Geisinger Health Plan

Provider Update

December 2019

Geisinger employee plans for 2020

Applies to: All providers **Plan(s): Geisinger employee TPA plans**

The Geisinger Provider Choice plan offers affordable premiums and access to the GHP network of providers across two groups: Group 1 providers and Group 2 providers. The Geisinger stand-alone PPO plan also remains available to all employees.

Overview

As of Jan. 1, 2020, all Geisinger employees will be enrolled in one of two plans:

1. Geisinger Provider Choice — Features two network groups. A member's out-of-pocket costs, such as copays, deductibles and coinsurance, are determined by the network group to which the provider they choose to see is designated. Members can see any provider from either group at any time. Referrals are not required for any specialist visits. Out-of-network services are not covered.
2. Geisinger PPO — A PPO plan that allows members to seek out-of-network services at an increased cost.

Network levels for Provider Choice plan

Members with the Geisinger Provider Choice plan will continue to have access to the entire GHP provider network. There are two groups of providers to choose from within the network: Group 1 providers and Group 2 providers.

Members can choose to receive any covered service from any network provider at any time, regardless of group designation. However, the provider's group designation will determine the member's out-of-pocket costs. Costs will be lowest for members who choose Group 1. Member costs for certain services, such as emergency department services, will be consistent across both groups.

Some services may require prior authorization from GHP medical management. A complete list of services/medications that require prior authorization and associated request forms are available on the GHP plan central page on NaviNet.

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 Dec 2019

Geisinger employee plans for 2020

What group are you in?

We encourage you to use the recently improved GHP provider search function at geisinger.org/health-plan/find to verify your information and your group designation for the 2020 Geisinger employee plan. GHP provider search results are available to patients seeking care and represent most of the important information we have on file for you and your office(s). Use the *Plans Accepted* feature to confirm your network grouping and make sure you refer your patient to providers in the lowest cost tier of their plan.

You can also use the feature to see if you accept other GHP plans. The *Plans Accepted* feature will show you a list of GHP plans the selected provider accepts and what network group or tier they are in.

New Provider Choice plan copay for diagnostic X-rays and labs; preventive screenings remain free

Applies to: All providers **Plan(s): Geisinger employee TPA plans**

When performed by a Group 1 provider or facility, laboratory and diagnostic procedures now have a $30 copay. All preventive X-rays, labs and other screenings will remain free.

Group 2 cost-sharing for laboratory and diagnostic services is subject to deductible and coinsurance.

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 on NaviNet.

Network group cost-sharing exception process

Under certain circumstances, medically necessary services rendered by a Group 2 provider may be paid at the Group 1 benefit level when a network group cost-sharing exception request is approved by GHP medical management.

You can request a network group cost-sharing exception for members under the following circumstances:

- When a Group 1 provider sees the member at a Group 2 office/facility
- When a Group 2 provider sees the member at a Group 1 office/facility
- When a particular service or specialty is not available from a Group 1 provider
- When a member is unable to schedule an appointment or reasonably access a Group 1 provider for needed services when those services are otherwise available from a Group 2 provider

There may be additional circumstances under which you may request a network group cost-sharing exception for the member. It is important to thoroughly document the reasons why the member should receive the exception during the request process.

Urgent admissions will automatically incur the Group 1 cost-sharing regardless of rendering provider group designation. The network group cost-sharing exception process does not affect existing prior authorization requirements. You should continue to obtain prior authorization for all services identified on GHP's prior authorization list.

How to request a network group cost-sharing exception

Network group cost-sharing exceptions must be obtained by the provider—not the member. There are two ways providers can request a network group cost-sharing exception for members:

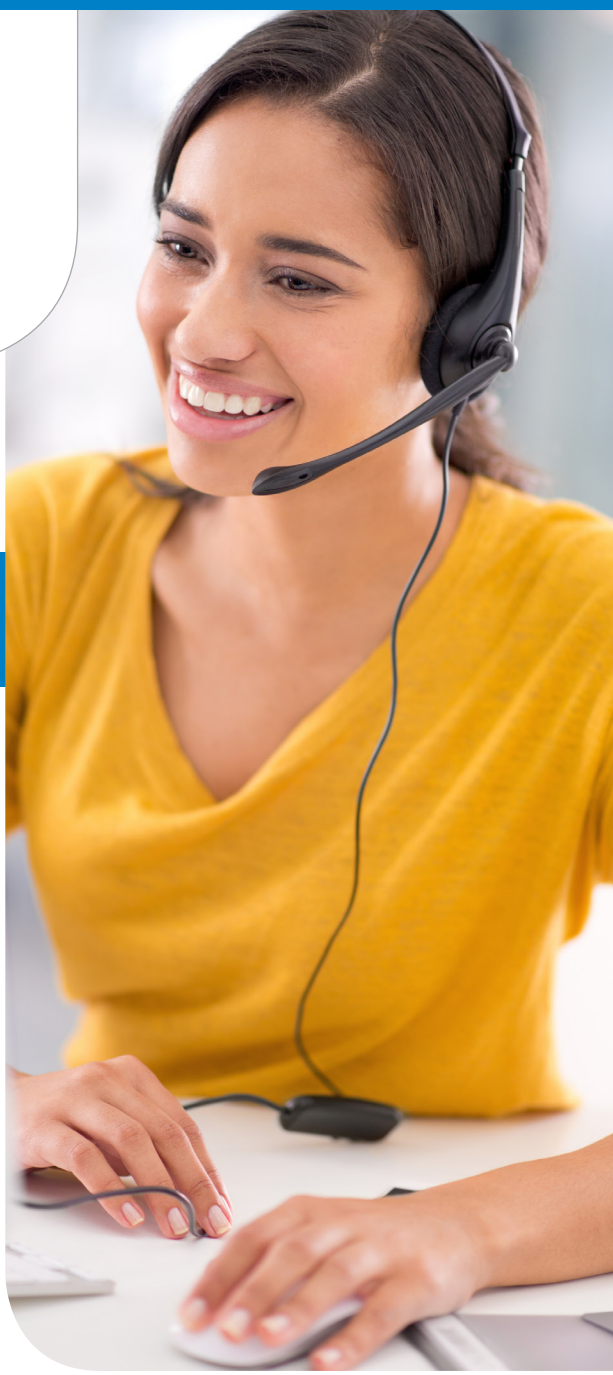
- Fax the request and supporting information to medical management at 570-271-5534, or;
- Call the Geisinger employee plan customer service team at 844-568-5229 or 570-214-8525.

GHP medical management will process the request. Notification will be sent to both the requesting provider and member upon determination. All granted exceptions will trigger member cost-sharing at the Group 1 level.

Customer service representatives are always available assist members who may be looking for a Group 1 PCP. Members who call GHP to request an exception will be directed to work with their provider to initiate the request.

For questions about the network group exception process or the Geisinger Provider Choice plan in general, contact GHP customer service at 844-568-5229.

Need to resolve a claim issue? GHP's new Provider Care Team answers the call



Have your claims questions answered quickly and correctly—the first time—by someone who cares.

Call 800-447-4000 and say, "claims" to connect with a dedicated claims resolution representative.*

We heard you

Geisinger Health Plan (GHP) is committed to improving the service experience for healthcare providers, like you, who take such great care of their GHP patients. We listened to your feedback about difficulty with claims inquiries and wait times, analyzed the issues and recognized the need to improve the claims resolution experience.

We took action

Over the last few months, GHP has restructured its customer care team to enhance provider service. Claims issues are being logged in a central repository, more staff has been added and substantial investments in provider service training have been made.

Here is how you benefit

- Shorter hold times when calling
- 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

*When requesting information about eligibility and benefits, 800-447-4000 may not always be the most direct line to call depending on your GHP patient's plan. Always check the back of your patient's GHP member ID card for the best customer care number to call for eligibility and benefits inquiries.

Statewide preferred drug list (PDL) effective Jan. 1, 2020 for GHP Family (Medicaid)

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

The Pennsylvania Department of Human Services (DHS) is implementing a statewide preferred drug list (PDL) to unify drug authorization guidelines between the Medical Assistance (MA) fee-for-service delivery system and managed MA plans like GHP Family.

Effective Jan. 1, 2020, the statewide PDL will replace GHP Family's current prior authorization guidelines/formulary for the drugs included in the statewide PDL. However, the process for requesting drug authorization from GHP Family will remain the same.

The current GHP Family prior authorization guidelines/formulary will remain in effect through Dec. 31, 2019 for drugs included in the statewide PDL. Current GHP Family guidelines will continue to apply to drugs not included on the statewide PDL after Jan. 1, 2020. GHP Family's current formulary is available at https://www.geisinger.org/health-plan/plans/ghp-family/pharmacy-coverage.

GHP Family patients have been notified that their current medication(s) may no longer be covered without prior authorization after Jan. 1, 2020. We will also be sending providers a list of their GHP Family patients whose current medication(s) may be affected by this change.

Providers should refer to the 2020 statewide PDL at https://papdl.com/preferred-drug-list, to familiarize themselves with the list of therapeutic classes and the preferred/non-preferred status of individual drugs included in the PDL. We encourage providers to review prescribed medications with their GHP Family patients to determine if a drug should be switched to a preferred alternative as of Jan. 1, 2020; or if a request for prior authorization to remain on a current drug is more appropriate.

Look for the Operations Bulletin dated Oct. 29, 2019 on NaviNet for more information.

Important message from NaviNet: Discontinuing support for Windows 7

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

The NaviNet Open portal will discontinue support for the Microsoft Windows 7 operating system beginning January 14th, 2020. This announcement is prompted by Microsoft's plan to end support for this operating system. NaviNet encourages all users on Windows 7 to move to a supported operating system to minimize any impact to your user experience. Visit NaviNet for more information on supported operating systems and browsers.

GHP Family encounter data reminder

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

Encounter data are necessary to characterize the context and purpose of each item and service provided to a Medical Assistance (MA) enrollee by any healthcare service provider. Encounter data are used by both Medicaid and contracted Managed Care Organizations to understand program costs, evaluate program quality and identify service utilization patterns. Encounter data are often referred to as claims data even when no claim for payment may actually be made.

Remember to submit claims and/or encounter data whenever you see your GHP Family patients, regardless of whether any member cost-sharing is due or if any additional or secondary payment is expected from Medicaid. Be sure to include third party liability (TPL) information when applicable. If you have claims questions that cannot be resolved through NaviNet or Instamed, call our customer care team at 800-447-4000.

CONNECT early intervention

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

Children with developmental delays and disabilities can benefit from a state-supported collaboration among parents, service practitioners and others who work with young children. The CONNECT Helpline assists families in locating resources and providing information regarding child development for children from birth to age 5. CONNECT can assist parents by making a direct link to their county or local preschool early intervention program.

Services such as parent education, support, developmental therapies and other services that assist in child development may be included in an early intervention program. Services can be provided in the home, child care center, nursery school, Head Start program or other settings that are familiar and comfortable for the family. Early intervention services are provided at no cost to the families.

To make referral for early intervention, call the CONNECT Helpline at 800-692-7288. Additional early intervention resources and education for families and providers can be found on the DHS website.

Lead screening

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

Protecting children from lead exposure is important to their health. Even low levels of lead in blood have shown to affect IQ, ability to pay attention and academic achievement. Effects of lead exposure cannot be corrected. All GHP Family children are considered at risk for lead toxicity. Risk questions should be asked at every visit. Lead screening is required at age 9 – 11 months. If not completed during that time, it must be done at the next screening opportunity of 12, 15 or 18 months and again at 24 months. If not completed at 24 months, it must be done at the next screening opportunity of 30 months, 3, 4, 5 or 6 years. Procedure code 83655 (lead testing) is used with the EP modifier.

GHP Family members with blood lead levels greater than 10 µg/dL need to be referred to GHP's Special Needs Unit (SNU) to coordinate environmental testing by a contracted vendor. You can refer patients directly by contacting the SNU at 855-214-8100. Inform the SNU that the referral is for an elevated blood lead level of 10 µg/dL or greater.

Additional data elements will be required on all electronic (837) claims submitted on or after Dec. 1, 2019

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

Effective Dec. 1, 2019, Geisinger Health Plan (GHP) will require an additional set of data elements on all electronic claims (EDI 837 transactions) for claims to process. Electronic claims submitted on and after Dec. 1, 2019 that do not include all the currently required data elements as well as the additional data elements listed in the Sept. 3, 2019 Operations Bulletin, will be rejected.

GHP claims data shows around 90% of participating providers currently submitting electronic claims are already in compliance with the new data element requirements and will not need to make a change to their electronic billing processes. However, we strongly encourage all providers to review the bulletin with their billing office/staff and/or clearinghouse to ensure the timely and accurate payment of GHP claims.

Providers should remind their billing office/staff and/or clearinghouse to continue including the data elements already required for GHP claims. The additional data element requirements listed in the bulletin will be required on GHP claims submitted on or after Dec. 1, 2019.

The Sept. 3, 2019 Operations Bulletin—*Update to 837 requirements – additional data elements needed for all electronic claims submitted to Geisinger Health Plan, Important information for your billing office or clearinghouse*—is available on the GHP plan central page on NaviNet. You can also contact your GHP account manager at 800-876-5357 for a copy of the bulletin.

For questions related to claims or claims submission requirements, call 800-447-4000 and say, "claims" to speak with our provider care team.

GHP now administers Behavioral Health services

Applies to: Behavioral health and other providers Plan(s): All plans except GHP Family

As of Jan. 1, 2020, GHP has assumed the administration of behavioral health benefits for members. Evidence supports that this type of integration optimizes member outcomes and controls medical costs. This approach will also allow GHP to have a more holistic view of member health, assist in better outcomes and improve overall satisfaction.

GHP will meet all federal and state network adequacy requirements, ensuring members have access to providers, regardless of location. We will maintain a current database of behavioral health providers so members can identify providers who meet their needs (e.g., location or specialty). To provide our members with continuity of care for their behavioral health needs, Magellan providers will be considered in-network for GHP's behavioral health network.

GHP will no longer use Magellan to manage our Behavioral Health Network as of Jan. 1, 2020. To continue seeing your GHP patients in 2020, you must have a direct contract and be credentialed with GHP.

2020 Geisinger Gold overview

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

Geisinger Gold serves more than 94,000 members in 44 counties throughout Pennsylvania. Geisinger Gold is contracted with more than 125 area hospitals, 33,000 plus providers and nearly 3,000 pharmacies in Pennsylvania to provide medical care for members.

The annual election period for Medicare enrollees runs from Oct. 15 through Dec. 7, 2019.

Check out the 2020 plan overview on NaviNet to familiarize yourself with the 2020 plan offerings and the benefit changes your existing Geisinger Gold patients can expect to encounter.

Important hearing aid benefits reminder: 2020 Geisinger Gold

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

Beginning Jan. 1, 2020, Geisinger Gold members in the following plans must receive hearing aid benefits from an AudioNet America provider.

- Classic Advantage (Rx) (HMO)
- Classic Complete Rx (HMO)
- Classic Essential Rx (HMO)
- Classic 360 Rx (HMO)
- Secure Rx (HMO D-SNP)

Members should be directed to a participating provider for their hearing aid needs for the services to be covered by their benefits. Members are eligible for this benefit once every three years. Members should be advised to contact AudioNet America at 570-290-8550 for assistance in locating a provider.

CAR T-cell therapy for Geisinger Gold: Bill original fee-for-service Medicare

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

Chimeric Antigen Receptor (CAR) T-cell therapy for cancer is now covered nationally, through the Centers for Medicare and Medicaid Services (CMS) issuing a National Coverage Decision for Medicare.

CAR T-cell therapy is considered a significant cost by CMS. For CY2019 and CY2020 only,original fee-for-service Medicare will pay for CAR T-cell therapy for cancer. Any claims Geisinger Gold receives for this therapy prior to 2021 will be denied as need to bill Original Medicare.

For more information and detailed billing instructions,
see the MLN Matters article number SE19024 released Oct. 24, 2019.

New skilled nursing and home health payment models

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

SNF PDPM (Patient Driven Payment Model)

Effective Oct. 1, 2019, the Centers for Medicare & Medicaid Services (CMS) transitioned from the Resource Utilization Group (RUG) rate payment classification to the Patient Driven Payment Model (PDPM). As of Oct. 1, 2019, providers are to bill for services under PDPM using the Health Insurance Prospective Payment System (HIPPS) code that is generated from assessments with an Assessment Reference Date (ARD) on or after Oct. 1, 2019.

Similar to RUG-IV, HIPPS codes under PDPM are still five-character codes. The first character of the HIPPS code represents the patient's PT and OT component, while the second character represents the SLP component. The third character represents the patient's nursing component, the fourth character is the patient's NTA classification, and lastly, the fifth character represents the AI code. All HIPPS codes need to be submitted along with the correct revenue codes, as they were under RUG-IV.

Providers should update their billing, in accordance with CMS guidelines, when submitting claims to Geisinger Health Plan for skilled nursing services. CMS has a dedicated web site for the change to the PDPM methodology. More information can be found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.

Home Health PDGM (Patient Driven Groupings Model)

Effective Jan. 1, 2020, the Centers for Medicare & Medicaid Services (CMS) will transition to a new Patient Driven Groupings Model which will rely heavily on two key points—patient information and clinical characteristics. This information will allow home health periods of care to be grouped into payment categories and eliminates the use of therapy service thresholds. In tandem with the new PDGM model, the home health payment episode will move from a 60-day episode to a 30-day episode.

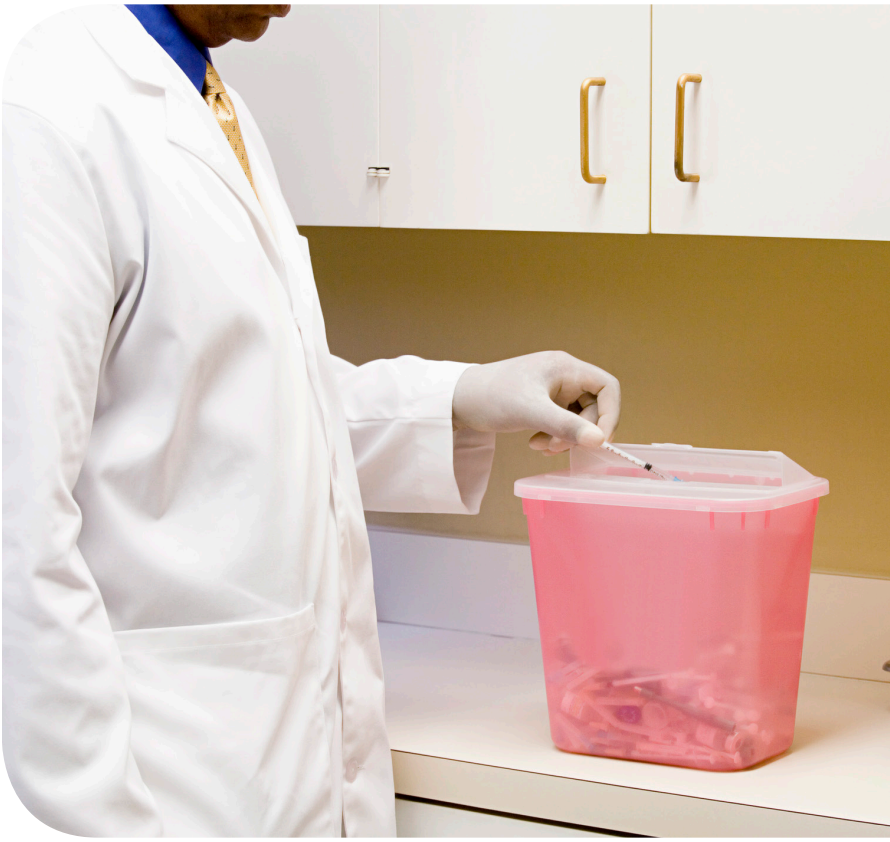
Providers should submit claims with the generated grouper-produced HIPPS code when submitting the claim for payment. The applicable revenue code is required as with the prior payment methodology.

Providers should update their billing, in accordance with CMS guidelines, when submitting claims to Geisinger Health Plan for home health services. More information from CMS can be found at: https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2019-02-12-PDGM-Presentation.pdf

Billing JW modifier for Part B drugs and biologicals

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

JW modifier is a HCPCS Level II modifier used to report the amount of drug or biological discarded and eligible for payment under Medicare's discarded drug policy. The JW modifier is used when the remainder of a single use vial or single use package must be discarded to ensure reimbursement for the amount of drug or biological administered and discarded—up to the total amount ordered per date of service.



Key points

- The JW modifier is billed for claims with unused drugs or biologicals from single use vials or single use packages.
- Providers are required to document the discarded drug or biological in the patient's medical record.
- The JW modifier is only applied to the amount of drug or biological that was discarded and is billed on a separate line.
- Multi-use vials are not subject to payment for discarded amounts of drug or biological
- The JW modifier cannot be billed for multiple dates on one line with date the drug was last received and there is no coverage for shipments not received due to weather.

For more information on billing the JW modifier, visit:
www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00142500
Or, search the Novitas Solutions webcenter for JW modifier.

Report fraud, waste and abuse

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

GHP's compliance program oversees the development, implementation and maintenance of a compliance and privacy program that meets or exceeds federal and state laws and regulations, contractual and accreditation obligations. We are committed to ethical and legal conduct and strive to correct wrongdoing whenever it may occur in the administration of our plans. If fraud, waste and/or abuse is suspected, you can call GHP's Fraud and Abuse Hotline at 800-292-1627. Calls may be made anonymously. You may also contact our Chief Compliance Officer directly at 570-271-7389.

Change to billing process for repeat hospital admissions occurring within seven days

Applies to: Hospital providers **Plan(s): All plans except GHP Family and TPA plans**

GHP requires hospital providers to combine and rebill inpatient hospitalization claims when a readmission occurs within seven days of discharge unless either admission meets one of the exclusion criteria outlined in the Types of admissions excluded from the combined billing and reimbursement process section below. Extensive claims analysis of repeat admissions within seven days that do not meet the exclusion criteria below show that this process has minimal impact on most hospital providers.

What is changing

Currently, GHP denies both the initial and subsequent claim when the readmission occurs within seven days; unless either admission meets any of the exclusion criteria outlined in the Types of admissions excluded from the combined billing and reimbursement process section below. Providers are directed through the denials to rebill a combined admission.

Effective Dec. 1, 2019, GHP will pay the initial claim and only deny the subsequent claim when the readmission occurs within seven days (subject to exclusion criteria). When the second claim is denied, providers will be directed through the denial to rebill the first admission using bill type 117 (replacement claim) as a combined admission for both claims. Payment for the first claim will be retracted and the corrected combined claim will be paid.

Claims for admissions that are denied based on medical necessity and/or member coverage should not be combined with any other admission, nor resubmitted.

See the Dec. 1, 2019 Operations Bulletin that updates the process outlined in the Operations Bulletin dated September 22, 2017— *New billing process for repeat hospital admissions occurring within seven days*—which explains the Geisinger Health Plan (GHP) billing process for repeat hospital admissions occurring within seven days.

Formulary and policy updates

Visit Geisinger Health Plan on NaviNet 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. 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 Dec. 15, 2019:

- MP020 Solid Organ Transplant Services – REVISED – revised criteria
- MP023 Keratoplasty – REVISED – updated indications
- MP091 Sacral Nerve Stimulation – REVISED – removed prior authorization
- MP104 Subcutaneous Insulin Pump – REVISED – updated exclusion language
- MP170 Gene Expression Profiling for Breast Cancer Treatment – REVISED – update criteria; removed prior authorization
- MP214 Iontophoresis – REVISED – updated indication language

The new and revised medical policies listed below go into effect Jan. 15, 2020:

- MP038 Oral Health – REVISED – added maxillofacial prosthetics and prior authorization
- MP051 Vagus Nerve Stimulation – REVISED – added medicare CED for depression
- MP105 Phototherapy for Seasonal Affective Disorder – REVISED – added exclusion
- MP260 Canaloplasty and Viscocanalostomy – REVISED – refined exclusion language
- MP261 Aqueous Drainage Shunt – REVISED – added approved devices
- MP301 Sacroiliac Joint Fusion – REVISED – refined criteria
- MP331 Inpatient Rehabilitation – NEW
- MP332 Skilled Nursing Facility – NEW

GHP continues to solicit physician and non-physician provider input concerning medical policies. Your feedback is encouraged and appreciated.
Send comments to Phillip Krebs at: pkrebs@GeisingerHealthPlan.com.

Formulary and policy updates

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.

- MP029 Bone Growth Stim
- MP030 IDET
- MP047 Hyperbaric Oxygen Therapy
- MP050 Surgical Correction of Chest Wall Deformities
- MP058 Negative Pressure Wound Therapy
- MP159 Voice Therapy
- MP187 Cryoablation
- MP197 Janus Kinase 2 (JAK 2) Gene Mutation Analysis
- MP243 Anorectal Fistula Repair Using an Acellular Plug
- MP244 Pelvic Floor Stimulation
- MP258 Hyperhidrosis
- MP278 Hyperthermia in Cancer Therapy
- MP307 Gender Dysphoria and Gender Confirmation Treatment
- MP311 Genotyping or Phenotyping for Thiopurine Methyltransferase
- MP313 Environmental Lead Testing
- MP015 Experimental/Investigational MP021 Dorsal Column Stimulation
- MP056 Management of Excessive Skin and Subcutaneous Tissue MP060 Lung Volume Reduction
- MP157 Prothrombin Time Home Testing
- MP162 Salivary Hormone Testing for Menopause and Aging MP164 Laser Treatment for Acne
- MP177 Sensory Integration Therapy MP194 Rhinophototherapy
- MP219 Percutaneous Neuromodulation Therapy MP270 Ocular Photoscreening
- MP300 Digital Breast Tomosynthesis
- MP308 Wireless Pulmonary Artery Pressure Monitoring

Medical pharmaceutical policy updates

The new and revised medical pharmaceutical policies listed below go into effect Jan. 15, 2020:

- MBP 117.0 Beleodaq (belinostat) – REVISED
- MBP 119.0 Keytruda (pembrolizumab) – REVISED
- MBP 139.0 Darzalex (daratumumab) – REVISED
- MBP 201.0 Zulresso (brexanolone) – NEW
- MBP 202.0 Evenity (romosozumab-aqqg) – NEW

Formulary and policy updates

The following policies have been reviewed with no change to the policy section.

- MBP 64.0 Arranon (nelarbine)
- MBP 65.0 Torisel (temsirolimus)
- MBP 90.0 Benlysta (belimumab)
- MBP 93.0 Nulojix (belatacept)
- MBP 96.0 Voraxaze (glucarpidase)
- MBP 111.0 Marqibo (vincristine sulfate liposome injection)
- MBP 133.0 Signifor LAR (pasireotide LAR)
- MBP 159.0 Kymriah (tisagenlecleucel)
- MBP 162.0 Yescarta (axicabtagene ciloleucel)
- MBP 166.0 Adcetris (brentuximab vedotin)
- MBP 167.0 Vabomere (meropenem-vaborbactam)
- MBP 168.0 Parsabiv (etelcalcetide)
- MBP 169.0 Baxdela IV (delafloxacin)
- MBP 170.0 Lutathera (lutetium Lu 177 dotatate)
- MBP 172.0 Trisenox (arsenic trioxide)
- MBP 184.0 Azedra (iobenguane I 131)
- MBP 186.0 Libtayo (cemiplimab-rwlc)
- MBP 187.0 Zemdri (plazomicin)
- MBP 189.0 Lumoxiti (moxetumomab pasudotox-tdfk)

For questions regarding drug benefits call 800-988-4861, 8:00 a.m. to 5:00 p.m., Monday through Friday.