GHP FAMILY PARTICIPATING PROVIDER ORIENTATION
Disclaimer

• This presentation is not intended to be all inclusive.

• All information is fully delineated in the Provider Guide, which may be amended from time to time by written correspondence and can be found online at www.ghpfamily.com.
About GHP Family

• On March 1, 2013 the Commonwealth’s Department of Human Services (DHS) expanded its Medical Assistance managed care program, “HealthChoices”, into a 22-county geographic “zone” referred to as the New East Zone.

• Due to the expansion, the ACCESS Plus physical health program for Medical Assistance recipients ended February 28, 2013.

• GHP Family is one of three Managed Care Organizations (MCO) offered within the New East Zone.
About GHP Family

• All Medical Assistance recipients residing in the New East Zone are required to choose one of the three managed care health plans.

• Those who do not choose a managed care health plan will be assigned one.
*Highlighted counties constitute the coverage area designated as the New East Zone by DHS.*
Provider Communications

Website:
www.geisinger.org/en/health-plan

Provider Portal:
www.NaviNet.net

• Participating Provider Guide
• Operations Bulletins
• Monthly Provider Newsletter
• Contact List/Who to Call
• Forms
Enrollment

• Eligibility is determined by the Pennsylvania Department of Human Services (DHS)

• DHS Enrollment Broker Benefit Consultants
  – New East Zone (800) 440-3989
  – Assist recipients in the selection of an MCO and PCP
  – Educate recipients on plan benefits, referral system, and provider network
  – Notifies DHS of plan selection
  – DHS then notifies GHP Family of new enrollees and their corresponding PCP selection
Member Appeals and Provider Disputes

• Detailed information on Member Complaints, Grievances, and DHS Fair Hearing Process can be found in the GHP Family Provider Manual and the GHP Family Member Handbook.

• The Provider Manual is available on the Provider Service Center at www.geisinger.org/health-plan/plans/ghp-family
Cultural Competency

DHS defines Cultural Competency as:

The ability of individuals 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 healthcare delivery to diverse populations.

Title III of the Americans with Disabilities Act (ADA) states that public accommodations, including healthcare provider sites, must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability.
Cultural Competency

- Communication is the first step in establishing a physician-patient relationship.

- If a GHP Family member requires or requests translation services because they are either non-English or limited English speaking, or the member has some other sensory impairment, the provider has a responsibility to make arrangement to procure translation services for those members, and to facilitate the provision of health care services.

- Providers who are unable to arrange for translation services can contact Customer Service at (855) 227-1302.
Enhancing Patient and Provider Communication

GHP Family encourages providers to embrace Cultural Competency to:

• Build rapport with the patient.
• Make sure patients know what you do.
• Keep patients’ expectations realistic.
• Work to build patients’ trust in you.
• Determine if the patient needs an interpreter for the visit.
Health Literacy

Health literacy is the ability to communicate with members in a way that is easy for them to understand and act upon. Members with both high and low reading levels can have limited knowledge of health care resulting in low health literacy. Low health literacy is a growing problem and difficult to detect with no outward signs. Members with low health literacy tend to be less compliant, which leads to lower quality of life and higher health care costs.
Health Literacy

Building a physician-patient relationship by taking the patient’s values and preferences into account is one strategy to improve health literacy.

To help ensure patient understanding, GHP Family recommends the following:

• Use plain, everyday words or pictures that are clear
• Provide easy-to-read health materials
• Encourage dialogue about diagnosis or medications to determine comprehension
Fraud and Abuse

• Fraud and abuse is estimated to account for the majority of loss in the health care industry.

• Geisinger Health Plan is committed to a policy of zero tolerance for fraudulent insurance acts.

• Providers can report suspected fraud and abuse directly to the DHS Provider Compliance Hotline by calling (866) DPW-TIPS.

• GHP and DHS maintain strict confidentiality concerning providers who report suspected fraud and abuse
Eligibility

• Each member is issued an identification card similar to this example.

![Identification Card Example]

• Providers should always verify benefits and coverage prior to rendering services.
Eligibility can be verified the following ways:

- GHP Family Customer Service at (855) 227-1302
- PROMISE Online at [http://promise.dpw.state.pa.us](http://promise.dpw.state.pa.us)
- PA Medical Assistance Eligibility Verification System (EVS) Telephone Line (800) 766-5387 using Member’s ID card and PA Access Card information.
Special Needs Plan (SNP)

- Dual Eligible SNP – members that are eligible for both Medicare and Medicaid. CMS wants GHP to manage the various benefits these members are eligible for, whether through CMS/Medicare or DHS/Medicaid. Geisinger Health Plan currently offers this product.
- Institutionalized or Institutionalized Equivalent SNP – members that reside or are expected to reside for 90 days or longer in a LTC facility (or) members living in the community but requiring an institutional level of care based on a State assessment tool. Geisinger Health Plan does not currently offer this product.
- Chronic Care SNP – members must fit into one of 15 CMS-approved conditions or one of 5 CMS-approved condition groups. Geisinger Health Plan does not currently offer this product.
• GHP Family members are entitled to certain covered services under the Medical Assistance Program of the Commonwealth of Pennsylvania.

• GHP Family also offers additional benefits outside the Medical Assistance Program.

• Member benefits can be verified online through NaviNet or by calling Customer Service.
## Primary Care and Specialty Care Provider Scheduling Procedures:

<table>
<thead>
<tr>
<th>Type</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent Care</td>
<td>Immediately or referred to the ER</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Routine Care</td>
<td>Within 10 business days of the Member’s call</td>
</tr>
</tbody>
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Provider Information

• Member wait times for PCPs should not be more than thirty (30) minutes for a routine care appointment.

• Providers are required to conduct affirmative outreach whenever a member misses an appointment.
Referrals

- Electronic Referral Submission and Inquiry are available through NaviNet at www.NaviNet.net
- Referrals must be submitted electronically through NaviNet at www.NaviNet.net
- Referrals are valid for 18 months.
When is a Referral Required?

• Outpatient specialty consultative, evaluation / management and surgical services by a participating provider
  - Excluding Emergency and Direct Access services

• Invasive procedures by a participating Provider
  - i.e., bronchoscopy, endoscopy and colonoscopy

• Specialty services immediately following an emergency room or an inpatient hospital discharge
No Referral Required

- Vision
- Dental Care
- Obstetrical and Gynecological (OB/GYN) services
- To be self-referred, the member must obtain self-referred services from GHP Family’s provider network
- Chiropractic services
- Physical Therapy services
- Family Planning services
Mental Health and Substance Abuse

- PCPs and all non-behavioral health practitioners are encouraged to recommend behavioral health services to GHP Family 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.

- Refer to the GHP Family Provider Manual for more information.
Prior Authorization

The following require prior authorization by GHP Family:

• Planned inpatient admission, including rehabilitation admissions
• Skilled level of care admissions
• Outpatient rehabilitative services (PT/OT/ST)
• Outpatient radiology services (CT Scan, MRI, PET Scan) *
• Private duty nursing (Shift Care) by Home Health Provider

* Use of the radiology decision support tool (NDSC) is required.
Prior Authorization

- Admitting or ordering physician is responsible for obtaining prior authorizations
- Requests may be telephonic, faxed, or submitted via U.S. Mail to:

  GHP Family
  Medical Management Department 30-20
  100 North Academy Avenue
  Danville, PA 17822
  Phone: (800) 544-3907 or (570) 271-6497
  Fax: (570) 271-5534
Pharmacy

• Outpatient Prescription Drug Coverage includes the use of a Formulary and Participating Pharmacies.

• Health Plan offers multi-tiered prescription benefit levels which generate member cost sharing based upon the type of medication prescribed.

• Tier Explanation:
  – Brand – mostly single source, includes specialty drugs
  – Generic
  – OTC – certain OTCs covered at retail pharmacy when prescription is provided by physician
Pharmacy continued

Opioid Prior Authorization. Documentation is required to address the following items when requesting prior authorization for opioid prescriptions for patients aged 18 or older:

- Why a non-opioid alternative is not advised
- Treatment for chronic non-cancer pain when the prescription is written by a pain management specialist, or the member has been referred to a pain management specialist, or documentation that a signed pain contract is in place
- Attestation that the prescriber will conduct urine drug screening (UDS) per the American Society of Addiction Medicine (ASAM) guidelines
- Agreement to evaluate member for risk of opioid use disorder using CAGE-AID, or a similar screening tool, upon initiation of opioids and every three months (or as needed)
- A plan for the tapering of benzodiazepines or rationale for continued use (if applicable)
- Proof you have queried the state’s Prescription Drug Monitoring system for the patient
- Statement showing you have discussed the risks of addiction and overdose with the member
- Proof you have educated the patient on the potential adverse effects of opioid analgesics, including the risk for misuse, abuse and addiction and, if you determine the member is at risk, that you have considered prescribing naloxone
Pharmacy continued

Opioid Prior Authorization Submission

- Opioid Use Prior Authorization Form is available on NaviNet.net or the provider portal or www.geisinger.org/health-plan/plans/ghp-family
- For assistance, please call 1-855-552-6028 or fax completed form to 570-271-5610.
- Medical documentation may be requested. This form will be returned if not completed in full
GHP Family Specialty Drug Program

Specialty Drug Process

- A list of specialty medications will be available on the GHP Family website.
- Prescribing physicians must fax a completed Specialty Vendor Drug Request Form and, when applicable, a PA form (forms can be found on GHP Family website).
- Upon request for PA and/or the receipt of a completed Specialty Vendor Drug Request Form, GHP will:
  - verify member eligibility and perform authorization review, if required.
  - notify the prescribing physicians of the approval or denial within applicable regulatory time frames.
- The Health Plan will reimburse the Pharmacy Vendor directly for the medication distributed by the Pharmacy Vendor.
- Participating Providers will not be reimbursed for medications obtained through the Pharmacy Vendor.
- Medication requests will be shipped according to the prescribing physician’s instructions.
Pharmacy Prior Authorization 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 a 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.

• Prior Authorization forms can be found at www.Geisinger.org/health-plan/plans/ghp-family.com. Health Care Providers can initiate such requests by contacting the Pharmacy Department by telephone, fax or written request.
Coordination of Benefits

GHP Family is the primary payer on the following services:

- Preventive pediatric care (including EPSDT services to children)
- Services to children having medical coverage under a Title IV-D child support order
Coordination of Benefits

- 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.
- 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.
- Providers cannot balance bill members.
“Right from the Start” Maternal Health Program

- GHP Family’s “Right from the Start” Maternal Health Program is the name of our “Healthy Beginnings Plus” program.
- This program is designed to serve the GHP Family member throughout her pregnancy, from early identification, through the prenatal experience and post-partum follow-up.
- Communication with the obstetrical provider is emphasized from the first identification of pregnant status.
- The OBNF Form should be completed with pregnancy determination [www.obcare.optum.com](http://www.obcare.optum.com)
- OBNF Form is part of the GHP Family Pay-for-Quality Program
- Refer to the GHP Family Provider Manual for more detailed information on this process.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

- EPSDT services are federally-mandated services intended to provide preventive health care to children and young adults (under the age of 21).

- GHP Family requires our network PCPs to provide all EPSDT services in compliance with federal and state regulations and periodicity schedules.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

• GHP Family encourages providers to contact members by written communication of upcoming or missed appointments.

• GHP Family will produce on a quarterly basis, an EPSDT & Child Immunization Membership Report indicating members with gaps in care or no encounters within the previous 12 months.

• Member Health Alerts can also be used by providers to identify members that are due for screenings.
Special Needs Unit

• The Special Needs Unit (SNU) is a dedicated resource for the unique needs of GHP Family members classified as having a special need.

• The Special Needs Unit (SNU) can be used as a resource for Providers, Members, and Caregivers to assist with the management of Members with Special Needs.

• The SNU will work collaboratively to provide Case Management services through its Proven Health Navigator Case and Health Management program.
Payment Information

Submission:

• All services rendered must be reported.
• Use a UB04 or CMS1500 claim form, or electronic format
• ICD-10 diagnosis coding to the highest specificity
• Include summarization by revenue code, which may include CPT-4® and/or HCPCS procedural codes with applicable modifiers
• Include the then current ICD-10 diagnosis coding to the highest level of specificity, as applicable, for all services and procedures
• Include NPI number in Box 33a of the CMS1500 Claim Form (Refer to Provider Guide for further instructions)
When to use a CRRF:

- Failure to Prior Authorize Services – Only when there is a compelling reason why the provider failed to precert and the dispute is within timely filing guidelines.
- Claim Edit Denials – Be sure to check the claim edit box on the CRRF form and attach supporting documentation.
- Timely Filing Denials – Only when there is a compelling reason for why the provider failed to submit in a timely manner.
- When information on a PAID CLAIM needs to be corrected.

For example:
Late charges, incorrect diagnosis, incorrect procedure code, incorrect revenue code, incorrect modifier, invalid member ID, location code
When NOT to use a CRRF:

- Non-participating provider
- Claim retractions – Providers should initiate through Customer Service or Secured Message via web.
- When information on a DENIED CLAIM needs to be corrected, providers should resubmit the corrected claim through their normal claims submission process.
- Questions related to provider contracts or fee schedules should be directed to your Provider Account Manager.
- Timely Filing Denials if no compelling reason exists. (COB claims are not subject to timely filing)
- Failure to Prior Authorize – if no compelling reason exists.
Claims Research Request Form (CRRF)

• No referral denials – providers should initiate either a phone call or a secured message to GHP.

GHP can:

1) Verify if the referral is on file. If referral is found, GHP will make the necessary claim adjustment; OR

2) If referral is not found, GHP can accept the referral via fax. Once the referral has been entered GHP can make the necessary claim adjustment.
Timely Filing

• 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
Reportable Conditions

Providers are required to ensure that reportable conditions are appropriately reported in accordance with PA Code, Title 28, Chapter 27. A list of reportable diseases can be obtained by visiting the Pennsylvania Department of Health website at:

http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/epidemiology/Pages/Reportable-Diseases.aspx#.V_0Zap3D-M8

For healthcare practitioners and healthcare facilities, all diseases are reportable within 5 work-days, unless otherwise noted.
GHP Family Pay-for-Quality Program

• Pay-for-Quality Program encourages and promotes the focus of exceeding standard quality of care for GHP Family members.

• The Pay-for-Quality program is available to Primary Care specialties (Family Practice, Internal Medicine/Pediatrics, Internal Medicine, and Pediatrics) and the specialty of Obstetrics and Gynecology.

• Physicians are rewarded for performing well on specific measures outlined in the GHP Family Pay-for-Quality Program.
GHP Family Pay-for-Quality Program

Measures

- Comprehensive Diabetes Care – HbA1c Poor Control
- Controlling High Blood Pressure
- Adolescent Well-Care Visits
- Well Child Visits in the 3rd, 4th, 5th or 6th Year
- Well Child Visits 15 Months (6+ visits)
- Annual Dental Visits (paid to the dentist)
- Medication Management for People with Asthma (75% compliance)
- Reducing Potentially Preventable Readmissions (lower is better)
- Emergency Room Utilization (lower is better)
Maternity Measures
- Prenatal Care – 1st Trimester
- Ongoing Prenatal Care: >81% expected visits
- Postpartum care
- Electronic Submission of OBNA Form thru Optum Web Portal

For more information on the GHP Family Pay-for-Quality Program, contact your Provider Account Manager.
Your Provider Account Manager is available to assist you with any of the following issues:

- On-Site education offered to your staff
- GHP Family Pay-for-Quality information
- Online services Training
- Policy questions
- Demographic changes (i.e., change in office locations, addition and/or termination of a physician, change in Tax identification number). Online form available at www.healthplan.geisinger.org/providers_us/providerad dchangeform.aspx

Your Provider Account Manager can be reached by calling (800) 876-5357.
Discrimination is against the law

Geisinger Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

Geisinger Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

Geisinger Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Geisinger Health Plan provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, contact Geisinger Health Plan at 800-447-4000.

If you believe that Geisinger Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation, you can file a complaint with:

**Civil Rights Grievance Coordinator**  Geisinger Health Plan
Appeals Department  100 North Academy Avenue,
Danville, PA  17822-3220
Phone:  (866) 577-7733, PA Relay 711,
Fax:  (570) 271-7225, or
Email:  GHPCivilRights@thehealthplan.com

The Bureau of Equal Opportunity
Room 223, Health and Welfare Building,
P.O. Box 2675, Harrisburg, PA  17105-2675
Phone:  (717) 787-1127, PA Relay 711,
Fax:  (717) 772-4366, or
Email:  RA-PWBEAO@pa.gov

You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, Geisinger Health Plan and the Bureau of Equal Opportunity are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

**U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201**

1-800-368-1019, 800-537-7697 (TDD)

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call: 800-447-4000 (PA RELAY 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-447-4000 (PA RELAY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-447-4000 (PA RELAY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-447-4000 (PA RELAY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-447-4000 (PA RELAY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-447-4000 (PA RELAY: 711) 번으로 전화해주십시오.

注意: 如果您说简体中文，您可以免费获得语言援助服务。请致电 800-447-4000 (PA RELAY: 711)。