Geisinger Health Plan

Briefly March 2011

A Publication for Providers and Office Personnel

GEISINGER HEALTH PLAN®

In this issue

Important changes to Physician Quality Summary

Over the past five years, Geisinger Health Plan's Physician Quality Summary (PQS) program has rewarded primary care physicians with more than $25 million in incentive payments. As a result our members have benefited from the quality preventive and chronic care services you have provided. Thank you for all your hard work.

As we move into a new decade marked by health care reform and increasing demands from patients, employers and regulators, we are looking for more effective ways to reward primary care providers. We must also balance this with reduced reimbursement from Medicare and greater accountability to employer groups who cannot afford to absorb higher premiums.

Therefore, we have refocused the PQS program on outcome-driven measures, removing some previous criteria to concentrate on more tangible metrics that will allow your practice to achieve maximum rewards.

The new PQS program period started in January and continues throughout 2011. Listed below are the 2011 PQS measurement categories. Please visit thehealthplan.com for more information on the new PQS measurement categories, eligibility standards and payout standards.

Category	Description	Percentage of total score
Acute/Chronic illness	5 acute/chronic care HEDIS measures	25%
Preventive health	9 preventive health HEDIS measures	25%
Pharmacy management	7 medication measures	25%
Emergency care management	Emergency department utilization	15%
Efficiency of care	Comparison of cost calculations	10%
Total		100%

Below is a listing of the payment schedule for PQS checks. TPA client checks will be separate from the HMO/Gold payments. If you have any questions, please contact your Provider Relations Representative.

Reporting period	Payout period
Calendar year 2009 HEDIS	October 2010 (Paid)
Calendar year 2009 HEDIS	April 2011
Calendar year 2010 HEDIS	October 2011
Calendar year 2010 HEDIS	April 2012
(New program) Calendar year 2011 PQS	September 2012

CHIP has new name, new dental network

Geisinger Health Plan's Children's Health Insurance Program (CHIP) is now called GHP Kids. Members have received new identification cards reflecting this name and logo change.

Also, beginning January 1, 2011, GHP Kids members will receive dental services from the DentaQuest network. Members can find a dentist by:

- Visiting GHPKids.com and clicking on "Find a Dentist" to be transferred to DentaQuest's Web site; or
- Visiting them directly to search for a dentist at http://dentaquestgov.com/FindProvider/FindProvider.aspx; or
- Calling the GHP Kids Customer Service Team for assistance.

Take advantage of online tools

Make 2011 more efficient by enrolling in all the electronic services offered by Geisinger Health Plan. Providers already receiving electronic EOPs will no longer receive paper EOPs beginning in January.

EDI Payor ID: #75273

Electronic Funds Transfer (EFT): Contact 570-271-5846 or complete EFT form online and fax to 570-214-1553

Electronic EOPs (835 transactions): Complete enrollment form and fax to 570-271-5341 with a letter of authorization

Electronic Verifications and Secure Messaging: Available through the Provider Service Center at www.thehealthplan.com

Who to call when you need assistance

Customer Service Team (800) 447-4000
Questions on claims, benefits, eligibility, prior authorization or referrals status

Webmaster (877) 571-5366
Questions on registration to secure section of web

Provider Relations Representative (800) 876-5357
Questions on your contract, incentive program, utilization reports, fee schedules or request an orientation

Medical Management (800) 544-3907
Questions on prior authorization

Provider education webinars

Beginning March 1, Geisinger Health Plan would like to invite you to participate in educational webinars covering topics that impact your busy practices. Learn about new programs and tools offered by Geisinger Health Plan and take the opportunity to ask the questions that you need answered.

Register today by contacting Janette Daniel at jedaniel@thehealthplan.com or at 570-271-8762.

Claim Reconsideration Process - *Every Thursday at Noon (30 minutes)*
Overview of claim reconsideration process.

PQS Program Overview - *Every Wednesday at Noon (1 hour)*
Overview of the entire PQS program, including measures, reimbursement, methodology, tools and training.

Credentialing Overview - *Every Monday at Noon (30 minutes)*
Overview of the credentialing processing, includes CAQH and demographic changes.

Medication Adherence - *March 24 at Noon (1 hour)*
Overview of new reports and tools

NIA Overview - *Every Tuesday at Noon (1 hour)*
Overview of prior authorization, facility selection, patient involvement and clinical guidelines. Please register one week in advance by calling (800) 327-0641.

Geisinger Health Plan Provider Service Center

The new Provider Service Center is available for use. Existing users will see some changes. Please start using the new Service Center if you have not done so already.

New or revised features include:

- Search for eligible members by last name & MRN, or last name and date of birth
- Copayment information for PCP, SCP, ER and inpatient services
- Coinsurance information listed
- Deductible information including remaining balances
- Claim information by member, tax identification or provider number
- EOP information with expanded printing features (note: Providers receiving 835 [electronic EOPs] will no longer receive paper EOP beginning shortly. You should use the Provider Service Center for copies of your EOPs)
- Subscriber ID has been added to the Member Detail page
- View eligibility history on the Member Detail page
- View EOPs greater than last 30 days by conducting a search

Billing codes for influenza vaccine

CMS has established separate billing codes for each brand-name influenza product under CPT code 90658. Effective January 1, 2011 CPT code 90658 is no longer payable by Medicare.

Providers should be reporting the flu vaccine based upon the brand name drug that is used. CMS has created five new HCPCs codes to be used for reporting this service.

Please refer to www.thehealthplan.com for more information on the billing codes for influenza vaccine.

Fecal occult blood test

If a patient refuses a colonoscopy, try requesting an annual Fecal Occult Blood Test (FOBT). An FOBT doesn't require prep, doesn't require fasting and doesn't require any significant member cost. It also gives you and the patient an opportunity to determine whether a medical condition exists.

For Geisinger Health Plan members over age 50, the test is free when performed at a participating laboratory provider. Completing an FOBT also improves PCP compliance in the Physician Quality Summary (PQS) incentive program, and your overall star rating.

If you'd like to learn more about HEDIS compliance with FOBTs, please contact your Provider Relations Representative at 800-876-5357.

CMS annual audit

Annually, the Centers for Medicare and Medicaid Services conducts audits on Medicare Advantage plans to ensure the claims data submitted to CMS is supported by the medical record. This audit requires the Health Plan to obtain a copy of the medical record to demonstrate to CMS the diagnosis reported on the claim is actually present in the medical record.

In anticipation of this year's audit, providers are asked for their cooperation with these requests in a timely way. The audit will allow a six week collection process. Results of the audit will be shared with physicians/providers as a training opportunity. We appreciate your cooperation in this audit process

Provider assistance assures HEDIS® success

The Health Plan would like to thank providers and office staff for their cooperation and assistance with HEDIS® chart audits. The information collected helps us identify patients who should receive necessary immunizations and tests. We also appreciate your support in encouraging patients to receive needed immunizations and screenings.

We will conduct our annual chart reviews in March and April, and with your help, we hope to have another successful HEDIS® year.

Health Plan policies and procedures available online

The Health Plan Participating Provider Guide (10/08) is available online at thehealthplan.com. You may also request a copy of the full guide, or select sections, by calling your Provider Relations Representative.

The Participating Provider Guide includes important Health Plan policy and procedure information, including:

- Member rights and responsibilities (HMO, PPO and Gold)
- Medical management information (communicating denials of coverage, how we make medical management decisions, and more)
- Quality Improvement information
- Privacy information
- Minimum standards for medical record documentation

Radiology Billing Reminder

As communicated in the Operations Bulletin dated November 30, 2010, the Health Plan adopted Medicare's policy on multiple procedure payment reduction for all product lines on the technical component (TC) of certain diagnostic imaging procedures. The reduction will be applied to the applicable procedures. Full payment is generated on the highest allowed procedure. Each subsequent procedure performed during the same encounter is reimbursement at 50 percent.

The Health Plan is committed to reimbursing providers promptly and accurately in accordance with our contractual agreements. We strive to inform providers of claims processing requirements in order to avoid administrative denials that delay payment and require resubmission of claims. We will use NIA claim editing guidelines on applicable claim encounters, and will reserve the right to rebundle to the primary procedure those services determined to be part of, incidental to, or inclusive of the primary procedure. We reserve the right to process the claim according to said standards.

National Imaging Associates (NIA) provider assessment application

In our continuing effort to improve the quality and safety of services rendered to Geisinger Health Plan members, we are initiating new protocols to evaluate providers of advanced diagnostic imaging services according to specific screening standards, effective February 1, 2011. Our diagnostic imaging management vendor, National Imaging Associates, Inc. (NIA), an affiliate of Magellan Health Services, has been directed to administer the evaluation and approval process.

If your practice performs the professional, technical or both components of an MR, CT, PET, echocardiography, stress echocardiography, nuclear cardiology or diagnostic nuclear medicine, you are required to complete an NIA Provider Assessment Application. This application and approval will ensure you will continue to receive applicable reimbursement for services provided.

To access the online application:

- Direct your Web browser to www.RadMD.com
- Click on the link for NIA Provider Assessment Application (located under online tools)
- Enter your login and click "Login".

A separate privileging application should be completed for each practice location performing MR, CT, PET, echocardiography, stress echocardiography, nuclear cardiology, or diagnostic nuclear medicine. If your practice has more than one location performing these diagnostic imaging services, please call NIA at **888-972-9642** to request an additional login.

Prior Authorization Requirements

Effective February 1, 2011, these outpatient cardiac-related procedures will also require prior-authorization:

- CCTA
- Echocardiography
- Stress Echo

Prior-authorization through NIA is also required for these outpatient radiology procedures:

- CT/CTA
- MRI/MRA
- PET Scan
- Nuclear Cardiology (MPI)
- Diagnostic Nuclear Medicine

NIA's Prior-Authorization guidelines will be posted under the "Health Plan Alerts" section of NIA's website at www.RadMD.com.

Key Provisions:

- Emergency room, observation and inpatient imaging procedures do not require authorization.
- The ordering physician must obtain authorization.
- Failure to verify that services have been preauthorized may result in non-payment of your claim.

Please note: Prior-authorization requirements may not apply to members with an employer self-funded plan for which the Health Plan acts as third party administrator.

To obtain prior authorization:

- Contact NIA at **866-305-9729**, 8:00 a.m. to 8:00 p.m. or at www.RadMD.com.
- If a current authorization is required and cannot be located at www.RadMD.com, contact the ordering provider to advise that prior authorization must be obtained and have the ordering provider (or their staff) call NIA to request an initial authorization.

Facility Selection Support Program Overview

National Imaging Associates, Inc. (NIA)* performs coverage certification reviews for Geisinger Health Plan relating to certain outpatient procedures (MRI, CT, PET, CCTA, Nuclear Cardiology, Diagnostic Nuclear Medicine, Stress Echo and Echocardiography). As part of NIA and Geisinger Health Plan's continued commitment to our customers to educate providers and members, we have launched a program called Facility Selection Support. Facility Selection Support is designed to provide information regarding convenient, in-network cost-effective imaging facilities to providers and members. In addition, NIA can assist the member in scheduling the approved non-emergent imaging tests at a facility that best meets the needs of the patient.

We recognize that patients want to make informed decisions when seeking health care services and that quality, convenience and cost are important factors. With the NIA Facility Selection Support program, NIA provides support to both the physician and the patient in the selection of an imaging facility that meets the needs of the patient and in scheduling imaging services at that facility. The program focuses on education and transparency. The final decision on a facility for imaging services is always the member's decision in conjunction with his/her doctor.

How the Program Works

- The ordering physician's office contacts NIA for pre-authorization of the imaging exam. NIA conducts medical necessity review.
- If the imaging test is for a non-cardiac study – CT, MR, or PET – NIA will assist the physician with the selection of an imaging facility that is both conveniently located and cost-effective for the member.
- NIA works with the physician if the member has clinical needs that the physician feels require a different facility.
- If the member's clinical needs can be met in an alternate

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Commercial formulary updates

A drug formulary is a continually updated list of prescription drugs that the health plan covers. The formulary list is determined by the clinical judgement of the Pharmacy and Therapeutics Committee, which is made up of a diverse health care team. As a general rule, drugs at tier 1 and tier 2 are considered preferred drugs, while non-preferred drugs are typically at tier 3. Prior authorization may be necessary for certain drugs. The table below represents recent updates to the Health Plan's formulary. For a hard copy of the entire Formulary, please contact our Pharmacy Customer Service Team at (800) 988-4861, Monday through Friday, 8 a.m. to 5 p.m. or go to thehealthplan.com to view and print a copy.

Drug	Status	Tier	Notes
Victoza	F	3*, t	Byetta is preferred, but it also requires a prior authorization
Besivance	F	3	
Pradaxa	F	3*,t	
Gilenya	F	3*, t	Betaseron and Copaxone are the preferred medications
Vagifem Divigel Elestrin	F	3	the prior authorization has been removed
Stromectol	F	3	
Pegasys	F	2	the prior authorization has been removed
Peg Intron	F	2	the prior authorization has been removed
Lipitor	F	2	Effective 1-1-2011, the prior authorization has been removed, and the tier has changed.

Status column key:

Formulary (F) -drug is a preferred product; prior authorization may still apply according to the table above

Non-Formulary (NF)-drug is not a preferred product; prior authorization will likely apply according to the table above

Tier key:

* =prior authorization applies for the traditional benefit
t = prior authorization applies for the triple choice benefit
** = quantity limit applies

Medication Adherence Reports from Geisinger Health Plan

Prescribing medications is a daily activity for physicians, nurse practitioners and physician assistants. The goal is to ensure your members are taking their medications as prescribed to prevent re-hospitalization or adverse events. Medication adherence reports are now available to you online at www.thehealthplan.com through the Health Care Provider link under reporting. To start tracking medication adherence of your members, please contact your Provider Relations Representative at 800-876-5357 or the Pharmacy Department at 570-214-1737.

Gold formulary updates

Drug	Status	Formulary A Tier	Formulary B Tier
Atacand, Atacand HCT, Avalide, Avapro, Benicar, Benicar HCT, Besivance, Diovan, Diovan HCT, Divigel, Elestrin, Invermectin, Micardis, Micardis HCT, Teveten, Teveten HCT, Vagifem	F	2	3
Gilenya	F	2*	3*
Pradaxa	F	2*	3*

The 2011 Formulary is available online at www.thehealthplan.com or by calling (800) 988-4861

Status column key:

Formulary (F) -drug is a preferred product; prior authorization may still apply according to the table above

Non-Formulary (NF) -drug is not a preferred product; prior authorization will likely apply according to the table above

Tier key:

Formulary A- Geisinger Gold standard formulary

Formulary B- Geisinger Gold $0 deductible formulary

* =prior authorization applies

** = quantity limit applies

To request a prior authorization, please contact the GHP Pharmacy Department at (800) 988-4861, Monday- Friday, 8 a.m.- 5 p.m.

Fraud, waste and abuse compliance program

Geisinger Health Plan, Geisinger Indemnity Insurance Company, and Geisinger Quality Options (collectively referred to as "the Health Plan") are committed to a policy of zero-tolerance for acts that comprise fraud, waste and abuse, and which victimize the Health Plan, its officers, employees, policyholders (members), business partners or any other stakeholder. We encourage providers to develop their own compliance program and routinely conduct steps to mitigate exposure while complying with payor and regulatory requirements. The Health Plan resists fraud-related losses by developing, refining, communicating and maintaining a fraud and abuse program to prevent, detect, investigate and report, as required by law, fraudulent, wasteful and abusive acts. The Health Plan will cooperate fully with all persons, entities and enforcement agencies engaged in combating health insurance fraud, waste and abuse.

Under the Patient Protection and Affordable Care Act (PPACA), the Centers for Medicare & Medicaid Services (CMS) have stepped-up efforts to prevent and detect fraud with its publication of a Proposed Rule addressing program integrity enhancements. The Proposed Rule would enhance background screening procedures for providers and suppliers participating or enrolling in the Medicare and Medicaid programs as well as the Children's Health Insurance Program (CHIP). These changes are consistent with the five-principle strategy adopted by the Office of the Inspector General for the Department of Health and Human Services (OIG) to fight health care fraud, waste and abuse. Both the OIG and CMS are emphasizing the need to scrutinize more closely individuals and entities seeking to participate in Medicare, Medicaid and other federal and state health care programs as well as those revalidating enrollment. Other elements of the Proposed Rule include background screening based on specific provider type categories, applications fee to participate with Medicare and a temporary moratoria on enrollment.

The OIG's five-principles target enrollment, payment, compliance, oversight and response, and are emphasized as areas to receive specific regulatory and enforcement attention in the annual workplan it has issued for 2011. The Health Plan endeavors to comply with these OIG principles. For example, we search the National Practitioner Data Bank to review past sanctions history, if any, and compare the Health Plan's existing and prospective providers to the debarred and excluded provider list obtained via the OIG's downloadable data base. Prospective providers matching the list are denied participation in the Health Plan's provider network. Existing providers are removed from the provider network if currently under contract.

For more information on the Health Plan's compliance program, please visit www.thehealthplan.com (https://www.thehealthplan.com/providers_us/Compliance Program Info-Provider.pdf) or contact our Compliance Office at 800-292-1627.

Medical and pharmaceutical policy updates

The following is a summary of select medical and pharmaceutical policies. The full text of these policies and all Health Plan policies are online at thehealthplan.com. Printed copies are available by contacting your Provider Relations Representative.

In the near future, information on policies and guidelines will be available exclusively online at thehealthplan.com. More details will be available in future issues of *Briefly*.

New and revised policies are effective March 1, 2011. Authorizations can be generated prior to March 1.

Revised medical policies

MBP 11.0 Botulinum Toxin

- **Requires prior authorization through Medical Management**
- Updated criteria to include coverage for the treatment of chronic migraine headache when certain criteria are meet.

MP 97 Genetic Testing for BRCA1/BRCA2 for Breast or Ovarian Cancer

- **Prior Authorization IS required for these services**
- Indications revised to be consistent with current National Comprehensive Cancer Network (NCCN) guidelines.

MP 98 Genetic Testing Related to Colorectal Cancer

- **Prior Authorization IS required for these services**
- Indications revised to be consistent with current National Comprehensive Cancer Network (NCCN) guidelines.

MP 205 Advanced Molecular Topographic Genotyping

- **Requires prior authorization through Medical Management**
- Coverage limited to the Medicare Business Segment in compliance with CMS directives

The prior authorization requirement has been **removed** from the following treatments, modalities, and pharmaceuticals:

MP 24 External Counterpulsation
MP 67 Kyphoplasty
MP 114 Vertebroplasty
MP 150 Carotid Artery Stenting
MBP 45.0 Herceptin® (trastuzumab)
MBP 52.0 Implanon™(etonogesterol implant)
MBP 66.0 Reclast® (Zoledronic Acid)

Retired Policies

The following Medical Policies have been removed:

- MP 70 Genetic Testing for Cystic Fibrosis
- MP 128 Essure™ Hysteroscopic Micro-insert Tubal Occlusion Sterilization

Clinical Guideline Update

The following clinical guideline has been recently updated and approved by the Geisinger Health Plan Quality Improvement Committee for use by participating providers, and has been posted on thehealthplan.com:

- Adult depression
- Diabetes
- Chronic kidney disease
- Adult obesity
- Pediatric obesity

The complete list of clinical guidelines is available online at thehealthplan.com. Providers are encouraged to contact their Provider Network Management Coordinator for assistance in accessing the guidelines online or to request hard copy versions. Comments can be sent to pkrebs@thehealthplan.com.

Clinical Guideline Review

The Health Plan continues to solicit physician and non-physician provider input concerning clinical guidelines. The following clinical guidelines are currently being reviewed:

- Adult sinusitis
- Hyperlipdemia
- Adult urinary tract infection

Your feedback is encouraged and appreciated. Comments should be sent to Phillip Krebs, Medical Management 30-20, or by e-mail to pkrebs@thehealthplan.com. Please provide your feedback by April 1, 2011.

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Briefly is published quarterly by Geisinger Health Plan, and serves as an informational resource for participating providers and office personnel.

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A copy of this newsletter can also be found at thehealthplan.com

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National Imaging Associates (NIA) provider assessment application

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facility, NIA works with the physician to ensure that the availability of alternative, cost-effective facilities is considered.

- If the facility selected could result in additional costs to the member or the employer, the physician is notified of the potential cost implication and the need to confirm the facility selected with the member.
- NIA will reach out to the member immediately to finalize the facility selection process.
- If the member is reached:
  - Member is notified that the test ordered by the physician's office has been clinically approved.
  - Member is provided information about the facility selected by the physician's office and the potential cost implications to his/her family or employer.
  - Member is educated about alternate, cost-effective facilities available nearby.
  - Member confirms the facility that best meets their needs.
  - NIA offers to assist in scheduling the appointment for any in-network facility selected.
- If the member is not reached, the imaging facility selected by the ordering physician is confirmed and the member is notified via letter of the potential cost implications and how to contact NIA for any questions or assistance.

Physician Quick Contacts
- Website: www.RadMD.com
- Toll Free Telephone Number: 866-305-9729
- Call Center Hours: Mon-Fri 8 a.m. to 8 p.m. (EST)
- Geisinger Provider Relations - 800-876-5357

**National Imaging Associates, Inc. is an affiliate of Magellan Health Services.*