Geisinger Health Plan

Provider Update

August 2018

Advanced imaging clinical decision support and notification process starts Sept. 1, 2018

Applies to: Participating providers who order or render advanced diagnostic imaging services

Plan(s): All

Physicians will be responsible for consulting the clinical decision support tool and providing GHP with a decision support number and score for certain advanced imaging services ordered or scheduled on or after Sept. 1, 2018. Services that require decision support consultation and GHP notification are listed in the outpatient radiology notification list. GHP will not conduct clinical review or deny the service you select based on the appropriateness score attributed to that service by the decision support tool. All that is required is verification that the decision support tool was consulted.

Key provisions

- Emergency room, observation and inpatient imaging procedures do not require authorization.
- The ordering physician must obtain a decision support number and score and provide notification of these to GHP. Ordering physicians will need to be registered with NaviNet.net to access the clinical decision support tool.
- Failure to notify GHP may result in disruption of patient care and unpaid claims.
- Services not covered by the member's benefits always require prior authorization.
- Members should always be referred to in-network radiology providers.

Access the decision support tool, notification list and form, and read the full operations bulletin on the GHP plan central page at NaviNet.net.

Contents

Geisinger Health Plan (GHP) may refer collectively to Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted.

HPM50 GHP MPU July 2018
Photo credits: iStock

Opioid prior authorization changes

Applies to: All participating providers **Plan(s): GHP Commercial, GHP Marketplace, GHP Family, GHP Kids, and in-state TPA**

Beginning Sept. 1, 2018, GHP will implement changes to authorization requirements for opioid medications based on guidance from the Commonwealth of Pennsylvania. Changes will occur in three phases.

	Phase 1 – Sept. 1, 2018	Phase 2 – Jan. 1, 2019	Phase 3 – July 1, 2019
Long-acting opioids (LAO)	All LAOs require prior authorization	Same as Phase 1	Same as Phase 1
Short-acting opioids (SAO)	Prior authorization for patients **NEW** to opioid therapy after 3 days for children or 5 days for adults	Prior authorization for **ALL** patients after 3 days for children or 5 days for adults	Same as Phase 2
Morphine milligram equivalents (MME)	Prior authorization required for ≥ 90 MME/day	Same as Phase 1	Prior authorization required for ≥ 50 MME/day
Exceptions	Active cancer, sickle cell crisis and palliative care/hospice	Same as Phase 1	Same as Phase 1

The Phase 2 changes will impact approximately 13,500 GHP members. We encourage you to evaluate your patient's opioid needs with these dates in mind and obtain authorization in a timely manner to avoid any issues. Opioid prior authorization request forms can be accessed on Navinet under Forms on the left side of your screen:

- GHP Family/GHP Kids opioid use prior authorization request form
- GHP Commercial/GHP Marketplace/TPA opioid use prior authorization request form

Providers can also submit electronic requests via PromptPA at https://ghp.promptpa.com.

PROMISe™ ID needed to see CHIP and GHP Kids patients

Applies to: All participating providers **Plan(s): GHP Kids**

DHS regulations require that you must enroll with the Pennsylvania Department of Human Services (DHS) as soon as possible to continue seeing GHP Kids and other Children's Health Insurance Program (CHIP) enrollees. We encourage you to enroll immediately to minimize any disruption to your GHP Kids patients. Providers not registered with DHS at each service location risk delayed processing and/or denial of claims.

DHS has implemented Affordable Care Act (ACA) provisions requiring all providers and other practitioners who render, order, refer or prescribe items or services to CHIP enrollees be enrolled with DHS as a provider. You must complete an enrollment application for your provider type for each service location (provider's address) and submit all required documents to DHS. All applications, requirements and the step-by-step instructions are available at CHIP Provider Enrollment Information on the DHS website.

Keep your information current

Applies to: All participating providers **Plan(s): All**

It is essential we have your current information in order to best serve GHP members and ensure you receive important communications. You can update your information conveniently online. Visit the Healthcare Providers section at geisinger.org/thehealthplan, or look in *Provider Tools* on the GHP plan central page at NaviNet.net for links to the form.

We ask that you review your demographic information on file with GHP on a monthly basis and report any changes. Verify your current provider profile by using the *Find Providers* function on the left navigation bar at geisinger.org/thehealthplan to search the online directory for your office or organization. Delegated provider groups should submit data via the current process and verify the process with your credentialing organization.

If you have any questions on how to use the online add/change form, contact your account manager at 800-876-5357.

Reading Health System leaving the network

Applies to: All participating providers **Plan(s): All**

Reading Health System has decided to end its participation with all GHP plans on October 15, 2018. After October 15, services rendered by all Reading Health System facilities and providers will no longer be covered by GHP. Around 1,100 affected GHP members have been notified of this change.

We understand providers and members value choice in high quality health care providers and apologize for any inconvenience this change may cause. We encourage you to refer your GHP patients to participating providers for all inpatient and outpatient services. Your GHP account manager is prepared to assist you at 800-876-5357 during this transition.

Better paper claims processing

Applies to: All participating providers **Plan(s): All**

GHP is working to improve the way we process paper claims; but it is still quicker and easier to submit claims electronically through Instamed. Most of GHP providers are registered with Instamed and can access their ERA through the easy online portal. We recommend allowing your billing company to view your ERA information through Instamed for 24/7 access to payment details and print remittances. Contact InstaMed at 866-945-7990 if you or your billing company have questions regarding ERAs and access.

Not registered with InstaMed? Register today! (www.instamed.com/eraeft)

New address for paper claim submission:

Geisinger Health Plan
P.O. Box 853910
Richardson, TX 75085-3910

Coding corner

Frequently used hypertensive codes

Hypertension	Heart Disease	Heart Failure*	Kidney Disease**	ICD-10 Code
Yes	No	No	No	I10, essential (primary) hypertension
Yes	Yes	No	No	I11.9, Hypertensive heart disease without heart failure
Yes	Yes	Yes*	No	I11.0, Hypertensive heart disease with heart failure
Yes	No	No	Yes**	I12.9, Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
Yes	No	No	Yes**	I12.0, Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease
Yes	Yes	Yes*	Yes**	I13.0, Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
Yes	Yes	Yes*	Yes**	I13.2, Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease
Yes	Yes	No	Yes**	I13.10, Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
Yes	Yes	No	Yes**	I13.11, Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease

use additional code to specify type of heart failure** * use additional code to specify stage of kidney disease**

- Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present. CKD Should not be coded as hypertensive if the physician has specifically documented a different cause.
  - The appropriate code from category N18 should be used as a secondary code with a code from category I12 to identify the stage of chronic kidney disease.
- Hypertension with heart conditions classified to I50.- or I51.4-I51.9, are assigned to a code from category I11, Hypertensive heart disease.
  - Use an additional code from category I50, Heart failure, to identify the type of heart failure in those patients with heart failure.
  - The same heart conditions (I50.-, I51.4-I51.9) with hypertension, coded separately if the provider has specifically documented a different cause.

Coding is not always black and white; therefore, certain criteria and/or guidelines on this document may be subject to change depending on medical record documentation and/or professional coding discretion. HCC information can be found at cms.gov and within the AMA Coding Guidelines.

CMS will advance Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration

Applies to: All participating providers **Plan(s): Geisinger Gold**

Announced in late July, the MAQI demonstration tests how exempting eligible clinicians from Merit Based Incentive Payment System (MIPS) reporting requirements and payment adjustment will affect participation in alternative payment models with MAOs. Eligible clinicians may apply to the demonstration and those that qualify will be asked to provide documentation of their participation in qualifying payment arrangements in Fall 2018.

The Centers for Medicare and Medicaid Services (CMS) is currently seeking public comment on its proposed approach to collecting this information. For more information on the MAQI demonstration eligibility and to view the proposed standards for qualifying payment arrangements, visit the MAQI demonstration page on the CMS website at innovation.cms.gov/initiatives/maqi/.

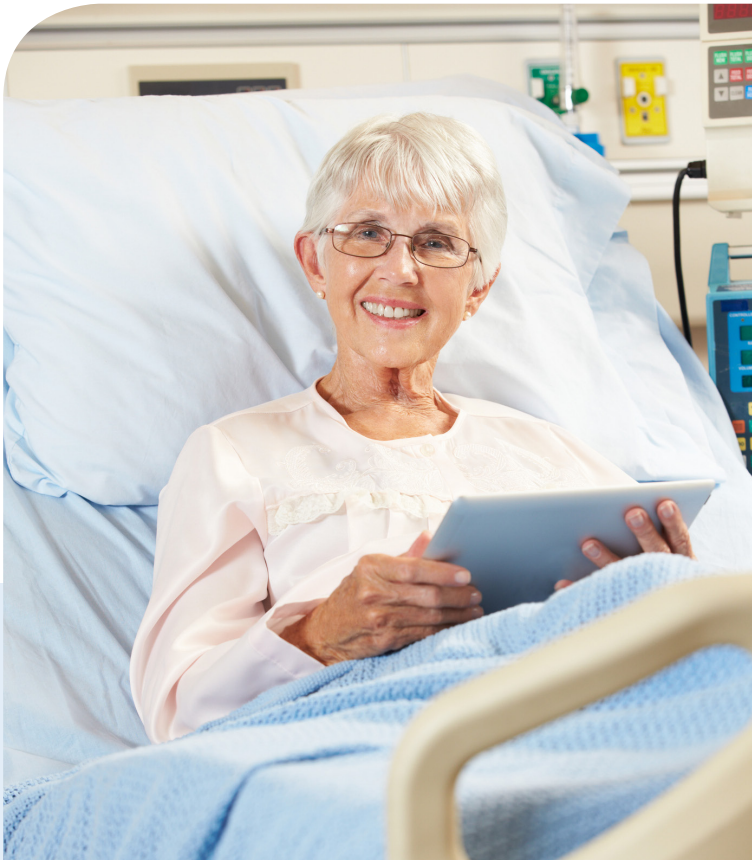
If you have a qualifying payment arrangement with GHP and Geisinger Gold, your account manager is ready to assist you in completing the requisite qualifying arrangement forms for the MAQI demonstration.

Prior authorization requirement for most planned inpatient admissions will be removed October 1, 2018

Applies to: All participating providers Plan(s): All

Effective Oct. 1, 2018, GHP will remove the prior authorization requirement for most planned inpatient hospital admissions. This will apply to all GHP lines of business including Geisinger Gold (Medicare Advantage) and GHP Family (PA HealthChoices Medicaid) plans.

View the complete Operations Bulletin regarding this change on NaviNet.net. Questions regarding this policy may be addressed to GHP medical management at 800-544-3907, Monday through Friday, 8:00 a.m. to 5:00 p.m.



The monthly Provider Update is published by Geisinger Health Plan and serves as an informational resource for the provider network. This update and more resources are available at NaviNet.net.

Medicare health outcomes survey — Monitoring physical activity

The Medicare Health Outcomes Survey (HOS) is used to gather clinically meaningful data from Medicare Advantage (MA) beneficiaries. The survey is used to gauge MA plan performance, inform MA beneficiaries' healthcare choices and advance research into population health. All managed care organizations with Medicare contracts, including Geisinger Gold, must participate.

With the focus on childhood obesity in recent years, we hear a lot about physicians encouraging exercise and active play for children. But when it comes to adults and those with disabilities, discussions about physical fitness and exercise are sometimes overshadowed by more immediate concerns over chronic conditions, medications and treatment plans. As a primary care provider, you are in a key position to influence participation in beneficial physical activity among your adult patients and those with disabilities.

The HOS survey will ask Geisinger Gold patients if their doctor or other healthcare provider discussed exercise or advised them to start, increase or maintain their physical activity. Prepare for a discussion about physical activity and exercise with your Geisinger Gold patients:

- Ask your patients about their level of physical activity and if they exercise regularly.
- Encourage your patients to start, increase or maintatin their level of exercise or physical activity. Suggest things like taking the stairs, walking 20 minutes per day or joining GHP's Silver Sneakers program.

For comprehensive information about the Medicare Health Outcomes Survey program, visit the CMS HOS website at http://hosonline.org.

Medicaid Eligibility Verification System (EVS)

Applies to: All participating providers **Plan(s): All**

The PROMISe EVS provides the most current information on a recipient's eligibility and scope of coverage. EVS also provides details of third party resources and managed care plans, when applicable. Eligibility is subject to change, so Medicaid recommends using EVS to verify eligibility each time services are provided to a recipient. Your practice can access EVS through the PROMISe provider portal, through the downloadable Provider Electronic Solutions Software or through your own certified software. EVS can also be accessed through an automated voice response system by calling 800-766-5387 and entering the recipient's social security number and date of birth.

Formulary and policy updates

Visit Geisinger Health Plan on NaviNet.net today to view 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 on Navinet.net. Clinical guidelines, formulary and medical policy information are also available in the "For Providers" section at GeisingerHealthPlan.com. Printed copies are available upon request.

Medical policy update

GHP uses medical policies as guidelines for coverage decisions made within the insured individuals 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. Click here for updates. **The new and revised medical policies listed below go into effect Sept. 15, 2018:**

- MP010 Blepharoplasty, Blepharoptosis and Brow Ptosis Repair – REVISED – updated title; clarified criteria
- MP201 Obstructive Sleep Apnea - REVISED – updated language in coding section

The following policies have been reviewed with no change to the policy section. Additional references or background information was added to support the current policy.

- MP005 Medical Policy Process
- MP048 Surgical and Minimally Invasive Therapies for the Treatment of BPH
- MP071 Subcutaneous Glucose Monitor
- MP100 Electrical Bioimpedance
- MP114 Vertebroplasty and Percutaneous Kyphoplasty
- MP125 Cranial Remodeling Orthotic
- MP137 Vibroacoustic Therapy
- MP227 Spaced Retrieval Testing
- MP240 Dermal Injections for Treatment of Facial LDS
- MP241 Non-invasive Measurement of Advanced Glycation Endproducts
- MP266 Magnetoencephalography and Magnetic Source Imaging
- MP268 Elective Laminectomy
- MP269 Elective Spinal Fusion
- MP279 Gene Expression Testing to Predict Coronary Artery Disease
- MP309 Computerized Dynamic Posturography

Medical pharmaceutical policy updates

The new and revised medical pharmaceutical policies listed below go into effect Sept. 15, 2018:

- MBP 176.0 Sublocade (buprenorphine ER subcutaneous injection) – NEW POLICY