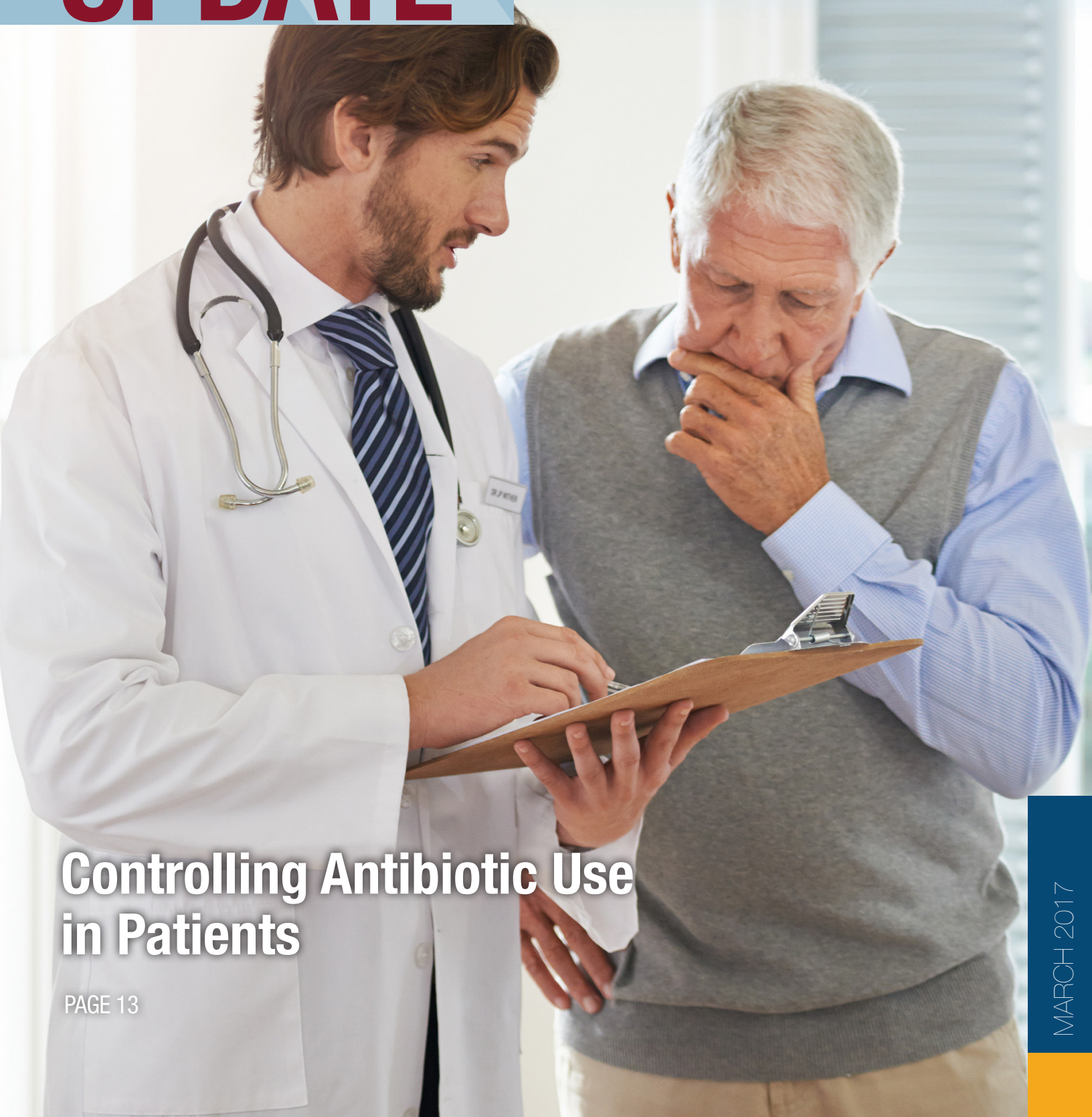


A Newsletter for  
Gateway Health<sup>SM</sup> Providers and Clinicians



# PROVIDER UPDATE



## Controlling Antibiotic Use in Patients

PAGE 13

MARCH 2017

# PROVIDER UPDATE



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- Green color for Medicare and Medicaid
- Light blue color for Medicare Assured
- Light yellow color for Medicaid

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OFFICE STAFF • MEDICARE & MEDICAID



# Provider Update

MARCH 2017

SPECIAL EDITION

## NOTICE OF PRACTICE/PRACTITIONER CHANGES

One of the many benefits to the Gateway Health member is improved access to medical care through Gateway Health's contracted provider network. To ensure our members have up to date and accurate information on availability, it is imperative that providers submit written 60 days advance notice of the following:

- Address changes
- Phone and fax number changes
- Changes to hours of operation
- Primary care practice (PCP) panel status changes (open, closed & existing only)
- Practitioner participation status (additions & terminations)
- Mergers and acquisitions

The Gateway Practice/Provider Change Request Form can be completed for conveying practice/practitioner changes or notice on your practice letterhead is acceptable. The form is available on [gatewayhealthplan.com](http://gatewayhealthplan.com) – select *Provider*, and then click on *Forms and Reference Materials*.

Please submit your change request via fax or mail.

Fax to: 1-855-451-6680  
Mail to: Gateway Health<sup>SM</sup>  
Provider Information Management  
Four Gateway Center  
444 Liberty Avenue, Suite 2100  
Pittsburgh, PA 15222-1222

If you have questions about this Provider Update, please contact your Provider Relations Representative directly.

Provider Relations Department  
Gateway Health<sup>SM</sup>



# IT'S CAHPS® SEASON

## THANK YOU FOR CONTINUING TO DELIVER EXCELLENT CARE TO OUR MEMBERS

Gateway Health members will be receiving their CAHPS® (Consumer Assessment of Healthcare Providers and Systems) member satisfaction surveys in March, with follow-up occurring in April and May. This survey will assess patient experiences with their healthcare, including overall satisfaction with network primary care physicians and specialists like you!

CAHPS® surveys are conducted annually in accordance with federal and state requirements. According to the Centers for Medicare and Medicaid Services (CMS), results of the CAHPS® surveys are an integral part of efforts to improve healthcare in the United States. Results are used to calculate a health plan's NCQA accreditation score and Medicare Advantage star ratings. In addition, Gateway Health uses its CAHPS® results to improve the services we offer members and to keep providers informed about how Gateway is doing and how they can help deliver better care. Results from the 2017 survey and related CAHPS® activities will be made available to network providers.



### How You Are Rated

- **Getting Needed Care** – Ease in getting care, tests, treatment and appointments with specialists.
- **Getting Care Quickly** – Ease of getting care and appointments as soon as needed.
- **How Well Doctors Communicate** – Includes doctor's use of understandable language, respectfulness, listening and amount of time spent with patient.
- **Shared Decision Making** – Doctor discusses reasons why patient may or may not want to take medicine.
- **Coordination of Care** – Doctor's awareness of patient's care from other providers.
- **Rating of Personal Doctor** – Scaled rating of doctor from 0-10 with 10 being the best.
- **Rating of Specialist** – Scaled rating of specialist from 0-10 with 10 being the best.

### How You Can Make a Difference

- Continue to be the champion of your patients through effective communication and by being accessible.
- Educate patients on how and where to get care after hours.
- Ask your patients what is important to them.
- Train your office staff to assist patients with scheduling and coordinating care between providers.
- Ensure your patients remain compliant with their care plans.
- Encourage your patients to complete preventive screenings.

You are critical part of your patients' and our members' healthcare experience. We applaud and thank you for continuing to provide excellent care and accessibility!

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

# REPORTABLE CONDITIONS

Gateway Health providers are contractually required to adhere to policies that are a part of the Gateway Health Quality Improvement program. This includes, but is not limited to, reporting certain diseases, infections or conditions as determined by 28 Pa. Code §27.1 et seq. of the Pennsylvania Code. Gateway Health's reportable conditions policy has been established to detail this requirement, as well as the methods by which practitioners will be notified of its necessity.

To request additional information or to obtain a copy of the reportable conditions policy, please contact Gateway's Provider Services department at either 1-800-685-5209 (Medicare) or 1-800-392-1147 (Medicaid). The regulations, which include the complete list of reportable conditions and time frames for reporting, can be found via the State of Pennsylvania Code website at [www.pacode.com](http://www.pacode.com).



# MEDICAL RECORD REVIEW STANDARDS

Every year, Gateway Health conducts a review of medical records from a sample of providers to ensure consistent documentation of medical care delivered to members. This review assesses compliance with multiple standards and critical elements developed and approved by the Gateway Health Quality Improvement and Utilization Management Committee to meet state, federal and regulatory requirements. Examples of these standards include documentation of continuity and coordination of care, execution of an advanced directive, legibility of written documentation, follow-up visits, and signing and dating of notes.

Should you or your practice be selected for medical record review, your cooperation with providing access to the requested records is required as a participating provider in the Gateway Health network. Please note that Gateway Health may not be held responsible for any costs that may be incurred with providing the requested medical records.

Results of the review will be provided by letter within 45 calendar days. It is our goal to ensure an efficient, informative and meaningful review as we assist you in fulfilling this important requirement.

The Medical Record Review Standards are available upon request, or can be found online at <http://www.gatewayhealthplan.com/providers/forms-and-reference-materials/quality-improvement-and-clinical-guidelines>.



# PRACTITIONER AND PROVIDER SATISFACTION SURVEY

Gateway Health conducted a Practitioner and Provider Satisfaction Survey from August 2016 to October 2016. The population sampled included primary care providers with a panel size greater than 50 members. The specialty care practitioners sample included high-volume specialists with at least five unique member visits and paid claims within the last year. Approximately 100 percent of the hospital network and a remaining sample of ancillary providers were also surveyed.

Gateway will continue to strive toward meeting the needs of our practitioner and provider network. Action plans are developed to improve those areas with deficiencies to assure ongoing improvement.

The complete survey results can be found on [www.gatewayhealthplan.com](http://www.gatewayhealthplan.com) under *Provider Updates, Forms and References*. A few of the questions and overall satisfaction in specific areas are shown in this newsletter.

The percentages are summary rate scores based on the sum of the most favorable response options from those who answered the survey.

## GATEWAY HEALTH<sup>SM</sup> 2016 PRACTITIONER AND PROVIDER SATISFACTION SURVEY

Question	2016 PCP	2016 SCP	2016 Hospital	2016 Ancillary
Continuity and Coordination of Care				
Do you use a computer or handheld device during your patients' visits to look up test results or other information, show information or order prescription medicines?	86.2%	74.0%	N/A	N/A
Review patients' medications at each visit and ask if there are any medication questions at each visit.	99.6%	98.6%	N/A	N/A
Routinely communicate test results to patients either by mail or phone.	98.2%	97.1%	N/A	N/A
Gateway Representative and Communication				
Your overall satisfaction with the quality of service from your Gateway Provider Relations representative	89.9%	87.0%	60.0%	83.3%
Provider Services and Claims				
Your satisfaction with clean claims being paid in a timely manner	86.7%	72.7%	46.7%	67.2%
Your overall satisfaction with the claims review and/or appeals process	76.7%	78.6%	37.5%	65.5%
Utilization Management				
Your overall satisfaction with the UM process	91.5%	84.3%	60.0%	85.2%
Pharmacy Authorization Process, Staff and Drug Formulary				
Your overall satisfaction with the Gateway pharmacy prescription authorization process	87.9%	83.3%	N/A	N/A
Overall Satisfaction and Loyalty				
Overall satisfaction with Gateway Health <sup>SM</sup>	87.7%	75.0%	50.0%	75.4%

## GATEWAY HEALTH MEDICARE ASSURED<sup>SM</sup> 2016 PRACTITIONER AND PROVIDER SATISFACTION SURVEY

Question	2016 PCP	2016 SCP	2016 Hospital	2016 Ancillary
Continuity and Coordination of Care				
Do you use a computer or handheld device during your patients' visits to look up test results or other information, show information or order prescription medicines?	80.8%	68.1%	N/A	N/A
Review patients' medications at each visit and ask if there are any medication questions at each visit.	94.1%	95.7%	N/A	N/A
Routinely communicate test results to patients either by mail or phone.	92.8%	95.7%	N/A	N/A
Gateway Representative and Communication				
Your overall satisfaction with the quality of service from your Gateway Provider Relations representative	90.4%	87.8%	66.7%	84.2%
Provider Services and Claims				
Your satisfaction with clean claims being paid in a timely manner	91.3%	75.0%	50.0%	69.1%
Your overall satisfaction with the claims review and/or appeals process	83.3%	76.1%	35.3%	61.5%
Utilization Management				
Your overall satisfaction with the UM process	93.5%	85.7%	60.0%	88.7%
Pharmacy Authorization Process, Staff and Drug Formulary				
Your overall satisfaction with the Gateway pharmacy prescription authorization process	86.8%	82.9%	N/A	N/A
Overall Satisfaction and Loyalty				
Overall satisfaction with Gateway Health <sup>SM</sup>	88.1%	76.7%	56.5%	75.0%



# LIVING WILLS AND ADVANCE DIRECTIVES

## CONTINUITY OF CARE ACROSS SETTINGS

The seamless sharing of information between healthcare providers – such as between primary care physicians (PCPs) and specialists – presents many challenges to the continuity of care and treatment of our members.

Gateway's membership includes some of the most vulnerable individuals who may suffer from severe or chronic illnesses. Enhanced communication among and between all those who participate in providing care to a patient is imperative in ensuring that all decisions about the patient's care are informed and contribute to the patient's overall wellbeing. Continuity of care issues can result in suboptimal outcomes, increased costs and medical errors.

It is to the benefit of both the patient and healthcare professional to communicate any reports, therapies, medications and concerns identified by providers across treatment settings. Please contact your Provider Relations representative with questions about how you can help to improve patient care between settings.

The Omnibus Budget Reconciliation Act (OBRA) of 1990 included substantive new law that has come to be known as the Patient Self-Determination Act and which largely became effective on December 1, 1991. The Patient Self-Determination Act applies to hospitals, nursing facilities, providers of home healthcare or personal care services, hospice programs, and health maintenance organizations that receive Medicare or Medicaid funds.

The primary purpose of the act is to assure that the beneficiaries of such care are made aware of advance directives and are given the opportunity to execute them if they so desire. It is also to prevent discrimination in care if the member chooses not to execute advance directives. As a participating provider within Gateway's network, you are responsible for determining if the member has executed an advance directive and for providing education when it is requested.

Gateway's Medical Record Review Standards state that providers ask members age 21 and older whether they have executed advance directives and will document the response. **Providers with members age 65 and older need a notation of annual review of a members advance directive.** There is no governmentally mandated form, but you can request a copy of a "living will" form from the Quality Improvement department by calling 412-255-7277. A copy of the "living will" form should be maintained in the patient's medical record.

Providers will receive educational material regarding members' rights to advance directives upon entering the Gateway practitioner network as well. Advance directive forms are made available through [www.gatewayhealthplan.com](http://www.gatewayhealthplan.com). To access these forms, select *Forms and Reference Materials* under the *I Am A Healthcare Provider* section, then select #15 *Living Will Declaration* under the *General Provider Forms & References* section.



# GATEWAY TO LIFESTYLE MANAGEMENT<sup>SM</sup> PROGRAMS

## Balancing Lifestyle for Optimum Health & Wellness

Program	Asthma	Cardiac	COPD	Diabetes	Maternal Outreach and Management (MOM Matters <sup>®</sup> )
Eligibility	Ages 2 and older with a diagnosis of asthma	Ages 21 and older with CAD, MI or HF	Ages 21 and older with COPD	All ages with Type 1 or Type 2 diabetes	Pregnant females
Contact for Referrals and Information	Medicaid PA - 1-800-392-1147  Medicare Assured <sup>SM</sup> HMO SNP PA - 1-800-685-5209 OH - 1-888-447-4505 NC - 1-855-847-6430 KY - 1-855-847-6380				
Description	<ul style="list-style-type: none"><li>• The programs provide patient education and self-empowerment for treatment plan adherence, as well as tools to reduce inpatient utilization and emergency room utilization.</li><li>• Education is aimed at delaying or preventing the onset of disease specific complications.</li><li>• The programs support the provider's plan of care.</li></ul>				This prenatal program offers care coordination to reduce low birth weight, pre-term deliveries and NICU admissions.
Provider Benefits and Support	<ul style="list-style-type: none"><li>• Gateway to Lifestyle Management<sup>SM</sup> Programs aim to:<ul style="list-style-type: none"><li>- Enhance patient-provider communication</li><li>- Decrease inpatient and emergency room utilization</li><li>- Increase treatment plan adherence including immunizations such as flu and pneumonia</li><li>- Improve patient satisfaction</li></ul></li><li>• The MOM Matters<sup>®</sup> maternity program has a proven record of decreasing the number of premature deliveries.</li><li>• The 24/7 Nurse Line can help your patients achieve better outcomes and decrease ED visits.</li></ul>				
Enrollment	Members are identified through claims; Gateway's utilization management, pharmacy and member services departments; member self-referrals; and provider referrals.  Your Referrals are Welcome!				Provider submission of the ONAF helps identify high-risk women in need of interventions.
Coordination of Care	Care coordinators assist you and your patients with coordination of care for specialist visits, home health, behavioral health, and DME and community referral needs.				
Web-Based Tools	Go to the provider pages at <a href="http://www.gatewayhealthplan.com">www.gatewayhealthplan.com</a> and choose <i>Providers</i> under <i>Educational Tools</i> , then choose <i>Member Programs</i> .				
Referral Source to Help Members Quit Tobacco	Refer patients to the toll-free Quitline at 1-800-784-8669.				



## THE APPEAL

If your patient received a denial for a service or item that was requested, you can ask us to reconsider our decision on behalf of the patient. The appeal process can either follow a standard or expedited review timeframe.

If a *standard review* is requested, the member's written signature will be needed before your request can be processed. To help with our review, medical records supporting your request should accompany your request. After the member's signature is received, the standard review timeframe can be 30 to 45 days.

Our *expedited review* process is provided only **when the member's life, health or ability to regain maximum function would be placed in jeopardy**. Expedited requests require a physician written certification stating the clinical rationale or facts supporting the need for an urgent review period. The review timeframe can be 24 to 72 hours (depending on the insurance product). The member's signature is not required for expedited requests. If you request an expedited appeal, please fax us your request certifying the need option as the review timeframe and medical records supporting the appeal request.

A request for payment of a service that has already been provided is not eligible to be reviewed as an expedited request. For more details regarding our appeal process, please refer to our website or your Provider Manual.

## PATIENT AUTHORIZATION HIPAA

Gateway Health makes protecting the privacy and security of member health information a priority!

Gateway understands that there are times when we need to share information with health care professionals to enable proper care, timely payment and reimbursement. Understand that in some instances, HIPAA guidelines do permit health care providers to use or give out member medical information without the need for written authorization from the member. A few examples include:

- For public health activities, such as disclosing an outbreak.
- Student immunization records can be released to the school when required by law or if written or oral agreement is documented.
- Release of a decedent's personal health information (PHI) to coroners, medical examiners, funeral directors and for organ donations.
- For judicial proceedings, such as court orders.

When a request is received for another purpose, Gateway will provide PHI in situations when the member has given authorization or consent to release information to the requesting party. In the event the member does not give authorization or consent to release their information, Gateway will follow the parameters defined in 45 CFR 164.512 (uses and disclosures for which an authorization or opportunity to agree or object is not required) to determine if the information can be released.

Annually, Gateway's employees are trained to avoid inappropriate disclosures and to provide minimal necessary information when responding to inquiries.

To learn more about how Gateway uses or discloses member information or to view our "Notice of Privacy Practices," please visit us online at [www.gatewayhealthplan.com](http://www.gatewayhealthplan.com). To request a paper copy of Gateway's "Notice of Privacy Practices," please call Customer Service at 1-800-392-1147 for Medicaid or 1-800-685-5209 for Medicare Assured.

Gateway takes great pride in protecting member information and looks forward to working with providers to manage our members' health care needs.

## LEARNING AND EARNING WITH GATEWAY

### PROFESSIONAL EDUCATION CME/CEU WEBINAR SERIES

## ENROLL TODAY!

Gateway Health<sup>SM</sup>, in conjunction with Allegheny Health Network, is pleased to present the "Learning and Earning with Gateway" professional development series. Healthcare professionals that are part of the Gateway network are invited to participate in a monthly webinar and earn **FREE** CME and CEU credits. The series will feature guest speakers who will cover a range of topics relevant to your clinical practice, including:

- Getting Paid for Great Care: HEDIS Measures, Pay-for-Performance Programs and You
- Managing Chronic Diabetes
- Improving Asthma Outcomes
- Caring for the Older Adult
- Reducing Hospital Readmissions

Webinars will be held monthly, usually on the first Wednesday of the month from 12 p.m. (noon) to 1 p.m. All Gateway providers and office staff are invited to attend.

In order to receive CME/CEU credits and webinar dial-in information, healthcare providers **MUST ENROLL PRIOR** to their first webinar using the following link:

<https://www.surveymonkey.com/r/NZJYDF7>

Enrollment is only necessary once for the entire series.

Questions? Please contact your dedicated Gateway Clinical Transformation Consultant or email us at [ProviderEngagementTeam@Gatewayhealthplan.com](mailto:ProviderEngagementTeam@Gatewayhealthplan.com).

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Allegheny General Hospital and Gateway Health Plan. Allegheny General Hospital is accredited by the ACCME to provide continuing medical education for physicians.

Allegheny General Hospital designates this live webinar activity for a maximum of 1.0 *AMA PRA Category 1 Credit*<sup>™</sup>. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

# SCREENING FOR SUBSTANCE ABUSE IN THE PHYSICAL HEALTH SETTING

As the number of individuals using alcohol and other substances increases, and the age of first use continues to decline, it becomes increasingly important that patients be screened for alcohol and other substance use disorders. Timely identification of use disorders and initiation in treatment can decrease the potential for negative impacts on physical health.

Patients ages 13 and older should be screened for substance use to allow for early detection. In addition, patients who are pregnant or have a health condition that has the potential to be negatively impacted by substance use should be of high priority for screening.

There are some commonly used screening tools to assist in the assessment of patients for alcohol or other substance use disorders. Some of these assessment tools include the Alcohol Use Disorders Identification Test (AUDIT); Drug Abuse Screening Test (DAST); Alcohol, Smoking, Substance Involvement, Screening Test (ASSIST); and the Cut Down, Annoyed, Guilty, Eye-Opener (CAGE). These can all be administered in the office setting as part of a routine visit and take about five to ten minutes to complete.

If a patient screens positive for an alcohol or other substance use disorder, it is important to talk with them about the negative impact their use could have on their overall health and encourage them to seek help. Education regarding the long-term effects of use can be used as a motivation tool to encourage patients to change their current behaviors.

If alcohol or substance use is identified, it is important that the patient be linked to the appropriate treatment. Patients should initiate treatment for substance abuse within 14 days of receiving the initial diagnosis. Patients should also have two additional treatment visits within 30 days of initiating treatment to demonstrate engagement in treatment.

There are some common barriers to patients initiating and engaging in treatment. These barriers include lack of coordination of care between physical and behavioral health providers, lack of social supports,



and member resistance to treatment or fear of the stigma associated with treatment. You may need to work with your patient to help them overcome some of these barriers by helping to motivate them to seek treatment.

Identification of members with alcohol or other drug dependence can facilitate early treatment, allowing for optimal likelihood of recovery and decrease the likelihood of the development of co-morbid medical conditions. Improved treatment for members with alcohol or other drug dependence can improve the outcome of other medical and behavioral health conditions and decrease the overuse of health care services, including outpatient and inpatient services and emergency department utilization.

If you are in need of assistance in identifying treatment resources for your patient or feel that they could benefit from the additional support of a Care Manager, please feel free to refer them to the Care Management department at Gateway Health.

# PROMOTING DIABETES SELF-MANAGEMENT AND COORDINATION OF CARE

Diabetes mellitus (DM) is one of the fastest-growing and most alarming of chronic illnesses. DM and its associated complications impose a huge health care burden worldwide, presenting major challenges to patients, health care systems and health plans.

A multidisciplinary team approach and promoting awareness of diabetes self-management are critical to success in diabetes care and complications prevention. Providers can assist patients with diabetes lower their risk for micro and macrovascular complications – such as eye and kidneys disease, heart disease and stroke – by educating and coordinating care.

Below is a list of key messages all providers can reinforce with their diabetic patients.

- Emphasize the importance of metabolic control and the control of other cardiovascular risk factors such as the ABCs.
- Promote a healthy lifestyle that includes physical activity, healthy eating and coping skills.
- Explain the benefits of diabetes comprehensive team care.
- Recommend routine checkups to prevent complications, including a dental exam, comprehensive foot exam and complete dilated eye exam.
- Reinforce self-exams for foot care and dental care and others as appropriate. Recognize the danger signs for foot and dental problems and seek help from a health care provider.
- Promote the pharmacist's role in drug therapy management.

Patients who increase their use of effective behavioral and self- management interventions tend to lower their risks of complications and progression of the disease. This in turn can also lead to better quality of life, improved health outcomes, lower health care costs, increased patient satisfaction with care and enhanced coordination of care.





# CONTROLLING ANTIBIOTIC USE IN PATIENTS

Antibiotic resistance is one of the greatest public health threats today leading to untreatable deadly infections. Each year, more than two million Americans develop a serious antibiotic resistant infection, with 23,000 cases resulting in death.<sup>1</sup>

The majority (62%) of antibiotic prescriptions occur in community outpatient settings. It is estimated that at least one in three prescribed antibiotics are unnecessary. Additionally, more antibiotics are prescribed incorrectly by type, dose and duration. However, inappropriate prescribing is rarely due to clinician knowledge gaps alone. Barriers also include pressure to see patients quickly and the perception that patients expect treatment with antibiotics.<sup>2</sup> Given the burden of preventable deaths and resistant infections, outpatient clinicians must establish standards for antibiotic prescribing.

The high priority conditions that lead to inappropriate prescribing are upper respiratory infection, acute bronchitis, acute otitis media and viral pharyngitis. Rapid strep tests are indicated to distinguish between GAS and viral pharyngitis as antibiotics are only indicated for GAS pharyngitis treatment.<sup>1,2</sup>

The CDC's "Core Elements of Outpatient Antibiotic Stewardship" recommend the following principles be adopted by all practices and clinicians.<sup>2</sup>

- **Commitment** – Demonstrate dedication to and accountability for optimizing antibiotic prescribing and patient safety.  
- *Best Practice:* Write and display antibiotic stewardship public commitment posters in exam rooms.
- **Tracking and Reporting** – Monitor and provide regular feedback to individual clinicians on their antibiotic prescribing for one or more high priority conditions.  
- *Best Practice:* Compare individual clinicians' prescribing patterns to their peers'.
- **Action for Policy and Practice** – Implement at least one policy or practice and assess whether it is working.  
- *Best Practice:* Provide patient communications skills training for clinicians.
- **Education and Expertise** – Provide educational resources to clinicians and patients.  
- *Best Practice:* Explain to patients why antibiotics are not needed in combination with education on how to manage symptoms and/or seek care if they don't improve.

Education and patient and healthcare provider resources are freely available through the CDC's "Get Smart Program" available at [www.cdc.gov/getsmart](http://www.cdc.gov/getsmart).

## References

<sup>1</sup> U.S. Centers for Disease Control and Prevention. *Antibiotic Resistance Threats in the United States*, 2013, accessed January 25, 2017, <http://www.cdc.gov/drugresistance/threat-report-2013/>.

<sup>2</sup> U.S. Centers for Disease Control and Prevention (Producer). November 15, 2016. *Core Elements of Outpatient Antibiotic Stewardship*.

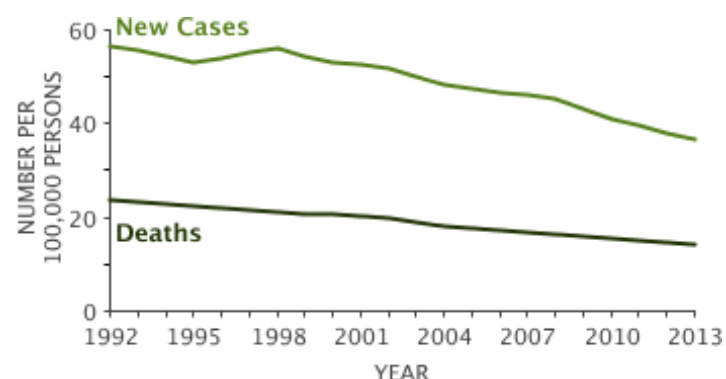


# MARCH IS COLORECTAL CANCER AWARENESS MONTH

According to the CDC, colorectal cancer causes the second most cancer-related deaths in the United States and is the third most common cancer in both men and women. In 2013, 136,119 people were diagnosed with the disease and 51,813 died from it in the United States<sup>1</sup>.

The number of new cases and deaths caused by colorectal cancer, however, has been dropping over the last 25 years (see the table below). This trend can be attributed to increased screening, but there are still many adults who do not get the recommended screening for this cancer.

## NEW COLORECTAL CANCER CASES AND DEATHS PER 100,000 PEOPLE



SOURCE: AMERICAN CANCER SOCIETY

## Sources:

<sup>1</sup> U.S. Cancer Statistics Working Group. *United States Cancer Statistics: 1999–2013 Incidence and Mortality Web-based Report*. Atlanta (GA): Department of Health and Human Services, Centers for Disease Control and Prevention, and National Cancer Institute; 2016. Available at: <http://www.cdc.gov/uscs>.

Currently, the United States Preventive Services Task Force recommends most men and women ages 50 to 75 years be screened regularly. The most popular screening types are:

- **Colonoscopy** – This test examines the whole colon with an endoscope and keeps the person up to date for ten years.
- **Sigmoidoscopy** – Uses an endoscope to examine the distal colon for polyps and keeps the person up to date for five years.
- **Fecal Immunochemical Test (FIT)** – This at-home test looks for trace amounts of blood in the person's stool and will keep them up to date for one year.

Like most cancers, early detection is key to increased survival rates for patients.

Colorectal cancer is unique in the number of different screening methods that there are. However, these options have different requirements for preparation and frequency, which can be confusing for patients. That's why it is so important for them to receive recommendations from their physicians. Colorectal Cancer Awareness Month is a perfect time to be sure that your patients are up to date on screening.

13

Colonoscopy  
8am





Four Gateway Center  
444 Liberty Avenue, Suite 2100  
Pittsburgh, PA 15222-1222  
[www.gatewayhealthplan.com](http://www.gatewayhealthplan.com)

## **MEDICARE ASSURED IMPORTANT PHONE NUMBERS**

### **FOR INQUIRIES, PLEASE CALL PROVIDER SERVICES**

**MONDAY – FRIDAY, 7 A.M. - 5 P.M.**

1-855-847-6380 (KY)  
1-855-847-6430 (NC)  
1-888-447-4505 (OH)  
1-800-685-5209 (PA)

### **TTY/TDD (FOR ALL DEPARTMENTS)**

**24 HOURS A DAY, 7 DAYS A WEEK**

711 or  
1-800-648-6056 (KY)  
1-800-735-2962 (NC)  
1-800-750-0750 (OH)  
1-800-654-5988 (PA)

### **MTM (Transportation Services)**

**MONDAY – FRIDAY, 8 A.M. – 5 P.M.**

**SATURDAY, 9 A.M. – 1 P.M.**

1-844-549-8363 (KY, NC and OH)  
1-866-670-3063 (PA)  
TTY is 1-800-855-2880

### **VOIANCE LANGUAGE SERVICES**

**24 HOURS A DAY, 7 DAYS A WEEK**

(Offers bilingual interpreters at a special Gateway rate)

1-866-742-9080, ext. 1  
[www.voiance.com/gateway](http://www.voiance.com/gateway)

## **MEDICAID IMPORTANT PHONE NUMBERS**

**CALL TO INQUIRE ABOUT:**

### **MEMBER PROGRAMS**

**MONDAY - FRIDAY, 8:30 A.M. - 4:30 P.M.**

**1-800-392-1145**

- Care Management, select option 1
- Maternity/MOM Matters®, select option 2
- Asthma/ Cardiac/ COPD/ Diabetes, select option 3
- Preventive Health Services/ EPSDT/Outreach, select option 4

### **FRAUD AND ABUSE AND COMPLIANCE HOTLINE**

**24 HOURS A DAY, 7 DAYS A WEEK**

**1-800-685-5235**

### **TTY/TDD (FOR ALL DEPARTMENTS)**

**MONDAY - FRIDAY, 8 A.M. - 5 P.M.**

711 or  
1-800-682-8706

Voicemail during off hours. The call will be returned the next business day. Please do not leave multiple voicemail messages or call for the same authorization request on the same day.