



GEISINGER
HEALTH PLAN®



HealthChoices Provider Manual

Revised as of
7/1/2013

The Geisinger Health Plan Family (GHP Family) HealthChoices Provider Manual (Manual), as may be amended from time to time, is incorporated by reference to the Agreement. The Manual is designed for use by, and applicable to, all GHP Family Participating Providers. The Manual supports all applicable federal and state laws, DPW regulations and policies as promulgated through Medical Assistance Bulletins and the specifications of the HealthChoices RFP and HealthChoices Agreement.

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ABOUT GEISINGER HEALTH PLAN FAMILY

Geisinger Health Plan Family (GHP Family) is a Geisinger Health Plan Medicaid managed care plan serving the East Zone for the HealthChoices managed care program offered to Medical Assistance recipients by the Commonwealth of Pennsylvania Department of Public Welfare.

Geisinger Health Plan is recognized as a national leader among managed care organizations and, through GHP Family, brings a physician-led, patient-centered approach to health care delivery for the Medical Assistance enrollees of Pennsylvania. A model for healthcare reform, with documented success in innovative patient management programs and performance based provider reimbursement, Geisinger Health Plan consistently ranks among America's top ten health plans.¹

This manual pertains to the participation with GHP Family and the HealthChoices Physical Health Program in the East Zone. The East Zone is home to over 210,000 Medical Assistance recipients and includes the twenty-two following counties: Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, and Wyoming.

This manual is intended to be used as an extension of the Participating Provider Agreement and a reference guide for Participating Providers and their office staff. While this manual contains basic information about the Commonwealth of Pennsylvania Department of Public Welfare (DPW) and the Centers for Medicare and Medicaid Services (CMS), providers are required to fully understand and apply DPW and CMS requirements when administering covered services. Please refer to www.dpw.state.pa.us and www.cms.hhs.gov. The Commonwealth of Pennsylvania Medical Assistance Program can be found at www.dpw.state.pa.us.

¹ NCQA's Private Health Insurance Plan Rankings 2011-2012; NCQA's Medicare Health Insurance Plan Rankings 2011-2012; NCQA's Health Insurance Plan Rankings 2010-2011 - Private; NCQA's Health Insurance Plan Rankings 2010-2011 - Medicare; U.S. News/NCQA America's Best Health Insurance Plans 2007-2009 (annual). "America's Best Health Insurance Plans" is a trademark of U.S. News & World Report

CONTACT INFORMATION

All paper Claims should be submitted to:

Geisinger Health Plan or Claims Administrator
P.O. Box 8200
Danville, PA 17821-8200

Visit GHP Family Provider Web portal at www.ghpfamily.com to utilize the following online tools:

- Member eligibility and authorizations
- View Claims
- EDI enrollment
- Prior authorization list, medical policies, and clinical guidelines
- Pay-for-Quality data
- Provider and formulary searches

Additional GHP Family contact information:

Name	Phone Number [Fax Number]	Hours of Operation
Case Management	(800) 883-6355 or (570) 271-8763 Fax: (570) 271-7860	Monday - Friday 8:00 a.m. - 4:30 p.m.
Customer Service	(855) 227-1302	Monday, Tuesday, Thursday, Friday 8:00 a.m. - 5:00 p.m. Wednesday 8:00 a.m. - 8:00 p.m.
Customer Service - Interactive Voice Response System	(855) 227-1302	24 Hours/Day, 7 Days/Week
Dental Services – DentaQuest www.dentaquestgov.com	All DentaQuest Providers: (800) 341-8478 General Provider Services Queue: (877) 468-5581	Monday – Friday 9:00 a.m. - 6:00 p.m.
Durable Medical Equipment Network	(800) 883-6355 or (570) 271-8763 Fax: (570) 271-7860	Monday - Friday 8:30 a.m. - 4:30 p.m.

Name	Phone Number [Fax Number]	Hours of Operation
Home Health & Hospice Network	(877) 466-3001 or (570) 271-5506 Fax: (570) 271-5507	Monday - Friday 8:30 a.m. - 4:30 p.m.
Medical Management	(800) 544-3907 or (570) 271-6497 Fax: (570) 271-5534	Monday – Friday 8:00 a.m. - 5:00 p.m.
Outpatient Rehabilitation Therapy Network	(800) 270-9981 or (570) 271-5301 Fax: (570) 271-5302	Monday – Friday 8:30 a.m. - 5:00 p.m.
Pharmacy	(855) 552-6028 or (570) 214-3554 Fax: (570) 271-5610	Monday – Friday 8:00 a.m. - 5:00 p.m.
Provider Relations Representative	(800) 876-5357	Monday – Friday 8:00 a.m. - 5:00 p.m.
Special Needs Program	(855) 214-8100	Monday – Friday 8:30 a.m. - 5:00 p.m.
TDD for the Hearing Impaired	(800) 447-2833 or 711 for PA Relay services	Monday – Friday 8:30 a.m. – 4:30 p.m. PA Relay Services available 24 Hours/Day, 7 Days/Week

DPW contact information:

Name	Phone Number	Hours of Operation
Department Of Public Welfare	DPW HelpLine: (800) 692-7462	24 Hours/Day, 7 Days/Week
Department of Public Welfare	DPW ChildLine: (800) 932-0313 TDD: (866) 872-1677	24 Hours/Day, 7 Days/Week

Name	Phone Number	Hours of Operation
Department of Public Welfare OMAP-HealthChoices Program Complaint Grievance and Fair Hearings	(800) 798-2339	Monday – Friday 8:30 a.m. - 4:30 p.m.
Eligibility Verification System (EVS)	(800) 766-5EVS (5387)	24 Hours/Day, 7 Days/Week
Medical Assistance Provider Compliance Hotline (Formerly Fraud and Abuse Hotline)	(866) 379-8477	Monday – Friday 9:00 a.m. - 3:30 p.m.
Provider Inquiry Hotline	(800) 537-8862 Prompt 4	Monday - Friday 8:00 a.m. - 4:30 p.m.
Medical Assistance Provider Enrollment Applications In-Process (Inpatient and Outpatient Providers)	(800) 537-8862 Prompt 1	Monday-Friday 8:30 a.m. - 12:00 noon and 1:00 p.m. – 3:30 p.m.
Medical Assistance Provider Enrollment Changes	(800) 537-8862 Prompt 1	Monday - Friday 8:00 a.m. - 4:30 p.m.
Outpatient Providers Practitioner Unit	(800) 537-8862 Prompt 1	Monday - Friday 8:00 a.m. - 4:30 p.m.
Pharmacy Hotline	(800) 558-4477 Prompt 1	Monday – Friday 8:00 a.m. - 4:30 p.m.

Behavioral Health contact information:

For referrals to a Behavioral Health Provider, please use the information below which is current as of the published date of this manual.

County	Behavioral Health Plan	Phone number	En Español	TTY/TDD
Bradford	Community Care Behavioral Health http://www.ccbh.com	(866) 878-6046	(866) 229-3187	(877) 877-3580
Carbon	Community Care Behavioral Health http://www.ccbh.com	(866) 473-5862	(866) 229-3187	(877) 877-3580

County	Behavioral Health Plan	Phone number	En Español	TTY/TDD
Centre	Community Care Behavioral Health http://www.ccbh.com	(866) 878-6046	(866) 229-3187	(877) 877-3580
Clinton	Community Care Behavioral Health http://www.ccbh.com	(855) 520-9787	(866) 229-3187	(877) 877-3580
Columbia	Community Care Behavioral Health http://www.ccbh.com	(866) 878-6046	(866) 229-3187	(877) 877-3580
Juniata	Community Care Behavioral Health http://www.ccbh.com	(866) 878-6046	(866) 229-3187	(877) 877-3580
Lackawanna	Community Care Behavioral Health http://www.ccbh.com	(866) 668-4696	(866) 229-3187	(877) 877-3580
Luzerne	Community Care Behavioral Health http://www.ccbh.com	(866) 668-4696	(866) 229-3187	(877) 877-3580
Lycoming	Community Care Behavioral Health http://www.ccbh.com	(855) 520-9787	(866) 229-3187	(877) 877-3580
Mifflin	Community Care Behavioral Health http://www.ccbh.com	(866) 878-6046	(866) 229-3187	(877) 877-3580
Monroe	Community Care Behavioral Health http://www.ccbh.com	(866) 473-5862	(866) 229-3187	(877) 877-3580
Montour	Community Care Behavioral Health http://www.ccbh.com	(866) 878-6046	(866) 229-3187	(877) 877-3580
Northumberland	Community Care Behavioral Health http://www.ccbh.com	(866) 878-6046	(866) 229-3187	(877) 877-3580
Pike	Community Care Behavioral Health http://www.ccbh.com	(866) 473-5862	(866) 229-3187	(877) 877-3580
Schuylkill	Community Care Behavioral Health http://www.ccbh.com	(866) 878-6046	(866) 229-3187	(877) 877-3580

County	Behavioral Health Plan	Phone number	En Español	TTY/TDD
Snyder	Community Care Behavioral Health http://www.ccbh.com	(866) 878-6046	(866) 229-3187	(877) 877-3580
Sullivan	Community Care Behavioral Health http://www.ccbh.com	(866) 878-6046	(866) 229-3187	(877) 877-3580
Susquehanna	Community Care Behavioral Health http://www.ccbh.com	(866) 668-4696	(866) 229-3187	(877) 877-3580
Tioga	Community Care Behavioral Health http://www.ccbh.com	(866) 878-6046	(866) 229-3187	(877) 877-3580
Union	Community Care Behavioral Health http://www.ccbh.com	(866) 878-6046	(866) 229-3187	(877) 877-3580
Wayne	Community Care Behavioral Health http://www.ccbh.com	(866) 878-6046	(866) 229-3187	(877) 877-3580
Wyoming	Community Care Behavioral Health http://www.ccbh.com	(866) 668-4696	(866) 229-3187	(877) 877-3580

County Behavioral Health Crisis Intervention contact information:

In the event of a life-threatening emergency, please dial 9-1-1.

County	Toll Free Phone Number	Non -Toll Free Phone Number
Bradford	(877) 724-7142	N/A
Carbon	(800) 338-6467	(610) 377-0773 (MH/DS) (570) 992-0879 TTY: 570-420-1904
Centre	(800) 643-5432	N/A
Clinton	(800) 525-7938 Drug & Alcohol: (888) 941-2721	(570) 326-7895 Drug & Alcohol: (570) 323-8543
Columbia	(800) 222-9016	(570) 275-4962 (Daytime, weekdays only)
Juniata	(800) 929-9583	N/A
Lackawanna	N/A	(570) 348-6100
Luzerne	Child Crisis only: (888) 829-1341	(570) 552-6000

Lycoming	1-800-525-7938 Drug & Alcohol: (888) 941-2721	(570) 326-7895 Drug & Alcohol: (570) 323-8543
Mifflin	(800) 929-9583	N/A
Monroe	(800) 338-6467	(570) 421-2901 (MH/DS) (570) 992-0879 TTY: (570) 420-1904
Montour	(800) 222-9016	(570) 275-4962 (Daytime, weekdays only)
Northumberland	(800) 222-9016	(570) 495-2040 or (570) 495-2041 (Daytime only)
Pike	(800) 338-6467	(570) 296-6484 (MH/DS) (570) 992-0879 TTY: (570) 420-1904
Schuylkill	(877) 993-4357	(570) 628-0152 or (570) 628-4731
Snyder	(800) 222-9016	(570) 275-4962 (Daytime, weekdays only)
County	Toll Free Phone Number	Non -Toll Free Phone Number
Sullivan	(877) 724-7142	N/A
Susquehanna	N/A	(570) 282-1732 or (570) 278-3393
Tioga	(877) 724-7142	(570) 724-5766 or (570) 724-7911
Union	(800) 222-9016	(570) 275-4962 (Daytime, weekdays only)
Wayne	N/A	(570) 253-0321
Wyoming	Child Crisis only: (888) 829-1341	(570) 836-3118
National Suicide Prevention Hotline	(800) 273-TALK (8255)	N/A

Medical Assistance Transportation Program (MATP) county contact information:

The Medical Assistance Transportation Program, also known as MATP, provides non-emergency transportation to medical appointments for Medical Assistance Members who do not have transportation available to them. The individual's county of residence will provide the type of transportation that is the least expensive while still meeting their needs.

County	Local Phone Number	Toll Free Phone Number
Bradford	(570) 888-7330	(800) 242-3484
Carbon	(570) 669-6380	(800) 990-4287
Centre	(814) 355-6807	Same as Local

County	Local Phone Number	Toll Free Phone Number
Clinton	(570) 323-7575	(800) 222-2468
Columbia	(570) 784-8807	(866) 936-6800
Juniata	(717) 242-2277	(800) 348-2277
Lackawanna	(570) 963-6482	Same as Local
Luzerne	(570) 288-8420	(800) 679-4135
Lycoming	(570) 323-7575	(800) 222-2468
Mifflin	(717) 242-2277	(800) 348-2277
Monroe	(570) 839-8210	(888) 955-6282
Montour	(570) 271-0833	Same as Local
Northumberland	(570) 644-4463	(800) 479-2626
Pike	(570) 296-3408	(866) 681-4947
Schuylkill	(570) 628-1425	(888) 656-0700
Snyder	(570) 522-1390	(877) 877-9021
Sullivan	(570) 888-7330	(800) 242-3484
Susquehanna	(570) 278-6140	(866) 278-9332
Tioga	(570) 659-5330	(800) 242-3484
Union	(570) 522-1390	(877) 877-9021
Wayne	(570) 253-4280	(800) 662-0780
Wyoming	(570) 288-8420	(800) 679-4135

PROVIDER RESPONSIBILITIES

GENERAL PROVISIONS

Participating Provider and GHP Family agree to abide by the following General Provisions:

A. Assignment. The Agreement or any part, articles or sections thereof may not be assigned during the term of the Agreement by any of the parties without the prior written consent of the other party(s), except (i) as may otherwise be provided for in the Agreement and (ii) each party may at any time assign its rights and obligations under the Agreement to any corporation controlled by, in control of or under common control of the assigning party provided, however, it

provides the non-assigning party(s) with thirty (30) days prior written notice of said assignment.

B. Compliance. The parties agree to comply with all applicable federal and state laws and rules including, but not limited to (i) Title VII of the Civil Rights Act of 1964; (ii) The Age Discrimination Act of 1975; (iii) The Rehabilitation Act of 1973; (iv) The Americans With Disabilities Act; (v) other laws applicable to recipients of Federal funds; (vi) Medicare laws, regulations and Centers for Medicare and Medicaid Services (“CMS”) instructions; (vii) Patients’ bill of Rights in accordance with OPM; (viii) the Genetic Information Nondiscrimination Act of 2008; (ix) Health Insurance Portability and Accountability Act of 1996 (HIPAA); and all other applicable laws and rules. Furthermore, Participating Provider hereby warrants and represents that it shall comply and shall be responsible for requiring any party that it may subcontract with to furnish services to Members to comply with GHP Family’s policies and procedures and all other terms and conditions of the Agreement. Additionally, it is hereby disclosed that payments made by GHP Family to related entities, contractors and subcontractors are, in whole or in part, from federal funds received by the GHP Family through its contracts with the Centers for Medicare and Medicaid Services.

C. Entire Agreement/Amendments/Multiple Originals. The Agreement, together with any attachments, exhibits, or applicable Provider Manual(s), as amended from time to time, set forth the entire Agreement between the parties with respect to the subject matter. Any prior purchase orders, agreements, promises, negotiations or representations, whether oral or written, not expressly set forth in the Agreement, are of no force or effect. The Agreement shall be executed in multiple originals, one for Participating Provider and the other for GHP Family. The parties agree that the Agreement shall be automatically amended to comply with applicable federal and state laws and regulations; otherwise, the Agreement may not be amended except in writing, signed by the parties.

D. Exhibits. All exhibits within the Agreement are incorporated by reference and made part of the Agreement as if they were fully set forth in the text of the Agreement.

E. Governing Law. The Agreement shall be deemed to have been made and shall be construed and interpreted in accordance with the laws of the Commonwealth of Pennsylvania, and the parties hereto agree to the jurisdiction of the Commonwealth of Pennsylvania.

F. Indemnification. Participating Provider and GHP Family agree to protect, indemnify and hold harmless the other party(s) from and against any and all loss, damage, cost and expense (including attorneys’ fees) which may be suffered or incurred under the Agreement as a result of the negligent or intentional acts of the indemnifying party, its employees, agents, consultants or subcontractors. Said indemnity is in addition to any other rights that the indemnified party may have against the indemnifying party and will survive the termination of the Agreement.

G. Insurance. The parties agree to maintain, at its own cost and expense, insurance coverage as necessary and reasonable to insure itself and its employees and agents in connection with the performance of its duties and responsibilities under the Agreement. Upon request, the parties agree to provide one another with a Certificate of Insurance evidencing said insurance coverage. Participating Provider shall notify GHP Family within ten (10) days of the cancellation or material alteration of such coverage.

H. Notices. All notices and communications hereunder shall be in writing and deemed given, when personally delivered to or upon receipt when deposited with the United States Postal Service, certified or registered mail, return receipt requested, postage prepaid; a nationally recognized overnight courier, with all fees prepaid; or e-mail addressed as set forth on the first page of the Agreement or to such other person and/or address as the party to receive may designate by notice to the other.

I. Notification of Incidents. The parties agree to notify the other party (s) within twenty-four (24) hours after the discovery of any incidents, occurrences, Claims or other causes of action involving the Agreement. Upon receipt of

discovery by any party of any incident, occurrence, Claim (either asserted or potential), notice of lawsuit or lawsuit involving the Agreement, said party agrees to immediately notify the other party(s). The parties hereto agree to provide complete access, as may be provided by law, to records and other relevant information as may be necessary or desirable to resolve such matters. This Section shall survive the termination of the Agreement.

J. Other Parties. The Agreement is solely between the parties hereto and is not intended to be enforceable by any other party or to create any express or implied rights hereunder of any nature whatsoever in any other party.

K. Partial Invalidity/Interpretation. If any term or provision of the Agreement is determined to be invalid or unenforceable, the remainder of the Agreement will not be affected thereby. The section headings in the Agreement are solely for reference purposes. Participating Provider acknowledges that portions of the Agreement are subject to review by Governmental Agencies and/or their designated representatives, as applicable, and in the event that such Governmental Agencies and/or their designated representatives require any material change to the terms and conditions of the Agreement, Participating Provider agrees to renegotiate the affected terms and conditions upon being notified of such required change by GHP Family.

L. Promotional Materials. Participating Provider consents to GHP Family's use of its name, address and the names and professional designations of its healthcare professionals in traditional membership and marketing materials. The parties hereto agree not to use the name of or any trademark, service mark or design registered to the other parties or their affiliates or any other party in any additional publicity, promotional or advertising material, unless review and written approval of the intended use shall first be obtained from the releasing party(s) prior to the release of any such material. Said approval shall not be unreasonably withheld by any of the parties. Notwithstanding anything to the contrary in the preceding sentences, GHP Family shall have the right to publish Participating Provider's summary rating as part of GHP Family's Physician Quality Summary Program without obtaining the consent by Participating Provider prior to the release of such rating.

M. Relationship Among Parties. The parties hereto expressly acknowledge and agree that: (i) GHP Family's duties and responsibilities under the Agreement apply solely to GHP Family Members; (ii) in its capacity as third party administrator, Company's duties and responsibilities under the Agreement apply to Members of an Employer-Sponsored Program; and (iii) with the exception of (ii) of this Section, Company's duties and responsibilities under the Agreement apply to Company Members. Each party hereto shall be considered independent entities with respect to each other. None of the provisions of the Agreement are intended to create nor shall be deemed or construed to create any relationship between the parties other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of the Agreement. Neither the parties nor any of their respective agents or employees shall be construed to be the agent, employee, joint Employer or representative of the other. The parties shall not have any express or implied rights or authority to assume or create any obligation or responsibility on behalf of or in the name of the other, except as may be otherwise set forth in the Agreement.

N. Release of Information. The provisions of the Agreement are confidential and protected from disclosure to any other party unless: (i) otherwise provided for in the Agreement; (ii) disclosure is required by GHP Family, an Employer or Participating Provider to meet any federal, state or local rule, law or regulation; or (iii) any party hereto engages a third party for purposes such as quality assurance or auditing.

O. Unforeseen Circumstances. In the event either party's operations are substantially interrupted by war, fire, insurrection, the elements, earthquakes, acts of God or, without limiting the foregoing, any other cause beyond the control of the affected party (including the GHP Family no longer meeting all material requirements imposed on GHP Family by Federal or State law resulting in a significant impact on the GHP Family's operations), the affected party shall be relieved of its obligations only as to those affected portions of this Agreement for the duration of such interruption. In the event that the performance of the affected party hereunder is substantially interrupted pursuant to such event, the other party shall have the right to terminate this Agreement upon ten (10) days' prior written notice to

the affected party.

P. Waiver. Failure of a party to complain of any act or omission on the part of another party shall not be deemed to be a waiver. No waiver by a party of a breach of the Agreement will be deemed a waiver of any subsequent breach. Acceptance of partial payment will be deemed a part payment on account and will not constitute an accord and satisfaction.

PRIMARY CARE PROVIDERS (PCP)

A Primary Care Practitioner (PCP) is a specific physician, physician group or a Certified Registered Nurse Practitioner (CRNP) operating under the scope of his/her licensure, and who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating and monitoring other medical care and rehabilitative services and maintaining continuity of care on behalf of the Member. Additional PCP responsibilities include, but are not limited to:

- Providing primary and preventive care and acting as the Member's advocate, providing, recommending and arranging for care.
- Documenting all care rendered in a complete and accurate encounter record that meets or exceeds the DPW data specifications.
- Maintaining continuity of each Member's health care.
- Communicating effectively with the Member by using sign language interpreters for those who are deaf or hard of hearing and oral interpreters for those individuals with LEP when needed by the Member. Services must be free of charge to the Member.
- PCPs are responsible for initiating and coordinating referrals of Members for Medically Necessary services beyond the scope of their contract of practice. PCPs must monitor the progress of the referred Members' care.
- Maintaining a current medical record for the Member, including documentation, of all the services provided to the Member by the PCP, as well as any specialty or referral services.
- Arranging for Medically Necessary Behavioral Health Services for Members by appropriate referrals to a HealthChoices Behavioral Health – Managed Care Organization (BH-MCO) in accordance with the specifications of the provider agreement.

MEMBER ASSIGNMENT TO PCP

Upon enrollment, Members may choose a PCP for themselves and any other eligible family Members. Any Member who does not select a PCP within fourteen (14) Business Days of enrollment will automatically be assigned to a PCP. If the Member is dissatisfied with the auto-selection assignment, or wishes to change their PCP for any other reason, the Member may choose an alternative PCP at any time by calling Customer Service. GHP Family will promptly grant the request and process the PCP change in a timely manner.

GHP Family manages each PCP's panel to automatically stop accepting new Members after the limit of 1,000 Members has been reached. Upon contracting with GHP Family, if the PCP/PCP Site employs Certified Registered Nurse Practitioners/Physician Assistants, then the Provider/Provider Site will be permitted to add an additional 1,000 Members to the practice's panel. Other exceptions to the 1,000 Member panel policy will be considered on a case by case basis. Please contact your GHP Family Provider Relations Representative for more information.

Assignment of Newborns

Newborns are immediately enrolled in the program and all Medically Necessary services are provided to newborns. GHP Family makes every effort to identify what PCP/pediatrician the mother chooses to use for the newborn prior to the birth, so that the provider chosen by the parent can be assigned to the newborn on the date of birth.

Hospitals need to notify the Member's County Assistance Office (CAO) as soon as the Member gives birth to ensure that the newborn will be appropriately enrolled in Medical Assistance and in GHP Family. Payment for deliveries will be delayed to the extent that accurate enrollment can be confirmed.

CHANGING PCPS

If a Member is dissatisfied with the auto-selection assignment, or wishes to change their PCP for any other reason, the Member may choose an alternative PCP at any time by calling the Customer Service number on the back of their GHP Family identification card. GHP Family will promptly grant the request and process the PCP change in a timely manner. Members will receive a new ID card indicating the new PCP's name.

GHP Family maintains policies and procedures allowing Members to select or be assigned to a new PCP whenever requested by the recipient, when a PCP is terminated from the Network or when a PCP change is required as part of the resolution to a Grievance or Complaint proceeding.

In cases where a PCP has been terminated for reasons other than cause, GHP Family informs Members assigned to that PCP within thirty (30) days prior to the effective date of the PCP's termination in order to allow them to select another PCP prior to the PCP's termination effective date. In cases where a Member fails to select a new PCP, the Member is reassigned to another compatible PCP prior to their previous PCP's termination date, informing the Member of the change in writing.

Please Note: Upon notification from DPW that a Participating Provider is suspended or terminated from participation in the Medicaid or Medicare Programs, GHP family will immediately act to terminate the provider from participation. Terminations for loss of licensure and criminal convictions must coincide with the MA effective date of the action.

SPECIALTY CARE PROVIDERS (SCP)

The PCP is responsible for initiating, coordinating and documenting referrals to Specialty Care Providers (SCPs) within the GHP Family Network. Members may request a second opinion from providers within the Network. If there is not a second provider with the same specialty in the Network, Members may request a second opinion from a provider out of Network at no charge to the Member.

SCPs must coordinate with the PCP when Members need a referral to another provider. Upon request, such records must be shared with the appropriate providers and forwarded at no cost to the Member or other providers. SCPs are responsible for obtaining referrals from referral physicians and bringing referred Members into compliance with medical treatment plans.

Members with a disease or condition that is life threatening, degenerative, or disabling may request a medical evaluation. If evaluation standards are met, Members will receive one of the below:

- A standing referral to a SCP for treatment of their disease or condition. If a Member needs on-going care from a SCP, GHP Family will authorize, if Medically Necessary, a standing referral to the SCP with clinical expertise in treating the Member's disease or condition. In these cases, GHP Family may limit the number of visits or the period during which such visits are authorized and may require the SCP to provide the PCP with regular updates on the specialty care provided, as well as all necessary medical information.

- A designated SCP to provide and coordinate both primary and specialty care for the Member. The SCP treating the Member's disease or condition will serve as the Member's PCP, coordinating care and making referrals to other SCPs, as needed.

Please refer to Medical Management & Prior Authorizations section of Manual for more information.

SCP AS PCP

A Member may qualify to select a SCP to act as PCP if she/he has a disease or condition that is life threatening, degenerative, or disabling. The SCP as a PCP must agree to provide or arrange for all primary care, consistent with GHP Family preventive care guidelines, including routine preventive care, and to provide those specialty health care services consistent with the Member's "special need" in accordance with GHP Family's standards and within the scope of the specialty training and clinical expertise. In order to accommodate the full spectrum of care, the SCP as a PCP also must have admitting privileges at a hospital in GHP Family's Network.

PCPs are responsible for initiating and coordinating referrals of Members for Medically Necessary services beyond the scope of their contract of practice. PCPs and SCPs must monitor the progress of the referred Members' care and SCPs must see that Members are returned to the PCP's care as soon as medically appropriate.

APPOINTMENT STANDARDS

GHP Family works with providers to outreach to HealthChoices Members concerning appointments for Medically Necessary care, preventive care and scheduled screenings and examinations. Contracted GHP Family providers are responsible to adhere to the appointment availability standards for Members. Providers must monitor the adequacy of their appointment processes and reduce unnecessary emergency room visits.

Condition	Member(s)	Provider Types	Standards
Emergency	All	PCP	Recipients must be seen immediately or referred to an emergency facility.
		SCP	Appointments immediately upon referral.
Urgent	All	PCP	Appointments must be scheduled within 24 hours.
		SCP	Appointments within 24 hours of referral.
Routine	All	PCP	Appointments must be scheduled within 10 Business Days.

	All	SCP: Otolaryngology Dermatology Pediatric Endocrinology Pediatric General Surgery Pediatric Infectious Disease Pediatric Neurology Pediatric Pulmonology Pediatric Rheumatology Dentist Orthopedic Surgery Pediatric Allergy & Immunology Pediatric Gastroenterology Pediatric Hematology Pediatric Nephrology	Appointments must be scheduled within 15 Business Days.
		All Other Specialty	Appointments must be scheduled within 10 Business Days.
Condition	Member(s)	Provider Types	Standards
Health Assessment	All	PCP	Appointments must be scheduled within three (3) weeks of enrollment.
Initial Appointment	HIV/AIDs Recipients	PCP or SCP	Appointments must be scheduled within seven (7) days of enrollment unless the Member is already in an active care with a PCP or SCP.
	SSI Recipients	PCP or SCP	Appointments must be scheduled within 45 days of enrollment unless the Member is already in an active care with a PCP or specialist.
Initial Prenatal care Appointment	Pregnant Recipients	OB/GYN or Certified Nurse Midwife	
	First Trimester		Appointments must be scheduled within 10 Business Days of the Member being identified.
	Second Trimester		Appointments must be scheduled within five (5) Business Days of Member being identified.
	Third Trimester		Appointments must be scheduled within four (4) Business Days of Member being identified.
	High Risk Pregnancy		Appointments must be scheduled within 24 hours of identification or immediately if an emergency exist.

EPSDT Screens	All under the age of 21	PCP	Appointments must be scheduled within 45 days of enrollment unless the child is already under the care of a PCP and current with screens.
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GHP Family’s appointment availability standards reflect minimum requirements. GHP Family routinely monitors providers for compliance with these standards. Noncompliance may result in the initiation of a corrective action plan or further corrective actions.

PCP WAIT TIMES

Waiting time standards for PCPs require that Members, on average, should not wait at a PCP office for more than thirty (30) minutes for an appointment for routine care. On rare exceptions, if a physician encounters an unanticipated urgent visit or is treating a Member with a difficult medical need, the waiting time may be expanded to one hour. GHP Family monitors compliance with appointment and waiting time standards and works with providers to ensure that these standards are met.

APPOINTMENT NOTIFICATION AND FOLLOW-UP

The PCP or SCP is required to conduct affirmative outreach whenever a Member misses an appointment and to document this in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the Member. Such attempts may include, but are not limited to: written attempts, telephone calls and home visits. At least one (1) such attempt must be a follow-up telephone call. Communications with the Member should take the language and literacy capabilities of Members into consideration.

EARLY PERIODIC SCREENING, DIAGNOSIS, and TREATMENT (EPSDT)

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services are federally-mandated services intended to provide preventive health care to children and young adults (under the age of 21 years) at periodic intervals which are based on the recommendations of the American Academy of Pediatrics (AAP), and the Centers for Disease Control and Prevention (CDC). All PCPs who provide services to Members under age twenty-one (21) are required to provide comprehensive health care, screening and preventive services. GHP Family requires Network PCPs to provide all EPSDT services in compliance with federal and state regulations and periodicity schedules.

EPSDT screens for any new Member under the age of twenty-one (21) must be scheduled within forty-five (45) days from the effective date of Enrollment unless the child is already under the care of a PCP and the child is current with screens and immunizations. Members with suspected developmental delays under the age of five (5) are required to be referred by their PCP through CONNECT [(800) 692-7288] for referral for local Early Intervention Program services.

GHP Family will distribute quarterly lists to each PCP that identify Members who have not had an encounter during the first six (6) months of enrollment or Members who have not complied with EPSDT periodicity and immunization schedules for children. PCPs shall be responsible to contact all Members who have not had an Encounter during the previous twelve (12) months or within the MA appointment time frames. These EPSDT Member lists are also available upon request from GHP Family.

Please reference the most recent periodicity guidelines published on the Pennsylvania DPW Web site for the HealthChoices program at: <http://services.dpw.state.pa.us/olddpw/bulletinsearch.aspx?BulletinDetailId=4561>

2012 Recommended Childhood and Adolescent Immunization Schedules can be viewed at these links:

- [Recommended Immunization Schedule for Persons Aged 0 Through 6 Years, United States, 2012](#)
- [Recommended Immunization Schedule for Persons Aged 7 Through 18 Years, United States, 2012](#)
- [Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind, United States, 2012](#)

SCHOOL-BASED HEALTH SERVICES

School-based health services can play a pivotal role in ensuring children receive the health care they need. PCPs are required, with the assistance of GHP Family, to coordinate and/or integrate into the PCP's records any health care services provided by school-based health services. GHP Family's Special Needs Unit can assist PCPs with the coordination of services among the PCP, parents or guardians, and other providers.

SUSPECTED CHILD ABUSE OR NEGLECT

When the County Children and Youth Agency system notifies GHP Family or a Participating Provider suspects a potential case of child neglect and/or abuse of a HealthChoices Member, GHP Family works with the agency and the Participating Providers to ensure that the Member receives timely physical examinations for the abuse or neglect in accordance with the Child Protective Services Law, 23 Pa. C.S. 6301 et seq. and DPW regulations. If a Participating Provider determines that a mental health assessment is needed, the Participating Provider must inform the Member or the County Children Youth Agency representative of how to access mental health services and coordinate access to these services, when necessary. GHP Family's Special Needs Unit can assist providers as necessary to connect with local county agencies to remain compliant with mandatory reporting requirements.

In addition to conducting physical examinations, providers must proactively report suspected abuse and/or neglect of HealthChoices Members. Participating Providers can report abuse to the **DPW's ChildLine at: (800) 932-0313; TDD: 866-872-1677**. ChildLine accepts calls from the public and professional sources 24 hours/day, 7 days/week. The ChildLine provides information, counseling, and referral services for families and children to ensure the safety and well-being of the children of Pennsylvania.

Professionals who have reasonable cause to suspect that a child has been abused are required to file a report. The individual may remain anonymous. Each call to ChildLine is answered by a trained intake specialist who will interview the caller to determine the most appropriate course of action. Actions include forwarding a report to a county agency for investigation as child abuse or general protective services, forwarding a report directly to law enforcement officials or refer the caller to local social services (such as counseling, financial aid and legal services).

For additional information on how to assist children and families, please visit the Child Welfare Services section of the DPW's Web site <http://www.dpw.state.pa.us>.

REPORTABLE CONDITIONS

In accordance with 28 Pennsylvania Code 27.1 Providers must comply with mandatory reporting requirements for Members with identified communicable diseases. A complete listing of responsibilities and disciplinary actions for failure to comply with said requirements by the Pennsylvania licensing boards can be found at: <http://www.pacode.com/secure/data/028/chapter27/chap27toc.html>.

A quick summary of the provider responsibilities include requirements to:

- Report an outbreak within 24 hours in accordance with § 27.4 (relating to reporting cases).
- Report a suspect public health emergency or an unusual occurrence of a disease, infection or condition not listed as reportable in Subchapter B (relating to reporting of diseases, infections and conditions) or defined as an outbreak, within 24 hours, and in accordance with § 27.4.

- Report any unusual or group expression of illness which the Department designates as a public health emergency within 24 hours, and in accordance with § 27.4.

GHP Family will conduct random chart audits on an annual basis to verify compliance with this requirement. For assistance in contacting the designated local county/municipal health department, please contact the Special Needs Unit.

INFECTION CONTROL MEASURES

GHP Family wants to ensure providers exercise approved and effective infection control practices. The Guide to Infection Control Prevention for Outpatient Settings: Minimum Expectations for Safe Care, produced by the Centers for Disease Prevention can be found at <http://www.cdc.gov/HAI/pdfs/guidelines/standatds-of-ambulatory-care-7-2011.pdf>.

RETURN COMMUNICATION

Participating Providers are responsible for providing the Member's PCP with information pertaining to the Member's recent episode of care or treatment after each visit or as often as necessary according to federal and/or state laws. PCPs should accurately file written correspondence in the Member's medical record and review such material to assure coordination of the Member's care.

GHP Family provides the "Obstetrical Needs Assessment Form" (OBNA) and the "Retinal Evaluation/Examination Form" to applicable Participating Providers. Contact your Provider Relations Representative for a supply of these forms.

PCP PRACTICE ACCEPTANCE STATUS AND MEMBER LIMITATIONS

In the event a PCP determines it is necessary to limit their clinical practice to new Health Plan membership as a result of the PCP practice member capacity, the following conditions are required:

- Advanced written notification of a minimum of thirty (30) Business Days prior to effective date of the limitation.
- PCP acknowledges that they will continue to accept all current Health Plan membership and will continue to provide Medical Services to assigned Member(s), regardless of a pre-existing physician-patient relationship.
- PCP acknowledges that changing to "accepting existing patients only" status represents that they will continue to accept all patients who may change to Health Plan coverage and the change will not be published in written Member and/ or provider material until next acceptable printing.
- PCP must concurrently establish a limited membership acceptance status with all other managed care plans with which PCP participates.

REFERRALS

GHP Family has established and maintains a referral process to effectively utilize and manage the care of Members. GHP Family may require a referral for any health care services, which cannot be provided by the PCP except where specifically provided for in this manual.

Participating Providers should submit and retrieve referrals through GHP Family's online referral tool available at www.GHPFamily.com. Provider Relations Representatives are available to provide information regarding the online referral process and applicable setup.

DIRECT ACCESS AND SELF-REFERRAL

The following services do not require a referral from the PCP:

- Vision
- Dental care
- Obstetrical and Gynecological (OB/GYN) services
- Chiropractic services may be accessed in accordance with the process set forth in Medical Assistance Bulletin 15-07-01: <http://services.dpw.state.pa.us/olddpw/bulletinsearch.aspx?BulletinId=4092>
- Physical therapy services may be accessed in accordance with the amended Physical Therapy Act (63 P.S. 1301 et seq.)

Please Note: To be self-referred, the Member must obtain these self-referred services from GHP Family's Network.

Family Planning Services do not require Prior Authorization or referral. Members may access Family Planning Services from any qualified provider. Family Planning Services include, but are not limited to:

- Health Education
- Counseling necessary to make an informed choice about contraceptive methods
- Pregnancy testing and breast and cervical cancer screening services
- Contraceptive supplies such as oral birth control pills, diaphragms, foams, creams, jellies, condoms (male and female), Norplant, injectables, intrauterine devices, and other family planning procedures
- Diagnostic screens, biopsies, cauterizations, cultures, and assessments

Members have direct access to OB/GYN services and have the right to select their own OB/GYN provider; this includes nurse midwives participating in GHP Family's Network. They can obtain maternity and gynecological care without prior approval from a PCP. This includes:

- Selecting a provider to give an annual well-woman gynecological visit
- Primary and preventive gynecology care
- PAP smear and referrals for diagnostic testing related to maternity and gynecological care, and Medically Necessary follow-up care
- Perinatal and Postpartum maternity care

In situations where a new pregnant Member is already receiving care from an out-of-Network OB-GYN SCP at the time of enrollment, the Member may continue to receive services from that SCP throughout the pregnancy and postpartum care related to the delivery.

SUBSTANCE ABUSE AND BEHAVIORAL HEALTH REFERRALS

Many behavioral health disorders such as depression, anxiety and substance abuse often occur in Members who present for medical care. PCPs and all non-behavioral health practitioners are encouraged to recommend behavioral health services to Members when deemed appropriate. Substance abuse and behavioral health services are available to all GHP Family Members through the Member's local county mental health office or that office's sub-contracted provider. PCP must inform the Member or the County Children and Youth Agency representative how to access these mental health services and coordinate access to these services, when necessary. To refer GHP Family Members for these services, please reference the behavioral health contact information table in the Contact Information section of this manual for county, provider, and contact details. Members may also self-refer.

For state wide information visit: <http://pa.networkofcare.org>

To search for a Community Care Behavioral Health Organization provider visit: <http://www.ccbh.com>

MEDICAL MANAGEMENT & PRIOR AUTHORIZATIONS

MEDICAL MANAGEMENT PLAN

The Medical Management Plan defines and clarifies the structure and function of the Medical Management Department. This document provides a definition of authority and accountability for medical management activities within the organization, articulates the scope and content of the Medical Management program, identifies the roles and responsibilities of individuals involved, and outlines the program evaluation process.

A copy of the complete MM Plan can be requested from GHP Family's Medical Management Department.

QUALITY MANAGEMENT PLAN

The Geisinger Health System's mission is to enhance the quality of life through an integrated health service organization based on balanced patient care, education, research, and community service. GHP Family supports the overall mission of Geisinger Health System. The GHP Family Quality Management (QM) Plan provides the structure and processes for continuously monitoring, analyzing, and improving the clinical care and services provided under GHP Family products in order to further that mission.

The scope of the QM Plan is comprehensive in nature, allowing for improvement, and is consistent with the DPW's goals related to access, availability, and quality of care.

A copy of the complete QM Plan can be requested from GHP Family's Quality Improvement Department.

POPULATION MANAGEMENT PROGRAMS

GHP Family's Case Management Department offers Population Management Programs for Members across the healthcare continuum including Case Management and Disease Management programs to assist Members with chronic conditions.

GHP Family's Case Management Department engages patients as part of a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality and cost-effective outcomes.

GHP's Family Case Management Department is responsible for the delivery of Case Management/Disease Management programs to Insured Individuals. GHP Family provides the following services and programs.

Case Management

Case Managers work in collaboration with the PCP to manage patients with complex co-morbid conditions. The Case Manager completes a comprehensive assessment and prioritizes the patient's needs that allow the provider, Member and/or Member representative, and Case Manager to develop a patient centric plan of care and self-management action plan. Post discharge transitions of care are integral to this patient centered model and include: medication reconciliation, confirmation that services are in place i.e. home health and durable medical equipment, and that there is adequate social support in place. Case Managers facilitate a five (5) to seven (7) day follow-up appointment with the PCP as this is essential to the continuity of care.

For advanced illness, case managers will facilitate palliative care, home health and hospice referrals and the Physician Orders for Life-Sustaining Treatment (POLST) form, if appropriate. Contact your Provider Relations Representative for a supply of this form. Advanced directives are facilitated for all Members and are discussed further in the *Advanced Directives* section of this manual.

Heart failure and COPD are progressive conditions that are managed by case managers in collaboration with the PCP/SCP.

- **Heart Failure**
An ongoing combination of education and management that provides patient education and activation, teaching Members the importance of medications, symptom monitoring that includes daily weights and exacerbation management. Diuretic protocols may be implemented as part of the treatment plan that can be initiated by the Member or family, if determined appropriate by the provider. Diet and life-style habits are also part of the education process to improve the management of heart failure. Overall effort is to manage the condition and improve the Member's quality of life.
- **Chronic Obstructive Pulmonary Disease (COPD)**
The Chronic Obstructive Pulmonary Disease (COPD) Program helps Members with COPD to better manage the condition through the inclusion of pulmonary function testing, education, medication management and symptom monitoring including COPD Rescue Kits, if appropriate, in the treatment plan. Information about tobacco cessation and life-style modification is provided by a Case Manager.

Complement the Care provided by the PCP and/or SCP

Case Managers/Health Managers work with Members and the PCP/SCP to assist Members in the community with chronic health/social problems. The Case Managers/Health Managers also provides monitoring and education to help Members better manage the following health conditions: The following programs are available for all Members:

- **Adult and Pediatric Asthma**
Education is a key factor in the Asthma Care Program. Nurse Case Managers/Health Managers work with Members and their families to help them understand and manage asthma triggers and symptoms and adhere to treatment plans. Case Managers/Health Managers work with Members to educate them about medications, proper use of inhalers, spacers, nebulizers, and peak flow monitoring. The Case Manager/Health Manager collaborates with the PCP/SCP to develop an individualized Asthma Action Plan with the Member.
- **Chronic Kidney Disease (CKD)**
The purpose of the CKD program is to improve the coordination of appropriate services with a PCP or nephrologist for Members with kidney disease. Case Managers/Health Managers provide education about the importance of proper nutrition, medications, blood pressure control, and other important health care information.
- **Diabetes**
Members in the Diabetes Care Program work with a Case Manager/Health Manager who provides education including: pathophysiology, medications, dietary management, exercise and other self-care strategies that will assist Members in taking control of their diabetes. The Case Managers/Health Managers coordinate services for Members that facilitate standards of care and HEDIS® measures to ensure quality.

- **Coronary Artery Disease (CAD)**
Managing risk factors and promoting proper medication management is the focus of the CAD program for Members with heart disease. Cholesterol and blood pressure management are key aspects of the program. Case Managers/Health Managers also provide education about diet and exercise strategies, and work with providers to coordinate recommended therapies.
- **Hypertension**
Case Managers/Health Managers assist Members in learning what they can do to control blood pressure and reduce the risk of developing other health problems that can result from poorly controlled blood pressure. Education and optimizing a treatment plan are key to “moving a Member to Goal”.
- **Osteoporosis**
This program provides education to women and men at risk for osteoporosis, as well as those who have already been diagnosed. Case Managers/Health Managers outline steps to prevent osteoporosis and to reduce the risk of complications. Case Managers/Health Managers work with providers to facilitate DEXA Scans and appropriate therapy with patients, as appropriate.
- **Tobacco Cessation (teen and adult)**
In the Tobacco Cessation Program, professional support is provided by Case Managers/Health Managers/Wellness Coaches through phone, group, web-based, or individual coaching. The program goal is to help break the addiction to tobacco products such as cigarettes, pipes and smokeless tobacco, and help Members quit.
- **Well on Your Weigh (weight management)**
Designed for both adults and children, the program focuses on developing a healthy lifestyle rather than dieting. Members work with Case Managers/Health Managers/Wellness Coaches to set manageable goals, eat healthy and stay active to control their weight long term.

To refer a Member to a Case Management/Disease Management Program, or to learn more about a specific Case Management/Disease Management Program, Participating Providers should visit GHP Family’s Provider Information Center at www.ghpfamily.com or contact the Case Management Department at (570) 271-8763 or toll free (800) 883-6355, Monday through Friday from 8:00 a.m. to 4:30 p.m.

Disease Management Program Development

Case Management conducts an analysis of the disease under consideration prior to the development of a Case Management/Disease Management program. The following criteria are evaluated:

- Disease prevalence
- Disease complexity
- Potential for reducing complications, improving quality
- Current cost of managing the disease
- Existence of an evidence-based clinical guideline to assist practitioners in the management of the disease
- Value to the Participating Provider, Member and GHP Family if the program is implemented

Case Management leadership determines the need for a specific Case Management/Disease Management program based upon the criteria listed above and submits a proposal to GHP Family’s Medical Management Administrative Committee and Quality Improvement Committee for review and approval. Actively practicing

practitioners are participating Members of Case Management/Disease Management teams and assist in the development, implementation, and monitoring of new and established Case Management/Disease Management programs.

Practitioner Program Content

The design of all Case Management/Disease Management programs includes, but is not limited to: evidence-based clinical guidelines, Member identification, passive or active enrollment, stratification, interventions based on stratification level, practitioner decision support and evaluation of program effectiveness.

Evidence-based clinical guidelines are a core component of all Disease Management programs. Board certified SCPs and/or PCPs are involved in the review and approval of evidenced-based guidelines.

Clinical guidelines are reviewed every two years or when the appropriate guideline team, GHP Family's Guideline Committee and the Quality Improvement Committee make recommendations. Identified primary and SCPs are involved in the development and review of new Case Management/Disease Management programs. GHP Family's Case Management Department and the accompanying teams are responsible for program content that is consistent with current clinical practice guidelines.

Evidence-based guidelines are posted online at www.ghpfamily.com, and announcements are made in the provider newsletter, *Briefly*, to inform practitioners of their availability. Printed copies or electronic PDF files are available upon request for practitioners who do not have Internet access by contacting GHP Family's Case Management department at (570) 271-8763 or toll free (800) 883-6355, Monday through Friday from 8:00 a.m. to 5:00 p.m.

Identification of Members who benefit from Case Management/Disease Management programs is accomplished through Claims analysis using standard clinical specifications from criteria such as the Health Plan Employer Data & Information Set (HEDIS®). Member identification is also facilitated by direct referrals from primary and SCPs, the Member and/or family, and from various GHP Family departments including Medical Management, Customer Service, Appeals, and Quality Improvement.

Enrollment and Patient Participation

All Members with a disease-specific diagnosis are identified by Claims analysis and/or HEDIS® criteria and mailed a disease-specific informational newsletter. Members are informed of their enrollment in the program and have the opportunity to "opt out" by contacting GHP Family's Case Management Department.

All enrollees receive disease-specific informational newsletters each year to increase their knowledge of disease self-management. Each newsletter also encourages the Members to become "active" participants in the disease management program(s).

A Member becomes actively enrolled in the appropriate disease management program when the Member contacts GHP Family's Case Management Department directly, is referred by a Health Care Provider or a GHP Family department, or accepts an invitation extended by GHP Family's Case Management Department (through disease-specific Member newsletters or direct Member invitation by letter or phone as the result of Claims analysis information).

A Case Manager/Health Manager reviews the referral information and contacts the Member to either schedule an office appointment with the Proven Health Navigator Health/Case Manager or to arrange to routinely communicate with the Member telephonically. After the Member's verbal and/or written consent for participation is obtained, the Member is actively enrolled in the appropriate program.

Risk stratification

Case Managers/Health Managers stratify active Members based on clinical criteria according to low, moderate or high risk. For example, Members enrolled in the Congestive Heart Failure program are stratified according to the American College of Cardiology (ACC). Members with diabetes are stratified using glycosolated hemoglobin (A1c) control and the presence of risk factors.

Interventions

The degree of intervention is based on the Member's risk stratification. For example, a Member classified as low risk receives a minimum of one (1) program informational newsletter each year, self-management education, a plan of care, and one or more follow-up office or phone appointments. A Member with a high-risk stratification receives these interventions in addition to more frequent office/phone visits and referrals for necessary specialty or case management services.

Practitioner decision support

The Case Management/Disease Management decision support model includes evidence-based clinical guidelines (previously described), Case Managers/Health Managers, the plan of care, and the Practitioner Quality Feedback Report. The program is designed for actively practicing PCPs.

Case Managers/Health Managers are key to providing collaborative "real time" decision support to PCPs. The Case Manager/Health Manager follow internally developed education Care Paths (Algorithms) that complement the clinical guidelines. The education Care Paths (Algorithms) provide a framework for self-management education, the recommended laboratory/diagnostic studies, and targeted clinical goals.

The plan of care includes information regarding the Member's self-management of their condition, barriers, special considerations or exceptions, review of medical test results, management of co-morbidities, collaborative goal-setting and problem-solving, medication review, plans for follow-up, and preventive health monitoring. The plan of care is reviewed and discussed by the PCP and/or SCP and the Case Manager/Health Manager in person, by phone, or through an electronic medical record messaging process.

Additional decision support information is mailed to Participating Providers annually from the Case Management administrative staff in the form of a letter accompanied by the Practitioner Quality Feedback Report.

The involvement of the practitioner is integral in the design of program content for all Case Management/Disease programs. Practitioner participation ensures program content is appropriate for the actively practicing PCP. All PCPs are surveyed annually in order to elicit feedback regarding the program(s).

Evaluation of program effectiveness

Program effectiveness is measured by conducting a pre-and post-analysis of pertinent clinical measures, annual Member/practitioner program satisfaction surveys and pre- and post-comparisons of services utilized by Members in the programs.

Practitioner's Rights

Practitioners who care for Members have the right to:

- Obtain information regarding Case Management/Disease Management programs and services in conjunction with GHP Family as outlined herein; and
- Obtain information regarding the qualifications of the Case Management staff; and
- Obtain information regarding how the Case Management staff facilitates interventions via treatment plans for individual Members; and
- Know how to contact the Case Managers/Health Managers responsible for managing and communicating with their patients; and
- Request the support of the Case Manager/Health Manager to make decisions interactively with Members regarding their health care; and
- Receive courteous and respectful treatment from Case Management staff at all times; and
- File a Complaint when dissatisfied with any component of the Case Management/Health Management programs by contacting the Case Management Department at (570) 271-8763, toll free at (800) 883-6355, or the customer service team at the number listed on your patient's insurance card.

PRIOR AUTHORIZATION (PRECERTIFICATION)

Precertification is GHP Family's response to information presented relating to a request for specified health care services.

Precertification does not guarantee a Member's coverage or GHP Family payment.

A Member's coverage is pursuant to the terms and conditions of coverage set forth in a Member's applicable benefit document. Please contact the Customer Service Department (CST) at (855) 227-1302 for verification of precertification requirements.

A Member is not financially responsible for a Participating Provider's failure to (i) obtain precertification, or (ii) provide required and accurate information to GHP Family. Copayments are the financial responsibility of the Member, when applicable.

A complete list of services requiring Prior Authorization is available online at www.GHPfamily.com.

Precertification Determination and Communication Process

Precertification of services may be required and will be performed by GHP Family Medical Management staff, or through delegated vendor relationships. Delegated vendors may review services such as, but not be limited to, radiology, and non-emergent ambulance transportation.

Precertification staff, which includes appropriate practitioner reviewers, utilizes nationally recognized medical guidelines as well as internally developed medical benefit policies, individual assessment of the Member, and other resources to guide precertification, Concurrent Review, and Retrospective Review processes in accordance with the Member's eligibility and benefits.

Upon submission of required information, the precertification staff will provide the Member, the Member's PCP and the prescribing provider with notification of the determination of coverage as expeditiously as the Member's health condition requires, or at least orally, within two (2) Business Days of receiving the request, unless additional information is needed. If no additional information is needed, GHP Family will mail written notice of the decision to the Member, the Member's PCP, and the prescribing provider within two (2) Business Days after the decision is made.

If additional information is needed to make a decision, GHP Family will request such information from the appropriate provider within forty-eight (48) hours of receiving the request and allow fourteen (14) days for the provider to submit the additional information. If GHP Family requests additional information, GHP Family will notify the Member on the date the additional information is requested, using the Request for Additional Information Letter template supplied by the Department. If the requested information is provided within fourteen (14) days, GHP Family will make the decision to approve or deny the service, and notify the Member orally, within two (2) Business Days of receipt of the additional information. GHP Family will mail written notice of the decision to the Member, the Member's PCP, and the prescribing provider within two (2) Business Days after the decision is made. If the requested information is not received within fourteen (14) days, the decision to approve or deny the service will be made based upon the available information and the Member will be notified orally within two (2) Business Days after the additional information was to have been received. GHP Family will mail a written notice of the decision to the Member, the Member's PCP, and the prescribing provider within two (2) Business Days after the decision is made. In all cases, the decision to approve or deny a covered service or item will be made and the Member must receive written notification of the decision no later than twenty-one (21) days from the date GHP Family receives the request, or the service or item is automatically approved.

When Precertification results in a denial of services, as defined in this manual's *Glossary*, GHP Family will issue a written notice of denial to the Member, and copy the Participating Provider, using the appropriate notice which includes the Member's appeal rights. In addition, the notice will be available in accessible formats for individuals with visual impairments and for persons with limited English proficiency.

Concurrent Review Determination and Communication Process

As it relates to urgent Concurrent Review approvals, GHP Family has a process with Participating Providers that, once approval has been given it remains in effect until GHP Family notifies the provider otherwise. This means that as Concurrent Review of care is ongoing and the case continues to meet criteria for approval, GHP Family does not provide repeated notices of approval.

When Concurrent Review results in a denial of services, as defined in this manual's *Glossary*, GHP Family will issue a written notice of denial to the Member, and copy the Participating Provider, using the appropriate notice which includes the Member's appeal rights. In addition, the notice will be available in accessible formats for individuals with visual impairments and for persons with limited English proficiency.

Participating Providers are verbally notified of any pending medical review denial(s) and are offered the opportunity to discuss pending adverse decision(s) directly with an appropriate practitioner reviewer making the initial determination; or reviewer available at a time convenient for the Participating Provider. The Participating Provider's request to discuss the pending determination is required to occur within one (1) Business Day of GHP Family's pending verbal denial notification in order to meet stringent regulatory timelines for the generation of denial notices. The Participating Provider has the opportunity to supply additional supportive information for discussion.

Please note: The Member only bears potential copay liability for a given service. Depending on whether the Member exercises their appeal rights and the timeframe in which the Member does so, the Member may bear potential payment for a given service only if the Member decides to receive a service after having been informed before receiving the service that the Member will be liable to pay for the service.

Medical Management's IVR system is available 24 hours/day, 7 days/week at (800) 544-3907 or (570) 271-6497. Participating Providers may call this number to request precertification or to leave a message for the Medical Management staff. For a listing of delegated vendors, please contact the customer service number on the back of the Member's identification card.

Authorization Required for Payment

Any service, with or without an authorization, rendered by a Participating Provider and determined to be clinically inappropriate by the Medical Director will be paid at an appropriate alternate level of care or payment will be denied completely. Medical Director determinations are in accordance with individual Member's needs, characteristics of the local delivery system, applicable medical criteria and clinical expertise. At the time of a claim payment denial, the Participating Provider is verbally notified of the option to speak with a Medical Director regarding such payment denial. The Provider Appeal process is also available to Participating Providers for claims payment issues.

Medical Benefit Policies

A medical policy is the written description of GHP Family's position concerning the use or application of a biologic, device, pharmaceutical, or procedure, based on any or all of the following: Regulatory guidelines, clinical practice guidelines, nationally accepted standards, and the findings and conclusions drawn from a complete Technology Assessment (TA). Additionally, a medical policy is an informational resource that establishes the Medical Necessity criteria for the biologic, device, pharmaceutical, or procedure. It also functions as an informational resource by describing any special requirements for Claims processing.

New and revised medical benefit policies, which include services deemed to require precertification, are communicated in the quarterly provider newsletter, *Briefly*. *Briefly* is accessible online at www.ghpfamily.com, or a hard copy may be obtained from your Provider Relations Representative. A minimum of thirty (30) days advance notice is provided regarding those services, which have been added to GHP Family's precertification list. For a current listing refer to the GHP Family web site at www.ghpfamily.com.

Participating Providers with questions about the above medical policies can contact the Medical Management Department at the number listed below:

Monday through Friday 8:00 a.m. to 4:30 p.m.
(800) 544-3907 or (570) 271-6497
Fax: (570) 271-5534

Verification of Eligibility and Benefit Limit

Prior to coordinating health care services, a Member's eligibility and benefits should always be verified through the online Provider Service Center at www.ghpfamily.com (registration required; contact your Provider Relations Representative to register) or by contacting the DPW Eligibility Verification System (EVS) at (800) 766-5EVS (5387), or by calling the applicable Customer Service Team. Providers, acting upon a referral from the Member's PCP, should contact the GHP Family Customer Service Team at (855) 227-1302 to verify eligibility and benefits.

Except in an Emergency or as otherwise permitted in accordance with the terms and conditions of coverage set forth in a Member's benefit document, all healthcare services for a Member must be provided by and rendered in a Participating Provider or must be approved in advance by the GHP Family Medical Director.

Inpatient Hospitalization

Requests for precertification of a planned inpatient hospital admission are the responsibility of the admitting Participating Provider.

Requesting Precertification

Prior to a planned inpatient admission to a hospital provider, the admitting Participating Provider is responsible for initiating precertification by contacting the Medical Management Department anytime by faxing the requested information to the number below.

GHP Family Medical Management Department
Fax: (570) 271-5534

Hospitals should verify authorization has occurred by contacting either the admitting Participating Provider or by calling GHP Family's Medical Management Department at (800) 544-3907 or (570) 271-6497.

Inpatient admissions excluded from precertification:

- Emergency and/or Urgent Care inpatient admissions, which may be an (i) admission from an emergency room that results in a direct admission, (ii) a direct admission from an ambulatory surgery center or (iii) an admission directly from a physician's office.
- An inpatient admission to a hospital provider where GHP Family is secondary to another payer who requires precertification and authorization has been obtained from the primary carrier. However, notification for Concurrent Review is required.
- A full term pregnancy with intent to deliver, either vaginal or cesarean section.
Please note: Inpatient hospital admissions unrelated to the course of pregnancy may require precertification.
- A transfer from one hospital Participating Provider to another hospital Participating Provider where the first inpatient admission was precertified and/or followed by GHP Family Concurrent Review and has been determined appropriate for an acute inpatient level of care.
- Retrieval of a Member from a non-participating facility to a Participating Facility through GHP Family's out-of-Network retrieval process. Transfer may only occur at such time when the Member's condition has stabilized and the Member can be transported safely to a Participating Facility without suffering detrimental consequences or aggravating the Member's condition.
- Observation services furnished by a hospital provider in an outpatient setting that include the use of a bed and periodic monitoring by a hospital provider's nursing or other staff and does not exceed a maximum of twenty-three (23) hours in duration.

Planned Inpatient Admission

Precertification for a planned inpatient hospital admission is required no less than two (2) Business Days prior to the planned date of admission.

Please note: Planned admissions to an acute rehabilitation facility or rehabilitation unit within a hospital are considered inpatient hospital admissions and are subject to the precertification requirements listed in the Section titled "Inpatient Rehabilitation Admission" within this Manual.

Observation Services

Precertification is required for observation services expected to exceed twenty-three (23) hours.

Information Required when Requesting Precertification

The following information should be readily available when the admitting Participating Provider initiates the request for precertification:

- Requestor name and contact information
- Member name, date of birth, and ID number
- Name of the admitting Physician
- Admitting Physician's Fax Number
- Admitting facility name

- Admission date (not to exceed 30 days from the date of request)
- Diagnosis and associated diagnosis codes
- Procedure and associated procedure codes
- Any additional/supportive information

Concurrent Review

Participating Providers are required to initiate Concurrent Review with the Medical Management Department within one (1) Business Day of any inpatient admission (planned or unplanned). This information can be submitted via fax to (570) 271-5534 or by emailing the information to GHP_MM_AUTH@thehealthplan.com. Each inpatient admission is subject to the Concurrent Review process, including instances where a case rate/MS-DRG may apply.

During Concurrent Review, a determination of continued coverage and a subsequent assigned Concurrent Review date will be provided by the Medical Management Department staff.

- Information required from hospital providers to conduct Concurrent Review:
 - Date and time
 - Authorization number
 - Member name, date of birth, and ID number
 - Admitting facility and admitting Physician
 - Date of admission and admission diagnosis
 - Reviewer's name and contact information
 - Abnormal vital signs
 - Abnormal lab results including cultures
 - Imaging results including CXR, CT, MRI/MRA
 - Current Orders/Plans/Management
 - Any unplanned surgeries, complications, etc
 - Anticipated length of stay
 - Discharge plans/needs
 - Needed outpatient referrals

Newborn Notification

- Information required from hospital providers to give notice of new births:
 - Mother's information:
 - Mother's name, Member ID number, date of birth and contact information
 - Facility name
 - Reviewer's name and contact information
 - Date of admission
 - Date of Discharge
 - Diagnosis (vaginal or c-section delivery)
 - Attending physician
 - Baby's information:
 - Mother's name and Member ID number
 - Baby's name, sex, and date of birth
 - Baby's weight and Apgar score
 - Discharge/NICU/Detained
 - Attending physician
 - Baby's primary care physician (if known)

Preferred Modes of Data Submission to GHP Family Medical Management

- Electronic Medical Record (EMR) – If your office or facility has EMR capability and would like to coordinate precertification and Concurrent Review with GHP Family using EMR, please contact your assigned GHP Family Medical Management Reviewer. *Please note: Do not send the entire chart.* Only send the applicable information such as admission history and physical, pertinent lab and test information, physician progress notes, etc.
- E-mail – Send a brief email containing only pertinent information to GHP_MM_AUTH@geisinger.edu. In the subject line of the email, please identify your submission as one of the following:
 - Inpatient Planned Precertification
 - Inpatient Admission Notification
 - Concurrent Review
 - Newborn Notification
- Facility Specific Forms – If your facility currently uses a form that captures the required data, GHP Medical Management will accept these forms via fax at (570) 271-5534 or email at GHP_MM_AUTH@geisinger.edu.

Please note: GHP Family Medical Management staff is available to assist with discharge planning, especially for complex or hard to place Members.

Inpatient Rehabilitation Admissions

Request for precertification of an inpatient rehabilitation admission is the responsibility of the admitting Participating Provider.

Please note: Precertification is not required when GHP Family is secondary to another payer who requires precertification and authorization has been obtained from the primary carrier. However, Concurrent Review is required. Copayments are the financial responsibility of the Member, when applicable. This may be a limited benefit.

Requesting Precertification

Inpatient rehabilitation admissions are required to be precertified no less than two (2) Business Days prior to the planned date of admission.

Submit the Inpatient Rehabilitation Precert Worksheet via fax to (570) 271-5534. The Inpatient Rehabilitation Precert Worksheet is available online at www.ghpfamily.com or by calling the Medical Management Department at (800) 544-3907.

GHP Family will only accept the Inpatient Rehabilitation Precert Worksheet as appropriate fax precertification request documentation. Utilization of the Inpatient Rehabilitation Precert Worksheet will ensure GHP Family receives all applicable information. No other forms or alternative fax processes will be accepted unless mutually agreed upon by GHP Family in advance.

The Inpatient Rehabilitation Precert Worksheet must be legible and all areas applicable to the admission must be completed. GHP Family will be unable to accurately process incomplete or illegible worksheets, which may result in unnecessary denials.

Participating Providers are required to notify GHP Family within one (1) Business Day of an inpatient rehabilitation admission that occurred during non-business hours utilizing the fax process listed above. The Medical Management

Department will complete a clinical review and authorize or deny the admission retrospectively pursuant to the Member's condition at the time of the admission.

Concurrent Review

Participating Providers are required to contact the Medical Management Department within one (1) Business Day of any inpatient rehabilitation admission at (800) 544-3907 to verify admission and establish the next review date. Each rehabilitation admission is subject to the Concurrent Review process.

During Concurrent Review a determination of continued coverage and a subsequent assigned Concurrent Review date will be provided by the Medical Management Department staff. The following information will be discussed during the initial Concurrent Review:

- current inpatient care needs
- plan of care
- overall goals and anticipated length of stay (if known)
- discharge planning

Skilled Level of Care Admissions

Requesting Precertification

SNF or hospital Participating Providers accepting skilled admissions are responsible for requesting precertification by contacting the Medical Management Department anytime by faxing pertinent clinical information to the fax number below. *Please note:* Only fax the pertinent information; do not fax an entire chart.

GHP Family Medical Management Department
Fax: (570) 271-5534

Precertification must be requested no less than two (2) Business Days prior to admission unless the Member is being admitted from the Emergency Department or home. Requests received after 3 p.m. may be pended to the next Business Day. *Please note:*

- A three (3) day hospital stay is not required by GHP Family prior to a skilled admission.
- Specialty consultative, surgical, and evaluation/management services provided in the skilled or Intermediate level of Care setting do not require an Outpatient Referral Form to be issued by a Member's PCP.
- Precertification is also required when GHP Family is not the Member's primary insurance coverage.
- Copayments are the financial responsibility of the Member, when applicable.

SNF or hospital providers are required to notify GHP Family within one (1) Business Day of a skilled level of care admission that occurred during non-business hours (Monday through Friday 4:30 p.m. to 8:00 a.m., or on a weekend or Holiday (New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day and Christmas Day).

The Medical Management Department will complete a clinical review, and authorize or deny the admission retrospectively pursuant to the Member's condition at the time of admission. If the admission is denied, GHP Family will send the Member the appropriate denial notice with appeal rights information in the required timeframes; a copy will be sent to the requesting Participating Provider.

GHP Family is responsible for payment for up to thirty (30) days of nursing home care (including hospital reserve or bed hold days) and for notifying the Department in accordance with the Department's disenrollment guidelines if a

Member is admitted to a Nursing Facility. FFS is financially responsible for nursing home care effective on the 31st day following admission to the Nursing Facility.

Information Required when Requesting Precertification

The information below should be readily available when the accepting SNF or hospital provider initiates the request for precertification:

- Demographics: Member's name, GHP Family identification number, admission date, admitting Participating Provider's full name, SNF or hospital provider and Member's PCP, with requestor's name, fax number and telephone number.
- Reason for Admission: objective, subjective findings, and Member's primary diagnosis.
- Clinical Findings: current functional status and rehabilitative therapy evaluations or recommendations (if known).
- Area Agencies on Aging (AAA)/OPTIONS Assessment and Pre-admission Screening.
- Previous Clinical Findings: level of functioning and anticipated disposition (if known).
- Anticipated plan of care.

Concurrent Review of a Skilled Admission

Initial Concurrent Review: SNF or hospital providers are required to initiate Concurrent Review with the Medical Management Department staff within two (2) Business Days of the skilled admission. All skilled admissions will be subject to the Concurrent Review process, including SNF admissions where GHP Family is not the Member's primary insurance coverage, as well as a Member who transfers from one SNF or hospital provider to another SNF or hospital provider. During Concurrent Review, a determination for continued coverage at the appropriate level of care and a subsequent assigned Concurrent Review date will be provided by the Medical Management Department staff.

The following Member information will be discussed during the initial Concurrent Review:

- Verification of admission date and attending physician.
- Current skilled needs to include skilled nursing and/or therapies.
- Rehabilitative therapy evaluations and plan of care (if appropriate), and
- Overall goals and anticipated length of stay (if known).

Subsequent Concurrent Review: Subsequent Concurrent Review is required to occur telephonically or by fax with the assigned Medical Management Department staff.

The following Member information will be discussed during each subsequent Concurrent Review:

- Skilled nursing or therapy updates including quantitative progress toward goals (nursing notes, therapy notes or logs may be requested by the Medical Management Department staff).
- A plan of care with anticipated disposition and estimated length of stay.

The Medical Management Department staff will authorize continued coverage as deemed Medically Necessary, confirm level of care and establish the date for next review.

Preferred Modes of Data Submission to GHP Family Medical Management

- Electronic Medical Record (EMR) – If your office or facility has EMR capability and would like to coordinate precertification and Concurrent Review with GHP Family using EMR, please contact your assigned GHP

Family Medical Management Reviewer. *Please note: Do not send the entire chart.* Only send the applicable information such as admission history and physical, pertinent lab and test information, physician progress notes, etc.

- E-mail – Send a brief email containing only pertinent information to GHP_MM_AUTH@geisinger.edu. In the subject line of the email, please identify your submission as one of the following:
 - Inpatient Planned Precertification
 - Inpatient Admission Notification
 - Concurrent Review
 - Newborn Notification
- Facility Specific Forms – If your facility currently uses a form that captures the required data, GHP Medical Management will accept these forms via fax at (570) 271-5534 or email at GHP_MM_AUTH@geisinger.edu.

PCP Management

Members admitted to a SNF or hospital provider under a skilled or intermediate level of care do not require an Outpatient Referral Form for services rendered in the facility setting, however, for services required outside the skilled or intermediate care setting an Outpatient Referral Form issued by a Member's PCP is required.

SNF Services Requiring Coordination

- **Hospice Election:** The SNF or hospital provider is required to notify GHP Family's Home Health/Hospice Management Department at (877) 466-3001 immediately upon a Member's decision to invoke their hospice benefit. Notification should also be made to GHP Family's Medical Management Department at (800) 544-3907.
- **Personal Care Facility:** GHP Family does not consider a Personal Care Facility (PCF) an institutionalized facility, regardless of a PCF's affiliation with a SNF or hospital provider. A PCF is considered an alternative to home living. Excluding Emergency Services and Direct Access Services, Members residing in a PCF require an Outpatient Referral Form issued by the Member's PCP for Specialty consultative, evaluation and management and surgical services.
- **Infusion Therapy Services:** Participating Providers are encouraged to refer to their Agreement for specific information regarding the reimbursement inclusions/exclusions for infusion therapy services. Questions regarding infusion therapy services should be reviewed during the Concurrent Review process with the Medical Management Department.
- **Mental Health and Substance Abuse Services:** Participating Providers may assist Members in obtaining authorization and coordinating mental health and substance abuse services. Refer to the reverse side of the Member's Identification Card for the applicable mental health and substance abuse vendor's name and telephone number or contact the applicable Customer Service Team for further assistance.
- **Laboratory/Pathology Services:** All laboratory/pathology specimens for Members admitted to a SNF/hospital under any level of care must be forwarded to a Participating Provider for analysis.
- **Home Phlebotomy Services:** Home phlebotomy services for Members residing in a PCF who meet homebound criteria must be coordinated through the Home Health/Hospice Management Department. Please refer to the portion of this section titled "Home Health and Home Phlebotomy Services" for specific information.
- **Radiology Services:** All radiology and mobile radiology services, excluding routine chest x-rays, for Members admitted to a SNF must be coordinated with a radiology Participating Provider. A complete listing of radiology Participating Providers can be located at www.ghpfamily.com.

A Participating Provider rendering outpatient physical, occupational and speech therapy services should refer to the section of this Manual titled “Outpatient Physical, Occupational and Speech Therapy Services” for specific instruction regarding GHP Family’s policy and procedure for coordinating outpatient rehabilitative therapy services.

Precertification of outpatient physical, occupational and speech therapy services is the responsibility of the rehabilitative Participating Provider (or designee) rendering the service.

SNF or hospital providers who do not have an Agreement to provide outpatient physical, occupational and speech therapy services must ensure such services are arranged with an outpatient rehabilitative therapy Participating Provider. A listing of outpatient rehabilitative therapy Participating Providers can be located in the then current Provider List or at www.ghpfamily.com.

Notification of a Non-Skilled Admission

Prior to a non-skilled admission and again upon discharge of a Member, SNF or hospital provider accepting the admission is required to notify the Medical Management Department. Failure to notify GHP Family of a non-skilled admission or discharge may reflect non-compliant behavior and result in GHP Family administrative action.

Home Health/Hospice, Home Infusion and Home Phlebotomy Services

Referrals for home health/hospice services and/or home phlebotomy services are the sole responsibility of the rendering home health/ hospice Provider or home phlebotomy Participating Provider.

Please note:

- Certain Home Infusion services may require precertification. Providers should contact VITALine Pharmacy Services at (800) 527-6249 or fax a Referral to (570) 271-5843.
- Precertification/Referral is also required when GHP Family is not the Member’s primary insurance coverage.
- Copayments are the financial responsibility of the Member, when applicable.

Home Health/Hospice Services Referral Process

When a Member requires home care services, a Participating Provider should issue a written or verbal order to the applicable home care services Participating Provider. Home health/hospice providers utilize a referral process to initiate the request for additional visits within one (1) Business Day of completion of the admission assessment.

The mechanism utilized by the home health/hospice provider when initiating a referral to the Medical Management Department’s Home Health/Hospice Management Department is the Home Health/Hospice Management Department Referral Form. Home phlebotomy Participating Providers should utilize a mutually agreeable form approved by the Home Health/Hospice Management Department when initiating a referral.

The Medical Management Department’s Home Health/Hospice Management Department requires notice of election, revocation, transfer, or death. Standard CMS or provider forms will be accepted.

Hospice Election and Notice

When a Member elects hospice services, the hospice must complete an election notice. In addition, the hospice must complete a change form when the election is for a patient who has changed an election from one hospice to another. The hospice provider is responsible for submitting all hospice forms to GHP Family.

When hospice coverage is elected, the beneficiary waives all rights to standard coverage payments for services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an attending physician, which may include a nurse practitioner.

To be covered, hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and; a certification that the individual is terminally ill must be completed by the patient's attending physician (if there is one), and the Medical Director. Nurse practitioners serving as the attending physician may not certify or re-certify the terminal illness. A plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care. Certification of terminal illness is based on the physician's or medical director's clinical judgment regarding the normal course of an individual's illness. It should be noted that predicting life expectancy is not always exact.

Completing the Home Health/Hospice Management Department Referral Form

The applicable forms are required to be completed in their entirety and must be submitted prior to rendering services and no later than within one (1) Business Day of completion of the admission assessment. Referrals should be submitted by facsimile to GHP Family's Medical Management Department's Home Health/Hospice Management Team at (570) 271-5507.

GHP Family Medical Management Department
Home Health/Hospice Management Team
(877) 466-3001 or (570) 271-5506
Fax: (570) 271-5507
Monday through Friday 8:00 a.m. to 4:30 p.m.

Medical Management Department Home Health/Hospice Management Determination

The Medical Management Department's Home Health/Hospice Management Team will typically return processed referral forms to the applicable home care services Participating Provider within one (1) Business Day of receipt of the referral request. In the event additional clinical information or Medical Director review is required to make a determination, the timeframe may be extended. If this occurs, the Medical Management Department will provide verbal or written update to the requesting applicable home care services Participating Provider.

Questions regarding an extension of an existing authorization may be directed to the Home Health/Hospice Management Department.

Concurrent Review Process

Concurrent Review is required on all home health services. The home health provider is required to contact the Medical Management Department's Home Health/Hospice Management Team to provide clinical information including a Member's treatment plan. Based on Concurrent Review, a determination of continued coverage will be provided by the Home Health/Hospice Management Department.

Home phlebotomy services are discontinued when concurrent home health services end, unless unique circumstances warrant continued consideration for coverage.

Medical Management Department's Home Health/Hospice Management Team utilizes nationally recognized guidelines as well as internal medical benefit policies, and other resources to guide Concurrent Review and Retrospective Review processes in accordance with the Member's applicable benefit document and eligibility.

Discharge Notification of Home Health and Hospice Services Ending

As designated by the Medical Management Department's Home Health/Hospice Management Team, the home health/hospice provider will provide verbal or written periodic progress reports to the Home Health/Hospice Management Department for each Member under the home health/hospice provider's care. In order to provide continuity of care, the Home Health/Hospice Management Department requires a discharge notification via fax or

phone to the Medical Management Department's Home Health/Hospice Management Team within one week of discharge.

Hospice Admission Criteria

- Hospice eligibility is determined after the referring physician verifies that Member's life expectancy is less than six (6) months.
- Member chooses to accept hospice.
- Hospice services are provided by a hospice provider.
- Acknowledgment that Member understands hospice services, as outlined in the Hospice Election Form.
- Regular GHP Family benefits are waived for care related to the terminal illness diagnosis.
- Member agrees to palliative care treatment.

Hospice Discharge

The hospice provider will discharge any Member from the hospice program, who, as determined by the hospice Medical Director and hospice provider, no longer meets the hospice admission criteria.

Hospice Forms Description

Hospice form(s) are required to be submitted to the Home Health/Hospice Management Department by facsimile at (570) 271-5507.

Programs Available through Medical Management Department's Home Health/Hospice Management Team

The Medical Management Department's Home Health/Hospice Management Team has established the following programs to effectively serve specific populations of Members.

- **Post-Partum Early Discharge Home Care:** The Home Health/Hospice Management Department has established specific guidelines for approval of home health services for mothers and infants discharged from the hospital less than forty-eight (48) hours after a vaginal delivery or less than ninety-six (96) hours after a cesarean section. Time limits of covered services are in accordance with regulatory requirements. Infants requiring follow-up care for elevated bilirubin levels are eligible for home health Services provided home phototherapy is being utilized.
Please note: Home phototherapy should be arranged through a DME Participating Provider. Coverage is subject to medical necessity.
- **Orthopedic Joint Recovery:** The Medical Management Department's Home Health/Hospice Management Team has implemented a program for Members undergoing elective joint replacement surgery (i.e., hip, knee). Upon a scheduled operative date, a home health visit may be ordered by a Participating Provider to enroll the Member in the joint-recovery home program. One (1) physical therapy home visit is scheduled within seven (7) to fourteen (14) days preoperatively to educate a Member about pain management and exercises, as well as conduct a home safety evaluation. The visit documentation should be faxed as directed within one Business Day of the pre-operative visit so that it can be utilized for discharge planning. Following the surgery and upon discharge to home, the rendering agency would resume home health services. The Home Health/Hospice Management Department Community Case Manager will coordinate home health services with the same Participating Provider. Additional home health services will be tailored to the Member's individual needs.
- **Home Management of Deep Vein Thrombosis (DVT):** Through new technology and pharmaceutical alternatives to IV anticoagulation, Members can be instructed in subcutaneous home administration of low molecular weight heparin products. After a first dose administration in a controlled setting, such as the physician office, care can be coordinated for home drug delivery. Education on self-administration will be conducted by a registered nurse from a home health provider.

For more information about the above listed programs or to make recommendations for a new program(s), please contact the Home Health/Hospice Management Department at (877) 466-3001 or (570) 271-5506.

Durable Medical Equipment (“DME”)

Precertification and Concurrent Review for outpatient DME services are the sole responsibility of the rendering DME Participating Provider. DME Participating Providers are required to submit the applicable precertification forms to the Medical Management Department’s DME Management Department when all documentation required by traditional Medicare can be provided with the request. This includes urgent DME requests (i.e., oxygen) received during the DME Management Department’s non-business hours. A coverage decision provided by the DME Management Department is required in advance of release, delivery or purchase of DME, except in the case of after-hours or weekend urgent DME requests (i.e., oxygen). Items delivered prior to determination of coverage by GHP Family require clear and detailed advance notice of potential cost with signature of insured. No reimbursement will be provided for delivery of purchased items without such advance notice and signature.

Please note:

- Precertification is also required when GHP Family is not the Member’s primary insurance coverage.
- Prosthetic and orthotic devices are not considered DME and do not require precertification.
- Copayments are the financial responsibility of the Member, when applicable.

When a Member requires outpatient DME, a Participating Provider should issue a verbal or written order to a DME Participating Provider that includes the following:

- **Member Demographics:** Member’s name, primary residence address, telephone number, and GHP Family identification number.
- **Requested DME service/item.**
- **Clinical Findings:** Diagnosis and applicable diagnosis code.
- **Prescribing or ordering Participating Provider name and telephone number.**
- **Anticipated duration of DME need.**
- **Additional clinical information** to support request for DME.

DME Participating Providers are can be found on www.ghpfamily.com. Participating Providers with questions related to outpatient DME authorization or precertification may contact the GHP Family Medical Management Department at the following:

GHP Family Medical Management Department
Monday through Friday, 8:00 a.m. to 4:30 p.m.
(866) 248-1972 or (570) 271-7127
Fax: (570) 271-7171

Consignment DME

Consignment DME provided by a non-branch location (i.e., physician office stocked with DME by a DME Participating Provider) are limited to those approved in advance by the Medical Management Department. No purchased items with value greater than \$100 can be provided on a consignment basis. The scheduled delivery date should be the dispense date appearing on the applicable precertification form(s). Consignment DME provided by a non-branch location is required to be submitted for Retrospective Review within thirty (30) days of issuance utilizing the applicable precertification form(s). The form must be clearly marked to show “consignment” with clear indication of the date equipment was provided to the Member. Misrepresentation of issue date will result in denial of payment and the Member will not be held liable for payment in these circumstances.

Completing Medical Management Department's DME Management Department Precertification Form

All Medical Management Department's DME Management Department precertification forms are required to be completed and submitted within **one (1) Business Day** of receipt of the written or verbal order issued by a provider, via facsimile to the Medical Management Department at (570) 271-7171. Required fields are marked with an asterisk (*).

- **Precertification Form 1:** General Request for DME: This form is required to be completed and submitted for each initial precertification request for outpatient DME.
- **Precertification Form 2:** Oxygen/Continuous Positive Airway Pressure (CPAP) Device Request: Upon DME Participating Provider's receipt of a written or verbal order issued by a provider for oxygen or CPAP, both the General Request Precertification Form 1, as well as the Oxygen/CPAP Prescription Precertification Form 2 is required to be completed in their entirety. Both precertification forms are required to be submitted by facsimile to the DME Management Department within one (1) Business Day of receipt of the written or verbal order issued by a provider.
CPAP units must be dispensed with two (2) smart cards. Payment will be denied if this requirement is not met. Patient education material provided by the DME Management Department should be included with every oxygen and CPAP delivery.
- **Precertification Form 3:** Respiratory Assist Device: Upon DME Participating Provider's receipt of a written or verbal order issued by a Participating Provider for respiratory assistance device(s) both the General Request Precertification Form 1, as well as the Respiratory Assist Device Precertification Form 3, is required to complete in their entirety. Both precertification forms are required to be submitted by facsimile to the DME Management Department within one (1) Business Day of receipt of the written or verbal order issued by a provider.
- **Precertification Form 4:** Multiple HCPCS Code: In the event a DME Participating Provider is initiating a request for precertification which has more than four (4) requested DME services, both the General Request Precertification Form 1, as well as the multiple HCPCS Code Form 4, is required to be completed in its entirety.

Both precertification forms are required to be submitted by facsimile to the Medical Management Department within one (1) Business Day of receipt of the written or verbal order issued by a provider.

Medical Management Department DME Determination

The Medical Management Department will return an authorization report to the DME Participating Provider within two (2) Business Days of receipt of the precertification request. In the event additional clinical information or Medical Director review is required to make the determination, the Medical Management Department will request necessary information from the DME Participating Provider within forty-eight (48) hours of receiving the request and will allow fourteen (14) days for the DME Participating Provider to submit the additional information. GHP Family will notify the Member of this request for additional information using the Department's notification template. Medical Management Department review will not exceed twenty-one (21) days. The Medical Management Department will provide a verbal and written determination to the Member and the requesting DME Participating Provider. If the request is denied, GHP Family will send the Member the appropriate denial notice with appeal rights information in the required timeframes; a copy will be sent to the requesting provider. The authorization report will be returned and include the following: 1) DME by HCPCS code and modifier specificity and 2) quantity of DME and 3) authorized date range of DME, if applicable. For items that are provided on a recurring basis, including but not limited to DME accessories or ostomy and urological supplies, the general rule is that providers may dispense no more than a three (3) month supply at any one time. Surgical dressings may be dispensed only one month at a time; less in the early or late course of treatment when needs may change based on an improving or worsening condition or the type of the supply may be expected to change.

Please note: Questions regarding an authorization may be directed to the Medical Management Department. Participating Providers must contact the Medical Management Department via phone if they have not received a response within two (2) Business Days, in order to confirm that the precertification form was received. An interactive voice recording (IVR) is in place to accept these calls.

- **Form 6:** Request to Modify Previously Authorized Outpatient DME. In the event a DME Participating Provider requests a modification of an existing Medical Management Department determination, a completed Change Form is required and should be submitted to the Medical Management Department by facsimile. A Change Form may be completed for the following purposes which include, but are not limited to:
 - Return of DME to the DME Participating Provider (i.e., physician order discontinued, Member expired, Member elected hospice benefit, Member voluntary discontinuation; DME Participating Provider should not state, “no longer using”).
 - Actual date of service changed from the initial anticipated delivery date.
 - Change to an initial DME request.
 - HCPCS coding change.
 - Member identification correction.
- **Form 7:** Extension of an Existing Authorized Outpatient DME: DME Participating Providers are required to request an extension of an existing authorization decision, as applicable, prior to the expiration date indicated on the returned original authorized precertification form. This extension request is initiated by the DME Participating Provider via the DME Recertification Form. The DME Recertification Form should be completed in its entirety and submitted via facsimile no sooner than two (2) weeks before the end of an authorization period, but no later than one (1) Business Day prior to the expiration date.

Outpatient Physical, Occupational and Speech Therapy Services

Precertification and Concurrent Review for outpatient rehabilitative services are the sole responsibility of the rendering Outpatient Therapy Participating Provider.

Please note:

- An Outpatient Referral Form is not required when ordering outpatient rehabilitative therapy services, however, the completion and submission of GHP Family designated form(s) by the outpatient rehabilitative therapy Participating Provider are required as outlined in this Manual.
- Precertification and Concurrent Review are also required when GHP Family is not the Member’s primary insurance coverage or when workers’ comp or auto insurance may be primary.
- Co-payments are the financial responsibility of the Member, when applicable.

A Participating Provider should issue a signed written order to an outpatient rehabilitative therapy Participating Provider when a Member requires outpatient physical, occupational and/or speech therapy services. Outpatient rehabilitative therapy Participating Providers can be located online at www.ghpfamily.com. Outpatient rehabilitative therapy Participating Providers are required to initiate the request for services within seven (7) calendar days of the initial rehabilitative evaluation by submitting the Outpatient Rehabilitative Therapy Precertification Form A (available online at www.ghpfamily.com) and the prescribing physician’s order via fax submission. If Form A does not have Section 1 completed in its entirety, it will be considered incomplete.

Participating Providers with questions related to outpatient rehabilitative therapy authorization may contact the Medical Management Department at the following telephone numbers:

GHP Family Medical Management Department
Monday through Friday, 8:00 a.m. to 4:30 p.m.

(800) 270-9981 or (570) 271-5301
Fax: (570) 271-5302

An outpatient rehabilitative therapy Participating Provider is encouraged to begin rehabilitative services upon the initial evaluation of a Member. Requests received seven (7) calendar days beyond the date of service will be denied. The prescribing physician's order for rehabilitative services is required to be faxed to the Medical Management Department with Precertification Form A.

Please note: A maximum of two (2) outpatient rehabilitative visits will be authorized upon receipt of only Section 1 of Precertification Form A.

Concurrent Review

All services beyond the initial review by GHP Family will require Outpatient rehabilitative therapy Participating Providers to complete Outpatient Rehabilitative Therapy Precertification Form B (available online at www.ghpfamily.com) in its entirety and submit via facsimile when additional rehabilitative visits beyond those previously authorized are being requested. Forms without complete visits to date will be considered incomplete. Specific measurements and/or functional assessments are highly encouraged in order to make an optimal determination of progress toward goals, as well as for determination of ongoing need.

Medical Management Department Determination

Whenever possible, the Medical Management Department will return processed form(s) by facsimile to the Participating Provider within two (2) Business Day of receipt of the precertification request. In the event additional clinical information or Medical Director review is required to make the determination, the Medical Management Department will request necessary information from the Participating Provider within forty-eight (48) hours of receiving the request and will allow fourteen (14) days for the Participating Provider to submit the additional information. Failure to do so could result in Denial of Services provided without authorization. GHP Family will notify the Member of this request for additional information using the Department's notification template. Medical Management Department review will not exceed twenty-one (21) days in its decision to approve or deny a service or item and notify the Member and provider(s). The Medical Management Department will provide a verbal and written decision with appeal rights information in the required timeframe to the Member; a copy will be sent to the requesting DME Participating Provider. Medical Management Department authorization for pediatric Members with a diagnosis of autism, attention deficit hyperactivity disorder, cerebral palsy, developmental delay, Down's syndrome, pervasive Developmental Disability, and/or speech and language delay automatically expire at the end of the Member's benefit year. Participating Providers should initiate the request for precertification by completing and submitting Section 1 and 2 of Precertification Form A prior to the end of the Member's benefit year.

Outpatient Radiology and Imaging Services

Requesting Precertification

The ordering Participating Provider is required to contact GHP Family's contracted vendor, National Imaging Associates, Inc. (NIA), online through www.radmd.com or toll free at (866) 305-9729, 8:00 a.m. to 8:00 p.m. Monday through Friday to request precertification for an outpatient advanced diagnostic imaging service.

The ordering Participating Provider is responsible for obtaining precertification from NIA and providing the authorization number to the rendering Participating Provider in advance of an outpatient advanced diagnostic imaging service(s). *Please note:* If the request is urgent, please call NIA; do not submit the request online.

Urgent/non-emergency outpatient advanced diagnostic imaging services scheduled and performed after normal business hours, on weekends or holidays may be conducted by the rendering Participating Provider/facility as requested by the

ordering Participating Provider. However, the ordering Participating Provider must contact NIA within two (2) Business Days to obtain proper authorization for the service, which is subject to the normal review process.

It is the responsibility of the rendering Participating Provider to ensure that precertification through NIA has occurred and an authorization number has been provided for the ordered test prior to the rendering of an outpatient advanced diagnostic imaging service. NIA's Web site (www.radmd.com) is the most efficient way to confirm an ordered test has been authorized. Services performed that have not been properly authorized or exceed the authorization period will not be eligible for reimbursement and the Member cannot be balanced billed.

Information required when requesting precertification through NIA:

- Ordering physician's name, office and fax telephone numbers.
- Member's name and GHP Family identification number.
- Requested outpatient advanced diagnostic imaging service(s).
- Name and address of rendering Participating Provider's office or facility where the service will be performed.
- Anticipated date of service (if known).
- ICD-9 code.
- Third party insurance (if involved).
- Details justifying examination:
 - Symptoms and their duration
 - Physical Exam Findings
- Conservative treatment Member has already completed (i.e., physical therapy, chiropractic or osteopathic manipulation, hot pads, massage, medications).
- Preliminary procedures already completed (e.g., x-rays, CT's, lab work, ultrasounds, scoped procedures, SCP evaluations).
- Reason the study is being ordered (e.g., further evaluation, rule out a disorder, base new treatment, evaluation of current therapy or treatment).

Please be prepared to fax clinical notes, conservative treatment reports, and/or preliminary procedures, if requested. If a case has already been initiated but is pending additional clinical notes, the documentation should be faxed to (800) 784-6864, the number to NIA's Clinical Support Department (CSD) who will attach the notes to the case and route it for appropriate determination.

If it is a new case with no prior initiation, please call (866) 305-9729. Collecting the data NIA needs to address clinical algorithms verbally allows the process to flow more expediently.

Please note: Ordering Participating Providers can initiate authorization for several Members during a single telephone call, which is referred to as "batch authorization".

NIA's Prior-Authorization guidelines are available under the Geisinger Health Plan/GHP Family section of NIA's website at www.RadMD.com.

Ambulance

GHP Family's contracted ambulance management vendor, Medical Transportation Management, Inc. (MTM) will coordinate and reimburse Medically Necessary ambulance transportation for GHP Family Members. **Members experiencing a medical emergency are instructed to immediately contact their local emergency rescue service – 911.**

GHP Family will assist Members in accessing non-emergency transportation services for physical health appointments through the Medical Assistance Transportation Program (MATP). However GHP Family is not financially responsible for payment for these services. Members should be advised to contact the BH-MCO in their county of residence for assistance in accessing non-emergency transportation for behavioral health appointments. Please refer to the Contact Information section of this manual for MATP contact information by county.

Requesting Non-Emergency Ambulance Precertification

The ordering Participating Provider is required to contact GHP Family's contracted vendor, MTM, online through www.ambulance.mtm-inc.net or toll free at (888) 409-6881 (twenty-four (24) hours/day, seven (7) days/week) to request non-emergent ambulance transportation for GHP Family Members.

Requesting a Non-Emergency Ambulance

There are three ways to secure non-emergent ambulance transportation through MTM for GHP Family Members in your care:

1. Online (recommended)
 - a. Complete the online Ambulance Certification Statement (ACS) form at: www.ambulance.mtm-inc.net.
 - b. Once the form data is processed, a MTM care manager will contact the ordering provider with information about the assigned ambulance provider or the reason prior-authorization was denied.
2. Fax
 - a. Complete a hard-copy ACS (attached on page 3 of this bulletin).
Please Note: The ordering provider must sign the ACS for it to be considered complete.
 - b. Fax the completed ACS to (866) 453-0247. Once the form data is processed, a MTM care manager will contact the ordering provider with information about the assigned ambulance provider or the reason prior-authorization was denied.
3. Phone
 - a. Contact MTM's call center at (888) 409-6881. Follow the prompts to request ambulance transportation.
 - b. A MTM care manager will fax an ACS to the ordering provider.
 - c. Complete the ACS. The ordering provider's signature is required.
 - d. Fax the completed ACS to (866) 453-0247. Once the form data is processed, a MTM care manager will contact the ordering provider with information about the assigned ambulance provider or the reason prior-authorization was denied.

When an order for non-emergent ambulance transportation is denied by MTM, the appropriate denial notice with appeal rights will be sent to the Member in the required timeframes; a copy will be sent to the requesting Participating Provider.

Initiation of Non-Emergency Transport Services

Upon ordering provider request for Prior Authorized ambulance transport services, MTM will contact the ambulance provider's dispatcher or non-emergency ambulance coordinator to arrange a pre-scheduled pickup time or to request the next available ambulance. MTM will communicate the following during the call:

- Prior authorization Number
- Pickup address (room or office location if applicable)
- Drop off location (room or office location if applicable)
- Patient Information
- Primary Diagnosis
- Mileage Approval
- Service Level Approval
- Other pertinent information (e.g., infection precautions)

Please Note: If the ambulance provider’s dispatcher or non-emergency ambulance coordinator receives a request for non-emergency transport for a Member, please direct the caller to the MTM Call Center at (888) 409-6881.

Requests for Level of Service Upgrade

An ambulance provider request for an upgrade to a previously agreed upon level of service must have prior approval from MTM. This includes any of the following examples:

- Basic Life Support (BLS) to Advanced Life Support (ALS)
- ALS to Specialty Care Transport (SCT)
- Additional staff or assist units as may be needed for bariatric transfers, etc.

Completion of Transport Services

Once transport services are completed, the ambulance provider’s dispatcher or non-emergency ambulance coordinator should contact MTM to verify the level of service, report loaded miles, and/or discuss any complications (including reasons for variations in mileage).

More detailed information regarding authorization of non-emergent medical transportation through MTM for GHP Family Members (including the MTM/GHP Ambulance Provider Manual) is available at www.ghpfamily.com or by calling your GHP Family Provider Relations Representative at (800) 876-5357.

Specialty Pharmacy Vendor Program

Certain prescription and injectable drugs are covered only through the Specialty Pharmacy Vendor Program. For more detail and a complete list of drugs available through this program, refer to www.ghpfamily.com.com, or call the GHP Family Pharmacy Department at (855) 552-6028. Medication requests are the responsibility of the prescribing Participating Provider.

Please note: Precertification may be required for certain drugs. Please refer to the section titled “Other Services Requiring Precertification” within this Manual for further information.

Specialty Pharmacy Vendor Program Process

To initiate the program, the prescribing Participating Provider is required to complete GHP Family’s Specialty Pharmacy Vendor Request Form and fax it to GHP Family Pharmacy Department at (570) 271-5610. Telephone orders will not be accepted or processed. The Specialty Pharmacy Vendor Request Form and other information regarding the Specialty Pharmacy Vendor Program can be found online at www.ghpfamily.com under “Formulary Information.”

Notification Process

Upon receipt of the Specialty Pharmacy Vendor Program Request Form, the Pharmacy Department will:

- verify the Member’s eligibility and benefits.
- review the form to ensure appropriate information has been provided.
- Perform precertification if required.
- if approved, forward the form to GHP Family’s contracted specialty vendor.
- if denied, GHP Family will send the Member a denial notice with appeal rights information in the required timeframes and send a copy to the prescribing provider.

The vendor will process the request and ship the medication to the destination (i.e., provider’s office, Member’s residence, etc.) identified on the form within forty-eight (48) hours.

Pharmacy Department
(855) 552-6028 or (570) 214-3554
Monday – Friday 8:00 a.m. - 5:00 p.m.
Fax: (570) 271-5610

Outpatient Prescription Drugs

GHP Family utilizes a Formulary for purposes of Member care through the rational selection and use of medications, and to ensure quality, cost-effective prescribing. The Formulary is developed with the input of practicing physicians and pharmacists. Medications in each therapeutic class have been reviewed for efficacy, safety, and cost. Maintenance of the Formulary is a dynamic process; the Pharmacy and Therapeutics Committee continually review new medications as well as information related to medications currently included in the Formulary.

- **GHP Family:** The GHP Family benefit includes coverage only for prescription and over-the-counter (OTC) drugs listed in the Formulary. Formulary exceptions may be granted on a case by case basis.
 - Tier 1—Includes Generics. Prior authorization may be necessary.
 - Tier 2—Includes Brand name drugs. Prior authorization may be necessary.

The most current GHP Family Formulary is available online at www.GHPFamily.com.

Non-Formulary medications: The Formulary is designed to meet most therapeutic needs of the population served by GHP Family. Occasionally, because of allergy, therapeutic failure, or a specific diagnostic-related need, Formulary medications may not meet the special needs of an individual Member. In these special instances, the prescribing physician may make requests to the GHP Family Pharmacy Department for non-Formulary or restricted medications through the exception process. The prescribing physician will receive written documentation and/or a verbal response from the GHP Family Pharmacy Department regarding the request. Under the GHP Family plan, non-Formulary medications not requiring an exception will be available at the appropriate copayment tier (Tier 1 – generic; Tier 2 – brand).

Formulary addition requests: Requests for changes or additions to the Formulary can be made by written request to the GHP Family Pharmacy Department at the address listed below. Any additions or deletions to the Formulary may be found in the publication *Briefly*, which is issued quarterly to Participating Physicians.

Geisinger Health Plan
Pharmacy Department
100 North Academy Avenue
Danville, PA 17822-3246
(855) 552-6028; (570) 214-3554
Fax: (570) 271-5610

Pharmacy Formulary Prior Authorization and non-Formulary Exception Process

GHP Family's Pharmacy Department maintains a process by which Health Care Providers can:

- Request Prior Authorization for medications designated in the Formulary as requiring such. Drugs that require Prior Authorization are designated in the Formulary with a "PA" indicator.
- Request a Formulary exception for specific drugs, drugs used for an off-label purpose, and biologicals and medication(s) not included in GHP Family's then current drug Formulary.

Requesting Prior Authorization

Prior authorization forms can be found at www.ghpfamily.com. Health Care Providers can initiate such requests by contacting the Pharmacy Department by telephone, fax or written request at the following:

Geisinger Health Plan Pharmacy Department
100 North Academy Avenue
Danville, PA 17822-3246
(855) 552-6028 or (570) 214-3554
Monday – Friday 8:00 a.m. - 5:00 p.m.
Fax: (570) 271-5610

Information required to process the request includes:

- Caller's name and telephone number.
- Member's GHP Family identification number and, if applicable medical record number.
- Prescribing Health Care Provider's name and telephone number.
- The medication requested.
- Supporting clinical rationale, which may include, but is not limited to, relevant pages from the medical record, laboratory studies, prior medication treatment history and other documentation, as determined by GHP Family to be relevant.

Prior authorization requests will be addressed within twenty-four (24) hours of the request being made. If a determination cannot be made in twenty-four (24) hours, the pharmacist will dispense either a seventy-two (72) hour supply for new or emergency medications or a fifteen (15) day supply for ongoing treatment. This does not apply if the pharmacist determines that taking the medication would put the Member at risk.

Exception Determination Process

Formulary exception requests will be evaluated and a determination of coverage made utilizing all the following criteria:

- Member's eligibility to receive requested services (enrollment in the plan, prescription drug coverage).
- Utilization of the requested agent for a clinically proven treatment indication or diagnosis.
- Therapeutic failure, intolerance or contraindication to use of Formulary agent and/or agents designated as therapeutically equivalent.
- Appropriateness of the non-Formulary agent compared with available Formulary agents, including but not limited to:
 - Safety
 - Efficacy
 - Therapeutic advantage as demonstrated by head to head clinical trails
 - Meets GHP Family criteria for drug or drug class Formulary exception

If it is determined that additional information is needed, the prescribing Health Care Provider will be contacted within forty-eight (48) hours and appropriate medical record documentation and treatment information will be requested verbally and in writing. GHP Family will notify the Member of this request for additional information using the Department's notification template. A due date for the required information (fourteen (14) days from the date of the request) will be included in the verbal and written notifications. When all requested information has been received, it will be attached to a flow sheet for documentation as a pre or post-service request.

- If the required information is not received by the due date, a determination of coverage will be rendered based on the information available. Requests for exception are reviewed and a determination of coverage made within two (2) Business Days.
- If the required information is received by the due date, a determination of coverage will be made within two (2) Business Days of receipt of all necessary information.

A GHP Family Pharmacist will perform the initial review of the necessary information and assemble documents necessary to recommend a course of action. A licensed physician shall make the final decision in those instances where a Formulary exception decision results in a denial based on Medical Necessity and appropriateness. Based on the determination of coverage made, one (1) of the following will occur:

If the Formulary exception is approved:

- An electronic override will be entered into the pharmacy Claims adjudication system. The Member (or Member's authorized representative) and provider will be notified of the determination of coverage within twenty-four (24) hours of decision being made.
 - At the time of notification, GHP Family will indicate the coverage provided in the amount disclosed by GHP Family for the service requested.
- A written confirmation of the approval will be sent to the provider and Member within two (2) days after the determination of coverage is made.
- If the request for a Formulary exception is denied, resulting in an adverse benefit determination, the following will occur:
 - GHP Family will mail the appropriate denial notice with information on appeal rights and process to the Member (or Member's authorized representative) and copy the Provider, within twenty-four (24) hours.
 - The Member and provider will be verbally notified of the adverse determination within twenty-four (24) hours of the decision. This verbal notification will include instruction on how to initiate a Complaint or Grievance.
 - The prescribing Health Care Provider will be offered the opportunity to discuss the determination of coverage with a GHP Family Pharmacist or Medical Director.
 - The written denial notice and verbal explanation shall include:
 - a. The specific reason for the determination;
 - b. The basis and clinical rationale utilized in rendering the determination of coverage, if applicable;
 - c. Any internal policy or criterion applied, if applicable, and;
 - d. Instructions regarding initiation of the Complaint or Grievance.

Formulary changes are printed in the quarterly provider newsletter, *Briefly*, available online at www.ghpfamily.com. A minimum of thirty (30) days advance notice is provided to Participating Providers regarding Formulary changes, except when the Formulary change is due to the approval or withdrawal of a medication by the Food and Drug Administration.

Outpatient Laboratory and Radiology Services

Outpatient laboratory and radiology services may be:

- Provided by the Member's PCP.
- Ordered by the Member's PCP without the issuance of a referral to the laboratory or radiology Participating Provider.
- Ordered by a Participating Provider who has received an Outpatient Referral Form issued by the Member's PCP, which indicates "evaluate and treat." Providers are required to utilize a laboratory or radiology Participating Provider for such services.
- Ordered by a Participating Provider who has been Directly Accessed by a Member in accordance with the terms and conditions of coverage set forth in their benefit document(s).

Please refer to the GHP Family's Participating Provider search at www.ghpfamily.com for a list of laboratory and radiology Participating Providers.

Participating Providers are reminded that when ordering an outpatient MRA, MRI, CT Scan, PET Scan or nuclear cardiology services, precertification is required. Refer to the Section in Manual titled “Outpatient Radiology Services” for additional information.

Urgent/Emergency Services

PCP authorization and/or an Outpatient Referral Form are not required for Emergency Services. PCPs agree to have health care services available and accessible to Members, twenty-four (24) hours per day, and seven (7) days per week. When the PCP is not available and accessible to Member, the PCP is responsible for ensuring appropriate arrangements are made for another PCP to provide Health care services to Member, in accordance GHP Family Access and Availability Standards.

PCPs can utilize the following to ensure Members have access to medical direction or care:

- PCP can utilize an answering service that forwards callers (i.e., Members) directly to the PCP or a designated covering PCP for medical direction or care during PCPs non-business hours.
- PCP can utilize any other delivery method that would provide the Member with direct access to the PCP or designated covering PCP with medical direction or care during PCPs non-business hours.

Participating Provider’s specialty services immediately following an emergency department discharge or an inpatient hospital discharge, whether in or outside the mandatory post-operative period, excluding direct access services, require an Outpatient Referral Form issued by the Member’s PCP.

All out-of-Network services immediately following an emergency department discharge or an inpatient hospital discharge, require precertification.

Orthotic and Prosthetic Service

When an orthotic or prosthetic has been determined to be Medically Necessary, the prescribing Participating Provider should verify benefit and eligibility with the applicable Customer Service Team and then issue a written prescription in the Member’s name for the applicable device. Written prescriptions issued by a Participating Provider for the orthotic or prosthetic device should be kept on file in the Member’s medical record.

An Outpatient Referral Form is not required for an orthotic or prosthetic when ordered by a Member’s PCP; or an SCP acting upon a valid referral issued by a Member’s PCP, specifying request for “Evaluate and Treat.”

Orthotic or prosthetic Participating Providers can be found online at www.ghpfamily.com.

Behavioral Health and Substance Abuse Services

GHP Family encourages all health care providers to be cognizant of the impact that behavioral health problems may have on physical health, to treat the Member accordingly and to refer to, and coordinate with, a behavioral health specialist when necessary. Providers are encouraged to be holistic in their approach and to promote the integration of behavioral health and physical health services in their Member’s care. All contact with behavioral health providers needs to be conducted in accordance with state and federal privacy policies in effect at the time.

Coordination of care with behavioral health providers is strongly encouraged and especially important for Members who present with physical health problems in addition to:

- Chronic history of depression, anxiety or substance abuse/dependence.
- Multiple psychotropic medications.

- New prescriptions for atypical anti-psychotics and/or antidepressants when Member is taking medication for a medical condition.
- Those with a substance abuse problem and prescribed potentially addictive medication.
- Pregnant women who require medication to manage a behavioral health condition.
- Other conditions which may warrant this same coordination and collaboration of care between GHP Family providers and behavioral health providers.

Cooperation between Participating Providers and behavioral health practitioners is critical to the provision of effective and appropriate care. Participating Providers are expected to:

- Refer Members to appropriate behavioral health provider.
- Be available for consultation with the Member’s behavioral health practitioner.
- Seek release of information in cases of known behavioral health provider involvement.
- Abide by all privacy and confidentiality laws and regulations governing the sharing of Protected Health Information.
- Assess all pregnant Members for depression, substance abuse and other behavioral health problems as well as nicotine dependence.
- Closely monitor any Members with diagnosis of diabetes and schizophrenia with special attention to LDL-C and HbA1c.
- Coordinate and collaborate with behavioral health providers for those Members with chronic medical conditions such as, but not limited to, CAD, CHF, COPD, Diabetes, etc.

To refer GHP Family Members for these services, please reference the behavioral health contact information table in the Contact Information section of this manual for county, provider, and contact details. Members may also self-refer.

For state wide information visit: <http://pa.networkofcare.org>

To search for a Community Care Behavioral Health Organization provider visit: <http://www.ccbh.com>

Outpatient Dialysis Services

Dialysis services provided in an outpatient setting do not require a referral. However, an SCP ordering the dialysis services must have a valid referral from the Member’s PCP to “Evaluate and Treat.”

Experimental/Investigational or Unproven Services

Experimental, investigational or unproven services are any medical, surgical, psychiatric, substance abuse or other health care technologies, supplies, treatments, diagnostic procedures, drug therapies or devices that are determined by GHP Family to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use, or not identified in the American Hospital Formulary Service as appropriate for the proposed use, and are referred to by the treating Health Care Provider as being investigational, experimental, research based or educational; or
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II, or III clinical trial set forth in the FDA regulation, regardless of whether the trial is subject to FDA oversight; or
- The subject of a written research or investigational treatment protocol being used by the treating Health Care Provider or by another Health Care Provider who is studying the same service.

If the requested service is not represented by criteria listed above, GHP Family reserves the right to require demonstrated evidence available in the published, peer-reviewed medical literature. This demonstrated evidence should support:

- The service has a measurable, reproducible positive effect on health outcomes as evidenced by well-designed investigations, and has been endorsed by national medical bodies, societies or panels with regard to the efficacy and rationale for use; and
- The proposed service is at least as effective in improving health outcomes as are established treatments or technologies or is applicable in clinical circumstances in which established treatments or technologies are unavailable or cannot be applied; and
- The improvement in health outcome is attainable outside of the clinical investigation setting; and
- The majority of Health Care Providers practicing in the appropriate medical specialty recognize the service or treatment to be safe and effective in treating the particular medical condition for which it is intended; and
- The beneficial effect on health outcomes outweighs any potential risk or harmful effects.

GHP Family reserves the right to make judgment regarding coverage of experimental, investigational and/or unproven procedures and treatments. Participating Providers are encouraged to contact the Medical Management Department for precertification review as indicated in the Section of this Manual titled “Other Medical Services Requiring Precertification”.

Transplant Services

Members are required to utilize designated transplant centers. Precertification is required for transplant evaluations testing and related services for organ, bone marrow and/or stem cell transplants. Participating Providers should contact the Medical Management Department at (800) 544-3907 or (570) 271-6497.

Vision Services

Members may be entitled to directly access, without PCP referral, a Participating Provider to obtain vision care services.

Participating Providers are reminded to verify benefits in order to ensure coverage and benefit limits have not been exhausted prior to rendering services. Eligibility and benefits can be verified online at www.ghpfamily.com. All appropriate authorizations should also be in place prior to rendering services. *Please note:* The Member’s identification card does not identify these benefits.

Other Services Requiring Precertification

Please note:

- Precertification is also required when GHP Family is not the Member’s primary insurance coverage.
- An Outpatient Referral Form issued by a Member’s PCP, in addition to precertification from GHP Family, may be required in accordance with the Member’s benefit document.
- Copayments are the financial responsibility of the Member, when applicable.

Other services requiring precertification

The listing of other services requiring precertification can be found online at www.ghpfamily.com. This listing is subject to change. A minimum of thirty (30) days advance notice is provided to Participating Providers regarding changes to this listing. Please contact the Medical Management Department if you have questions regarding the precertification of a particular service, or refer to our online listing.

Requesting Precertification

Requests for precertification may be submitted by U.S. Mail, telephone or facsimile to:

GHP Family Medical Management Department
100 North Academy Avenue
Danville, PA 17822-3218
(800) 544-3907 or (570) 271-6497
Monday through Friday 8:00 a.m. to 5:00 p.m.
Fax: (570) 271-5534

Information required when requesting precertification

- Demographics: Member's name, GHP Family identification number, admission date (if applicable), date of service, and provider of service full name, requesting physician with phone number and fax number.
- Reason for service: objective and subjective findings.
- Pertinent treatment/medication ordered.
- If request is for utilization of a non-Participating Provider, submission should include specifics as to why the service is not obtainable from a Participating Provider. Any information submitted by hard copy should clearly identify the requestor's name and contact information.
- Submission of photographs and/or medical records.
- Submission of photographs is considered confidential medical record information and should be forwarded to the above address in a sealed envelope labeled "CONFIDENTIAL MEDICAL RECORDS."

Upon submission of required information, the Medical Management Department will provide verbal and written notification of determination of coverage relative to the precertification request in accordance with regulatory timeframes. If denied, GHP Family will mail a denial notice with information on appeal rights and process to the Member (or Member's authorized representative) and copy the Provider.

It is the obligation of the Participating Provider to discuss all treatment alternatives and options with the Member. This should include a discussion of the GHP Family approval process and the importance of identifying the best alternatives for care. The optimal method for accomplishing this is to include GHP Family in the review process prior to making any arrangements. Failure to follow this process leads the Member and/or the Member's family to having inaccurate expectations.

MATERNAL HEALTH PROGRAM (Including Healthy Beginnings Plus)

Pregnant Member's coverage includes all Medically Necessary ultrasonography.

GHP Family's program entitled "Right from the Start" is designed to serve the GHP Family Member throughout her pregnancy, from early identification, through the prenatal experience and post-partum follow-up. GHP Family's comprehensive approach to assist Members through this life changing event engages many areas of health plan employees, provider offices, and most importantly the Member and caregivers.

Early Identification:

The process begins with early identification of the pregnancy. GHP Family will attempt to identify Members who are pregnant through a variety of processes including:

- Data extractions including, but not limited to, enrollment files, CHIP Chronic Conditions and Specialist Visits reports², positive laboratory testing results, and/or prescriptions filled for prenatal vitamins.
- New Member Calls conducted by the dedicated GHP Family Customer Service Team which asks if the Member or anyone in the household who also has GHP Family is pregnant.
- Direct referrals from Case Managers, providers or other health plan representatives.
- Claims information indicating pregnancy
- OBNA Form Completion received either via fax or secure electronic submission through the provider portal.

A master list of any identified Member who is pregnant will be reviewed by the QI Department. Any Member identified as “high risk” will be referred to the Women’s Health and EPSDT Coordinator (or designee) for case management intervention. Following this assessment, any case not deemed “high risk” will be forwarded electronically to the QI Specialist assigned for HEDIS preventative calls.

Quality Improvement and Regulatory Requirements:

The GHP Family has a strong commitment to HEDIS and other quality metrics to improve the overall health of the membership. As such, the Quality Improvement Department is charged with conducting scheduled outbound calls to improve Member compliance with measures including:

- Weeks of pregnancy at time of enrollment and live birth*
- Timeliness of physician visit (Measure: percentage of live births that had a prenatal visit within the first trimester or 42 days of plan enrollment)*
- Frequency and compliance with prenatal visits according to the Expected Number of Prenatal Care Visits for a Given Gestational Age and Month Member Enrolled in the Organization**
- Timeliness of post-partum visit (Measure: Post-partum visit within 21-56 days of delivery)*
- Cesarean Section for low-risk , first birth women***
- Percentage of live births less than 2,500 grams***
- Completion of Prenatal Depression Screening and treatment for those who scored positively***
- Prenatal screening for smoking and treatment discussion during a prenatal visit***
- Screening home environment for smoke***

*Table 1

**HEDIS Measure

*** Pennsylvania Performance Measure

Service Description

Member Assistance with Appointment Scheduling

GHP Family will help the Member obtain a provider visit as needed within twenty-four (24) hours to ten (10) days of notification of the pregnancy as required by the Department, depending on the risk level and trimester. See the table in the *Appointment Standards* section of this manual. GHP Family assists the Member in completing a minimum number of prenatal visits and also in completing a follow up visit within 21-56 days post-partum.

² Weekly CHIP Chronic Conditions & Specialist Visits report. Member flagged for pregnancy if there were any new Claims with an admission date in the last 2 years with diagnosis codes: 632, 633.0-633.9, 640-648.9, 650-659.9, 678.00, 678.01, 678.03, 678.10, 678.11, 678.13, 679.00-679.04, 679.10-679.14, 765.21-765.29, V22-V23.9, V27.0-V27.9, V89.01-V89.05, V89.09, 649.0-649.74, 660.0-669.94, 670.0-677. Resource: Preston Biegley Geisinger Health Plan - Clinical Informatics

Network Access

GHP Family Members have direct access to a women's health provider. In the event the Member is transferring from another health plan, GHP Family will cover maternity care through the course of the pregnancy and postpartum care with a non-participating provider.

High Risk Management

Members are screened for high risk management by Quality Improvement Specialists and referred to Women's Health case management nurses with seasoned experience in high risk fetal maternal health care as appropriate. Regionally based case management staff will coordinate services with perinatology specialty sites throughout the GHP Family service area. Services include telephonic outreach to ensure timely and continuous provider follow-up, assistance with overcoming barriers to care such as transportation or access to appointments or providing resources to assist with weight management and smoking cessation during pregnancy.

Coordination with Healthy Beginnings Plus

GHP Family encourages expectant mothers to participate with Participating Healthy Beginnings Plus Providers throughout the 22 county service areas. Healthy Beginnings Plus is a program that provides education and assistance to female Members with a goal of a healthy prenatal experience and compliant post-partum follow-up.

Behavioral Health Coordination

The Special Needs Unit (SNU) can assist Members to connect with the assigned Behavioral Health Managed Care Organization (BH MCO) based upon county of residence. The BH MCO can assist with concerns during pregnancy including depression or more serious mental illness conditions.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Management

Post-delivery, GHP is committed to facilitate timely access and compliance with recommended visits and vaccination schedules for children under the age of 21. Through a series of telephonic outreach program, GHP Family Quality Improvement (QI) nursing staff will review Members at key milestones for well child visits and immunization schedules. In the event Members are non-compliant with EPSDT visits, GHP Family will make every attempt to reach the Member/caregiver to facilitate compliance.

Member Health Education

GHP Family has a robust education strategy to outreach to Members upon identification of pregnancy. Topics include importance of scheduling and keeping prenatal appointments, healthy nutrition, and transportation coordination. Messaging may be accomplished through mailing print materials, reminder phone calls or cell phone texting depending on the risk stratification of pregnant condition and trimester.

Provider Relations

Education

GHP Family respects the value and contribution of the providers taking care of expectant Members. Communication with the obstetrical provider is emphasized from the first identification of pregnant status. The OBNA Form should be completed with pregnancy determination. Completion and submission of the form is part of the GHP Family Provider Pay for Performance Program. The process for submission of this form is discussed in the Maternal Health Program section of this manual.

Communication

GHP Family uses a variety of methods to keep providers up to date with current information to the management of women who are pregnant including a web based provider manual, operational bulletins and visits by Provider Network Staff.

Community Outreach

GHP Family will make efforts to engage local community agencies, school systems and providers to provide education and assistance in the care of our Members. Venues for health education include area high schools, family planning agencies such as Planned Parenthood, or other organizations dedicated to the care of women like Women in Transition.

GHP Family will outreach with States Family Health Nursing Services Consultant and PA Coalition to Prevent Teen Pregnancy specifically in the top four counties designated for teen pregnancy in the twenty-two county service area.

Member Incentives

GHP Family offers Member incentives to encourage compliance with keeping prenatal and post-partum appointments. Incentives will be offered to Members who complete the required number of prenatal visits to be compliant with the Frequency of Ongoing Prenatal Care HEDIS measure and a post-partum visit within 21-56 days after delivery to be compliant with the HEDIS Postpartum Care measure. Another incentive will be offered for Members who have six (6) well visits by age fifteen (15) months and have all recommended immunizations by age two (2) to be compliant for the Well Child Visits in the First 15 Months of Life and Childhood Immunization HEDIS measures. Incentives may include gift cards or items for mom and/or baby. Compliance will be determined through claims data. No additional reporting is required of the provider.

Reporting

GHP Family recognizes the responsibility to comply with the Department of Public Welfare’s reporting requirements specific to the care of women who are pregnant. The following table is a general summary for required reports, including report name, description, frequency and responsible party.

<i>Requirements for Medicaid Maternity/Pregnancy Reporting</i>			
Measure Title	Summary of Measure	Responsible Party	Frequency
Percentage of live births weighing less than 2,500 grams	Live births <2,500 grams as a percent of total live births	Clinical Informatics	Monthly
Perinatal Depression Screening (Pre and post-natal)	<ol style="list-style-type: none"> 1. Screened for depression during prenatal visit 2. Positive depression screen 3. Positive depression screen who received further evaluation or referral 4. Screened for depression during postpartum visit 5. Positive depression screen 6. Positive depression screen who received further evaluation or referral 	Clinical Informatics	Monthly

Requirements for Medicaid Maternity/Pregnancy Reporting

Measure Title	Summary of Measure	Responsible Party	Frequency
Prenatal Screening for Smoking and Treatment Discussion during a Prenatal Visit (Smoking and environmental smoke)	<ol style="list-style-type: none"> 1. Screened for smoking during one of first two visits 2. Screened for smoking during one of first two visits and currently smoke, given counseling/advice or referral 3. Screened for smoking during one of first two visits and quit during pregnancy 4. Screened for environmental tobacco smoke during one of first two visits 5. Screened for environmental tobacco smoke during one of first two visits, given counseling/advice or referral 	Clinical Informatics	Monthly
Cesarean Rate for Nulliparous Singleton Vertex	C-section rates for low-risk first birth women	Clinical Informatics	Monthly
Prenatal and Postpartum Care	<ol style="list-style-type: none"> 1. Percentage of live births that received a prenatal care visit within first trimester or within 42 days of enrollment 2. Percentage of live births that received a postpartum visit between 21 and 56 days after delivery 	Clinical Informatics	Monthly
Frequency of Ongoing Prenatal Care	Percentage of deliveries which had the expected number of prenatal visits: <21% of expected visits 21%-40% of expected visits 41%-60% of expected visits 61%-80% of expected visits >=81% of expected visits	Clinical Informatics	Monthly
Weeks of Pregnancy at Time of Enrollment	Percentage of women who delivered a live birth, by the weeks of pregnancy at time of enrollment	Clinical Informatics	Monthly
Maternity Outcome Counts	Provides counts of second and third trimester live maternity outcomes; broken out by recipient group for Cesarean Section (C-Section) and Vaginal live births;	Clinical Informatics	Annually
Annual Maternity Utilization	Provides maternity utilization information (discharges, days, and average length of stay) for both Cesarean Section (C-Section) and Vaginal live births.	Clinical Informatics	Annually
Annual Newborn Utilization	Provides newborn utilization information (discharges, days, and average length of stay) for both well newborns and complex newborns.	Clinical Informatics	Annually

Audit Checks

The GHP Family Women's Health Coordinator (or designee) will audit the Members identified with a Live Birth diagnosis against those screened and contacted through the Maternal Health Program on an annual basis. Any discoveries to better understand the variances between Members not identified during pregnancy and those with live birth will be assessed to improve processes for early identification of pregnancy for future implementation.

MEMBER RESTRICTION PROGRAM

DPW's Bureau of Program Integrity manages a centralized Member Restriction Program for all managed care and Fee-For-Service delivery systems. GHP Family maintains a Member Restriction Program that interfaces with the centralized program and cooperates with DPW. The program identifies, restricts and monitors Members who have been determined to be abusing and/or misusing Medical Assistance services or who may be defrauding the HealthChoices program. With the approval of DPW, Members may be restricted to receiving services from a single, designated provider for a period of five years.

GHP Family's Special Needs Unit monitors and evaluates the utilization of Members who are referred to the Member Restriction Program. Providers will receive notification of Members who are restricted and restrictions are enforced through the Claims payment system.

GHP Family may not pay for a service rendered by any provider other than the one to whom the Member is restricted, unless the services are furnished in response to an emergency or a Medical Assistance Member Referral Form (MA 45) is completed and submitted with the Claim. The MA 45 must be obtained from the practitioner to whom the Member is restricted. If a Member is restricted to a provider with your provider type, the EVS will notify you if the Member is locked into you or another provider. The EVS will also indicate all type(s) or provider(s) to which the Member is restricted. Valid emergency services are excluded from the lock-in process.

GHP Family obtains approval from DPW prior to implementing a restriction, including approval of written policies and procedures and correspondence to restricted Members.

GHP Family will:

- Refer to DPW's Bureau of Program Integrity (BPI) those Members identified as over utilizing or misutilizing health care services.
- Evaluate the degree of Abuse including review of pharmacy and medical Claims history, diagnoses and other documentation, as applicable.
- Propose whether the Member should be restricted to obtaining services from a single, designated provider for a period of five years.
- Forward case information and supporting documentation to BPI for review to determine appropriateness of restriction and to approve the action.
- Upon BPI approval, GHP Family will send notification via certified mail to Member of proposed restriction, including reason for restriction, effective date and length of restriction, name of designated provider(s) and option to change Provider, with a copy to BPI.
- Send notification of Member's restriction to the designated provider(s) and the County Assistance Office.
- Enforce the restrictions through appropriate notifications and edits in the Claims payment system.
- Prepare and present case at a DPW Fair Hearing to support restriction action.
- Monitor subsequent utilization to ensure compliance.
- Change the selected provider per the Member's or provider's request within thirty (30) days from the date of the request, with prompt notification to BPI through the Intranet provider change process.

- Continue a Member restriction from the previous delivery system as a Member enrolls in the managed care organization, with written notification to BPI.
- Review the Member's services prior to the end of the five-year period of restriction to determine if the restriction should be removed or maintained, with notification of the results of the review to BPI, Member, provider(s) and County Assistance Office.
- Perform necessary administrative activities to maintain accurate records.
- Educate Members and providers to the restriction program, including explanations in handbooks and printed materials.

Members have the right to appeal a restriction by requesting a DPW Fair Hearing. Members may not file a Complaint or Grievance with GHP Family regarding the restriction action. A request for a DPW Fair Hearing must be in writing, signed by the Member and sent to:

Department of Public Welfare
 Office of Medical Assistance Programs of Bureau of Program Integrity
 Division of Program and Provider Compliance: Member Restriction Section
 P.O. Box 2675
 Harrisburg, Pennsylvania 17 105-2675
 Phone number: (717) 772-462

PROGRAM EXCEPTION PROCESS

Participating Providers may request coverage for items or services that are included under the Member's benefit package, but are not current listed on the Medical Assistance Program Fee Schedule. Participating Providers may also request an exception for services or items that exceed limits on the fee schedule if the limits are not based in statute or regulation. These exceptions should be requested in advance of providing services. In order to request program exceptions, Participating Providers must follow the GHP Family Prior Authorization process.

SPECIAL NEEDS UNIT

The Special Needs Unit is a dedicated resource for the unique needs of the GHP Family Member. The circumstances for which a Member will be classified as having a special need will be based on a non-categorical or generic perspective that identifies key attributes of ongoing physical, developmental, emotional, or behavioral conditions, including, but not limited to, Children in Substitute Care, Members participating in community based waiver programs like HIV/AIDS, COMMCare, Infants, Children and Toddlers or the Independence Waiver program. The Special Needs Unit works collaboratively to provide a unified Case Management service through its Proven Health Navigator Case and Health Management program and collaborative agreements with behavioral health managed care organizations and community agencies. Examples of factors in the determination of a Member with a Special Need(s) include, but are not limited to, the following:

- Require care and/or services of a type or amount that is beyond what is typically required;
- Require extensive rehabilitative, habilitative, or other therapeutic interventions to maintain or improve the level of functioning for the individual;
- May require that primary care be managed by a SCP, due to the nature of the condition;
- May incur higher morbidity without intervention and coordination in the care of the individual;
- Require care and/or services that necessitate coordination and communication among Network providers and/or out-of-Network providers;
- Require care and/or services that necessitate coordination and collaboration with public and private community services organizations;

- Require coordination of care and/or services between the acute inpatient setting and other facilities and Community Providers;
- Result in the Member requiring assistance to schedule or make arrangements for appointments or services, including arranging for transportation to and from appointments;
- Result in the need for language, communication, or mobility accommodations; or
- Result in the need for a Member to be accompanied or assisted while seeking or receiving care by an individual who may act on the Member's behalf.

The Special Needs Unit can be used as a resource for Providers, Members and Caregivers to assist with management of Members with special needs. The Special Needs Unit can be reached at (855) 214-8100.

COVERED SERVICES

Members are entitled to certain covered services under the Medical Assistance Program of the Commonwealth of Pennsylvania. Member benefits can be verified online at www.ghpfamily.com or by calling Customer Service. Covered services for Members are represented in the GHP Family Benefit Grid below.

Copays are excluded for services provided to:

- Individuals under 18 years of age;
- Services to pregnant women, including through the postpartum period;
- Services provided to patients in long term care facilities (including ICF/ID and ICF/ORC);
- Services or items provided to a terminally ill individual who is receiving hospice care;
- Services provided to individuals residing in a personal care home or domiciliary care home;
- Services provided to women in the Breast and Cervical Cancer Prevention and Treatment (BCCPT) coverage group; and services provided to individuals of any age eligible under Titles IV-B and IV-E Foster Care and Adoption Assistance

Covered Services <i>Please note the information at the end of this grid for clarification.</i>	Copay for Medical Assistance Members Under Age 18 and All Pregnant Women	Copay for Medical Assistance Members Ages 18 through 20	Copay for Medical Assistance Members Ages 21 & Older	Copay for General Assistance Members Ages 21 & Older	Referral Needed	Prior Auth	Benefit Limits
Ambulance (per trip) Emergency	\$0	\$0	\$0	\$0	N	N	None
Ambulance Non-emergent Transportation (per trip) when Medically Necessary	\$0	\$0	\$0	\$0	N	Y	None
Outpatient Services (Medical Visits)							
Routine Office visits							

Covered Services <i>Please note the information at the end of this grid for clarification.</i>	Copay for Medical Assistance Members Under Age 18 and All Pregnant Women	Copay for Medical Assistance Members Ages 18 through 20	Copay for Medical Assistance Members Ages 21 & Older	Copay for General Assistance Members Ages 21 & Older	Referral Needed	Prior Auth	Benefit Limits
PCP including OB/GYN	\$0	\$0	\$0	\$0	N	N	None
Federal Qualified Health Center/Regional Health Center	\$0	\$0	\$0	\$0	N	N	None
Family Planning Services	\$0	\$0	\$0	\$0	N	N	None
Certified Nurse practitioner	\$0	\$0	\$0	\$0	N	N	None
Chiropractor	\$0	\$1	\$1	\$2	N	Y	18 visits per year. Limits are for ages 21 and older only (visit limit is combined with Chiropractor Optometrist and Podiatrist visits for these three providers.)
Optometrist	\$0	\$0	\$0	\$0	N	N	18 visits per year. Limits are for ages 21 and older only (visit limit is combined with Chiropractor Optometrist and Podiatrist visits for these three providers.)
Podiatrist	\$0	\$0	\$0	\$0	Y	N	18 visits per year. Limits are for ages 21 and older

Covered Services <i>Please note the information at the end of this grid for clarification.</i>	Copay for Medical Assistance Members Under Age 18 and All Pregnant Women	Copay for Medical Assistance Members Ages 18 through 20	Copay for Medical Assistance Members Ages 21 & Older	Copay for General Assistance Members Ages 21 & Older	Referral Needed	Prior Auth	Benefit Limits
							only (visit limit is combined with Chiropractor Optometrist and Podiatrist visits for these three providers.)
SCP office visit with referral	\$0	\$0	\$0	\$0	Y	N	None
Convenience Care or Urgent Care Centers	\$0	\$0	\$0	\$0	N	N	None
Periodic health assessments/routine physicals	\$0	\$0	\$0	\$0	N	N	None
Independent Medical /Surgical Center; Ambulatory Surgical Center; Short Procedure Unit	\$0	\$3	\$3	\$6	N	N	None
Ambulatory Infusion Center	\$0	\$0	\$0	\$0	N	N	None
Preventive Services							
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	\$0	\$0	Not Covered	Not Covered	N	N	None
Mammograms	\$0	\$0	\$0	\$0	N	N	None
Immunizations covered in accordance with accepted medical practices, excluding immunizations necessary for international travel	\$0	\$0	\$0	\$0	N	N	None
Pap smears	\$0	\$0	\$0	\$0	N	N	None
Chlamydia screening for females	\$0	\$0	\$0	\$0	N	N	None
Dexa-scan	\$0	\$0	\$0	\$0	N	N	None
Fecal occult blood testing	\$0	\$0	\$0	\$0	N	N	None
Cholesterol Screening	\$0	\$0	\$0	\$0	N	N	None
Diabetes Care including HbA1c testing, LDL-C screening and nephropathy screening	\$0	\$0	\$0	\$0	N	N	None

Covered Services <i>Please note the information at the end of this grid for clarification.</i>	Copay for Medical Assistance Members Under Age 18 and All Pregnant Women	Copay for Medical Assistance Members Ages 18 through 20	Copay for Medical Assistance Members Ages 21 & Older	Copay for General Assistance Members Ages 21 & Older	Referral Needed	Prior Auth	Benefit Limits
Lipid Panel	\$0	\$0	\$0	\$0	N	N	None
Newborn screening: one hematocrit and hemoglobin screening for infants under 24 months	\$0	\$0	\$0	\$0	N	N	None
Colorectal cancer screening, limited to flexible sigmoidoscopy, colonoscopy and related serviced covered 100%. Note preparation medication is not covered under the medical benefit; However, preparation medication may be covered under your pharmacy benefit, which will be subject to your normal pharmacy benefit cost-sharing.	\$0	\$0	\$0	\$0	N	N	None
Outpatient Facility Testing Services (Location 22 only) including portable X-ray							
X-rays and other diagnostic tests. These services billed from a physician office are not subject to copays. Professional component not subject to copays.	\$0	\$1/service	\$1/service	\$2/service	N	N	None
Computed Axial Tomography (CAT Scan), Magnetic Resonance Imaging (MRI), and Position Emission Tomography (Pet Scan), Magnetic Resonance Angiography (MRA) and nuclear cardiology	\$0	\$1/service	\$1/service	\$2/service	N	Y	None
Laboratory services	\$0	\$0	\$0	\$0	N	N	None
Audiology testing	\$0	\$0	\$0	\$0	N	N	None
Pulmonary Function Test	\$0	\$0	\$0	\$0	N	N	None
Ostomy and Other Disposable Medical Supplies							
Ostomy supplies	\$0	\$0	\$0	\$0	N	Y	None
Medically Necessary surgical and urological supplies	\$0	\$0	\$0	\$0	N	Y	None
Diapers for disabled children	\$0	\$0	\$0	\$0	N	Y	None
Well-Woman Care							

Covered Services <i>Please note the information at the end of this grid for clarification.</i>	Copay for Medical Assistance Members Under Age 18 and All Pregnant Women	Copay for Medical Assistance Members Ages 18 through 20	Copay for Medical Assistance Members Ages 21 & Older	Copay for General Assistance Members Ages 21 & Older	Referral Needed	Prior Auth	Benefit Limits
Annual gynecological examination, including pelvic examination and routine pap smears. Includes appropriate follow-up care and referrals for diagnostic testing and treatment services relating to gynecological care. No referral Required	\$0	\$0	\$0	\$0	N	N	None
Maternity Care							
Maternity care by your physician before and after the birth of your baby. No referral required	\$0	\$0	\$0	\$0	N	N	None
Maternity hospitalization	\$0	\$0	\$0	\$0	N	N	None
Hospitalization (Acute or Rehab)							
Medical and surgical specialist care, including anesthesia	\$0	\$0	\$0	\$0	N	Y	None
Care in a semi-private room at a participating facility. Includes intensive care, cardiac care unit services, medications, diagnostic tests and transplant services.	\$0	\$3 - per day \$21 maximum per admission	\$3 - per day \$21 maximum per admission	\$6 - per day \$42 – maximum per admission	N	Y	DPW Benefit General Assistance Limit = 1 hospital stay/year and 1 rehab stay/year; Medical Assistance: Limit (age 21 and older only) = 1 rehab stay/year but no limit on # of hospital stays.
Surgery for Correction of Obesity							
Facility charges	\$0	\$0	\$0	\$0	N	Y	None
Emergency Services							
Emergency care	\$0	\$0	\$0	\$0	N	N	None
Urgent care	\$0	\$0	\$0	\$0	N	N	None

Covered Services <i>Please note the information at the end of this grid for clarification.</i>	Copay for Medical Assistance Members Under Age 18 and All Pregnant Women	Copay for Medical Assistance Members Ages 18 through 20	Copay for Medical Assistance Members Ages 21 & Older	Copay for General Assistance Members Ages 21 & Older	Referral Needed	Prior Auth	Benefit Limits
Rehabilitation Services							
Physical therapy, speech therapy, occupational therapy	\$0	\$0	\$0	\$0	N	Y	None
Cardiac rehabilitation, outpatient	\$0	\$0	\$0	\$0	N	N	None
Pulmonary rehabilitation benefit, outpatient	\$0	\$0	\$0	\$0	N	N	None
Renal Dialysis Services	\$0	\$0	\$0	\$0	N	N	None
Diabetes Services and Supplies Note: The Plan reserves the right to restrict vendors and apply quantity limitations							
Nutritional counseling	\$0	\$0	\$0	\$0	Y	N	None
Diabetic eye examination	\$0	\$0	\$0	\$0	N	N	None
Prescription/supply coverage: Lifescan test strips, box of 200 test strips per month (One-Touch, One Touch Ultra, Surestep and Fast Take) and lancets are covered.	\$0	\$0	\$0	\$0	N	N	None
Diabetic foot orthotics	\$0	\$0	\$0	\$0	N	Y	None
Home blood glucose monitors: Lifescan brand diabetic supplies only. Must be purchased at a participating pharmacy	\$0	\$0	\$0	\$0	N	N	None
Diabetic medical equipment: The following may be limited to specific vendors: injection aids, insulin, pumps, syringe reservoirs and infusion sets.	\$0	\$0	\$0	\$0	N	Y	None
Skilled Nursing/Home Health Services							
Short-term, non-custodial medical care in a licensed, skilled nursing facility, as approved by a participating provider and GHP Family.	\$0	\$0	\$0	\$0	N	Y	30 consecutive days are covered then Fee-for-Service program provides coverage.

Covered Services <i>Please note the information at the end of this grid for clarification.</i>	Copay for Medical Assistance Members Under Age 18 and All Pregnant Women	Copay for Medical Assistance Members Ages 18 through 20	Copay for Medical Assistance Members Ages 21 & Older	Copay for General Assistance Members Ages 21 & Older	Referral Needed	Prior Auth	Benefit Limits
ICF-OCR and ICF-ID - Medically Necessary physical health professional services	\$0	\$0	\$0	\$0	N	Y	None
Home health care by PCP	\$0	\$0	\$0	\$0	N	Y	None
Home health care by SCP	\$0	\$0	\$0	\$0	N	Y	None
Home health care by other participating skilled professional	\$0	\$0	\$0	\$0	N	Y	None
Home care by aide or Homebound services	\$0	\$0	\$0	\$0	N	Y	None
Hospice care: home and inpatient care including home health aide and homemaker services, counseling and medical social services.	\$0	\$0	\$0	\$0	N	Y	None
Implanted Devices (Medical & contraceptive)							
Drug Delivery	\$0	\$0	\$0	\$0	N	Y	None
Contraceptives	\$0	\$0	\$0	\$0	N	Y	None
Durable Medical Equipment							
Equipment which can stand repeated use, such as wheelchairs, hospital beds and oxygen equipment. Standard equipment is covered when prescribed by a participating provider, purchased from a participating vendor	\$0	\$2	\$2	\$4	N	Y	None
same as above, rented from a participating vendor	\$0	\$0	\$0	\$0	N	Y	None
Prosthetic Devices							
Externally worn appliance or apparatus which replaces a missing body part, such as artificial limbs. Must be prescribed by a participating provider.	\$0	\$2	\$2	\$4	N	Y	None
Breast Prosthetic Benefit	\$0	\$0	\$0	\$0	N	N	None
Orthotic Devices							
Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by	\$0	\$2	\$2	\$4	N	Y	None

Covered Services <i>Please note the information at the end of this grid for clarification.</i>	Copay for Medical Assistance Members Under Age 18 and All Pregnant Women	Copay for Medical Assistance Members Ages 18 through 20	Copay for Medical Assistance Members Ages 21 & Older	Copay for General Assistance Members Ages 21 & Older	Referral Needed	Prior Auth	Benefit Limits
participating provider							
Outpatient Prescription Drugs							
<p>Outpatient prescription drugs from a participating pharmacy are covered if specified in GHP Family's formulary, a continually updated list of drugs covered by the GHP Family. Up to a 34-day supply per copayment is covered. Formulary drugs may require Prior Authorization. Non-formulary exceptions may be approved for coverage at the provider's request.</p> <p>* Note the list of the classes of drugs excluded from copays at the end of this grid.</p>	\$0	\$1 Generic \$3 Brand *(May not be covered for all Members.) Certain classes of drugs are excluded from copays; please refer to the list at the end of this grid.	\$1 Generic \$3 Brand *(May not be covered for all Members.) Certain classes of drugs are excluded from copays; please refer to the list at the end of this grid.	\$1 Generic \$3 Brand *(May not be covered for all Members.) Certain classes of drugs are excluded from copays; please refer to the list at the end of this grid.	Rx Required	N	None
Contraceptives; includes diaphragms	\$0	\$0	\$0	\$0	Rx Required	N	None
Specialty Drugs: For select high-cost specialty drugs.	\$0	\$1 Generic \$3 Brand *(May not be covered for all Members)	\$1 Generic \$3 Brand *(May not be covered for all Members)	\$1 Generic \$3 Brand *(May not be covered for all Members)	Rx Required	Y	None
Drugs received in a doctor's office or in the hospital	\$0	\$0	\$0	\$0	N	N	None
Vision							
Two eye exams per year to determine the refractive error of the eye. No PCP referral required.	\$0	\$0	\$0	\$0	N	N	None

Covered Services <i>Please note the information at the end of this grid for clarification.</i>	Copay for Medical Assistance Members Under Age 18 and All Pregnant Women	Copay for Medical Assistance Members Ages 18 through 20	Copay for Medical Assistance Members Ages 21 & Older	Copay for General Assistance Members Ages 21 & Older	Referral Needed	Prior Auth	Benefit Limits
Eyeglasses prescribed for Members under 21 years of age.	\$0	\$0	Not Covered	Not Covered	N	N	Limit to two complete pairs (two frames, four lenses)
Eyeglasses prescribed for adults age 21 and older.	\$0	\$0	\$0	\$0	N	N	Limit to one complete pair (one frame, two lenses)
Low vision aids prescribed when medically necessary are covered for all ages. Eye prostheses prescribed when medically necessary are covered for all ages.	\$0	\$0	\$0	\$0	N	Y	Limited to one per two years
Eye occluder	\$0	\$0	\$0	\$0	N	Y	Limited to one per year
Contact Lens for aphakia for Members under 21 years old.	\$0	\$0	Not Covered	Not Covered	N	Y	Limited to two pairs per year
Contact Lens for aphakia for adults age 21 and older.	\$0	\$0	\$0	\$0	N	Y	Limited to two pair per year
Hydrophilic spherical Contact Lens for aphakia or replacement cataract lens and overcorrection lens over contact lens or implanted lens.	\$0	\$0	\$0	\$0	N	Y	Limited to four per year
Dental							
Two routine exams/year, including x-rays	\$0	\$0	\$0	Not Covered Unless performed in an SPU or as an Inpatient	N	N	Two per year
Two cleanings per year	\$0	\$0	\$0	Not Covered Unless performed in an SPU or as	N	N	Two per year

Covered Services <i>Please note the information at the end of this grid for clarification.</i>	Copay for Medical Assistance Members Under Age 18 and All Pregnant Women	Copay for Medical Assistance Members Ages 18 through 20	Copay for Medical Assistance Members Ages 21 & Older	Copay for General Assistance Members Ages 21 & Older	Referral Needed	Prior Auth	Benefit Limits
				an Inpatient			
Sealants for Children	\$0	\$0	Not Covered	Not Covered	N	N	None
Fillings	\$0	\$0	Covered only through an approved benefit limit exception. *See note below for additional information.	Not Covered Unless performed in an SPU or as an Inpatient	N	N	None
Extractions	\$0	\$0	Covered only through an approved benefit limit exception. *See note below for additional information.	Not Covered Unless performed in an SPU or as an Inpatient	N	N	None
Dental Anesthesia	\$0	\$0	Covered only through an approved benefit limit exception. *See note below for additional information.	Not Covered Unless performed in an SPU or as an Inpatient	N	Y	None
Dentures	\$0	\$0	\$0	Not Covered Unless performed in an SPU or as an Inpatient	N	Y	One upper and one lower per lifetime for adults.
Root canals, crowns, periodontal work	\$0	\$0	Covered only through an approved benefit limit exception. *See note below for additional information.	Not Covered Unless performed in an SPU or as an Inpatient	N	Y	None

Covered Services <i>Please note the information at the end of this grid for clarification.</i>	Copay for Medical Assistance Members Under Age 18 and All Pregnant Women	Copay for Medical Assistance Members Ages 18 through 20	Copay for Medical Assistance Members Ages 21 & Older	Copay for General Assistance Members Ages 21 & Older	Referral Needed	Prior Auth	Benefit Limits
Braces	\$0	\$0	Not Covered	Not Covered	N	Y	If braces are put on before age 21, services covered until treatment completed or age 23.
Bony Impacted Teeth Extraction	\$0	\$0	Covered only through an approved benefit limit exception. *See note below for additional information.	Not Covered Unless performed in an SPU or as an Inpatient	N	Y	None
<p>*GHP Family will grant benefit limit exceptions to the dental benefits when one of the following criteria is met:</p> <ol style="list-style-type: none"> 1. GHP Family determines the recipient has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the recipient. 2. GHP Family determines the recipient has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the rapid, serious deterioration of the health of the recipient. 3. GHP Family determines that granting a specific exception is a cost effective alternative for the MA Program. 4. GHP Family determines that granting an exception is necessary in order to comply with Federal law. 							
Hearing							
Hearing Aids for Members under the age of 21	\$0	\$0	Not Covered	Not Covered	N	Y	None
Behavioral Health	Behavioral Health services, including mental health and substance abuse services are available through the County Behavioral Health Services – see page 34 of the Member Handbook or page 50 of the Provider Manual for more information.						

All Member categories, except General Assistance Members 21 to 65 years of age, do not have a copay for the following groups of medications:

- Antihypertensives (high blood pressure)
- Antidiabetes (high blood sugar)
- Anticonvulsants (seizure)
- Cardiovascular preparations (heart disease)
- Antipsychotics (except those that are controlled substance antianxiety drugs)

- Antineoplastics (cancer drugs)
- Antiglaucoma drugs
- Anti-Parkinson's drugs
- HIV/AIDS drugs

GHP Family works with DPW and their vendors to coordinate services that are covered by entities other than GHP Family. These services include mental health, drug and alcohol services, and transportation services.

Participating Providers may submit exception requests for benefit limitations to the Medical Management Department by U.S. Mail, telephone or facsimile to:

GHP Family Medical Management Department
 100 North Academy Avenue
 Danville, PA 17822-3218
 (800) 544-3907 or (570) 271-6497
 Monday through Friday 8:00 a.m. to 5:00 p.m.
 Fax: (570) 271-5534

FAMILY PLANNING SERVICES

Members can choose any provider for family planning services. Covered Family Planning Services include, but are not limited to:

- Medically Necessary abortions only as allowed in MA Bulletin 1141-95-01
- Contraceptive implants/injections
- Education/counseling
- In-office visit with PCP or PCP Obstetrician
- Tubal ligation/Hysterectomies/other sterilizations for both male and female are covered for all Members over age 20.

Required Family Planning Services Forms

When a Participating Provider performs certain family planning services, a federally required form must accompany a Claim for payment, regardless of its mode of transmission (electronically or hardcopy on the CMS-1500 Claim form). The Sterilization Patient Consent Form (MA 31), Patient Acknowledgement for Hysterectomy (MA 30), and the Physicians Certification for an Abortion (MA 3) are forms that are required by the Federal Government. Payment for sterilizations, abortions, and hysterectomies will only be made if the appropriate form(s) are completed and accurate, and the procedures were performed within any time frames specified within the regulations. Appropriate consent form must be received at least thirty (30) days prior to the procedure but not more than 180 days prior to the procedure.

Consent forms are available online at Department's

website: <http://www.dpw.state.pa.us/findaform/ordermedicalassistanceforms/index.htm>

Procedures Which May Be Included With a Family Planning Clinic Comprehensive Visit, a Family Planning Clinic Problem Visit or a Family Planning Clinic Routine Revisit:

- Insertion, implantable contraceptive capsules
- Implantation of contraceptives, including device (e.g. Norplant) (once every five years) (females only)
- Removal, Implantable contraceptive capsules
- Removal with reinsertion, Implantable contraceptive capsules (e.g., Norplant) (once per five years) (females only)
- Destruction of vaginal lesion(s); simple, any method (females only)

- Biopsy of vaginal mucosa; simple (separate procedure) (females only)
- Biopsy of vaginal mucosa; extensive, requiring suture (including cysts) (females only)
- Colposcopy (vaginocopy); separate procedure (females only)*
- Colposcopy (vaginocopy); with biopsy(s) of the cervix and/or endocervical curettage*
- Colposcopy (vaginocopy); with loop electrosurgical excision(s) of the cervix (LEEP) (females only)**
- Intensive colposcopic examination with biopsy and or excision of lesion(s) (females only)**
- Biopsy, single or multiple or local excision of lesion, with or without fulguration (separate procedure) (females only)
- Cauterization of cervix; electro or thermal (females only)
- Cauterization of cervix; cryocautery, initial or repeat (females only)
- Cauterization of cervix; laser ablation (females only)
- Endometrial and/or endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) (females only)
- Alpha-fetoprotein; serum (females only)
- Nuclear molecular diagnostics; nucleic acid probe, each
- Nuclear molecular diagnosis; nucleic acid probe, each
- Nuclear molecular diagnostics; nucleic acid probe, with amplification; e.g., polymerase chain reaction (PCR), each
- Fluorescent antibody; screen, each antibody
- Immunoassay for infectious agent antibody; quantitative, not elsewhere specified
- Antibody; HIV-1
- Antibody; HIV-2
- Treponema Pallidum, confirmatory test (e.g., FTA-abs)
- Culture, chlamydia
- Cytopathology, any other source; preparation, screening and interpretation
- Progestasert I.U.D. (females only)
- Depo-Provera injection (once per 60 days) (females only)
- ParaGuard I.U.D. (females only)
- Hemoglobin electrophoresis (e.g., A2, S, C)
- Microbial Identification, Nucleic Acid Probes, each probe used
- Microbial Identification, Nucleic Acid probes, each probe used; with amplification (PCR)

* Medical record must show a Class II or higher pathology.

** Medical record must show a documentation of a history of previous uterine cancer surgery or in-utero DES (diethylstilbestrol) exposure.

Procedures Which May Be Included With a Family Planning Clinic Problem Visit:

- Gonadotropin, chorionic, (hCG); quantitative
- Gonadotropin, chorionic, (hCG); qualitative
- Syphilis test; qualitative (e.g., VDRL, RPR, ART)
- Culture, bacterial, definitive; any other source
- Culture, bacterial, any source; anaerobic (isolation)
- Culture, bacterial, any source; definitive identification, each anaerobic organism, including gas chromatography
- Culture, bacterial, urine; quantitative, colony count
- Dark field examination, any source (e.g., penile, vaginal, oral, skin); without collection
- Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types
- Smear, primary source, with interpretation; special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala azar, herpes)
- Smear, primary source, with interpretation; wet mount with simple stain for bacteria, fungi, ova, and/or parasites

- Smear, primary source, with interpretation; wet and dry mount, for ova and parasites
- Cytopathology, smears, cervical or vaginal, the Bethesda System (TBS), up to three smears; screening by technician under physician supervision
- Level IV - Surgical pathology, gross and microscopic examination
- Antibiotics for Sexually Transmitted Diseases (course of treatment for 10 days) (two units may be dispensed per visit)
- Medication for Vaginal Infection (course of treatment for 10 days) (two units may be dispensed per visit)
- Breast cancer screen (females only)
- Mammography, bilateral (females only)
- Genetic Risk Assessment

ADVANCE DIRECTIVES

The Patient Self-Determination Act of 1990, effective December 1, 1991, requires providers of services and health maintenance organizations under the Medicare and Medicaid programs to assure that individuals receiving services will be given an opportunity to participate in and direct health care decisions affecting themselves and be informed of their right to have an advance directive. An advance directive is a legal document through which a Member may provide directions or express preferences concerning his or her medical care and/or to appoint someone to act on his or her behalf. Advance directives are used when the Member is unable to make or communicate decisions about his or her medical treatment. Advance directives are prepared before any condition or circumstance occurs that causes the Member to be unable to actively make a decision about his or her medical care.

In Pennsylvania, there are two types of advance directives:

- Living will or health care instructions
- Appointment of a Health Care Power of Attorney

Providers are required to comply with federal and state laws regarding advance directives (also known as health care power of attorney and living wills), as well as contractual requirements, for adult Members. In addition, GHP Family requires that providers obtain and maintain advance directive information in the Member's medical record.

Requirements for providers include:

- Maintaining written policies that address a Member's right to make decisions about their medical care, including the right to refuse care
- Providing Members with written information about advance directives
- Documenting the Member's advance directives or lack of one in his or her medical record
- Communicating the Member's wishes to attending staff in hospitals or other facilities
- Not discriminating against a Member or making treatment conditional on the basis of his or her decision to have or not have an advance directive
- Providing staff education on issues related to advance directives

GHP Family provides information about advance directives to Members in the Member Handbook, including the Member's right to make decisions about their medical care, how to obtain assistance in completing or filing a living will or health care power of attorney, and general instructions.

For additional information or Complaints regarding noncompliance with advance directive requirements, you can contact:

Pennsylvania Office of Attorney General

Strawberry Square, 16th Floor
Harrisburg, PA 17120
Phone: (717) 787-3391

REIMBURSEMENT & CLAIMS SUBMISSION

REIMBURSEMENT/FEE-FOR-SERVICE PAYMENT

GHP Family will reimburse Participating Providers at fee-for-service rates described in the Participating Provider's individual GHP Family Agreement.

BILLING INSTRUCTIONS

Medical Assistance Enrollment & PROMISe ID Number Required

All providers who provide services to HealthChoices Members must be enrolled in the Commonwealth's Medical Assistance (MA) program and possess an active PROMISe™ Provider ID in order to bill for services. For information on how to enroll in PROMISe™ and enrollment forms, please visit the DPW's Web site at: <http://www.dpw.state.pa.us/provider/promise/enrollmentinformation/index.htm>.

Member Eligibility Verification

A MA Identification Card, titled *Pennsylvania ACCESS Card*, is an identification card issued by DPW to each MA recipient. The card can be used by MA-enrolled Health Care Providers to access DPW's Eligibility Verification System (EVS) and verify the recipient's MA eligibility and specific covered benefits. Prior to rendering or billing for services, providers should verify each Member's eligibility for benefits through the online eligibility information from the EVS. The EVS offers Medicaid providers the information to make an informed decision prior to rendering a service or item.

The plastic ACCESS Card has a magnetic strip designed for swiping through a point-of-sale (POS) device to access eligibility information through the EVS. The MA recipient's current eligibility status and verification of which MCO they may be participating with can be obtained by either swiping the ACCESS Card or by calling the EVS phone number **(800) 766-5387**.

If a Member presents to a Provider's office and states he/she is a MA recipient, but does not have an ACCESS Card, eligibility can still be obtained by using the Member's date of birth (DOB) and Social Security number (SS#) when the call is placed to EVS.

For more information regarding the EVS and ways to access eligibility data, visit the following: <http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/softwareandservicevendors/eligibilityverificationinformation/index.htm>.

In addition to the ACCESS Card, Members will receive a GHP Family identification card upon enrollment with GHP Family. Below is a sample of the GPH Family identification card:

HMO



First Name Last Name

ID #: 12345678901 PCP Copay \$0
 Medical Record #: 12345678 Spec Copay \$0
 Primary Care: XXXX ER Copay \$0
 XXXXXXXXXXXXXXXXXXXX
 Office #: 123/456-7891
 Tel-A-Nurse #: 877-543-5061

BIN 003585 PCN ASPROD1


www.GHPFamily.com

Please call GHP Family toll free at 855-227-1302 immediately upon hospitalization or if you have questions concerning your coverage. For prescription questions, call 855-552-6028. Hearing-impaired users, please call the PA Relay at 711.

General Information: Mail Medical Claims to:
 Geisinger Health Plan Geisinger Health Plan
 100 N. Academy Avenue P.O. Box 8200
 Danville, PA 17822-3229 Danville, PA 17821-8200

XX-XX
 Benefit Code: ABCDEFGHIJ
 Issue Date: issuerdate

Pharmacists call 1-800-788-2949 for pharmacy benefit information.
 Mail Dental Claims to: DentaQuest-Claims, 12121 N. Corporate Parkway
 Mequon, WI 53092. For Dental benefit inquiries: Providers please call 1-800-341-8478.

Payment for Medically Necessary Services

In accordance with Pennsylvania Code 55, Chapter 1101, DPW will only pay for Medically Necessary services for covered benefits. DPW defines Medically Necessary services as a service or benefit that is compensable under the MA Program and meets any one of the following standards:

- The service or benefit will, or is reasonably expected to prevent the onset of an illness, condition or disability.
- The service or benefit will, or is reasonably expected to reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or on an exception basis, must be documented in writing. The determination is based on medical information provided by the Member, the Member’s family/caretaker and the PCP, as well as any other providers, programs, agencies that have evaluated the Member. All Medical Necessity determinations must be made by qualified and trained health care providers.

DPW has established benefit packages based on category of assistance, program status code, age, and, for some packages, the existence of Medicare coverage or a Deprivation Qualifying Code. Participating Providers are expected to provide services in the amount, duration and scope set forth by DPW and based on the Member's benefit package. GHP Family will ensure that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. GHP Family will not arbitrarily deny or reduce the amount, duration or scope of a Medically Necessary service solely because of the Member’s diagnosis, type of illness or condition.

Provider Billing

GHP Family accepts both electronic and manual Claims submissions. To assist us in processing and paying Claims efficiently, accurately and timely, GHP Family encourages providers to submit Claims electronically. To facilitate electronic Claims submissions, GHP Family has developed business relationships with major clearinghouses, including WebMD/Envoy.

GHP Family receives EDI Claims directly from these clearinghouses, processes them through pre-import edits to ensure the validity of the data, HIPAA compliance and Member enrollment and then uploads them each Business Day.

Within 24 hours of file receipt, GHP Family provides production reports and control totals to all trading partners to validate successful transactions and identify errors for correction and resubmission.

Providers can submit paper Claims to GHP Family's designated post office box. Paper Claims are scanned into our system each Business Day.

Geisinger Health Plan or Claims Administrator
P.O. Box 8200
Danville, PA 17821-8200

Co-payments

Certain services require a Member co-payment. This amount should be collected from the Member by the provider and deducted from the amount billed to GHP Family.

Providers must submit all Claims whether or not the Member made full payment. Providers should not deny services to a Member even if the Member has not made full payment of their cost-sharing amounts. It is important for providers to document on the Claim submitted the amount that the Member paid or the amount the provider has billed to the Member.

Coordination of Benefits/Third Party

GHP Family is the primary payer on the following services:

- Preventive care
- OB/GYN
- Prenatal or preventive pediatric care (including EPSDT services to children), and services to children having medical coverage under a Title IV-D child support order

GHP Family is the payer of last resort on all other services. Providers must bill third party insurance before submitting a Claim to GHP Family. GHP Family will pay the difference between the primary insurance payment and GHP Family allowable amount. Providers cannot balance bill Members.

If the primary insurance carrier denies the Claim as a non-covered service, the Claim with the denial may be submitted to GHP Family for a coverage determination under the Member's program.

It is the provider's responsibility to obtain the primary insurance carrier's explanation of benefits (EOB) or the remittance advice for services rendered to Members that have insurance in addition to GHP Family. The primary carrier's EOB or remittance advice should accompany any Claims submitted for payment. A detailed explanation of how the Claim was paid or denied should be included if not evident from the primary carrier's EOB or the remittance advice. This information is essential in order for GHP Family to coordinate benefits.

If a service is non-covered or benefits have been exhausted from the primary carrier, the provider is required to get an updated letter every January and July to submit with each Claim. Claims submitted without the EOB for Members where third party insurance is indicated will be denied in most cases.

In the event a Claim is paid by GHP Family and it is later discovered the Member has other insurance, the payment made to the provider will be recovered by either GHP Family or DPW.

GHP Family will neither unreasonably delay payment nor deny payment of Claims because they involved an injury stemming from an accident such as a motor vehicle accident, where the services are otherwise covered. Those funds under the scope of these Other Resources shall be recovered and retained by the Commonwealth.

If assistance with the billing of third party payers is required, please contact a Provider Relations Representative at (800) 876-5357.

To prevent denials for coding mismatches, Claims submitted to the primary carrier on a form that differs from GHP Family's requirements should be clearly marked with COB Form Type Conversion.

Timely Claim Submission Requirements

GHP Family requires that Claims be submitted within 180 days from the date of service. Providers have 12 months from the date of service to correct and resubmit Claims if the initial submission was within the 180 day time period whether or not the Claim was denied on the first submission. GHP Family requires Clean Claim submissions for processing.

Claims Payment Timeframes

In compliance with federal regulations applicable to Medicaid managed care plans, GHP Family processes Clean Claims in the following timeframes:

- 90.0% of Clean Claims must be adjudicated within thirty (30) days of receipt
- 100.0% of Clean Claims must be adjudicated within forty-five (45) days of receipt
- 100.0% of all Claims must be adjudicated within ninety (90) days of receipt

These timeframes apply to the HealthChoices program. The majority of Claims are processed by GHP Family within ten (10) days of receipt.

National Provider Identifier (NPI)

Any Claims submitted by a provider must be in compliance with HIPAA regulations regarding NPI numbers and the new Claim forms. Claims for the HealthChoices program must also contain the provider PROMISE identification number. Any Claims received not in compliance will be returned.

Compliance

The new CMS-1500 (08-05) form contains fields for the NPI numbers. Field 17 requires the NPI of the referring physician, if appropriate. Field 24J is available for the NPI number of the provider rendering service(s). Field 32 requires the NPI of the facility location if other than office. Field 33 should be completed with the billing provider's NPI number. The new UB-04 form requires the NPI number of the billing provider in field 56. The NPIs of the attending physician and the operating physician should be located in fields 76 and 77 respectively.

EDI Claims

Your electronic billing vendor should have provided you with the newest version of the software to comply with the NPI requirements. If EDI Claims are rejected, please check with your vendor first. If you are experiencing any issues with EDI Claims, please contact our Provider Relations Department at (800) 876-5357.

Acceptable Claims Forms

GHP Family requires all providers to use one of the following forms when submitting Claims:

- A CMS 1500 (formerly HCFA 1500) billing form is used to submit Claims for all professional services including ancillary services and professional services billed by a hospital
- Hospital inpatient and outpatient services, dialysis services, nursing home room and board, and inpatient hospice services must be billed on the UB 04 billing form
- GHP Family will not process Claims received on any other type of Claim form

Completing a CMS 1500

The CMS 1500 (formerly HCFA 1500) billing form is used to submit Claims for all professional services. When submitting a CMS 1500 form, certain fields are required.

CMS 1500 Documentation

Before submitting a Claim a provider should ensure that all required attachments are included. All Claims that involve other insurance or Medicare must be accompanied by an Explanation of Benefits (EOB) or a remittance advice that clearly states how the Claim was paid or the reason for payment denial.

Completing the UB 04

The UB 04 form is used when billing for facilities services including hospital inpatient and outpatient services, dialysis services, nursing home room and board and inpatient hospice service.

UB 04 Documentation

Inpatient, ER and Outpatient hospital Claims above a certain threshold require additional documentation which may include the medical record and an itemized bill.

Encounter Data Submission

In order to support timely statutory reporting requirements, we encourage PCPs to submit encounter information within thirty (30) days of the encounter. However, all encounters (Claims) must be submitted within 180 calendar days after the services were rendered or compensable items were provided.

The following mandatory information is required on the CMS-1500 form for a primary care visit:

- GHP Family Member's ID number
- Member's name
- Member's date of birth
- Other insurance information: company name, address, policy and/or group number, and amounts paid by other insurance, copy of EOB's
- Information advising if patient's condition is related to employment, auto accident, or liability suit
- Name of referring physician, if appropriate
- Dates of service, admission, discharge
- Primary, secondary, tertiary and fourth ICD-9-CM diagnosis codes, coded to the correct 4th or 5th digit
- Authorization or referral number
- CMS place of service code
- HCPCS procedures, service or supplies codes; CPT procedure codes with appropriate modifiers
- Charges
- Days or units
- Physician/supplier federal tax identification number or Social Security Number
- National Practitioner ID (NPI) and Taxonomy Code
- Individual GHP Family assigned practitioner number

- Name and address of facility where services were rendered
- Physician/supplier billing name, address, zip code, and telephone number
- Invoice date

Providers should refer to their contracts for documentation requirements and/or to the provider specific billing sections of this manual.

Explanation of Payment (EOP)

For each Claim that is paid or denied the provider receives a remittance advice (remit). If a Claim is denied, providers receive a remittance advice that summarizes:

- Payment activity for the provider (the provider's account balance, Claims processed, co- payments applied, interest payments or penalties, discounts, the amount recouped if the beginning balance was negative and the net paid amount
- The check number
- Denial reasons for Claims or line items denied
- Claims inquiry contact information
- Claims resubmission and reconsideration steps and details of resubmissions
- Appeals process

To access a copy of the EOP including a description of information provided on the remit, please log on to the secure web portal website.

Claims Resubmission

Claims may be resubmitted for two reasons; (1) to submit a corrected Claim or; (2) to submit a previously submitted Claim to which additional information has been attached. When resubmitting a Claim, providers need to indicate on the Claim whether it is a corrected Claim or a resubmitted Claim with appropriate supporting documentation.

- Submit a corrected Claim or a request for reprocessing a Claim within the contracted timely filing guidelines.
- Corrected or resubmitted Claims that do not require supporting documentation may be submitted through GHP Family Electronic Data Interface (EDI) vendors.
- Corrected or resubmitted Claims that require supporting documentation must be submitted on paper to the GHP Family Claims processing center.

GHP FAMILY PAY-FOR-QUALITY PROGRAM

GHP Family's Pay-for-Quality program was initiated to encourage and promote the focus of quality care for GHP Family Members. The Pay-for-Quality program is available to physicians in primary care (i.e., Family Practice, Internal Medicine, and Pediatrics) and Obstetrics and Gynecology. Each specialty within primary care is considered separately. Additionally, qualifying PCPs meeting measurement thresholds for each applicable category are eligible for reimbursement through the Pay-for-Quality incentive payment.

Physicians are rewarded for meeting and exceeding certain clinical measurement categories. The Pay-for-Quality program is not meant to be a static measurement system and will remain flexible in order to meet changing clinical practices and quality requirements.

Pay-for-Quality reports will be posted on GHP Family's Web site at a primary care site level, so that Members can judge the combined performance of all the physicians in a given practice. Those reports will be refreshed every quarter.

More information about the Pay-for-Quality program (including the GHP Family Pay-for-Quality Manual) is available online at www.ghpfamily.com. Your Provider Relations Representative is also available to work with you in meeting Pay-for-Quality measurement criteria to maximize your incentive.

MEMBER APPEALS & PROVIDER DISPUTES

MEMBER COMPLAINTS, GRIEVANCES AND DPW FAIR HEARINGS

Overview

The Appeal Department has the overall responsibility for the management of the Member Complaint and Grievance process. This includes:

- Documenting individual Complaints and Grievances
- Coordinating resolutions
- Maintaining logs and records of the Complaints and Grievances
- Tracking, trending and reporting data

The GHP Family Complaint, Grievance and Fair Hearing coordinator (the Coordinator) will serve as the primary contact person for the Complaint and Grievance process with the GHP Family Appeal Coordinator serving as the back-up contact person.

The Appeal Department, in collaboration with the Customer Service Department and Provider Relations Department, is responsible for informing and educating Members and providers about a Member's right to file a Complaint or Grievance or request a DPW Fair Hearing and for assisting Members in filing a Complaint or Grievance or in requesting a DPW Fair Hearing.

Members are advised of their Complaint, Grievance and DPW Fair Hearing rights and the Complaint, Grievance and DPW Fair Hearing process at the time of enrollment and at least annually thereafter. Members are provided this information via the Member handbook, Member newsletters and the GHP Family Web site. The information provided to Members includes, but is not limited to:

- The method for filing a Complaint, Grievance or for requesting a DPW Fair Hearing including procedural steps and timeframes for filing each level of a Complaint or Grievance or for requesting a DPW Fair Hearing.
- Notification of Member's rights related to Complaints, Grievances and DPW Fair Hearing, including the right to voice Complaints or Grievances about GHP Family or care provided.
- The availability of assistance from GHP Family with filing a Complaint, Grievance or requesting a DPW Fair Hearing along with GHP Family toll-free number and address for filing Complaints, Grievances or requesting a DPW Fair Hearing.
- Upon request, reasonable assistance with the Complaint, Grievance and DPW Fair Hearing process is provided to Members. This includes but is not limited to providing oral interpreter services and toll free numbers with TTY/TDD and sign language interpreter capability. GHP Family staff is trained to respond to Members with disabilities with patience, understanding and respect.

DPW defines “Complaint” and “Grievance” as two separate and distinct types of issues. Members and their representatives (including providers) may file a Complaint or Grievance if they are not able to resolve issues through informal channels with GHP Family or the DPW. Members and their representatives may request a DPW Fair Hearing.

Complaints

DPW defines “Complaint” as a dispute or objection regarding a participating health care provider or the coverage, operations, or management policies of GHP Family, which has not been resolved by GHP Family and has been filed with GHP Family or with the Department of Health or the Pennsylvania Insurance Department of the Commonwealth. This definition does not include Grievances.

Complaints include, but are not limited to:

- A denial because the requested service/item is not a covered benefit
- Failure of GHP Family to meet the required timeframes for providing a service/item
- Failure of GHP Family to decide a Complaint or Grievance within specified timeframes
- Denial of payment by GHP Family after a service has been delivered because the service/item was provided without authorization by a provider not enrolled in the Pennsylvania MA Program
- Denial of payment by GHP Family after a service has been delivered because the service/item provided is not a covered service/item for the Member

Grievances

A “Grievance” is a request to have GHP Family or a utilization review entity reconsider a decision solely concerning the Medical Necessity and appropriateness of a health care service. Members or their representatives (including providers) may file a Grievance. A Grievance may be filed regarding GHP Family’s decision to 1) deny, in whole or in part, payment for a service/item; 2) deny or issue a limited authorization of a requested service/item, including the type or level of service/item; 3) reduce, suspend, or terminate a previously authorized service/item; 4) deny the requested service/item, but approve an alternative service/item. This definition does not include Complaints.

DPW Fair Hearing

A DPW Fair Hearing is a hearing conducted by DPW Bureau of Hearings and Appeals or its subcontractor. Members or their representatives (including providers) may request a DPW Fair Hearing within 30 days from the mail date on the initial written notice of decision and within 30 days from the mail date on the written notice of GHP Family’s first or second level Complaint or Grievance notice of decision. Members do not have to exhaust the Complaint or Grievance process prior to filing a request for a DPW Fair Hearing.

GHP Family Complaint and Grievance Department provides Members with assistance as necessary, including interpreter and translation services, in filing Complaints, Grievances and requests for DPW Fair Hearings. Contact information is:

Geisinger Health Plan Appeals Department
100 North Academy Avenue
Danville, PA 17822-3220
Phone: (866) 577-7733, Opt. 0
Fax: 570-271-7225

PROCESS AND TIMEFRAMES FOR COMPLAINTS, GRIEVANCES, AND DPW FAIR HEARINGS

GHP Family will accept Complaints and Grievances telephonically via a toll-free telephone number, in writing or by facsimile. If the Member has a sensory impairment, GHP Family will assign a representative to assist that Member throughout the Grievance system process. GHP Family will accept Complaints and Grievances through a TTY/TDD line, Braille; tape or CD and other commonly accepted alternative forms of communication. If a Member should need a sign language interpreter, GHP Family will provide one at no cost to the Member. Additionally, GHP Family will train its staff to be aware of speech limitations of some Members with disabilities and treat these Members with patience, understanding and respect.

If a Complaint or Grievance is received in a written format (surface mail, facsimile, Braille), it will be forwarded to the Coordinator.

A Member who consents to the filing of a Grievance by a health care provider may not file a separate Grievance. The Member retains the right to rescind consent throughout the Grievance.

In order for a provider to represent the Member in the conduct of a Grievance, the provider must obtain written consent of the Member. A provider may not require a Member to sign a document authorizing the provider to file a Grievance as a condition of treatment.

The consent form must maintain the following elements:

- The Member's name, address, date of birth, and identification number
- If the Member is a minor or is legally incompetent, the name address and relationship to the Member of the person who signed the consent
- The name, address, and GHP Family provider identification number of the provider who is receiving the Member's consent to file a Complaint or Grievance
- The name and address of GHP Family
- An explanation of the specific service/item for which coverage was provided or denied to the Member to which the consent will apply
- The following statement – “The Member or the Member's representative may not submit a Grievance concerning the services/items listed in this consent form unless the Member or the Member's representative rescinds consent in writing. The Member or the Member's representative has the right to rescind consent at any time during the Grievance process”.
- The following statement – “ The consent of the Member or the Members representative shall be automatically rescinded if the provider fails to file a Grievance or fails to continue to prosecute the Grievance through the second level Grievance process”
- The following statement – “ The Member or the Members representative, if the Member is a minor or legally incompetent, has read, or has been read this consent form, and has had it explained to his/her satisfaction. The Member or the Member's representative understands the information in the Members consent form.”
- The dated signature of the Member, or the Member's representative, and the dated signature of a witness

The Coordinator will assign the appropriate category (Complaint or Grievance or DPW Fair Hearing request), level (first, second, expedited or external) and ensure the required timeframe.

Filing Complaints - Timelines

First Level

45 days from the date of the incident complained of or the date the Member receives written notice of the decision.

Second Level

45 days from the date the Member receives written notice of our first level Complaint decision.

Expedited Review

At any point prior to the second level Complaint decision.

External Review of Second Level Complaint

15 days from the date the Member receives the written notice of our second level Complaint decision.

Filing Grievances - Timelines

First Level

45 days from the date the Member receives the written notice to file a Grievance.

Second Level

45 days from the date the Member receives the first level Grievance decision.

Expedited Review

At any point prior to the second level Grievance decision.

External Review of Second Level Grievance

15 days from the date the Member receives the second level Grievance decision.

The external Grievance decision may be appealed by the Member, the Member's representative, or the Health Care Provider to a court of competent jurisdiction within sixty (60) days from the date the Member receives notice of the external Grievance decision.

Once the Complaint or Grievance has been verified, acknowledged and documented in the Complaint and Grievance database, the Coordinator will start the research process. GHP Family will issue an acknowledgement letter upon receipt of the Complaint or Grievance.

Depending on the nature of the Complaint or Grievance, the coordinator will forward the Complaint or Grievance to the GHP Family department with the appropriate expertise. For example, all clinical/quality issues and expedited review issues are immediately forwarded to the Appeal Department for investigation and resolution and services issues such as those related to changing the Member's PCP or providing assistance with scheduling an appointment are forwarded to the Customer Service Department for resolution.

If a provider believes that the usual timeframes for deciding a Member's Complaint or Grievance will endanger their health, the provider can call GHP Family at (866) 577-7733, Opt. 0 and request an expedited review of the Complaint or Grievance. This request must be accompanied by a Provider Certification letter stating that the usual timeframe for deciding the Complaint or Grievance will endanger the Member's health. This letter should be faxed to the attention of the Complaints and Grievance Department at (570) 271-7225. GHP Family will make a reasonable effort to obtain the certification from the provider.

If GHP Family is unable to obtain a Provider Certification from the provider within three (3) Business Days of a request for an expedited Complaint or Grievance, the Complaint or Grievance will be decided within the standard timeframes.

Complaint and Grievance Reviews

GHP Family Complaints and Grievances will be reviewed by the following committees:

Complaints – First Level

- Non-clinical – 1 or more employees of GHP who were not involved in any previous level review or decision making of the issue that is the subject of the Complaint.
- Clinical – One or more employees of GHP who were not involved in any previous level review or decision making of the issue that is the subject of the Complaint, and a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. The licensed physician must decide the Complaint.

Complaints – Second Level

Review team – Three or more individuals who were not involved in any previous level of review or decision- making on the matter under review. One-third of this committee will not be an employee of GHP or a related subsidiary or Affiliate. All Members of the committee have voting rights for this review.

Expedited Complaints

Review team - A licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate providers may participate in the review. The members of the Complaint review committee may not have been involved in any previous level of review or decision-making on the issue under review. The licensed physician must decide the Complaint.

Grievance – First Level

Review team - will include one or more employees of GHP who was not involved in any previous level of review or decision making on the subject of the Grievance and a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. The licensed physician must decide the Grievance.

Grievance – Second Level

Review team will include three or more individuals who were not involved in any previous level of review or decision making to deny coverage or payment for the service/item. One third of the committee will not be an employee of GHP or its subsidiary. The committee will include a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate providers may participate in the review.

All Members will have voting rights for this review.

Expedited Grievance

Review team- Three or more individuals who were not involved in any previous level of review or decision- making on the matter under review. One-third of this committee will not be an employee of GHP Family or a related subsidiary or Affiliate. Includes a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate providers may participate in the review. The licensed physician must decide the Grievance.

Member Notice

Members will receive a notice at least seven days prior to first level review committee meetings and fifteen (15) days prior to second level committee meetings. They will also have the opportunity to attend the meeting in person, via videoconferencing or telephonically.

Upon Request, all materials will be sent to the Member prior to the meeting in regular or alternative formats. All committee meetings for all levels of Complaints and Grievances will be transcribed verbatim and a summary prepared and maintained as part of the Complaint and/or Grievance record.

Timeframes for Resolution of Complaints, Grievances and Expedited and External Reviews

GHP resolves each Complaint or Grievance as expeditiously as the Member's health requires but no later than the timeframe identified by DPW.

Complaints Decision Timeframe

First Level Complaint

Thirty (30) days from receipt of the Complaint; this may be extended fourteen (14) days at the request of the Member.

Second Level Complaint

Forty-five (45) days from receipt of the Member's second level Complaint.

Expedited Review

Within either forty-eight (48) hours of receiving the Provider certification or three (3) Business Days of receiving the Member's request for an expedited review, whichever is shorter for an expedited Complaint.

External Review

GHP Family will send information to the Pennsylvania Department of Health or the Pennsylvania Insurance Department within thirty (30) days from the request.

Grievance Decision Timeframe

First Level Grievance

Thirty (30) days from receipt of the Grievance; this may be extended fourteen (14) days at the request of the Member.

Second Level Grievance

Forty-five (45) days from receipt of the Member's second level Grievance.

Expedited Review

Within either forty-eight (48) hours of receiving the Provider certification or three (3) Business Days of receiving the Member's request for an expedited review, whichever is shorter for the expedited review.

External Review

GHP Family will notify the Department of Health of the request for the external Grievance within five (5) Business Days. Within fifteen (15) days, GHP Family will forward the written information regarding the denial to the assigned Certified Review Entity (CRE). Within sixty (60) days from the filing of the request for the external Grievance review, the CRE conducting the external Grievance review shall issue a written decision.

If a Member files a Complaint or Grievance at any level stated above, to dispute a decision to discontinue, reduce, or change a service/item that the Member has been receiving, GHP's process allows the Member to continue to receive the disputed service/item at the previously authorized level pending resolution of the Complaint or Grievance, if the Complaint or Grievance is hand delivered or post-marked within 10 days from the mail date on the written notice of a Complaint or Grievance decision until the final decision is reached.

GHP Family's Complaint and Grievance process is linked to GHP Family's Quality Management Program and Medical Management Program, for resolving Members' formal Complaints and Grievances. This system includes:

- Procedures for registering and responding to Complaints and Grievances in the timeframe determined by DPW;
- Documentation of the substance of the Complaint or Grievance, and actions taken;
- Procedures to ensure a resolution of the complaint or Grievance, and;
- Aggregation and analysis of Complaint and Grievance data and use of the data for quality improvement. GHP Family maintains a log which is made available to DPW upon request which includes a short dated summary of the problem, the response and the resolution.

DPW Fair Hearing Process

The Member or the Member's representative has the right to request a DPW Fair Hearing within thirty (30) days from the mail date on the initial written notice of a decision and within thirty (30) days from the mail date on the written decision of any level Complaint or Grievance. Members do not have to exhaust the Complaint or Grievance process prior to filing a request for a DPW Fair Hearing.

The request for a DPW Fair Hearing must include a copy of the written notice of decision that is the subject of the request and be submitted to the DPW Complaint, Grievance and Fair Hearings Department. Fair hearing requests for a Fair Hearing should include the following information:

- Member name
- Member social security number and date of birth
- Telephone number where the Member can be reached during the day
- If the Member wants to have the Fair Hearing in person or by telephone
- Any letter(s) the Member may have received about the issue

Members and their representatives may attend and participate in the Fair Hearing in person or on the phone. Members will receive a letter from DPW's Bureau of Hearings and Appeals advising of where the hearing will be held and the date and time for the hearing at least ten (10) days before the hearing.

Members must request a Fair Hearing in writing by sending a letter to:

Department of Public Welfare Office of Medical Assistance Programs HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17 105-2675

Fair Hearings will be decided within ninety (90) days of the DPW receiving the request. The Bureau of Hearings and Appeals has three (3) Business Days from the receipt of the Member's oral or written request for an expedited review to process final administrative action.

The Bureau of Hearings and Appeals' adjudication is binding unless reversed by the Secretary of Public Welfare. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within thirty (30) days from the date of adjudication (or from the Secretary's final order, if reconsideration was granted). The decisions of the Secretary and the Court are binding.

PROVIDER APPEALS AND DISPUTES

GHP Family offers providers 1) an informal and formal dispute process for expressing dissatisfaction with a GHP Family decision that directly impacts the provider and 2) an informal and formal appeals process to request reversal of a denial by GHP Family. The definitions and processes for Provider Appeals and a Provider Disputes are as follows:

Provider Appeal – A request from a Provider for reversal of a denial by GHP Family, with regard to the three (3) major types of issues that are to be addressed in a Provider Appeal system as outlined in the Provider Dispute Resolution System. The three (3) types of Provider Appeals issues are:

1. Provider credentialing denial by GHP Family.
 - If a provider communicates dissatisfaction with a credentialing determination, Credentials Committee, at its next scheduled meeting, will review information provided by the provider

- and make a determination. If the provider's credentialing or recredentialing is denied, the provider has thirty (30) Business Days from receipt of notice to file an appeal.
2. Claims denied by GHP Family for Participating Providers participating in GHP Family's network. This includes payment denied for services already rendered by the Participating Provider to the Member.
 - **Informal Process** – All Participating Providers should use the existing Claim Research Request Form (CRRF) process as outlined in the Provider Service Center.
 - **Formal Process** – If a Participating Provider sends another CRRF stating 2nd level appeal, or requests additional review on a previously reviewed CRRF, the Provider Dispute/Appeals Committee (PDAC), will hear all formal Provider Appeals and make a determination within sixty (60) days.
 3. Termination of Participating Provider Agreement by GHP Family based on quality of care or service.
 - Suspension, non-renewal, or termination of Participating Provider's participation initiated by GHP Family entitles the Participating Provider to an appeal hearing upon timely and proper request by the Participating Provider for said appeal for any of the following reasons:
 1. Business need;
 2. Breach of Agreement;
 3. Suspected fraud and abuse;
 4. Non-compliant behavior that jeopardizes Member satisfaction;
 5. Temporary sanction, suspension or restriction by Medicare, any licensing board or professional review organization (Organizational Providers only*); and/or
 6. Failure to immediately notify Health Plan of substantive changes in credentialing information including, but not limited to, adverse licensure actions, termination/cancellation of professional liability insurance or sanctions from billing private, federal or state health insurance programs (Organizational Providers only*).
 - Participating Providers will have five (5) Business Days from receipt of notice to file a written request for a hearing to appeal suspension, non-renewal, or termination of GHP Family participation. Requests for a hearing shall:
 1. Specify in detail the reason(s) the Participating Provider wishes to contest the suspension, non-renewal or termination decision;
 2. Be delivered certified or registered mail to the GHP Family contact who executed the notice to Participating Provider of non-renewal/termination;
 3. Specify if Participating Provider intends to be represented by an attorney at the hearing;
 4. Include the name, address, phone, fax and email (if available) of Participating Provider's attorney, if applicable;
 5. Include a list of the name(s), title(s), address(es) and phone number(s) of any witnesses expected to testify on behalf of Participating Provider at the hearing; and
 6. Include copies of all additional information Participating Provider wishes to present at the hearing.

Provider Dispute – A written communication to GHP Family, made by a provider, expressing dissatisfaction with a Health Plan decision that directly impacts the provider. This does not include decisions concerning Medical Necessity.

Following are the informal and formal process:

- **Informal Provider Dispute Process** - When a written Provider Dispute is received, it will be forwarded to the appropriate department within GHP Family for resolution. The dispute will be researched and responded to within 45 days of receipt. This initial response is considered the informal settlement process for the dispute.
- **Formal Provider Dispute Process** -If a provider disagrees with our initial response and sends in an additional written inquiry within sixty (60) days of incident being disputed, the Provider Dispute/Appeals Committee will hear all formal Provider Disputes and make a determination. Once received, dispute will be reviewed, and a decision will be rendered within sixty (60) days after receipt. GHP Family may request an extension of up to thirty (30) days, if necessary.

GHP Family’s Provider Dispute/Appeal Committee includes the following personnel:

1. Director, PNM
2. Manager, Operations/Reimbursement Services
3. Medical Director, Medicaid
4. Medical Director (practicing physician) – GHP
5. Claims Designee
6. Provider Relations Representative, PNM

REGULATORY COMPLIANCE

CULTURAL COMPETENCY

Cultural Competency & Interpretive Services for the Disabled and Those with Limited English Proficiency

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, gender identification, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English.

GHP Family expects contracted providers to treat all Members with dignity and respect as required by federal law. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance, such as Medicaid.

GHP Family policies conform with federal government Limited English Proficiency (LEP) guidelines stating that programs and activities normally provided in English must be accessible to LEP persons. Services must be provided in a culturally effective manner to all Members, including those with Limited English Proficiency (LEP) or reading skills, those with diverse cultural and ethnic backgrounds, those who are deaf or hard of hearing, the homeless and individuals with physical and mental disabilities. To ensure Members’ privacy, they must not be interviewed about medical or financial issues within hearing range of other patients.

In compliance with federal and state requirements:

GHP Family makes certain that LEP Members and Members who are deaf or hard of hearing have access to health care and benefits by providing a range of language assistance services at no cost to the Member or the provider. GHP Family offers translation and interpreter services, including sign language interpreters, to providers and Members free of charge. These interpreters are qualified and familiar with medical terminology. The use of professional interpreters, rather than family or friends, is strongly encouraged. GHP offers telephonic interpretation. Providers can make advance

arrangements for personal interpreters. Contact your Provider Relations Representative or the Customer Service Department to learn more about these services.

- Bilingual staff members are available in the Member services department to assist LEP Members.
- Member Materials, such as the Member handbook, are available in English, Spanish, and each prevalent language as determined by DPW.

GHP Family provides alternative methods of communication for Members who are visually or hearing impaired, including Braille, audio tapes, large print and/or computer diskette. Upon Member request, we will make all written materials disseminated to Members accessible to visually impaired Members. GHP Family must provide sign language interpreters and TTY or Pennsylvania Telecommunication Relay Service for communicating with Members who are deaf or hearing impaired, upon request.

GHP Family must include appropriate instructions on all materials about how to access, or receive assistance with accessing, desired materials in an alternate format.

MAINSTREAMING

Pursuant to their Agreement, GHP Family Participating Providers must not intentionally segregate Members in any way from other persons receiving services.

GHP Family investigates Complaints and takes affirmative action so that Members are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, language, MA status, health status, disease or pre-existing condition, anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

- Denying or not providing a Member any covered service or access to a participating facility within the GHP Family Network. GHP Family policy provides access to complex interventions such as cardiopulmonary resuscitations, intensive care, transplantation, and rehabilitation when Medically Necessary. Health care and treatment necessary to preserve life must be provided to all persons who are not terminally ill or permanently unconscious, except where a competent Member objects to such care on his/her own behalf.
- Subjecting a Member to segregated, separate, or different treatment, including a different place or time from that provided to other Members, public or private patients, in any manner related to the receipt of any GHP Family covered service, except where Medically Necessary.
- The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, income status, program membership, language, MA status, health status, disease or pre-existing condition, anticipated need for health care or physical or mental disability of the participants to be served.

HIPAA AND CONFIDENTIALITY

HIPAA Notice of Privacy Practices

GHP Family maintains strict privacy and confidentiality standards for all medical records and Member health care information, according to federal and state standards. Providers can access up-to-date Health Insurance Portability and

Accountability Act (HIPAA) Notice of Privacy Practices on our web-site at www.ghpfamily.com. This includes explanations of Members' rights to access, amend, and request confidential communication of, request privacy protection of, restrict use and disclosure of, and receive an accounting of disclosures of Protected Health Information (PHI).

Confidentiality Requirements

Providers are required to comply with all federal, state and local laws and regulations governing the confidentiality of medical information including all laws and regulations pertaining to, but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and applicable contractual requirements.

Providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records and confidential provider and Member information, whether oral or written in any form or medium. All "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral is considered confidential PHI.

"Individually identifiable health information" is information, including demographic data, that relates to:

- The individual's past, present or future physical or mental health or condition
- The provision of health care to the individual
- The past, present, or future payment for the provision of health care to the individual
- Information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual
- Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number)

Excluded from PHI are employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g.

Providers' offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of GHP Family.

Release of data to third parties requires advance written approval from DPW, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by Members or releases required by court order, subpoena or law.

Member Privacy Rights

GHP Family's privacy policy assures that all Members are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements. Our privacy policy conforms with 45 C.F.R. (Code of Federal Regulations): relevant sections of the HIPAA that provide Member privacy rights and place restrictions on uses and disclosures of protected health information (§164.520, 522, 524, 526 and 528).

Our policy also assists GHP Family personnel and providers in meeting the privacy requirements of HIPAA when Members or authorized representatives exercise privacy rights through privacy request, including:

- Making information available to Members or their representatives about GHP Family's practices regarding their PHI
- Maintaining a process for Members to request access to, changes to, or restrictions on disclosure of their PHI
- Providing consistent review, disposition, and response to privacy requests within required time standards

- Documenting requests and actions taken

Member Privacy Requests

Members may make the following requests related to their PHI (“privacy requests”) in accordance with federal, state, and local law:

- Make a privacy Complaint
- Receive a copy of all or part of their designated record set
- Amend records containing PHI
- Receive an accounting of health plan disclosures of PHI
- Restrict the use and disclosure of PHI
- Receive confidential communications
- Receive a Notice of Privacy Practices

A privacy request must be submitted by the Member or Member’s authorized representative. A Member’s representative must provide documentation or written confirmation that he or she is authorized to make the request on behalf of the Member or the deceased Member’s estate. Except for requests for a health plan Notice of Privacy Practices, requests from Members or a Member’s representative must be submitted to GHP Family in writing.

Privacy Process Requirements

GHP Family’s processes for responding to Member privacy requests shall include components for the following:

Verification

If the requester is the Member, GHP Family personnel shall verify the Member’s identity; verification examples include asking for the last four digits of Member’s Social Security Number, Member’s address and Member’s date of birth. If the requester is not the Member, GHP Family personnel shall require an Authorization for Use or Disclosure completed by the Member to verify the requester’s authority to obtain the Member’s information. If the requester identifies him/herself as a Member’s authorized representative, GHP Family personnel shall require a healthcare Power of Attorney (POA) or comparable document for a representative to act on behalf of the Member.

Review, Disposition, and Response

GHP Family personnel review and disposition of privacy requests shall comply with applicable federal, state, and local laws and regulations, and applicable contractual requirements, including those that govern use and disclosure of PHI. Responses to privacy requests shall conform to guidelines prescribed by HIPAA, including response time standards, and shall include a notice of administrative charges, if any, for granting the request.

Use and Disclosure Guidelines

GHP Family personnel are required to use and disclose only the minimum amount of information necessary to accommodate the request or carry out the intended purpose.

Limitations

A privacy request may be subject to specific limitations or restrictions as required by law. GHP Family personnel may deny a privacy request under any of the following conditions:

- GHP Family does not maintain the records containing the PHI
- The requester is not the Member and GHP Family personnel are unable to verify his/her identity or authority to act as the Member’s authorized representative
- The documents requested are not part of the designated record set (e.g., credentialing information)

- Access to the information may endanger the life or physical safety of or otherwise cause harm to the Member or another person
- GHP Family is not required by law to honor the particular request (e.g., accounting for certain disclosures)
- Accommodating the request would place excessive demands on GHP Family or its personnel's time and GHP Family resources and is not contrary to HIPAA

FRAUD AND ABUSE

GHP Family Compliance Program

GHP Family is committed to a policy of zero tolerance for fraudulent insurance acts that victimize GHP Family and its stakeholders. Accordingly, GHP Family maintains a robust Compliance Program. GHP Family's Compliance Program is designed to oversee the development, implementation and maintenance of a compliance and privacy program that meets or exceeds federal and state laws and regulations, as well as contractual and accreditation obligations. GHP Family is committed to ethical and legal conduct that is compliant with all relevant laws and regulations, and to correcting wrongdoing whenever it may occur in the administration of any of our plans. This commitment encompasses our organization and any of the parties that we contract with to provide services related to the administration of our plans. For more detail on our compliance standards, please refer to Geisinger Health Plan's *Code of Conduct* available online through www.GHPFamily.com. Geisinger Health Plan policies and procedures regarding Fraud, Waste, and Abuse are available upon request. Said policies:

- (a) provide detailed information about the False Claims Act established under sections 3729 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements established under Chapter 38 of Title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in Section 1128B(f) [42 U.S.C.A. § 1320a-7b(f)]);
- (b) include detailed provisions regarding Geisinger Health Plan's procedures for detecting and preventing fraud, waste and abuse and;
- (c) establish inclusion in the employee handbook of a specific discussion of the laws described in subparagraph (a), the rights of employees to be protected as whistleblowers, and Geisinger Health Plan's policies and procedures for detecting and preventing fraud, waste and abuse.

Defining Fraud, Waste, and Abuse

- **Fraud** – An intentional deception or misrepresentation made by a person or entity that knows or should know the deception or misrepresentation could result in some unauthorized benefit to himself/herself or some other person(s) or entity(ies). The Fraud can be committed by many entities, including GHP Family, a subcontractor, a Provider, a State employee, or a Member, among others.
- **Waste** – Waste occurs when an act of carelessness in performance and/or lack of training result in otherwise unnecessary repetition of services or cost.
- **Abuse** – Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the MA Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the HealthChoices RFP, Agreement, and the requirements of state or federal regulations) for health care in a managed care setting. The Abuse can be committed by GHP Family, a subcontractor, Provider, State

employee, or a Member, among others. Abuse also includes Member practices that result in unnecessary cost to the MA Program, GHP Family, a subcontractor, or Provider.

Reporting Fraud and Abuse

Providers and Members can report suspected Fraud and Abuse directly to the DPW Provider Compliance Hotline by calling (866) DPW-TIPS ((866) 379-8477). Providers can also make a report by going online to <http://www.dpw.state.pa.us/learnaboutdpw/andabuse/index.htm> clicking on the Fraud and Abuse link and filling out the MA Provider Compliance Hotline Response Form or send communications via U.S. Mail to:

Bureau of Program Integrity
Medical Assistance Provider Compliance Hotline
P.O. Box 2675
Harrisburg, PA 17 105-2675

Reported problems will be referred to the Office of Medical Assistance Program's Bureau of Program Integrity for investigation, analysis and determination of the appropriate course of action. GHP Family and DPW maintain strict confidentiality concerning the providers and Members who report suspected Fraud and Abuse.

Suspected Fraud and Abuse can also be reported to GHP Family's Compliance Department via the Fraud and Abuse Hotline at (800) 292-1627. Calls to the hotline may be made anonymously. Alternatively, GHP Family's Chief Compliance Officer can be contacted directly at (570) 271-7389.

Examples of Risks for Fraud, Waste and Abuse

Prescriber Fraud, Waste and Abuse

- *Illegal remuneration schemes:* Prescriber is offered, or paid, or solicits, or receives unlawful remuneration to induce or reward the prescriber to write prescriptions for drugs or products.
- *Prescription drug switching:* Drug switching involves offers of cash payments or other benefits to a prescriber to induce the prescriber to prescribe certain medications rather than others.
- *Script mills:* Provider writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for patients that are not theirs. These scripts are usually written, but not always, for controlled drugs for sale on the black market, and might include improper payments to the provider.
- *Provision of false information:* Prescriber falsifies information (not consistent with medical record) submitted through a prior authorization or other formulary oversight mechanism in order to justify coverage. Prescriber misrepresents the dates, descriptions of prescriptions or other services furnished, or the identity of the individual who furnished the services.
- *Theft of prescriber's DEA number or prescription pad:* Prescription pads and/or DEA numbers can be stolen from prescribers. This information could illegally be used to write prescriptions for controlled substances or other medications often sold on the black market. In the context of e-prescribing, includes the theft of the provider's authentication (log in) information.

Member Fraud, Waste and Abuse Risks

- *Misrepresentation of status:* A Member misrepresents personal information, such as identity, eligibility, or medical condition in order to illegally receive the drug benefit. Enrollees who are no longer covered under a drug benefit plan may still attempt to use their identity card to obtain prescriptions.
- *Identity theft:* Perpetrator uses another person's GHP Family identification card to obtain prescriptions.
- *Prescription forging or altering:* Where prescriptions are altered, by someone other than the prescriber or pharmacist with prescriber approval, to increase quantity or number of refills.

- *Prescription diversion and inappropriate use:* Members obtain prescription drugs from a provider, possibly for a condition from which they do not suffer, and gives or sells this medication to someone else. Also can include the inappropriate consumption or distribution of a Member’s medications by a caregiver or anyone else.
- *Resale of drugs on black market:* Member falsely reports loss or theft of drugs or feigns illness to obtain drugs for resale on the black market.
- *Prescription stockpiling:* Member attempts to “game” their drug coverage by obtaining and storing large quantities of drugs to avoid out-of-pocket costs, to protect against periods of non-coverage (i.e., by purchasing a large amount of prescription drugs and then disenrolling), or for purposes of resale on the black market.
- *Doctor shopping:* Member or other individual consults a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.
- *Improper Coordination of Benefits:* Improper coordination of benefits where Member fails to disclose multiple coverage policies, or leverages various coverage policies to “game” the system.
- *Marketing Schemes:* A Member may be victimized by a marketing scheme where a sponsor, or its agents or brokers, violates the marketing guidelines, or other applicable Federal or state laws, rules, and regulations to improperly enroll a MA beneficiary.

Pharmacy Fraud, Waste and Abuse

- *Inappropriate billing practices:* Inappropriate billing practices at the pharmacy level occur when pharmacies engage in the following types of billing practices:
 - Incorrectly billing for secondary payers to receive increased reimbursement.
 - Billing for non-existent prescriptions.
 - Billing multiple payers for the same prescriptions, except as required for coordination of benefit transactions.
 - Billing for brand when generics are dispensed.
 - Billing for non-covered prescriptions as covered items.
 - Billing for prescriptions that are never picked up (i.e., not reversing claims that are processed when prescriptions are filled but never picked up).
 - Billing based on “gang visits,” (e.g., a pharmacist visits a nursing home and bills for numerous pharmaceutical prescriptions without furnishing any specific service to individual patients).
 - Inappropriate use of dispense as written (“DAW”) codes.
 - Prescription splitting to receive additional dispensing fees.
 - Drug diversion.
- *Prescription drug shorting:* Pharmacist provides less than the prescribed quantity and intentionally does not inform the Member or make arrangements to provide the balance but bills for the fully-prescribed amount.
- *Bait and switch pricing:* Bait and switch pricing occurs when a Member is led to believe that drug will cost one price, but at the point of sale the Member is charged a higher amount.
- *Prescription forging or altering:* Where existing prescriptions are altered, by an individual without the prescriber’s permission to increase quantity or number of refills.
- *Dispensing expired or adulterated prescription drugs:* Pharmacies dispense drugs that are expired, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- *Prescription refill errors:* A pharmacist provides the incorrect number of refills prescribed by the provider.
- *Illegal remuneration schemes:* Pharmacy is offered, or paid, or solicits, or receives unlawful remuneration to induce or reward the pharmacy to switch Member s to different drugs, influence prescribers to prescribe different drugs, or steer Member s to plans.

PROVIDER SELF-AUDIT PROTOCOL

The Pennsylvania MA Provider Self Audit Protocol allows providers to voluntarily disclose overpayments or improper payments of MA funds. The Fraud and Abuse protocol is available on the Department's website at <http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/index.htm>.

GLOSSARY

Abuse — Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the MA Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the RFP, Agreement, and the requirements of state or federal regulations) for health care in a managed care setting. The Abuse can be committed by the GHP Family, subcontractor, Health Care Provider, State employee, or a Member, among others. Abuse also includes Member practices that result in unnecessary cost to the MA Program, the GHP Family, a subcontractor, or Health Care Provider.

ACCESS Card — An identification card issued by DPW to each MA Member. The card must be used by MA-enrolled Health Care Providers to access DPW's EVS and verify the Member's MA eligibility and specific covered benefits.

Actuarially Sound Rates — Rates that reflect, among other elements:

- the populations and benefits to be covered;
- the rating groups;
- the projected Member months for each category of aid;
- the historical and projected future medical costs expected to be incurred by an efficiently and effectively operated Medicaid managed care program in the respective county/zone;
- program changes to the extent they impact actuarial soundness of the rates;
- trend levels for each type of service;
- administrative costs expected to be incurred by an efficiently and effectively operated Medicaid managed care program, including assessment costs and profit consideration.

Actuarially sound rates are developed using sound methods and assumptions that are reasonably attainable by the Medicaid managed care organizations in the relevant Agreement year and meet the standards of the Actuarial Standards Board.

Adjudicated Claim — A Claim that has been processed to payment or denial.

Affiliate — Any individual, corporation, partnership, joint venture, trust, unincorporated organization or association, or other similar organization (hereinafter "Person"), controlling, controlled by or under common control with the GHP Family or its parent(s), whether such common control be direct or indirect. Without limitation, all officers, or persons, holding five percent (5%) or more of the outstanding ownership interests of GHP Family or its parent(s), directors or subsidiaries of GHP Family or parent(s) shall be presumed to be Affiliates for purposes of the RFP and Agreement. For purposes of this definition, "control" means the possession, directly or indirectly, of the power (whether or not exercised) to direct or cause the direction of the management or policies of a person, whether through the ownership of voting securities, other ownership interests, or by contract or otherwise including but not limited to the power to elect a majority of the directors of a corporation or trustees of a trust, as the case may be.

Agreement — the written binding document between Participating Provider and Health Plan together with any attachments, exhibits, applicable Provider Guide and the Member benefit plan, as amended from time to time and made part of the Agreement by reference.

Appeal (Provider) — A request from a Health Care Provider for reversal of a denial by the PHMCO, with regard to the three (3) major types of issues:

- Health Care Provider credentialing denial by the GHP Family ;
- Claims denied by the GHP Family for Health Care Providers participating in the PHMCO's Network. This includes payment denied for services already rendered by the Health Care Provider to the Member; and

- Agreement termination by the GHP Family.

Behavioral Health Managed Care Organization (BH-MCO) — An entity, operated by county government or licensed by the Commonwealth as a risk bearing Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO), which manages the purchase and provision of Behavioral Health Services under an agreement with DPW.

Behavioral Health (BH) Services — Mental health and/or drug and alcohol services which are provided by the BH-MCO.

Business Day(s) — Includes Monday through Friday except for those days recognized as federal holidays and/or Pennsylvania State holidays.

Case Management — Services which will assist individuals in gaining access to necessary medical, social, educational and other services.

Centers for Medicare and Medicaid Services (CMS) — The federal agency within the Department of Health and Human Services responsible for oversight of MA Programs.

Certified Registered Nurse Practitioner (CRNP) — A registered nurse licensed in the Commonwealth of Pennsylvania who is certified by the boards in a particular clinical specialty area and who, while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with and under the direction of a physician licensed to practice medicine in Pennsylvania.

Claim — A bill from a Health Care Provider of a medical service or product that is assigned a unique identifier (i.e. Claim reference number). A Claim does not include an Encounter form for which no payment is made or only a nominal payment is made.

Clean Claim — A Claim that can be processed without obtaining additional information from the Health Care Provider of the service or from a third party. A Clean Claim includes a Claim with errors originating in the GHP Family 's Claims system. Claims under investigation for Fraud or Abuse or under review to determine if they are Medically Necessary are not Clean Claims.

Complaint — A dispute or objection regarding a participating Health Care Provider or the coverage, operations, or management policies of a Physical Health managed care organization (GHP Family), which has not been resolved by the GHP Family and has been filed with the GHP Family or with the Department of Health or the Pennsylvania Insurance Department of the Commonwealth, including but not limited to:

- A denial because the requested service/item is not a covered benefit; or
- A failure of the GHP Family to meet the required time frames for providing a service/item; or
- A failure of the GHP Family to decide a Complaint or Grievance within the specified time frames; or
- A denial of payment by the GHP Family after a service has been delivered because the service/item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program; or
- A denial of payment by the GHP Family after a service has been delivered because the service/item provided is not a covered service/item for the Member.

The term does not include a Grievance.

Concurrent Review — A review conducted by the GHP Family during a course of treatment to determine whether the amount, duration and scope of the prescribed services continue to be Medically Necessary or whether any service, a different service or lesser level of service is Medically Necessary.

County Assistance Office (CAO) — The county offices of DPW that administer all benefit programs, including MA, on the local level. DPW staff in these offices perform necessary functions such as determining and maintaining Member eligibility.

Cultural Competency — The ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Denial of Services — Any determination made by the GHP Family in response to a request for approval which: disapproves the request completely; or approves provision of the requested service(s), but for a lesser amount, scope or duration than requested; or disapproves provision of the requested service(s), but approves provision of an alternative service(s); or reduces, suspends or terminates a previously authorized service. An approval of a requested service which includes a requirement for a Concurrent Review by the GHP Family during the authorized period does not constitute a Denial of Service.

Deprivation Qualifying Code — The code specifying the condition which determines a Member to be eligible in nonfinancial criteria.

Developmental Disability — A severe, chronic disability of an individual that is:

- Attributable to a mental or physical impairment or combination of mental or physical impairments.
- Manifested before the individual attains age twenty-two (22).
- Likely to continue indefinitely.
- Manifested in substantial functional limitations in three or more of the following areas of life activity:
 - Self-care;
 - Receptive and expressive language;
 - Learning;
 - Mobility;
 - Capacity for independent living; and
 - Economic self-sufficiency.
- Reflective of the individual's need for special, interdisciplinary or generic services, supports, or other assistance that is of lifelong or extended duration, except in the cases of infants, toddlers, or preschool children who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided.

Disease Management — An integrated treatment approach that includes the collaboration and coordination of patient care delivery systems and that focuses on measurably improving clinical outcomes for a particular medical condition through the use of appropriate clinical resources such as preventive care, treatment guidelines, patient counseling, education and outpatient care; and that includes evaluation of the appropriateness of the scope, setting and level of care in relation to clinical outcomes and cost of a particular condition.

Dispute (Provider) – A written communication to a GHP Family, made by a Provider, expressing dissatisfaction with a GHP Family decision that directly impacts the Provider. This does not include decisions concerning Medical Necessity.

DPW — The Department of Public Welfare (DPW) of the Commonwealth of Pennsylvania.

(DPW) Fair Hearing — A hearing conducted by DPW, Bureau of Hearings and Appeals.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) — Items and services which must be made available to persons under the age of twenty-one (21) upon a determination of Medical Necessity and required by federal law at 42 U.S.C. §1396d(r).

Early Intervention Program — The provision of specialized services through family-centered intervention for a child, birth to age three (3), who has been determined to have a developmental delay of twenty-five percent (25%) of the child's chronological age or has documented test performance of 1.5 standard deviation below the mean in standardized tests in one or more areas: cognitive development; physical development, including vision and hearing; language and speech development; psycho-social development; or self-help skills or has a diagnosed condition which may result in developmental delay.

Eligibility Verification System (EVS) — An automated system available to MA Providers and other specified organizations for automated verification of MA Members' current and past (up to three hundred sixty-five [365] days) MA eligibility, GHP Family Enrollment, PCP assignment, Third Party Resources, and scope of benefits.

Emergency Services — (I) Health care services provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in one or more of the following:

- (a) Placing the health of the enrollee or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy.
- (b) Serious impairment to bodily functions.
- (c) Serious dysfunction of any bodily organ or part.

Transportation and related emergency services provided by a licensed ambulance service shall constitute an emergency service if the condition is as described in the above subparagraph.

(II) Covered inpatient and outpatient services that: (a) are furnished by a Health Care Provider that is qualified to furnish such service under Title XIX of the Social Security Act and (b) are needed to evaluate or stabilize an emergency medical condition described in (I).

Encounter Data — A record of any covered health care service provided to a GHP Family Member and includes Encounters reimbursed through Capitation, Fee-for-Service, or other methods of compensation regardless of whether payment is due or made.

Enrollment Assistance Program (EAP) — The program that provides Enrollment Specialists to assist Members in selecting the GHP Family and Primary Care Practitioner (PCP) and in obtaining information regarding HealthChoices Physical and Behavioral Health Services and service Health Care Providers.

Family Planning Services — Services which enable individuals voluntarily to determine family size, to space children and to prevent or reduce the incidence of unplanned pregnancies. Such services are made available without regard to marital status, age, sex or parenthood.

Federally Qualified Health Center (FQHC) — An entity which is receiving a grant as defined under the Social Security Act, 42 U.S.C. 1396d(l) or is receiving funding from such a grant under a contract with the recipient of such a grant, and meets the requirements to receive a grant under the above-mentioned sections of the Act.

Fee-for-Service (FFS) — Payment by DPW or GHP Family to Health Care Providers on a per service basis for health care services provided to Members.

Formulary — An exclusive list of drug products for which the Contractor must provide coverage to its Members, as approved by DPW.

Fraud — Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting. The can be committed by many entities, including the GHP Family, a subcontractor, a Health Care Provider, a State employee, or a Member, among others.

Grievance — A request to have a GHP Family or a utilization review entity reconsider a decision solely concerning the Medical Necessity and appropriateness of a health care service. A Grievance may be filed regarding a GHP Family decision to 1) deny, in whole or in part, payment for a service/item; 2) deny or issue a limited authorization of a requested service/item, including the type or level of service/item; 3) reduce, suspend, or terminate a previously authorized service/item; 4) deny the requested service/item but approve an alternative service/item. The term does not include a Complaint.

Health Care Provider — A licensed hospital or health care facility, medical equipment supplier or person who is enrolled in the Pennsylvania MA Program and licensed, certified or otherwise regulated to provide health care services under the laws of the Commonwealth or state(s) in which the entity or person provides services, including a physician, podiatrist, optometrist, psychologist, physical therapist, certified registered nurse practitioner, registered nurse, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, physician’s assistant, chiropractor, dentist, dental hygienist, pharmacist or an individual accredited or certified to provide behavioral health services.

HealthChoices Program — The name of Pennsylvania's 1915(b) waiver program to provide mandatory managed health care to Members.

HealthChoices Zone (HC Zone) — A multiple-county area in which the HealthChoices Program has been implemented to provide mandatory managed care to Medicaid Members in Pennsylvania.

HIV/AIDS Waiver Program — A Home and Community Based Waiver Program that provides for Expanded Services to Members who are diagnosed with Acquired Immunodeficiency Syndrome (AIDS) or symptomatic Human immunodeficiency Virus (HIV) as a cost-effective alternative to inpatient care.

Home and Community Based Waiver Program — Necessary and cost effective services, not otherwise furnished under the State’s Medicaid Plan, or services already furnished under the State’s Medicaid Plan but in expanded amount, duration, or scope which is furnished to an individual in his/her home or community in order to prevent institutionalization. Such services must be authorized under the provisions of 42 U.S.C. 1396n.

Medical Assistance (MA) — The Medical Assistance Program authorized by Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq., and regulations promulgated thereunder, and 62 P.S. and regulations at 55 PA Code Chapters 1101 et seq.

Medical Assistance Transportation Program (MATP) — A non-emergency medical transportation service provided to eligible persons who need to make trips to/from a MA reimbursable service for the purpose of receiving treatment, medical evaluation, or purchasing prescription drugs or medical equipment.

Medical Management (MM) — An objective and systematic process for planning, organizing, directing and coordinating health care resources to provide Medically Necessary, timely and quality health care services in the most cost-effective manner.

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

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis, must be documented in writing. The determination is based on medical information provided by the Member, the Member's family/caretaker and the PCP, as well as any other Providers, programs, agencies that have evaluated the Member. All such determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement.

Member — An individual enrolled in GHP Family who is eligible to receive physical and/or behavioral health services under the Medical Assistance (MA) Program of the Commonwealth of Pennsylvania.

Network — All contracted or employed Health Care Providers in the GHP Family who are providing covered services to Members.

OMAP Hotlines — Hotlines designed to address clinically-related systems issues encountered by Members and their advocates or Providers. The OMAP Hotlines facilitate resolution according to DPW policies and procedures and do not impose additional obligations on the GHP Family .

Other Resources — With regard to TPL, Other Resources include, but are not limited to, recoveries from personal injury Claims, liability insurance, first-party automobile medical insurance, and accident indemnity insurance.

GHP Family Coverage Period — A period of time during which an individual is eligible for MA coverage and enrolled with a GHP Family.

Participating Provider – A licensed hospital or health care facility, medical equipment supplier or person who is enrolled in the Pennsylvania MA Program and licensed, certified or otherwise regulated to provide health care services under the laws of the Commonwealth or state(s) in which the entity or person provides services, including a physician, podiatrist, optometrist, physical therapist, certified registered nurse practitioner, registered nurse, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, physician's assistant, chiropractor, dentist, dental hygienist or pharmacist that has a written Provider Agreement with and is credentialed by GHP Family to provide physical health services to GHP Family Members.

Primary Care Practitioner (PCP) — A specific physician, physician group or a CRNP operating under the scope of his/her licensure, and who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating and monitoring other medical care and rehabilitative services and maintaining continuity of care on behalf of a Member.

Primary Care Practitioner (PCP) Site — The location or office of PCP(s) where Member care is delivered.

Prior Authorization — A determination made by the GHP Family to approve or deny payment for a Provider's request to provide a service or course of treatment of a specific duration and scope to a Member prior to the Provider's initiation or continuation of the requested service.

PROMIS^e™ Provider ID — A 13-digit number consisting of a combination of the 9 digit base NPI Provider Number and a 4-digit service location.

Provider Medical Assistance Identification Number (MAID #) — Unique identification number which was formerly assigned by DPW to each individual Provider, Provider Group and Managed Care Organization. The MAID # was replaced by the PROMIS^e™ Provider ID.

Provider Reimbursement (and) Operations Management Information System electronic (PROMIS^e™) — A Claims processing and management system implemented by DPW that supports the Fee-for-Service and Managed Care Medical Assistance delivery programs.

Quality Management (QM) — An ongoing, objective and systematic process of monitoring, evaluating and improving the quality, appropriateness and effectiveness of care.

Retrospective Review — A review conducted by the GHP Family to determine whether services were delivered as prescribed and consistent with GHP Family's payment policies and procedures.

School-Based Health Services — An array of Medically Necessary health services performed by licensed professionals that may include, but are not limited to, immunization, well child care and screening examinations in a school based setting.

Special Needs Unit — A special dedicated unit within the GHP Family's and the EAP contractor's organizational structure established to deal with issues related to Members with Special Needs.

Third Party Liability (TPL) — The financial responsibility for all or part of a Member's health care expenses of an individual entity or program (e.g., Medicare) other than GHP Family.