the following situations:

- Complex medical issues and multiple services
- Illness requiring costly care or intervention
- Long term care at home or in a hospital
- High risk pregnancy or pregnancy with potential complications

12.2 Wellness Management

Wellness Management is developed on a client specific basis. Utilization and claims data are used to determine if there is a specific diagnosis that is prevalent in the client's claim history such as high blood pressure, high cholesterol, diabetes, heart disease, etc. GHA then determines if there is a program that GHA can initiate to reduce the cost for that specific disease.

It is important that you identify GHA members that you feel could benefit from this program on an inpatient or outpatient basis. Types of candidates would include:

- Chronic diabetes patients
- Newly diagnosed type 1 or type 2 diabetes patients
- Asthma patients
- Congestive heart failure/Hypertension patients
- Non-compliant patients

Once you or your office staff identifies a GHA member that has one of the above diagnoses, please have your office staff complete the referral form and fax to GHA at 434-799-4397. GHA's Wellness Nurse will monitor all referrals received and communicate identifiable needs and progress to your office.

12.3 Maternity Management

GHA's Maternity Management Program, "Baby Plus", is a proactive management plan that is designed to result in healthier babies. It is a voluntary educational program for eligible pregnant members. The objective of "Baby Plus" is to reduce the severity and incidence of pre-term births through early prenatal education and intervention by assisting the participant in understanding her condition and the vital role she plays as a manager of her own personal health. The Maternity Program supports the physician-patient relationship.

GHA's Maternity Management Program addresses the problems of high-risk maternity and premature births through a comprehensive program that includes:

- Promotion and recruitment
- Education and awareness
- Risk assessment and stratification
- Evaluation
- High risk maternity management

Members may enroll by calling Gateway Health Alliance at 434-799-0702, option 4. We encourage you to enroll your patient during the first trimester.

Section 13

Minimum Initial & Recredentials Standards

13.1 Minimum Initial & Recredentials Standards

All practitioners applying for initial and continued participation in the GHA network must meet the minimum credentials criteria, unless an exception is made by the Credentialing Committee.

All practitioners applying for initial and continued participation in the GHA network must meet all applicable criteria as outlined below:

- Have completed an application and a signed attestation statement.
- Have current, unrestricted state license in Virginia, and/or North Carolina.
- Be Board Certified in the primary specialty for which the physician is applying. The acceptance of a non-board certified physician might occur when it is determined.
 1. No board certified physicians are available or other exceptions of waiver requirements are met.
 2. Board Certification was not available at the time the physician entered practice.
- At the time of recredentialing, PCPs must perform adequately when information pertaining to member complaints, member satisfaction, utilization management, and/or results of quality improvement activities is evaluated.
- Additional Criteria for Credentialing Midwives:
 1. The applicant must have unrestricted license as Registered Nurse and Nurse-Midwife.
 2. The applicant must have Staff Membership in good standing at the network hospital for which he/she is applying. "Staff Membership" refers to any designation adopted by the hospital where the Nurse Midwife can provide services permitted by his/her licensure and certification.
 3. The applicant will have a formal working relationship with a network obstetrician/gynecologist.

Section 14

Provider Responsibilities

14.1 Provider Responsibilities

As a participating provider, you will be responsible for contacting Gateway Health Alliance for the following:

1. Change of address, telephone number, tax identification number
2. Addition and deletion of physicians in your medical group
3. Pre-certification/Authorization (s)
4. Verification of eligibility
5. Claim submission
6. General inquiries

Change of address, telephone number, TIN, addition or deletion of physicians should all be submitted in writing to:

Gateway Health Alliance, Inc.
Attn: Provider Relations
P.O. Box 1120
Danville, VA 24543

Fax: 434-799-3837

Email: cjanke@gatewayhealth.com or jholshouser@gatewayhealth.com

When adding or terminating a physician from your group, please be sure to list the following in your written correspondence:

- Provider's name (last, first, middle initial)
- Provider's title (MD, DO, PA)
- Provider's specialty (Family Practice, Podiatry, General Surgery)
- Provider's effective/termination date with practice
- Reason for termination
- Address and telephone number where provider will render services
- TIN (Tax Identification Number) provider will bill claims with

Please note that a separate contract for adding a new physician is only warranted if the TIN for billing will differ from the TIN that exist on file with your active contract. Should you need an additional contract, please call our Patient Relations Department, 434-799-3838.

Section 15 Forms

See Attached Forms



P.O. Box 1120
Danville, Virginia 24543

PLEASE FAX TO GATEWAY
(434-799-4397)
OR CALL
(434-799-0702)
OUT OF AREA
(877-846-8930 Option 1)

PRE-AUTHORIZATION REQUEST

Date: _____

Date of Service:		Ordering Physician:	
Patient Name:			
Subscriber's Employer:		Subscriber's ID#:	
Specialist/Hospital Referred to:			
Diagnosis/Reason for Referral:		DX Code:	
Clinical Summary (if not included in a referral letter)			
Referral Type			
<input type="checkbox"/> Consultation for diagnosis/treatment if applicable (1 visit only)			
<input type="checkbox"/> Consultation /treatment with follow up (up to 3 SCP visits within 90 days)			
<input type="checkbox"/> Extended referral (allergy, dialysis, radiation or chemotherapy, prolonged orthopedic care, burn care, prenatal care, neonatal care, complicated rheumatology or infectious disease care, advanced neuromuscular, other) Duration _____ (up to one year)			
<input type="checkbox"/> Hospital Admission <input type="checkbox"/> OP diagnostic/Services <input type="checkbox"/> Outpatient Surgery <input type="checkbox"/> Emergency Room <input type="checkbox"/> ELOS _____ Day(S)			
Scope of Services Authorized (N/A for hospital admission)			
Procedures:			

NOTE: This authorization is based on medical necessity and is not a guarantee of payment. Final payment will be based upon the available contractual benefits at the time services are rendered. For benefits and eligibility, please call the number on the back of the member's health plan care.

For HEALTHGRAM Office Use Only		
Authorization Number: _____		
EFFECTIVE DATES:		
FROM: _____	TO: _____	
<input type="checkbox"/> PCP	<input type="checkbox"/> SCP	<input type="checkbox"/> Facility
Medical Director <input type="checkbox"/> YES		

CONFIDENTIAL NOTICE: The documents accompanying this fax transmission contain confidential information belonging to the sender which is legally privileged. The information is intended only for the use of individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on or regarding the contents of this fax transmission is strictly prohibited. If this fax contains personal health information used for the purpose of a potential business contract or agreement and we do not contract with your company then you will need to destroy or return all personal health information on the attached documents. If you have received this fax in error, please immediately notify us by telephone or arrange for return of the original documents to us.



Accident/Injury Report Form

RE: PATIENT NAME:
MEMBER #:
GROUP:
DATE OF ACCIDENT:

We are in receipt of a claim for the above named patient. The diagnosis on the claim indicated that the services provided may be due to an accident or injury that may be covered under another party's insurance. Please complete the following questions for continued claim processing:

1

1. Was this due to an accident? _____ Yes _____ No If Yes, continue. If No, sign and date here and return the form.

Signature: _____ Date _____

2. Where did the accident take place? _____ Work _____ Home _____ Auto _____ Other

3. What was the date of the accident? _____

4. Please provide a brief description of how the accident occurred. (If additional space is needed, please continue on the back of this form).

5. Has civil or criminal action been initiated by or against claimant as a result of the incident causing the injury or illness? _____ If so, please explain:

6. I have inquired and other coverage (e.g. Workers Compensation, School, Premises, Medical Malpractice) _____ is or _____ is not available. If available, provide name and address of insured person, the insurance type, and the name, address, policy number and phone number of their insurance company:

7. Did a law enforcement officer investigate? _____ Yes _____ No

If Yes, please attach a copy of the official report of the accident/incident. For motor vehicle accidents, please note that an Exchange Slip or Notice of Requirement is NOT sufficient.

If the injury/illness/disease was not the result of an accident involving a motor vehicle, bicycle, all terrain vehicle, etc., you may skip this section.

1. Name, address, telephone number and policy number of claimant's automobile insurance:

2. Enclose a copy of the declaration page for claimant's automobile insurance policy.

3. If claimant was a passenger in a vehicle registered to another person, provide the name and address of that person and the name, address, telephone number, and policy number of that person's automobile insurance company. Provide copy of the declaration page for that policy.

4. Name address, telephone number and policy number of the insurance covering the other vehicle(s) involved in the collision.

5. Has an attorney been retained by the claimant in connection with this incident? If so, provide attorney's name, address and phone number:

SUBROGATION NOTIFICATION

Since your plan contains a Subrogation clause, it is necessary that we advise you that a Participant in the plan (or your dependent), You must reimburse the Plan for benefit paid by the Plan from any monies you (or your dependent) receive, in whole or in part, from a judgment or settlement, made by a third party from any recovery. You as the participant or the dependent must also take action to assist the Plan in recovering this reimbursement. You or your dependent must sign and deliver all necessary documents that the Plan may need to enforce its rights to obtain reimbursements.

Signature _____ **Date** _____

The information provided on this Statement of Injury/Illness is complete and true to the best of my knowledge.

PAYMENT OF THIS CLAIM IS PENDING YOUR RESPONSE

If you have any questions, please contact our office at 434-799-3838

SINCERELY,
CLAIMS DEPARTMENT
GATEWAY HEALTH ALLIANCE



Authorization to Disclose Health Information

To: _____

From: _____
[Insert name of individual whose PHI is requested]

Date: _____

The purpose of this form is to authorize you to release certain medical information about me to the parties indicated below. I have described the information that I would like for you to release, and I understand that I will need to sign another form if my description is not broad enough to allow you to disclose all of the needed information. I have also indicated the reason I am requesting the disclosure and the people to whom the information should be released. I understand that if I authorize the release of information to a person or entity that is not subject to the federal privacy rules (HIPAA), the information may later be disclosed by that person or entity and may no longer be protected by the federal privacy rules. I understand that I can revoke this authorization by delivering a written statement of my written revocation to you. My revocation will be effective only on a prospective basis; it will not affect any actions you may already have taken in reliance on my authorization. I also understand that the Plan cannot require me to sign this authorization as a condition for enrollment in the Plan or for eligibility or payment of benefits.

The information requested is medical or claims payment information about:

(Describe information specifically, but broadly enough to serve its purpose.)

The individual(s) authorized to make this disclosure is (are):

(Name any person or class of persons who are permitted to disclose the information.)

The information may be disclosed to: _____.

[Identify entity or person who can receive this information.]

I have requested this disclosure for the following purpose(s): _____

(List the reason for the disclosure. For example, if you want your spouse to be able to make claims inquiries, list that. Or, if you prefer, you may just state "at my request.")

This authorization will remain in effect until: _____

(You must indicate when the authorization will expire. You can give a date, or you may list an event that causes it to expire, such as "release from hospital.")

Signature

Date

Gateway Health Alliance

WELLNESS PROGRAM/PATIENT REFERRAL FORM

(CONGESTIVE HEART FALIURE, DIABETES, ASTHMA, HYPERTENSION)

CONFIDENTIAL

NAME: _____

MEMBER # _____

AGE: _____

PHYSICIAN: _____

PAST MEDICAL HISTORY: _____

****You may fax typed office visit reports in lieu of full completion of referral form.**

ALLERGIES: _____

MEDICATIONS: _____

LAST DR. APPT: _____

Fax from: _____

Fax to: Wellness Nurse

Dr. Office: _____

Gateway Health Alliance

Date of Referral: _____

Fax Number: (434) 799-4397

GATEWAY PHONE: (434) 799-0702 Option 5