GEISINGER HEALTH PLAN

Provider Update

October 2023

Geisinger

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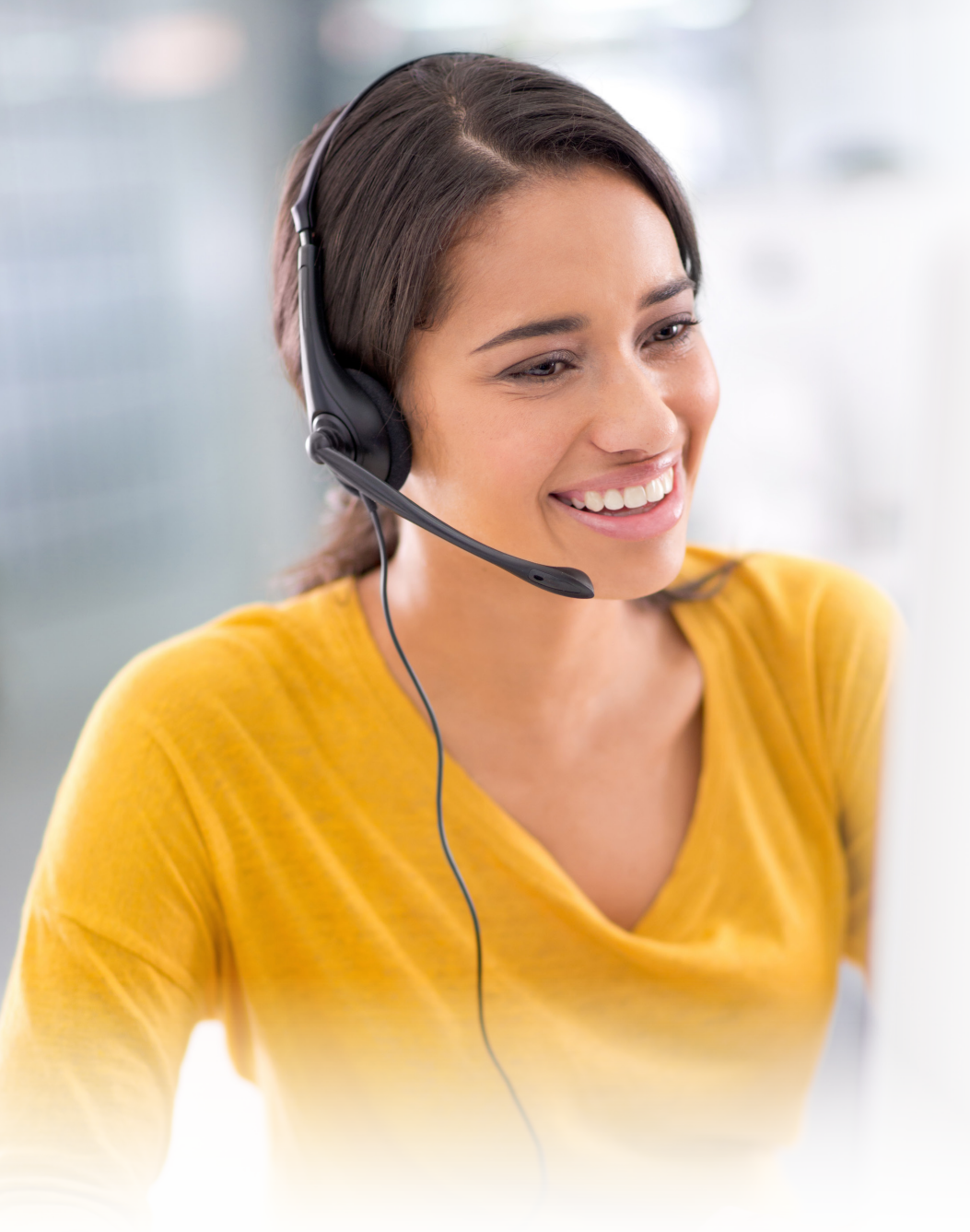

Navitus is our new PBM

Applies to: All providers | Plan(s): All plans

Geisinger Health Plan has chosen Navitus Health Solutions as our new pharmacy benefits manager (PBM) starting Jan. 1, 2024. For 20 years, Navitus has provided an alternate solution to traditional PBM models that delivers drug cost savings and unmatched financial and operational transparency. Navitus will support all Geisinger plans to improve access to affordable and clinically appropriate medications. Geisinger will continue to manage the formulary, or list of covered drugs, provide utilization management services, and handle customer service responsibilities.

It's important that your patients use their new member ID card that includes the Navitus information at the pharmacy after Jan. 1, 2024.

Read more on Geisinger.org.

Questions about formulary exceptions, drug authorization and prescription drug information? Call our pharmacy team at 800-988-4861.

One number for your claims and member benefits questions: 844 GHP PROV

No more transfers, no matter your patient's plan.

Applies to: All providers | Plan(s): All plans

Call **844-447-7768 or 844 GHP PROV** to connect with a dedicated claims resolution representative today.

How you benefit:

- Short hold times
- Faster claims issue resolution; expected turn-around times provided when necessary
- Claims issues are logged and tracked through resolution; no more repeat calls
- Complete resolution follow-up; GHP will close the loop to ensure your needs are met
- One number to contact; no need to call your GHP account manager with claims questions
- Tracking numbers are provided for your secure message requests through NaviNet

New address for paper claims as of Jan. 1, 2024

Applies to: All providers | Plan(s): All plans

If you submit hardcopy paper CMS 1500 or UB04 claims, be sure to start using the new address. You can begin using the new address for your claims immediately. All Geisinger Health Plan forms and resources are being updated accordingly. The new address is:

Geisinger Health Plan

PO Box 160

Glen Burnie, MD 21060

Replacement claims billing policy

Applies to: All providers | Plan(s): All plans

A replacement claim is billed when a specific claim needs to be entirely replaced with new claim information. The original claim is considered null and void and is completely replaced by the information on the replacement claim submission.

Providers may submit replacement claims electronically and must be submitted 60 days from the date of the first Explanation of Payment of the original claim. Claims submitted outside the 60-day timeframe will be denied for timely filing and cannot be resubmitted. Once a replacement claim has been received, the original claim will be considered null and void. Any payments made on the original claim will be retracted. Consider payments made on your replacement claim as payment in full. If the replacement claim has been denied, your original payment will not be reinstated.

Replacement claims FAQ

If the replacement claim I want to submit is over the 60-day timely filing timeframe, should I still submit the replacement claim?

No. You should submit a CRRF (Claims Research Request Form) with a specific reason of why the replacement claim was not submitted timely. Our claims research analysts will review.

What will happen if the replacement claim is within the 60-day timely filing timeframe, and I call or send in written correspondence on a claim that requires a replacement claim?

Our provider care team will guide you to the replacement claim process by phone or return mail. However, the adjustment will not be completed over the phone or through written correspondence (unless a timely filing dispute is involved; see question 1).

In what instance should I submit a replacement claim?

Replacement claims should be submitted for all claims that you need to make corrections to, including:

- Changing previously submitted diagnosis codes
- Changing member data; except for the member ID
- Changing the billed amount on the original claim
- Changing previously submitted procedure codes
- Adding services in addition to data corrections to the original claim.

In what instance should I NOT submit a replacement claim?

Do not submit a replacement claim when:

- The claim is beyond timely filing (see question 1 above)
- The billing NPI number is changing
- You are making a correction to the subscriber ID

I need to correct the subscriber ID on an original claim. If I should not submit a replacement claim, how should I proceed?

You will need to submit a complete void/cancel claim using frequency code 8 for full voids/retractions and then submit a brand-new claim with the correct subscriber ID.

I need to correct the NPI billed on an original claim. If I should not submit a replacement claim, how should I proceed?

You will need to submit a complete void/cancel claim using frequency code 8 for full voids/retractions and then submit a brand-new claim with the correct billing NPI.

I need to void/cancel a claim due to it being billed in error. Should I submit a CRRF (Claims Research Request Form) with the reason for the void/cancel?

Instead of submitting the CRRF, submit an electronic void/cancel claim using frequency code 8 for full voids/retractions. The claim will be retracted as a void/canceled claim.

My replacement claim was rejected at the EDI clearinghouse. Why can't I submit electronically?

Review and ensure you are submitting the replacement claim with the correct internal control number of the original claim.

If I am submitting a second or third replacement claim, which internal control number (ICN) should I submit?

Include the most recent ICN on the claim.

Reporting encounter data can pay, even when no payment is expected

Applies to: All providers | Plan(s): GHP Family

Often, providers are reluctant to submit claims and encounter data to GHP Family when no payment is expected; especially when GHP Family is the secondary insurance for patients with more than one insurance plan.

We encourage you to submit claims for all covered services provided to your GHP Family patients, even when no payment is expected. Doing so will not only ensure you are acting in accordance with PA Department of Human Services regulations and your agreement with GHP Family; you'll also maximize your Pay-for-Quality incentive payments. Remember, you still earn incentive payments by submitting claims and encounter data for certain covered services that are not reimbursed otherwise.

If you have claims questions that cannot be resolved through NaviNet or Instamed, call our provider care team at 844-447-7768 or 844 GHP PROV.

Cotiviti to enhance future post payment claims review

Applies to: All providers | Plan(s): All plans

We're working with Cotiviti to enhance our periodic post payment reviews of paid medical claims.
Cotiviti is a nationwide healthcare payment accuracy company specializing in the review of inpatient claims. Geisinger Health Plan has contracted with Cotiviti to provide post-payment Diagnosis Related Group (DRG) audit validation for inpatient services.

Cotiviti may reach out to you in the future regarding your Geisinger Health Plan patient medical records and claims. We ask that you extend Cotiviti your professional courtesy and hope you'll find future interactions with Cotiviti to be a collaborative experience.

You may already be familiar with Cotiviti as a leader in the industry with health plans across the United States. Cotiviti will perform its responsibilities on behalf of Geisinger Health Plan in full compliance with HIPAA requirements.

Prior authorization through Cohere

Applies to: All providers | Plan(s): All plans

Cohere implementation timeline:

- Requests for MSK, cardiology and pain management services that require authorization through HealthHelp transitioned to Cohere on Oct. 1, 2023. Additional services require prior authorization beginning with dates of service Oct. 1, 2023, and after. See the full bulletin.
- You'll need to wait a bit longer to use Cohere to request authorization for inpatient services. We've postponed the launch of Cohere for inpatient requests so we can make sure the request processes are optimized for providers and their GHP patients. Authorization for inpatient services that require prior authorization should continue to be requested directly from GHP as before. See the latest bulletin.
- Requests through Cohere for most other outpatient services started May 15, 2023. See the full bulletin.
- Requests through Cohere for home health and outpatient therapy services started Jan. 16, 2023. See the full bulletin.
- Know when to call Cohere and when to call Geisinger Health Plan
- Cohere provider resources

Drug claim NDC verification

Applies to: All providers | Plan(s): All plans

Reminder regarding NDC requirements

- Validation of NDC units dispensed and units of measure against reported claim units for GHP Family and GHP Kids started Oct. 1, 2023.
- NDC verification of drug claims for Geisinger Gold, Geisinger Marketplace, commercial group and TPA plans started Oct. 1, 2023.

Read the full bulletin.

Procedure code change for Electronic Visit Verification (EVV) personal care services began Oct. 1, 2023

Applies to: Home health agencies and personal care service providers | Plan(s): GHP Family

You'll need to use procedure code G0156 and applicable modifiers for EVV personal care services (PCS) beginning with dates of service Oct. 1, 2023, and after. T1019 is no longer be accepted.

G0156 replaces T1019 for GHP Family claims Oct. 1, 2023. As of Oct. 1, 2023, use G0156 for EVV PCS services in addition to HHCS services. PCS claims with T1019 billed for dates of service Oct. 1, 2023, and after will not match with EVV data and will be denied. For dates of service Oct. 1, 2023, and after, use procedure code G0156.

G0156 is defined as services of home health/hospice aide in home health or hospice settings, each 15 minutes. When billing GHP Family for EVV PCS services, use G0156 with the appropriate U7 or U7 and SC modifier(s).

Read more about this procedure code change.

At-home screenings help close potential care gaps in 2023

We continue to send thousands of home test kits to members who are managing diabetes or at risk for chronic kidney disease or colorectal cancer. Engaging members in preventive care at home is the first step toward knowing what further testing or treatment may be needed.

Applies to: Primary care providers | Plan(s): All Plans

What the program looks like

Through the fall, we'll be sending at-home test kits to members. The kits contain all the supplies members need and clear instructions on how to complete the tests. Members will receive automated follow-up phone calls to encourage them to complete their at-home testing. The program will run through November. Test results will be shared with members' doctors to coordinate any additional testing or treatment that may be needed.

To give you a sense of the scale of our annual at-home test kit initiative, here's what we plan to send:

- About 18,000 Hemoglobin A1c test kits
- About 26,000 Urine albumin and/or eGFR test kits
- About 50,000 Colorectal cancer screening test kits

Helping members close care gaps

Consistent screenings — whether done at home or in a provider's office — help detect risky abnormalities before larger problems like kidney disease and colorectal cancer emerge. Consider talking to your patients about the benefits of at-home test kits or schedule in-office testing for patients you know are overdue for these screenings. For some primary care providers, closing these care gaps can result in more robust quality incentive payments.

Contact the GHP quality and assurance team at **866-847-1216** or your GHP provider account manager at **800-876-5357** if you have questions about our at-home screening initiatives.

Who is ordering tests for my patients?

As part of the administration of our at-home test kit initiative, you may see in a patients' record that one or more of these tests are ordered by a physician you don't recognize. For the program to work, all test kits must be ordered by a physician. We've teamed up with our Geisinger clinical pathology partners and Dr. Michelle Pramick to serve as the ordering physician **for administrative purposes only**. You may see Dr. Pramick's name on patient records or other reporting as the ordering provider.

MFTs and LPCs are eligible to see Geisinger Gold Medicare Advantage members in 2024

Applies to: Behavioral health and referring providers | Plan(s): Geisinger Gold

On December 23, 2022, the Mental Health Access Improvement Act (S.828/ H.R.432) was signed into law allowing Licensed Professional Counselors (LPCs) and Marriage and Family Therapists (MFTs) to enroll as Medicare providers. Starting Jan. 1, 2024, approved services provided by LPCs and MFTs will be eligible for Medicare reimbursement.

Our Geisinger Gold Medicare Advantage plans will also begin to reimburse LPCs and MFTs for approved services as of Jan. 1, 2024. If you're already providing quality behavioral health care for non-Medicare Geisinger Health Plan members, you may receive email correspondence from our contracting team to join us in extending access to Geisinger Gold members.

If you're referring Geisinger Gold members for certain behavioral health services in 2024, know that they'll have more in-network providers to choose from. Always check our online provider search so you can help your Geisinger Health Plan patients see providers that accept their plan.

Formulary and policy updates

Visit us on NaviNet today to see new, revised and recently reviewed medical and pharmaceutical policies, as well as the latest clinical guidelines, formulary changes and drug recalls. Updates may affect prior authorization. The most current prior authorization list is also available. And you can find clinical guidelines, formulary and medical policy information in the *For Providers* section at GeisingerHealthPlan.com. Printed copies are available if needed.

Medical policy update

Geisinger Health Plan uses medical policies as guidelines for coverage decisions made within the insured individual's written benefit documents. Coverage may vary by line of business. Providers and members are encouraged to verify benefit questions regarding eligibility before applying the terms of the policy. Visit our clinical policies pages.

The new and revised medical policies listed below go into effect Oct. 15, 2023:

- MP246 Multigene Expression Assay for predicting Recurrence in Colon Cancer – (Revised) – Revised Description; Add Commercial Header
- MP267 Amniotic Membrane Transplantation – (Revised) – Add Indications
- MP273 Gene-based Testing and/or Protein Biomarkers – (Revised) – Add ExoDx Indications
- MP304 Genetic Testing for Inherited Cardiomyopathies and Channelopathies – (Revised) – Extensive Revisions
- MP316 High Intensity Focused Ultrasound and Laser – (Revised) – Add Indication
- MP324 Genetic Testing for Disease Carrier Status – (Revised) – Extensive Revisions
- MP325 Genetic Testing for Familial Hypercholesterolemia – (Revised) – Extensive Revisions
- MP327 Autonomic Testing – (Revised) – Add Exclusion
- MP374 Genetic Testing for Inheritable Diseases – (NEW)

The new and revised medical policies listed below go into effect Nov. 15, 2023:

- MP053 Cochlear Implant and Auditory Brainstem Implant – (Revised) – Added Criteria; Added Exclusion
- MP065 Obesity Surgery – (Revised)
- MP069 Ultrafiltration – (Revised) – Revised Criteria
- MP228 HPV DNA Testing – (Revised) – Clarify Gender Language
- MP371 Intraosseous Basivertebral Nerve Ablation – (NEW)
- MP373 Medication Assisted Treatment – (NEW)

Medical pharmaceutical policy updates

These new and revised medical pharmaceutical policies go into effect for all plans Oct. 15, 2023:

All members:

- MBP 264.0 Enjaymo (sutimlimab-jome) – Updated Policy
- MBP 286.0 Hemgenix (etranacogene dezaparvovec-drlb) – Updated Policy
- MBP 289.0 Elfabrio (pegunigalsidase alfa-iwxj) – New Policy
- MBP 290.0 Epkinly (epcoritamab-bysp) – New Policy
- MBP 291.0 Lamzede (velmanase alfa-tycv) – New Policy
- MBP 292.0 Omisirge (omidubicel-onlv) – New Policy
- MBP 293.0 Qalsody (tofersen)– New Policy

Commercial, Marketplace, TPA, and Medicare GHP members only:

- MBP 13.0 Viscosupplementation – Updated Policy
- MBP 42.0 Boniva (ibandronate sodium) Intravenous – Updated Policy
- MBP 94.0 Eylea (aflibercept) – Updated Policy

These new and revised medical pharmaceutical policies go into effect for all plans Nov. 15, 2023:

All members:

- MBP 2.0 Synagis (palivizumab) – Updated Policy
- MBP 297.0 Beyfortus (nirsevimab-alip) – New Policy

Commercial, Marketplace, TPA, and Medicare GHP members only:

- MBP 24.0 Aloxi (Palonosetron) – Updated Policy
- MBP 59.0 White Blood Cell Stimulating Factors – Updated Policy
- MBP 104.0 Emend IV (fosaprepitant) – Updated Policy
- MBP 242.0 Evkeeza (evinacumab-dgnb) – Updated Policy
- MBP 288.0 Leqembi (lecanemab-irmb) – Updated Policy
- MBP 299.0 Aponvie (aprepitant) – New Policy