

The guidelines contained herein are meant to assist GHP Family Participating Providers in billing appropriately for medically necessary services rendered to GHP Family Members. Being a Pennsylvania Medical Assistance (MA) managed care (HealthChoices) plan, there are some procedural nuances and differences among GHP Family, previous MA plans (including Access Plus), and other GHP HMO plans. Please let this document serve as a reference for important GHP Family billing considerations. Billing correctly and in accordance with the guidelines outlined in this document will ensure timely reimbursement. Guidelines are arranged by provider type/specialty. Guidelines will be made available online at www.GHPFamily.com.

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Professional Provider Reimbursement (Primary Care and Specialty Providers)

Providers will be reimbursed as per their agreement with GHP Family. GHP Family will pay for all medically necessary services as subject to standard billing/coding guidelines.

Claim Editing

- Standard Geisinger Health Plan editing will occur with GHP Family claims. Providers are to follow the same reconsideration process for appealing the edits with documentation.
 - Modifier 25 – GHP Family will recognize modifier 25 claims. Providers are to follow the current GHP guideline for modifier 25 claims which is to submit medical documentation when billing modifier 25 for GHP Family.
 - Modifier 50 – Previously, Pennsylvania Medicaid required providers reporting services with modifier 50 to report a count of 2. GHP Family requires providers reporting services with modifier 50 to bill with a count of 1. Billing services to GHP Family with a count of 2 in conjunction with modifier 50 may result in claim edit denials for these services.

Consultations

- GHP Family will recognize the billing of consultation services by providers. Standard correct coding guidelines will apply.
- If the provider bills both a consultation service and an inpatient hospital service on the same day, standard code editing may apply.

Drug Billing

- Providers are required to bill GHP with the applicable NDC and CPT/HCPCs codes for drugs.
- For a drug product to be compensable through the Medical Assistance (MA) program, the company (labeler) that markets the product must participate in the Federal Medicaid Drug Rebate Program. The MA Program maintains a comprehensive list of participating labelers that is available on the Department of Human Services (DHS) website through the [Pharmacy Services link for providers](#). Providers can also periodically [check here](#) for any revisions to Participating Drug Company lists.

Reporting NDC on a CMS-1500 claim form

- Enter the NDC in the shaded sections of item 24A through 24G
 - To enter the NDC information, enter the qualifier and then the 11-digit NDC information. Please enter the information without hyphenation.
 - Providers are to bill each drug for a compound medication as a separate line item with the appropriate NDC.
- Enter the drug name and strength

- Enter the NDC quantity unit qualifier
- Enter the NDC quantity

Reporting NDC on a UB-04 claims form

- Enter the NDC in the revenue description field (form locator 43)
 - To enter the NDC information, enter the qualifier in the first two positions, left-justified, followed immediately by the 11-character NDC without hyphenation.
- Enter the NDC quantity unit qualifier
- Enter the NDC quantity

Reporting NDC through EDI

- The NDC is to be billed in loop 2410 LIN3
 - Reimbursement for specialty pharmaceuticals (i.e. hematology/oncology drugs), will follow Medicaid reimbursement guidelines.

Modifier Billing

- Providers are to continue to bill all applicable modifiers for services in the same manner they bill Medicaid.

Service Limits (i.e. EKGs)

- GHP Family will be applying medically unlikely edits to services through Claim Edit software. Providers are to bill for all services rendered and should be aware of these edits.

Miscellaneous Codes

- Providers are to follow standard coding guidelines for services deemed not otherwise classified or unlisted.
- Providers should submit supporting medical documentation describing the unlisted or not otherwise classified service(s).

Telemedicine/Telehealth

- Telehealth is covered for the following:

CPT Code	Provider Type	Place of Service
99213 - GT	09,31,33	11
99214 - GT	09,31,33	11
99215 - GT	09,31,33	11
99241 - GT	31	11
99242 - GT	31	11
99243 - GT	31	11

CPT Code	Provider Type	Place of Service
99244 - GT	31	11
99245 - GT	31	11
Q3014 - GT	09,31,33	11

- Referring physicians, CRNPs, and CNMs enrolled in the MA Program who participate in a telemedicine consultation that is performed at the same time as an office visit may continue to bill using office visit procedure codes 99213, 99214, and 99215 and appropriate pricing modifiers and the GT informational modifier. They can also continue to bill using the telehealth originating site facility fee procedure code Q3014 and GT informational modifier in order to be paid for the technology service.
- When the recipient accesses the consultation separate from the office visit, whether at the referring provider's or another participating physician, CRNP or CNM enrolled office site (i.e., the originating site), the physician, CRNP or CNM serving as the originating site may bill for the technology service using the telehealth originating site procedure code Q3014 with the GT informational modifier only. If the referring provider, or other physician, CRNP or CNM is not physically present at the originating site, a nurse or other clinical professional, such as a physician's medical assistant, must be available to assist the recipient if needed.
- Specialists enrolled in the MA Program may bill for a consultation rendered using interactive telecommunication technology using procedure codes 99241, 99242, 99243, 99244 and 99245 with the GT informational modifier and other appropriate modifiers.
- Providers should fully document the specific interactive telecommunication technology used to render the consultation, and the reason the consultation was conducted using telecommunication technology, and not face-to-face, in the MA recipient's medical record, in accordance with MA regulations at 55 [Pa.Code](#) § 1101.51 relating to ongoing responsibilities of providers.
- [View the Medical Assistance Bulletin regarding telemedicine/telehealth here.](#)

Family Planning

- GHP Family will recognize family planning providers as valid providers for GHP Family Members.
- GHP Family will be suppressing Member Explanations of Benefits (EOBs) for GHP Family Members who see a Family Planning provider.

Primary Care Reimbursement

Primary Care Physicians (PCPs) are reimbursed by GHP Family on a fee-for-service basis. PCPs are to bill for all services performed in the primary care office. Reimbursement is in accordance with the PCP's GHP Family Agreement.

Vaccines for Children Program

- PCPs are to use the Vaccine for Children (VFC) Program. VFC covers children up until their 19th birthday.

- PCPs are to bill GHP Family the vaccine code and will be reimbursed for the administration fee.

Non-VFC Vaccines

- PCPs are to bill GHP Family the vaccine code and the administration code for members who do not qualify for VFC (members 19 year and older).
- PCPs are required to bill the NDC with the vaccine code.

Mental Health Care by a PCP

- GHP Family will not deny claims with a Mental Health diagnosis submitted by a PCP. There is no benefit limit on PCP visits billed with a Mental Health diagnosis.

Children and Youth Required Visits

- GHP Family will reimburse PCPs for these additional visits even when billed with a preventative diagnosis of Z00.00. There will be no limit.

Services Rendered by a PCP Other than the Member's Assigned PCP

- Members are encouraged to visit their assigned PCP for services. However, in the instance a Member obtains services by a PCP not listed on their account, GHP Family will honor these PCP claims without denial.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visits are a unique opportunity to perform a comprehensive evaluation of a child's health and provide appropriate and timely follow-up diagnostic and treatment services. To encourage providers to perform complete EPSDT screenings, support the additional time needed to perform such screenings, and increase the number of screenings performed, an EPSDT rate has been established. Please refer to the EPSDT billing guidelines available online at www.GHPFamily.com.

Right from the Start Program (Healthy Beginnings)

Right from the Start is a program developed to ensure pregnant GHP Family Members have a positive prenatal care experience. This program significantly expands the list of maternity services eligible for reimbursement by GHP Family. Please refer to the Right from the Start billing guidelines available online at www.GHPFamily.com.

Specialty Care Reimbursement

Specialty Care Physicians (SCPs) are reimbursed by GHP Family on a fee-for -service reimbursement. SCPs are to bill for all services performed in the specialty care office. Reimbursement is in accordance with the SCP's GHP Family Agreement.

Obstetrical Needs Assessment Form

- This form will serve as GHP Family's initial notification of a Member's pregnancy. Prompt submission of the form will allow GHP Family to enroll Members in the maternity program as soon as possible.
- The Obstetrical Needs Assessment Form is available online at www.GHPFamily.com.

Physician Extenders (Mid-Level Providers)

GHP Family will be credentialing Mid-Level Providers (physician assistants and CRNPs). These providers will be reimbursed by GHP Family on a fee-for -service basis.

Certified Registered Nurse Practitioners (CRNPs)

- CRNPS can bill GHP Family for services under their own name.

Physician Assistants

- The Health Plan **does not separately reimburse** physician assistants (PA), nurse practitioners (NP) and/or clinical nurse specialists (CNS) for assistant at surgery services. The Health Plan requests that Participating Providers not submit claims for these provider types. However, if such services must be reported, the following must be present on the claim:
 - The supervising physician name must be listed in Field 31 on the CMS1500 Claim Form.
 - Modifier –AS must be appended to the services reported as being rendered by a PA, NP or CNS.
- Do not use modifier –80, -81, or –82 to represent non-physician assistant at surgery

Inpatient Hospital Reimbursement

Inpatient hospital services are reimbursed by GHP Family based on the APR-DRG grouper system. Hospital providers are to bill GHP Family in the same manner they bill Medicaid for these services.

Inpatient Rehabilitation Reimbursement

Inpatient Rehabilitation services are reimbursed by GHP Family based on the provider's current rate letter as identified on the files received from Department of Health Services (DHS). Providers are to bill GHP Family in the same manner they bill Medicaid for these services.

Skilled Nursing Facility (SNF)

GHP Family will reimburse SNFs based on the level of care rendered to the Member. Reimbursement is in accordance with the SNF's GHP Family Agreement.

Pharmaceutical Services

- For a GHP Family Member in a SNF, pharmaceuticals are covered under the SNF contracted rate.

Outpatient Hospital Reimbursement

Most outpatient hospital services (exceptions are below) are reimbursed by GHP Family on a fee-for-service basis. Providers are to bill for all services performed in the outpatient setting. Reimbursement is in accordance with the provider's GHP Family Agreement.

Observation Services

- For those providers contracted for observation services, the contracted reimbursement rate will include all ancillary services billed.

Surgical Packages

- GHP Family is required to provide a transition of care period for Member's who change carriers. This time frame includes current services that are prior authorized. GHP Family expects the authorization files to be shared among HealthChoices Managed Care Organizations.

Ambulatory Surgery Center (ASC) Reimbursement

ASC services are reimbursed by GHP Family based on Medicaid methodology. Providers are to bill for all services performed in the ASC setting. Reimbursement is in accordance with the ASC's GHP Family Agreement.

Place-of-Service Codes

- Providers are to bill GHP Family in the same manner they bill Medicaid.

Modifier Billing

- Providers are to continue to bill all applicable modifiers for services in the same manner they bill Medicaid.

Federally Qualified Health Care Centers (FQHCs)/Rural Health Care Centers (RHCs)

GHP Family will reimburse FQHCs and RHCs at an all-inclusive rate based on the applicable rate letter as submitted to GHP Family.

- All services for FQHCs and RHCs must be billed on the CMS1500 claim form.
 - Providers can continue to bill \$0.00 for all other services than the visit code on their claims submitted to GHP Family.
- FQHCs and RHCs need to bill the applicable location code (50 or 72), the appropriate CPT/HCPCs codes (T1015) on the first line of the claim and any applicable modifiers.
- FQHCs and RHCs will be reimbursed at the all-inclusive rate on the first line of the claim.

Anesthesia Services

Anesthesia services are reimbursed by GHP Family based on a per-minute methodology as is the current standard for all other Geisinger Health Plan lines of business.

Anesthesia Time

- Anesthesia time is calculated using the total minutes reported on the claim in box 24G.

Modifier Billing

- Providers are to report all applicable anesthesia modifiers on the claim.

Home Health Services

GHP Family will reimburse Home Health providers on a fee-for-service basis. Providers are to bill for all services performed at the Home Health visit. Reimbursement is in accordance with the Home Health provider's GHP Family Agreement.

Social Work Visits

- GHP Family will grant additional reimbursement for Social Work visits in the home. Home Health providers are to

bill the applicable revenue code for Social Work visits.

Other services

- All other services are to be reported with the applicable CPT/HCPCs code in the same manner they are billed to Medicaid.
- Home Health providers can bill GHP Family on either claim form (UB04 or CMS1500) that they use to bill Medicaid.

DME/Prosthetics & Orthotics

DME and Prosthetics/Orthotics are reimbursed by GHP Family according to the provider's GHP Family Agreement. DME and Prosthetics/Orthotics providers are to bill for all DME and Prosthetics/Orthotics services performed.

Modifier Billing

- DME and Prosthetics/Orthotics providers should continue to bill all applicable modifiers for services in the same manner they bill Medicaid.

Prior Authorization Requirements

- Providers are to follow all prior authorization requirements for equipment/services as outlined by GHP Family.

Vision

Vision providers are reimbursed by GHP Family based on current Medicaid methodology. Providers are to bill for all services performed at the vision visit. Reimbursement is in accordance with the provider's GHP Family agreement and the Member's benefit document.

Vision Hardware

- Providers are to submit the optometry exam and any materials with the date of service as the date the services are rendered. This is to occur even if the exam and materials are done on the same date of service.
- Providers are to contact GHP Family Customer Service at (855) 227-1302 for additional information on a Member's specific vision [benefits.fiers](#) for services in the same manner they bill Medicaid.

Additional Information

GHP Family will be utilizing the following vendors for management of specified services for Members:

- Dental Services: Avesis

References

- GHP Family Website: www.GHPFamily.com