Member Appointment Availability Standards

GHP Family works with providers to outreach to members concerning appointments for medically necessary care, preventive care, and scheduled screenings and examinations. GHP Family Providers are expected to meet the following standards regarding appointment availability and response to Members:

Appointment Accessibility Standards	
Medical Care:	**GHP Family Standard:**
Preventive Care must be scheduled (health assessment/general physical examinations and first examinations)	Within 3 weeks of the Member's Enrollment
Routine Primary Care and Specialty Care must be scheduled	Within 10 business days of the Member's call
Routine Specialty Care for the following specialties must be scheduled: *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 Hematology, Pediatric Oncology, Pediatric Rehab Medicine, and Pediatric Urology.*	Within 15 business days of the Member's call
Urgent Medical Condition Care must be Scheduled by PCP and/or SCP	Within 24 hours of the Member's call
Emergency Medical Condition Care must be seen by PCP and/or SCP	Immediately upon the Member's call or referred to an emergency facility
After-Hours Accessibility Standards	
Medical Care:	**GHP Family Standard:**
After-hours Care by a PCP or a covering PCP must be available	24 hours/7 days a week

- When the PCP uses an answering service or answering device to intake calls after normal business hours, instructions for reaching the PCP or another designated covering PCP must be included.

The following are requirements for Members who require specific services and/or have Special Needs. GHP Family asks that PCPs contact all new panel Members for an initial appointment. GHP Family has Special Needs and Care Management Programs that also reach out to Members in the following categories. GHP Family expects that PCPs will cooperate in scheduling timely appointments.

Initial Examination for Members …	Appointment Scheduled with a PCP or Specialist
With HIV/AIDS	No later than 7 days of the effective date of Enrollment, unless the Member is already being treated by a PCP or Specialist.
Who receive Supplemental Security Income (SSI)	No later than 45 days of Enrollment, unless the Member is already being treated by a PCP or a Specialist.
Under age of 21	For an EPSDT screen no later than 45 days of the effective date of Enrollment, unless the Member is already being treated by a PCP or Specialist and the Member is current with screens and immunizations.
Members who are pregnant	**Appointment Scheduled with an OB/GYN practitioner**
Pregnant women in their 1st trimester	Within 10 business days of GHP Family learning the Member is pregnant.
Pregnant women in their 2nd trimester	Within 5 business days of GHP Family learning the Member is pregnant.
Pregnant women in their 3rd trimester	Within 4 business days of GHP Family learning the Member is pregnant.
Pregnant women with high-risk pregnancies	Within 24 hours of GHP Family learning the Member is pregnant or immediately if an Emergency Medical Condition exists.

Additional Requirements of PCPs

- The average waiting time for scheduled appointments must be no more than 30 minutes unless the PCP encounters an unanticipated urgent visit or is treating a patient with a difficult medical need. In such cases, waiting time should not exceed one (1) hour.
- The PCP must have a "no show" follow-up policy to conduct affirmative outreach whenever a Member misses an appointment and to document this in the medical record. Three (3) attempts to contact the member should be made either by, but not limited to, written attempts, telephone calls, and home visits. At least one (1) attempt must be a follow-up telephone call. Communications with the member should take the language and literacy capabilities of the member into consideration.
    - As a reminder, Medical Assistance providers are prohibited from billing Medical Assistance recipients for missed appointments.
- PCPs must comply with all Cultural Competency standards. Please refer to the Cultural Competency section of the Provider Manual for additional information on Cultural Competency.

Completion of Encounter Data

PCPs must complete and submit a CMS-1500 form or file an electronic claim every time a GHP Family Member receives services. Completion of the CMS-1500 form or electronic claim is important for the following reasons:

- It allows GHP Family to gather statistical information regarding the medical services provided to GHP Family's Members, which better support our statutory reporting requirements.
- It allows GHP Family to identify the severity of illnesses of our Members.

GHP Family can accept Encounter Claim submissions via paper or electronically (EDI). For more information on electronic claim submission and how to become an electronic biller, please contact your Provider Relations Representative.

In order to support timely statutory reporting requirements, we encourage PCPs to submit Encounter information within 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

Cultural Competency

GHP Family 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 recipients 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 recipients, 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 recipients' 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 recipients and recipients 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 recipient or the provider. GHP Family offers translation and interpreter services, including sign language interpreters, to providers and recipients 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 in over 175 languages. Providers can make advance arrangements for personal interpreters. Contact your Provider Relations representative or our member services department at 1-855-227-1302 to learn more about these services.

- Bilingual staff is available in the recipient services department to assist LEP recipients.
- Recipient Materials, such as the member handbook, are available in English, Spanish, and each prevalent language as determined by the Department of Public Welfare.

GHP Family provides alternative methods of communication for recipients who are visually or hearing impaired, including Braille, audio tapes, large print and/or computer diskette. Upon recipient request, we will make all written materials disseminated to recipients accessible to visually impaired recipients.

Health Literacy

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

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.

Low health literacy leads to problems with understanding:

- Physical instructions
- Consent forms
- Medical brochures
- Instruction for medications

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

For additional information, please refer to the GHP Family Provider Manual.

GEISINGER HEALTH PLAN®

GHP FAMILY

APPROPRIATE USE OF EMERGENCY DEPARTMENT

GHP Family encourages Primary Care Providers to help minimize Emergency Department (ED) use by educating members on appropriate usage and utilization of an ED. Member needs to have a clear understanding of an emergency medical condition and when appropriate use of the ED should be sought. Providers are urged to inform patients to contact their PCP, when possible and appropriate, before seeking ED services.

While there are no hard and fast rules for what is a "true emergency" and what is not, the American College of Emergency Physicians suggest the following for appropriate use of an ED:

- Chest pain lasting two minutes or more
- Uncontrolled bleeding
- Sudden or severe pain
- Coughing or vomiting blood
- Difficulty breathing; shortness of breath
- Sudden dizziness, weakness, or change in vision
- Severe or persistent vomiting or diarrhea
- Change in mental status
- Poisoning
- Drug Overdose

Members should be apprised that non-emergent illnesses should be handled through the Primary Care Physician. Examples of illnesses or injuries that can be provided to members for treatment through their PCP are:

- Cold, a cough, or sore throat
- Earache
- Menstrual and muscle cramps
- Sprains, and othe strains or muscles and joints
- Bruises, small cuts, or minor burns
- Rashes or minor swelling

MINIMIZING USE OF EMERGENCY DEPARTMENT

Avoidable emergency room visits are defined as "a visit, which could have more appropriately been managed and/or referred to a primary care provider in an office or clinic setting." Some ways to assist with minimizing ED usage are:

- Discuss with patients when a visit to the emergency room is based on the patient's medical history.
- Encourage members to call your office when they are not sure it's an emergency.
- Encourage members to schedule regular check ups

EARLY PERIODIC SCREENING, DIAGNOSIS, and TREATMENT (EPSDT)

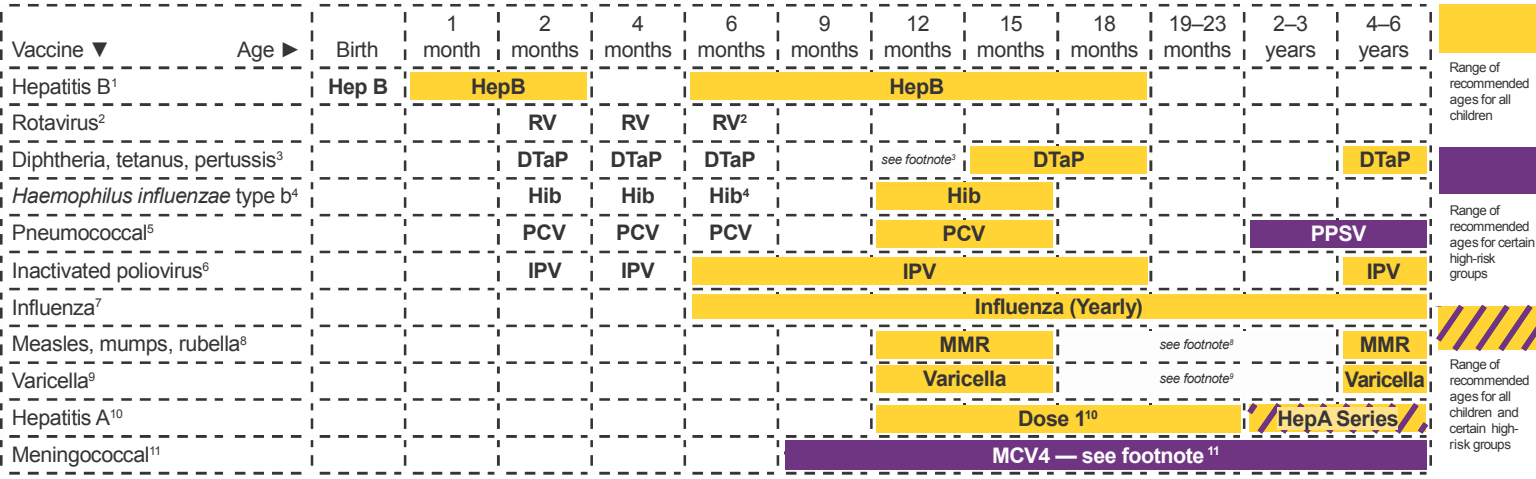
Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services are federally-mandated services intended to provide preventive health care to children and young adults (under the age of 21 years) at periodic intervals which are based on the recommendations of the American Academy of Pediatrics (AAP), American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD). All PCPs who provide services to recipients under age 21 are required to provide comprehensive health care, screening and preventive services. GHP Family requires our 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.

GHP Family will distribute quarterly lists to each PCP in its Provider Networks which identify Members who have not had an encounter during the previous twelve (12) months or Members who have not complied with EPSDT periodicity and immunization schedules for children.

Please reference the most recent periodicity guidelines published on the Pennsylvania DPW Web site for the HealthChoices program.

FIGURE 1: Recommended immunization schedule for persons aged 0 through 6 years—United States, 2012 (for those who fall behind or start late, see the catch-up schedule [Figure 3])



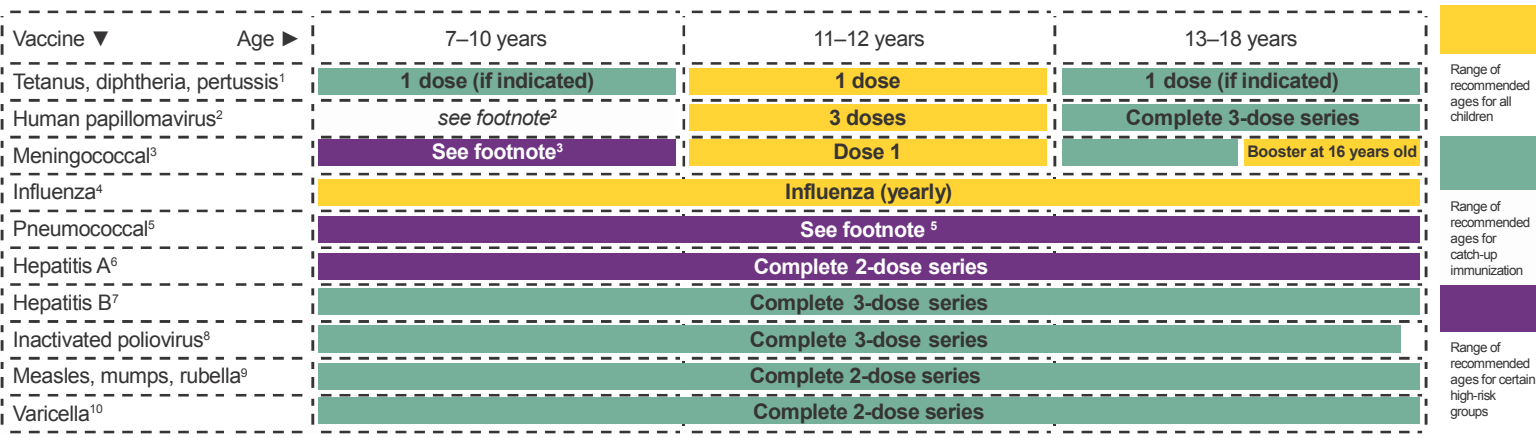
This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).

1. **Hepatitis B (HepB) vaccine.** (Minimum age: birth)
   At birth:
   - Administer monovalent HepB vaccine to all newborns before hospital discharge.
   - For infants born to hepatitis B surface antigen (HBsAg)–positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) 1 to 2 months after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).
   - If mother's HBsAg status is unknown, within 12 hours of birth administer HepB vaccine for infants weighing ≥2,000 grams, and HepB vaccine plus HBIG for infants weighing <2,000 grams. Determine mother's HBsAg status as soon as possible and, if she is HBsAg-positive, administer HBIG for infants weighing ≥2,000 grams (no later than age 1 week).

   Doses after the birth dose:
   - The second dose should be administered at age 1 to 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
   - Administration of a total of 4 doses of HepB vaccine is permissible when a combination vaccine containing HepB is administered after the birth dose.
   - Infants who did not receive a birth dose should receive 3 doses of a HepB- containing vaccine starting as soon as feasible (Figure 3).
   - The minimum interval between dose 1 and dose 2 is 4 weeks, and between dose 2 and 3 is 8 weeks. The final (third or fourth) dose in the HepB vaccine series should be administered no earlier than age 24 weeks and at least 16 weeks after the first dose.
2. **Rotavirus (RV) vaccines.** (Minimum age: 6 weeks for both RV-1 [Rotarix] and RV-5 [Rota Teq])
   - The maximum age for the first dose in the series is 14 weeks, 6 days; and 8 months, 0 days for the final dose in the series. Vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
   - If RV-1 (Rotarix) is administered at ages 2 and 4 months, a dose at 6 months is not indicated.
3. **Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine.** (Minimum age: 6 weeks)
   - The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
4. ***Haemophilus influenzae* type b (Hib) conjugate vaccine.** (Minimum age: 6 weeks)
   - If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
   - Hiberix should only be used for the booster (final) dose in children aged 12 months through 4 years.
5. **Pneumococcal vaccines.** (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])
   - Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
   - For children who have received an age-appropriate series of 7-valent PCV (PCV7), a single supplemental dose of 13-valent PCV (PCV13) is recommended for:
     — All children aged 14 through 59 months
     — Children aged 60 through 71 months with underlying medical conditions.
   - Administer PPSV at least 8 weeks after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. See *MMWR* 2010:59(No. RR-11), available at http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf.
6. **Inactivated poliovirus vaccine (IPV).** (Minimum age: 6 weeks)
   - If 4 or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years.
   - The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.
7. **Influenza vaccines.** (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])
   - For most healthy children aged 2 years and older, either LAIV or TIV may be used. However, LAIV should not be administered to some children, including 1) children with asthma, 2) children 2 through 4 years who had wheezing in the past 12 months, or 3) children who have any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see *MMWR* 2010;59(No. RR-8), available at http://www.cdc.gov/mmwr/pdf/rr/rr5908.pdf.
   - For children aged 6 months through 8 years:
     — For the 2011–12 season, administer 2 doses (separated by at least 4 weeks) to those who did not receive at least 1 dose of the 2010–11 vaccine. Those who received at least 1 dose of the 2010–11 vaccine require 1 dose for the 2011–12 season.
     — For the 2012–13 season, follow dosing guidelines in the 2012 ACIP influenza vaccine recommendations.
8. **Measles, mumps, and rubella (MMR) vaccine.** (Minimum age: 12 months)
   - The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
   - Administer MMR vaccine to infants aged 6 through 11 months who are traveling internationally. These children should be revaccinated with 2 doses of MMR vaccine, the first at ages 12 through 15 months and at least 4 weeks after the previous dose, and the second at ages 4 through 6 years.
9. **Varicella (VAR) vaccine.** (Minimum age: 12 months)
   - The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
   - For children aged 12 months through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
10. **Hepatitis A (HepA) vaccine.** (Minimum age: 12 months)
    - Administer the second (final) dose 6 to18 months after the first.
    - Unvaccinated children 24 months and older at high risk should be vaccinated. See *MMWR* 2006;55(No. RR-7), available at http://www.cdc.gov/mmwr/pdf/rr/rr5507.pdf.
    - A 2-dose HepA vaccine series is recommended for anyone aged 24 months and older, previously unvaccinated, for whom immunity against hepatitis A virus infection is desired.
11. **Meningococcal conjugate vaccines, quadrivalent (MCV4).** (Minimum age: 9 months for Menactra [MCV4-D], 2 years for Menveo [MCV4-CRM])
    - For children aged 9 through 23 months 1) with persistent complement component deficiency; 2) who are residents of or travelers to countries with hyperendemic or epidemic disease; or 3) who are present during outbreaks caused by a vaccine serogroup, administer 2 primary doses of MCV4-D, ideally at ages 9 months and 12 months or at least 8 weeks apart.
    - For children aged 24 months and older with 1) persistent complement component deficiency who have not been previously vaccinated; or 2) anatomic/functional asplenia, administer 2 primary doses of either MCV4 at least 8 weeks apart.
    - For children with anatomic/functional asplenia, if MCV4-D (Menactra) is used, administer at a minimum age of 2 years and at least 4 weeks after completion of all PCV doses.
    - See *MMWR* 2011;60:72–6, available at http://www.cdc.gov/mmwr/pdf/wk/mm6003. pdf, and Vaccines for Children Program resolution No. 6/11-1, available at http://www. cdc.gov/vaccines/programs/vfc/downloads/resolutions/06-11mening-mcv.pdf, and *MMWR* 2011;60:1391–2, available at http://www.cdc.gov/mmwr/pdf/wk/mm6040. pdf, for further guidance, including revaccination guidelines.

This schedule is approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

FIGURE 2: Recommended immunization schedule for persons aged 7 through 18 years—United States, 2012 (for those who fall behind or start late, see the schedule below and the catch-up schedule [Figure 3])



This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).

1. **Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine.** (Minimum age: 10 years for Boostrix and 11 years for Adacel)
   - Persons aged 11 through 18 years who have not received Tdap vaccine should receive a dose followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter.
   - Tdap vaccine should be substituted for a single dose of Td in the catch-up series for children aged 7 through 10 years. Refer to the catch-up schedule if additional doses of tetanus and diphtheria toxoid–containing vaccine are needed.
   - Tdap vaccine can be administered regardless of the interval since the last tetanus and diphtheria toxoid–containing vaccine.
2. **Human papillomavirus (HPV) vaccines (HPV4 [Gardasil] and HPV2 [Cervarix]).** (Minimum age: 9 years)
   - Either HPV4 or HPV2 is recommended in a 3-dose series for females aged 11 or 12 years. HPV4 is recommended in a 3-dose series for males aged 11 or 12 years.
   - The vaccine series can be started beginning at age 9 years.
   - Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
   - See *MMWR* 2010;59:626–32, available at http://www.cdc.gov/mmwr/pdf/wk/mm5920.pdf.
3. **Meningococcal conjugate vaccines, quadrivalent (MCV4).**
   - Administer MCV4 at age 11 through 12 years with a booster dose at age 16 years.
   - Administer MCV4 at age 13 through 18 years if patient is not previously vaccinated.
   - If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years with a minimum interval of at least 8 weeks after the preceding dose.
   - If the first dose is administered at age 16 years or older, a booster dose is not needed.
   - Administer 2 primary doses at least 8 weeks apart to previously unvaccinated persons with persistent complement component deficiency or anatomic/functional asplenia, and 1 dose every 5 years thereafter.
   - Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive a 2-dose primary series of MCV4, at least 8 weeks apart.
   - See *MMWR* 2011;60:72–76, available at http://www.cdc.gov/mmwr/pdf/wk/mm6003.pdf, and Vaccines for Children Program resolution No. 6/11-1, available at http://www.cdc.gov/vaccines/programs/vfc/downloads/resolutions/06-11mening-mcv.pdf, for further guidelines.
4. **Influenza vaccines (trivalent inactivated influenza vaccine [TIV] and live, attenuated influenza vaccine [LAIV]).**
   - For most healthy, nonpregnant persons, either LAIV or TIV may be used, except LAIV should not be used for some persons, including those with asthma or any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see *MMWR* 2010;59(No.RR-8), available at http://www.cdc.gov/mmwr/pdf/rr/rr5908.pdf.
   - Administer 1 dose to persons aged 9 years and older.
   - For children aged 6 months through 8 years:
     — For the 2011–12 season, administer 2 doses (separated by at least 4 weeks) to those who did not receive at least 1 dose of the 2010–11 vaccine. Those who received at least 1 dose of the 2010–11 vaccine require 1 dose for the 2011–12 season.
     — For the 2012–13 season, follow dosing guidelines in the 2012 ACIP influenza vaccine recommendations.
5. **Pneumococcal vaccines (pneumococcal conjugate vaccine [PCV] and pneumococcal polysaccharide vaccine [PPSV]).**
   - A single dose of PCV may be administered to children aged 6 through 18 years who have anatomic/functional asplenia, HIV infection or other immunocompromising condition, cochlear implant, or cerebral spinal fluid leak. See *MMWR* 2010:59(No. RR-11), available at http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf.
   - Administer PPSV at least 8 weeks after the last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with anatomic/functional asplenia or an immunocompromising condition.
6. **Hepatitis A (HepA) vaccine.**
   - HepA vaccine is recommended for children older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A virus infection is desired. See *MMWR* 2006;55(No. RR-7), available at http://www.cdc.gov/mmwr/pdf/rr/rr5507.pdf.
   - Administer 2 doses at least 6 months apart to unvaccinated persons.
7. **Hepatitis B (HepB) vaccine.**
   - Administer the 3-dose series to those not previously vaccinated.
   - For those with incomplete vaccination, follow the catch-up recommendations (Figure 3).
   - A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.
8. **Inactivated poliovirus vaccine (IPV).**
   - The final dose in the series should be administered at least 6 months after the previous dose.
   - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
   - IPV is not routinely recommended for U.S. residents aged18 years or older.
9. **Measles, mumps, and rubella (MMR) vaccine.**
   - The minimum interval between the 2 doses of MMR vaccine is 4 weeks.
10. **Varicella (VAR) vaccine.**
    - For persons without evidence of immunity (see *MMWR* 2007;56[No. RR-4], available at http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
    - For persons aged 7 through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
    - For persons aged 13 years and older, the minimum interval between doses is 4 weeks.

This schedule is approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).
Department of Health and Human Services • Centers for Disease Control and Prevention

FIGURE 3. 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

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. **Always use this table in conjunction with the accompanying childhood and adolescent immunization schedules (Figures 1 and 2) and their respective footnotes.**

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to dose 2	Dose 2 to dose 3	Dose 3 to dose 4	Dose 4 to dose 5
Persons aged 4 months through 6 years					
Hepatitis B	Birth	4 weeks	8 weeks and at least 16 weeks after first dose; minimum age for the final dose is 24 weeks		
Rotavirus[1]	6 weeks	4 weeks	4 weeks[1]		
Diphtheria, tetanus, pertussis[2]	6 weeks	4 weeks	4 weeks	6 months	6 months[2]
Haemophilus influenzae type b[3]	6 weeks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose) if first dose administered at age 12–14 months No further doses needed if first dose administered at age 15 months or older	4 weeks[3] if current age is younger than 12 months 8 weeks (as final dose)[3] if current age is 12 months or older and first dose administered at younger than age 12 months and second dose administered at younger than 15 months No further doses needed if previous dose administered at age 15 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months	
Pneumococcal[4]	6 weeks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose for healthy children) if first dose administered at age 12 months or older or current age 24 through 59 months No further doses needed for healthy children if first dose administered at age 24 months or older	4 weeks if current age is younger than 12 months 8 weeks (as final dose for healthy children) if current age is 12 months or older No further doses needed for healthy children if previous dose administered at age 24 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age	
Inactivated poliovirus[5]	6 weeks	4 weeks	4 weeks	6 months[5] minimum age 4 years for final dose	
Meningococcal[6]	9 months	8 weeks[6]			
Measles, mumps, rubella[7]	12 months	4 weeks			
Varicella[8]	12 months	3 months			
Hepatitis A	12 months	6 months			
Persons aged 7 through 18 years					
Tetanus, diphtheria/ tetanus, diphtheria, pertussis[9]	7 years[9]	4 weeks	4 weeks if first dose administered at younger than age 12 months 6 months if first dose administered at 12 months or older	6 months if first dose administered at younger than age 12 months	
Human papillomavirus[10]	9 years	Routine dosing intervals are recommended[10]			
Hepatitis A	12 months	6 months			
Hepatitis B	Birth	4 weeks	8 weeks (and at least 16 weeks after first dose)		
Inactivated poliovirus[5]	6 weeks	4 weeks	4 weeks[5]	6 months[5]	
Meningococcal[6]	9 months	8 weeks[6]			
Measles, mumps, rubella[7]	12 months	4 weeks			
Varicella[8]	12 months	3 months if person is younger than age 13 years 4 weeks if person is aged 13 years or older			

1. **Rotavirus (RV) vaccines (RV-1 [Rotarix] and RV-5 [Rota Teq]).**
   - The maximum age for the first dose in the series is 14 weeks, 6 days; and 8 months, 0 days for the final dose in the series. Vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
   - If RV-1 was administered for the first and second doses, a third dose is not indicated.
2. **Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine.**
   - The fifth dose is not necessary if the fourth dose was administered at age 4 years or older.
3. ***Haemophilus influenzae* type b (Hib) conjugate vaccine.**
   - Hib vaccine should be considered for unvaccinated persons aged 5 years or older who have sickle cell disease, leukemia, human immunodeficiency virus (HIV) infection, or anatomic/functional asplenia.
   - If the first 2 doses were PRP-OMP (PedvaxHIB or Comvax) and were administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
   - If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a final dose at age 12 through 15 months.
4. **Pneumococcal vaccines.** (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])
   - For children aged 24 through 71 months with underlying medical conditions, administer 1 dose of PCV if 3 doses of PCV were received previously, or administer 2 doses of PCV at least 8 weeks apart if fewer than 3 doses of PCV were received previously.
   - A single dose of PCV may be administered to certain children aged 6 through 18 years with underlying medical conditions. See age-specific schedules for details.
   - Administer PPSV to children aged 2 years or older with certain underlying medical conditions. See *MMWR* 2010:59(No. RR-11), available at http:// www.cdc.gov/mmwr/pdf/rr/rr5911.pdf.
5. **Inactivated poliovirus vaccine (IPV).**
   - A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.
   - In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk for imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
   - IPV is not routinely recommended for U.S. residents aged 18 years or older.
6. **Meningococcal conjugate vaccines, quadrivalent (MCV4).** (Minimum age: 9 months for Menactra [MCV4-D]; 2 years for Menveo [MCV4-CRM])
   - See Figure 1 ("Recommended immunization schedule for persons aged 0 through 6 years") and Figure 2 ("Recommended immunization schedule for persons aged 7 through 18 years") for further guidance.
7. **Measles, mumps, and rubella (MMR) vaccine.**
   - Administer the second dose routinely at age 4 through 6 years.
8. **Varicella (VAR) vaccine.**
   - Administer the second dose routinely at age 4 through 6 years. If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
9. **Tetanus and diphtheria toxoids (Td) and tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccines.**
   - For children aged 7 through 10 years who are not fully immunized with the childhood DTaP vaccine series, Tdap vaccine should be substituted for a single dose of Td vaccine in the catch-up series; if additional doses are needed, use Td vaccine. For these children, an adolescent Tdap vaccine dose should not be given.
   - An inadvertent dose of DTaP vaccine administered to children aged 7 through 10 years can count as part of the catch-up series. This dose can count as the adolescent Tdap dose, or the child can later receive a Tdap booster dose at age 11–12 years.
10. **Human papillomavirus (HPV) vaccines (HPV4 [Gardasil] and HPV2 [Cervarix]).**
    - Administer the vaccine series to females (either HPV2 or HPV4) and males (HPV4) at age 13 through 18 years if patient is not previously vaccinated.
    - Use recommended routine dosing intervals for vaccine series catch-up; see Figure 2 ("Recommended immunization schedule for persons aged 7 through 18 years").

Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967). Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and

Fraud and Abuse

Fraud and abuse is estimated to account for the majority of loss in the health care industry. The National Health Care Anti-Fraud Association estimates conservatively that 3% or $68 Billion is lost to health care fraud. Law enforcement and government agencies estimate up to 10% of $226 Billion.

As an insurer, Geisinger Health Plan has an obligation to help control rising health care costs. Geisinger Health Plan is committed to a policy of zero tolerance for fraudulent insurance acts. In order to have an effective Anti-Fraud program, it is essential for all providers to help identify and prevent fraud, waste, and abuse.

Some examples of provider fraud and abuse are:

- Billing for services not rendered
- Misrepresentation of the service (upcoding)
- Accepting payments or other benefits in exchange for referrals or for prescribing certain brands of medications
- Supplying an excessive amount of prescriptions, narcotic or other, without medical necessity

Some examples of member fraud and abuse are:

- Alteration of claim-related documents when seeking direct reimbursement
- Forging or altering prescriptions in order to receive a larger quantity or higher dosage than originally prescribed
- Reselling prescriptions for illegal street distribution

Providers and members can report suspected fraud and abuse directly to the Pennsylvania Department of Public Welfare's Provider Compliance Hotline by calling (866) DPW-TIPS. Providers can also make a report by going online to http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/index.htm and clicking on the Fraud and Abuse link and filling out the Medical Assistance 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 17105

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

Prior Authorization

Prior authorization is the Health Plan's response to information presented relating to a request for specified Health Care Services.

Prior authorization does not guarantee a Member's coverage or Health Plan payment.

A Member's coverage is pursuant to the terms and conditions of coverage set forth in a Member's applicable Benefit Document. Prior authorization requirements may vary based on the Member's applicable product line. Please contact the Customer Service Department (CST) for verification of prior authorization requirements (contact information available on following page).

A Member is not financially responsible for a Participating Provider's failure to (i) obtain prior authorization, or (ii) provide required and accurate information to the Health Plan.

Copayments, Coinsurance and/or Deductibles are the financial responsibility of the Member, when applicable.

Prior authorization is required for the following:

- Inpatient Hospitalization
- Inpatient Rehabilitation Admissions
- Skilled Level of Care Admissions
- Home Health/Hospice, Home Infusion, and Home Phlebotomy Services
- Durable Medical Equipment
- Outpatient Physical, Occupational, and Speech Therapy Services
- Outpatient Radiology and Cardiac Imaging Services, including:
    - MRI/MRA
    - CT/CTA
    - PET Scan
    - Nuclear Cardiology (MPI)
    - Diagnostic Nuclear Medicine
    - CCTA
    - Echocardiography
    - Stress Echo
- Specialty Pharmacy Vendor Program
- Non-formulary Prescription Drugs

Prior Authorization Determination and Communication Process

Prior authorization may be performed by Health Plan Medical Management staff, or through delegated vendor relationships. Delegated vendors may review services such as, but not be limited to, mental health, radiology, dental, and vision.

Prior authorization staff, which includes appropriate practitioner reviewers, utilize nationally recognized medical guidelines as well as internally developed medical benefit policies, individual assessment of the Member, and other resources to guide prior authorization, Concurrent Review, and retrospective review processes in accordance with the Member's eligibility and benefits.

Upon submission of required information, the prior authorization staff will provide verbal and written notification of determination of coverage in accordance with regulatory timeframes.

As it relates to urgent Concurrent Review approvals, the Health Plan has an understanding with Participating Providers that, once approval has been given it remains in effect until the Health Plan notifies the provider otherwise. This means that as Concurrent Review of care is ongoing and the case continues to meet criteria for approval, the Health Plan does not provide repeated notices of approval. Participating Providers will be notified every time a Concurrent Review results in a denial.

Participating Providers are verbally notified of any medical review denial(s) and are offered the opportunity to discuss adverse decision(s) directly with an appropriate practitioner reviewer who made the initial determination; or reviewer available at a time convenient for the Participating Provider. The Participating Provider's request to discuss the determination is required to occur within one (1) Business Day of the Health Plan's 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. In most cases, a decision will be rendered during the telephone discussion. The Participating Provider will then be notified of the determination in writing within timeframes specified by product type, and if denied, information regarding the right to appeal the determination shall be included.

Participating Providers are encouraged to notify the Member of a Health Plan's decision within the same Business Day of the decision notification from the Health Plan to the Participating Provider. It's important that any discussion regarding a Health Plan's decision be documented in the Member's medical record and should include key components, such as contact person/Member's name, date of notification, Health Plan's decision, alternative plan of care, if applicable and Member's appeal opportunities.

Medical Management's IVR system is available 24 hours a day, 7 days a week at (800) 544-3907 or (570) 271-6497. You will be prompted to say "prior authorization" for calls pertaining to acute inpatient prior authorization. Or say "another reason" if you are calling for something other than acute inpatient prior authorization. The IVR system also allows you to make multiple prior authorization requests during the same call.

Contact the Medical Management Department at the number listed above for a listing of delegated vendors and contact numbers. Please refer to GHP Family's HealthChoices Provider Manual for more specific information as it relates to each prior authorization process.

TIPS FOR SUCCESSFUL PATIENT ENCOUNTERS

GHP Family is committed to providing superior service without discrimination to any of our members including those who have special needs and those who are at high risk of developing special needs. An increasing body of health service research indicates that the provision of culturally and linguistically appropriate services leads to improved health outcomes and increased patient satisfaction.

In an effort to enhance patient and provider communication, GHP Family encourages providers to be aware of the following:

- **Styles of Speech**
  - People vary greatly in length of time between comment and response, the speed of their speech, and their willingness to interrupt.
  - Tolerate gaps between questions and answers, impatience can be seen as a sign of disrespect.
  - Listen to the volume and speed of the patient's speech as well as the content. Modify your own speech to more closely match that of the patient to make them more comfortable.

- **Eye Contact**
  - The way people interpret various types of eye contact is tied to cultural background and life experience.
  - Some cultures expect to look people directly in the eyes and interpret failure to do so as a sign of dishonesty. For many other cultures, direct gazing is considered rude or disrespectful.
  - Never force a patient to make eye contact with you. If a patient seems uncomfortable with direct gazes, try sitting next to them instead of across from them.

- **Body Language**
  - The meaning of body language varies greatly by culture, class, gender, and age.
  - Gestures can mean very different things to different people. Be very conservative in your own use of gestures and body language.

- **Gently Guide Patient Conversation**
  - Initial greetings can set the tone for the visit.
  - Many older people from traditional societies expect to be addressed more formally, no matter how long they have known their physician.
  - If the patient's preference is not clear, ask how they would like to be addressed.
  - Facilitate patient-centered communication by asking open-ended questions whenever possible.

GEISINGER HEALTH PLAN®

GHP FAMILY

TIPS FOR ENCHANCING PATIENT COMMUNICATION

- **Build rapport with the patient.**
  - Address patients by their last name. If the patient's preference is not clear, ask, "How would you like to be addressed?"
  - Focus your attention on patients when addressing them.
  - Learn basic words in your patient's primary language, like "hello" or "thank you".
  - Recognize that patients from diverse backgrounds may have different communication needs.
  - Explain the different roles of people who work in the office.

- **Make sure patients know what you do.**
  - Take a few moments to prepare a handout that explains office hours, how to contact the office when it is closed, and how the PCP arranges for care (i.e. PCP is the first point of contact and refers to specialists).

- **Keep patients' expectations realistic.**
  - Inform patients of delays or extended waiting times.
  - If the wait is longer than 15 minutes, encourage the patient to make a list of questions for the doctor or review health materials.

- **Work to build patients' trust in you.**
  - Inform patients of office procedures such as when they can expect a call with lab results, how follow-up appointments are scheduled, and routine wait times.

- **Determine if the patient needs an interpreter for the visit.**
  - Document the patient's preferred language in the patient chart.
  - Have an interpreter access plan.

- **Make sure patients know what to do.**
  - Review any follow-up procedures with the patient before he or she leaves your office.
  - Verify call back numbers, the locations for follow-up services such as labs, X-ray or screening tests, and whether or not a follow-up appointment is necessary.

SPECIAL NEEDS UNIT

The primary purpose of the Special Needs Unit is to ensure that each GHP Family member with Special Needs receives access to appropriate primary care, access to specialists trained and skilled in the needs of the member, information about the access to a specialist as PCP if appropriate, information about and access to all covered services appropriate to the member's condition or circumstance, including pharmaceuticals and DME, and access to needed community services.

The circumstances for which a member is classified as having a special need is 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, HIV/AIDS, Children in Substitute Care, and Mental Retardation/developmental disabilities. 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 specialist, 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 outside GHP Family;
- 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.

GHP Family's Special Needs Unit ensures the receipt of care and/or services by acting as a case manager for each member with an identified Special Need. The case manager is responsible for coordinating the delivery of all services for which the member is eligible under the GHP Family benefits.

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.