

Frequently Asked Questions

General Questions

1. What is a deemed provider?

A deemed provider is a physician or other health care provider who knows in advance of providing services that the member is enrolled in Gold Open and renders services based on this knowledge and has reasonable access to our Terms and Conditions. If a physician or health care provider renders care to a Gold Open member, the physician or health care provider is considered deemed to have a contract or deemed for that member. Physicians and other health care providers must be licensed and must be eligible to provide care to Medicare-eligible patients with no sanctions against their licensure. For a copy of our full Terms and Conditions, please visit our Web site, thehealthplan.com, or contact our Customer Service Team at 800-498-9731.

2. Does the physician have a responsibility to notify the plan that he or she is deemed?

No. There are no contracts to sign, and there is no paperwork required to participate. As with any insurance plan, the physician or other health care provider should ask to see the member's ID card to identify the individual as a Gold Open member. If the provider renders care to the member, that provider is deemed. You may choose to provide care to Gold Open members on a patient-by-patient basis and may stop treating Gold Open members at any time.

3. What is the reimbursement for a deemed provider?

Deemed providers are reimbursed the Medicare allowed amount from the Medicare fee schedule. If a physician or other health care provider did not know the member was a Gold Open member and submitted a claim as unassigned, that provider is considered non-deemed. Gold Open pays the non-deemed physician or other health care provider the Medicare limiting charge, minus the CMS-approved Gold Open member's cost-sharing amount. Once Gold Open has paid a physician or other health care provider, that provider has met the deeming requirements for that enrollee and will be considered deemed for all future care of that member. A physician or other health care provider will only be paid once as a non-deemed provider for a Gold Open member. Non-deemed providers may not balance bill the patient.

4. Which fee schedule does Gold Open use to determine the physician payment rate?

As with Original Medicare, the fee schedule for the locality where the service is rendered is used to reimburse physicians and other health care professionals. Please review the reimbursement methodology section of this manual for more information.

5. What services are subject to the annual deductible?

Gold Open members do not have inpatient or outpatient deductibles.
Gold Reserve members have an annual \$3,000 deductible.

6. What happens in an emergency?

Physicians and other health care providers who render care in an emergency are not considered deemed by default because a claim was submitted to Gold Open. In accordance with 42 CRF 422.216(f), Gold Open will not assume that the services provided by a hospital, physician or other health care provider in an emergency department are provided by deemed providers. Gold Open will process the claims as filed (accepting Medicare or not accepting Medicare assignment) and will pay the accepting provider the Medicare allowable, minus the Gold Open member's cost-sharing amount. Gold Open will pay the non-accepting Medicare health care provider the Medicare limiting charge, minus the Gold Open member's cost-sharing amount.

7. What Local Medical Review Policies (LMRPs) do you use?

We use the same LMRPs as Original Medicare. Gold Open uses the LMRPs in effect for the area where care is rendered.

8. Are Medicare ID numbers or provider NPI numbers required on claims submitted to Geisinger Gold Open?

Yes. The health care provider's tax ID and Medicare ID or UPIN number are required to price and process the claims appropriately. In addition, facilities should use sub-unit identifiers with their facility ID when submitting claims.

9. What happens if a member disenrolls from Gold Open and goes back to Original Medicare? How are the member's cost-shares calculated?

If a member disenrolls from Gold Open and returns to Original Medicare, then Original Medicare cost-sharing provisions apply.

10. What format does Gold Open require for claims?

Use the same format as you use for Original Medicare. Geisinger Gold Open accepts paper or electronic claims. If your office currently submits claims electronically to Geisinger Health Plan, you can continue to submit Gold Open claims using the same process. However, paper claims should be submitted to:

Geisinger Gold Open
P.O. Box 8200
Danville, PA 17822

11. Do additional documentation requirements (ADR) apply to this plan?

The same ADR requirements apply as they do for Original Medicare.

12. Are there contracted participating providers, which are required to be used?

No. There are no contracted participating providers under this plan. The member can have services performed at any Medicare-approved provider that is willing to accept the Gold Open Terms and Conditions.

13. Does Gold Open require Advanced Beneficiary Notices (ABN) for services, which are not covered under Medicare?

No. You must inform the member in advance that a specific service will not be covered. The notice may be verbal or in writing, however, you are encouraged to document the discussion.

14. What is the claims payment timeliness standard for Gold Open?

As a Medicare Advantage Organization (MAO) under contract with the Centers for Medicare & Medicaid Services (CMS), Gold Open must follow the Medicare Advantage rules. These contain provider protections, including prompt payment to health care providers. Under this provision, a MAO must pay 95 percent of clean claims within 30 days of receipt for services rendered under deemed or written contracts. The MAO must pay interest on all claims that are not paid within 30 days. All other claims must be approved or denied within 60 days of the request.

15. How does a physician or health care provider verify their claims status or a Gold Open member's eligibility?

Providers should call Customer Service at (800) 498-9731, seven days a week from 8 a.m. to 8 p.m.

16. What if a provider does not want to accept the Gold Open plan?

A physician or other health care professional may decide on a patient-by-patient basis to accept Gold Open. If the provider chooses not to be deemed and not to accept the payment Terms and Conditions that provider **must not** provide services to the Gold Open member.

17. If a member has services rendered by both deemed and non-deemed physicians or health care providers, how are member cost-sharing amounts handled?

The Gold Open member's cost-sharing amounts are not affected by the deemed status of the physician or other health care provider. The member is responsibility only for the copayments or coinsurance as stated in their Subscription Certificate.

Facility Provider Questions

1. How are payments for outpatient hospital services determined?

Reimbursement is determined by Ambulatory Payment Classification (APC) codes. However, under Original Medicare, the APC code payment methodology often includes a high beneficiary cost-share; this is not the case under Gold Open. For Gold Open members, Gold Open pays the full Medicare-allowed amount, minus the member's Gold

Open cost-sharing amount. Outpatient copayments/coinsurance are based on the type of facility where care is rendered.

2. How does inpatient reimbursement work?

Reimbursed is determined by the full Diagnostic Related Group (DRG) allowable amount, minus the Gold Open member's cost-share amount for inpatient services. Teaching hospitals receive an extra payment from Medicare.

3. Does Gold Open pay the teaching hospital this extra payment as well?

No. The Centers for Medicare & Medicaid Services (CMS) carved out operating Indirect Medical Education (IME), Direct Graduate Medical Education (DGME), nursing and allied health from the Medicare Advantage contractors. Medicare pays these add-ons directly through its fiscal intermediaries.

4. Should hospitals include the Gold Open case experience in their cost reports?

Yes. According to CMS, hospitals should include their Private Fee-For-Service (PFFS) cases in their cost reports.

5. Under Original Medicare, hospital patients must fill out a Medicare Secondary Payer (MSP) questionnaire. Should hospitals implement this process for Gold Open members?

Yes. Hospitals should have their patients fill out the MSP. Gold Open reimburses physicians or other health care providers and attempts to recover the money from any third party that might be liable after the fact.

6. Under Original Medicare, hospitals submit cost reports to Medicare on a yearly basis. Adjustments to payments are made if necessary. Is this process implemented under the Gold Open plan?

No. The previous year's cost reports are the basis for determining the payment rates. Gold Open will not make year-end settlements.

7. If a Gold Open member transfers from an acute inpatient facility to an acute rehabilitation facility, is the member responsible for another admission copayment?

No, as long as the member is **transferred**. If the member is discharged to the acute rehabilitation facility, this is considered a separate admission and the inpatient copayment would apply.

8. In inpatient situations, how would a physician(s) know if the beneficiary is enrolled in the Gold Open plan?

Physicians and other health care providers must know the type of health plan the patient has in order to bill for their services. They must know a patient's plan enrollment if they billed Gold Open. Therefore, if the physician or other health care provider renders

services to a Gold Open member, Gold Open will reimburse the provider as a "deemed provider."

Home Health/DME Provider Questions

1. What eligibility criteria are required for home health care services?

Gold Open uses the same home health criteria as Original Medicare. Contact Customer Service at (800) 498-9731, Seven days a week from 8 a.m to 8 p.m. (TDD/TTY (800) 447-2833) with your questions.

2. Are payments the same as the Medicare Prospective Payment System (PSS)?

Yes, Gold Open uses the Original Medicare PPS as the payment fee schedule for home health services.

3. Is there an initial and final payment, as with Original Medicare, or is there one payment per 60-day episode?

Gold Open pays the same way as Original Medicare with an initial and final payment. However, home health agencies may request reimbursement per 60-day episode of care by submitting a request for accelerated payment (RAP).

4. Is reimbursement from Home Health Resource Group (HHRG) codes for a 60-day episode of care?

Yes, the same as Original Medicare.

5. What is the copayment for infusion care provided in a home health care setting?

Some plans have cost sharing for home health services. There is member coinsurance for DME related to home health services, including the infusion pump. As with Original Medicare, most Medicare-covered drugs for home health are included in the home health PPS rate. Please refer to the cost sharing charts in this document.

Questions About Terms & Conditions

1. When are PFFS plans allowed to change their terms and conditions?

Gold Open Terms and Conditions will not change more frequently than annually with the exception of changes made in payment rates and methodologies directed by CMS under Original Medicare or mid-year benefit enhancements to the member's cost-sharing amount. Any changes are posted on our Web site at www.thehealthplan.com. Reimbursement rates are tied to Medicare fee schedules and only change if Medicare rates change. Under Gold Open Terms and Conditions, we continue to pay at least the Medicare reimbursement rate.

2. Where are changes posted and how are physicians or other health care providers notified?

Any changes to the Terms and Condition are posted on our Web site, www.thehealthplan.com. You can also get information on our Terms and Conditions by contacting our Customer Service Team at (800) 498-9731, Seven days a week from 8 a.m to 8 p.m. (TDD/TTY (800) 447-2833). Gold Open provides information by telephone, mail, or fax, as requested. Our goal is to send an annual notice to providers.

3. Is it the responsibility of the physician/health care provider to check the terms and conditions?

While Gold Open does not anticipate frequent or significant changes to the Terms and Conditions, it is the physician's or other health care provider's responsibility to understand the Terms and Conditions. The physician or health care provider should check the Terms and Conditions as frequently as necessary.

Prescription Drug Coverage Questions

1. Are Gold Open members eligible for Medicare prescription drug coverage?

Yes. Geisinger Health Plan offers Medicare prescription drug coverage to all Gold Open members. Members who elect this coverage will have an identification card separate from their medical coverage identification card.

2. What medications are covered?

For a copy of our formulary, please visit our Web site at www.thehealthplan.com and select "providers" followed by "formulary search."

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Geisinger Gold Open Provider Manual
Dev.10/05 Rev.6/06 Rev.5/07 Rev. 12/07