

Online tools enhance provider experience

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creased delay and costs. Electronic billing streamlines the billing process and proves to be more accurate. Electronic billing also helps reduce paperwork.

The Health Plan invites you to evaluate your current billing practices and examine the positive impacts of electronic claim submission. If you currently submit paper claims and decide to submit electronically, please visit www.thehealthplan.com/GHPCommon/new_privacy/privacy_claim_submission.cfm for more information.

Electronic Fund Transfer

Claims payments can be made faster and easier through the Health Plan's new electronic fund transfer (EFT) system. Payments will be deposited directly into your specified bank account.

A registration form is available by visiting the Provider Information Center at thehealthplan.com. Once this form is received, we will validate your bank account and routing information by sending a pre-note to your bank. Once your bank account information has been verified, we will let you know when to expect your first EFT transaction.

Please note:

- Paper explanation of payment (EOP) will continue to be generated and distributed by mail; however, no check will accompany the EOP.
- EFT payments can start in as little as two weeks. You will be notified prior to this occurring.
- EFT payments for all line of businesses except Third Party Administrator (TPA) are processed on Mondays (except bank holidays).
- TPA transfers will be made when funded. This is the same as without EFT.

Please call our Finance Department at (570) 271-5846 if you have any questions regarding EFT.

Health management program enrollment

Members can now enroll in Geisinger Health Plan health management programs online. Case managers work with members and providers to provide education and health care coordination. Current health management programs are:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Tobacco cessation
- Hypertension
- Chronic kidney disease
- Heart failure
- Diabetes
- Heart disease
- Osteoporosis

To learn more about these programs or to enroll online, members can login to our Web site and choose *Information for Members* from the menu along the right side of the screen. The link, *Care Coordination and Case Management*, offers more information on the programs. An enrollment link can be found with each description. For more information, please call the Care Coordination department at (800) 883-6355.

Tel-a-Nurse online chat

Members can now use our Tel-a-Nurse online chat service to receive general health information. Nurses can answer questions about health information and guide members to online health resources. To chat with a nurse, members should click on *Information for Members* in the member section of our Web site, and then follow the *Chat live with Tel-a-Nurse* link. This service should only be used for health information. Members experiencing symptoms should call Tel-a-Nurse at (877) 543-5061 or their provider. Tel-a-Nurse, a staff of specially trained nurses, is available 24 hours a day, 365 days a year to provide medical advice in both urgent and routine situations.

If you have any questions about our online tools and services, or would like assistance registering for the Web site, please contact your Provider Relations Representative.

Danville: (800) 876-5357
Harrisburg: (888) 281-5338
Sayre: (800) 734-3141
Scranton: (800) 350-6486
State College: (888) 669-4834

Listed below are the recent changes made to policies within the Geisinger Health Plan Medical Policy Portfolio effective May 1, 2008. The Plan uses medical policies as guidelines for coverage decisions made within the insured individuals written benefit documents. Coverage may vary by line of business and providers and members are encouraged to verify benefit questions regarding eligibility before applying the terms of the policy. This section has been included for you convenience.

Medical Policy	Change
Janus Kinase 2 (JAK2) Gene Mutation Analysis (MP 197)	Updated Policy to include coverage for the evaluation of polycythemia vera or idiopathic erythrocytosis
Interspinous Distraction Technology (MP 190)	Policy Renamed - Formerly Titled: X-Stop Interspinous Process Decompression System.
Iontophoresis (MP 214)	New Policy

Policy "What's New" feature available

In response to provider feedback, the Health Plan has added a "What's New" section to the medical benefit policy page online at thehealthplan.com. For your convenience, this section will list policies that have been recently added or revised, and include a summary of the change as appropriate. The full text of all policies will continue to be available.

Geisinger Health Plan scores high in quality

Geisinger Health Plan ranked #1 in three measures in a new report released by the Pennsylvania Health Care Cost Containment Council (PHC4), an independent state agency. In addition, the Health Plan was consistently ranked among the state's top four health plans. This report follows the 2007 U.S. News and World Report/America's Best Health Plans list released in November, in which Geisinger Health Plan was ranked in the top 15 percent of all health plans in the nation.

We thank you for the vital role you play in achieving these rankings. Your dedication to our members, as well as your assistance with Health Plan initiatives, helps provide superior service to our members.

The annual report, "Measuring the Quality of Pennsylvania's Commercial HMOs," compares Pennsylvania's health plans in how well they keep members healthy, prevent hospitalizations through primary care, manage ongoing illnesses and perform on surgical procedures. Approximately 40 different measures are compared. The Health Plan was ranked #1 in monitoring kid-

"The PHC4 report contains valuable information designed to help consumers make more informed decisions."

- Duane E. Davis, M.D, vice president and chief medical officer

ney disease for members with diabetes, screening for breast cancer and annual monitoring for patients on persistent medications.

Geisinger Health Plan scored well in many of the measures. In 13 of the 17 "Staying Healthy" measures, the Health Plan ranked among the top four health plans in the state. In addition, some of the Health Plan's best results were related to its nationally accredited disease management program for members with diabetes and asthma. The Health Plan scored higher than state and national averages in members receiving A1c blood tests and eye exams in the past year and screening members with diabetes for cholesterol. We also scored higher than state and national averages in childhood immunizations, timely initiation of prenatal care, screening for colorectal and cervical cancer, control-

ling high blood pressure and using beta-blockers after a heart attack.

In service measures, the Health Plan exceeded the national average in getting needed care and seeing a specialist.

"The PHC4 report contains valuable information designed to help consumers make more informed decisions," says Duane E. Davis, M.D, the Health Plan's vice president and chief medical officer. "By providing an apples-to-apples comparison of health plans, this resource encourages health plans to improve the quality of care they provide their members, helping to control the cost of health care in Pennsylvania."

An independent state agency, PHC4 was created under Pennsylvania statute (Act 89) to collect, analyze and report data to the public about the cost and quality of health care in Pennsylvania. This is the ninth year PHC4 has reported on the quality of care that HMO networks offer.

To obtain a free copy of the report, please call (717) 232-6787 or visit www.phc4.org.

Provider assistance assures HEDIS® success

The Health Plan would like to thank providers and office staff for their cooperation and assistance with HEDIS® chart audits. The information collected helps us identify patients who should receive necessary immunizations and tests such as pap smears, mammograms, cholesterol screenings and colorectal cancer screenings. We also appreciate your support in encouraging patients to receive needed immunizations and screenings.

Two HEDIS® measures of focus for the coming months are colorectal cancer screenings and cholesterol management.

Colorectal cancer

Colorectal cancer is the third most common cancer among both men and women in the United States. Colorectal cancer develops slowly and is often asymptomatic in its early stages. Treatment for early-stage colorectal cancer is extremely effective, with a five-year survival rate over 90%. Fewer than one in six cases are associated with a family history of the disease. The American Cancer Society recommends that women and

men, beginning at age 50, be screened for colorectal cancer. This can be accomplished by a yearly fecal occult blood test, a flexible sigmoidoscopy or double contrast barium enema every five years, or a colonoscopy every 10 years.

Cholesterol management

One in three Americans have some form of cardiovascular disease, which causes more deaths every year than cancer, chronic lower respiratory diseases, accidents and diabetes combined. Studies have shown cholesterol control to be especially critical after suffering a first heart attack, due to the increased risk of a subsequent attack or stroke. Screening and managing cholesterol levels in patients with cardiovascular conditions is very effective at reducing harm caused by coronary heart disease and other cardiovascular disease. Therapy to lower LDL cholesterol levels in patients with coronary heart disease reduces the risk of further heart events or stroke. Patients are 24 to 42 percent less likely to die from a heart-related event when they use a cholesterol-lowering drug.

Important information for providers

New hepatitis C screening program

Hepatitis C virus (HCV) infects approximately 3.9 million Americans, making it the most common cause of liver disease and the most common condition leading to liver transplantation. Routine HCV screening is recommended for the following individuals per guidelines established by the Centers for Disease Control and Prevention (cdc.gov):

- People with non-professional tattoos or body piercing
- People who ever injected illegal drugs, even if it was just once or a few times many years ago
- People who received a blood transfusion or organ transplant before July 1992
- People who received clotting factor concentrates before 1987
- People who were ever on long-term dialysis
- Children born to HCV-positive women
- Health care, emergency medical and public safety workers after needle sticks, sharps or mucosal exposures to HCV-positive blood
- People with evidence of chronic liver disease

Most acute hepatitis C cases are asymptomatic. In addition, it has been reported that no risk factors are identified in a significant number of cases. Therefore, there is a concern that people who may have HCV infection go undetected.

Geisinger Health Plan is recommending screening be offered to members between ages 18 and 30 as part of a pilot program. If a patient in this age group requests HCV screening, we suggest ordering a hepatitis C antibody test. Initial screening can be performed by any primary care physician, not only the member's designated PCP. Early identification and intervention can improve the chance of eradication in order to prevent progression to chronic liver disease, hepatocellular carcinoma and liver transplantation. A hepatitis C treatment guideline is available at thehealthplan.com.

thehealthplan.com. Member cost sharing may apply for these tests.

NPI compliance deadline May 23

On or before May 23, 2008, all electronic claims submitted require the use of National Provider Identifiers (NPI) only.

Electronic claims submitted on or after May 23 with legacy identifiers will be rejected for non-compliance.

As we approach the May 23 deadline, please follow some common guidelines:

- NPI should not be used in the legacy identifier section on electronic claim submissions
- Providers who use a billing company, software package or clearinghouse should confirm that submitting NPI only is a current capability, prior to dropping legacy identifiers
- NPI numbers should be used in the billing, rendering and service provider fields on electronic claims.

For additional information on correct NPI submission, please refer to our Companion Guide at www.thehealthplan.com/GHPCommon/new_privacy/privacy_companion_docs.cfm.

Geisinger Health Plan continues to receive a majority of claims electronically and we thank providers who use this method to submit claims. If you would like to enroll in Electronic Data Interchange (EDI) or learn about Geisinger Health Plan's NPI requirements, please visit thehealthplan.com. If you have any questions, please contact your Provider Relations Representative.

Provider Satisfaction Survey in offices soon

Eligible participating physicians recently received the 2008 Provider Satisfaction Survey. This survey helps the Health Plan learn more about how our services and processes affect your practice.

In 2007, overall provider satisfaction with the Health Plan increased to 71%, up from 63% in 2006. In physician sur-

veys, other managed care organizations averaged 61% in overall satisfaction for 2007.

Preventive care and wellness programs, as well as customer service and provider relations, were ranked highly by Health Plan providers.

Please take a few minutes to complete the 2008 Provider Satisfaction Survey. Your responses will assist us not only in improving services to our provider network, but to our members as well.

Survey results and action plans will be published in *Briefly* later this year.

Correct coding reminder

The Health Plan is currently upgrading our claim editing software process. This upgrade will expand on current editing capabilities.

The Health Plan reminds providers to always code services to the highest level of specificity in order to ensure timely and accurate payment on claims. Proper units should be reported, and modifiers used as appropriate.

Pharmacy prior authorization information

To help promote appropriate utilization, select medications require prior authorization to be eligible for coverage under the member's prescription benefit. For a listing of these medications, please visit thehealthplan.com.

The Pharmacy and Therapeutics Committee uses several resources to determine prior authorization applicability and value your feedback. To reduce barriers, we encourage prescribing providers to utilize the prior authorization form and submit supporting medical documentation via fax to (570) 271-5610. You can locate the form, instructions and other related information at thehealthplan.com. If you have any questions or require assistance with the prior authorization or formulary exception process, please contact the Pharmacy Department at (800) 988-4861.

Important pharmacy information for providers

Specialty pharmacy vendor program update

The Health Plan has recently approved the following changes to the Specialty Pharmacy Vendor Program, effective July 1, 2008:

- Revlimid, Tykerb, Letairis, Pegasys and Peg-Intron have been added to the list of drugs available exclusively through the program. Prior authorization will be required and can be obtained by medical record documentation, along with a completed Specialty Pharmacy Vendor Drug Request Form to the Health Plan's Pharmacy Department at (570) 271-5610. The form is available in the Provider Information Center online at thehealthplan.com. Approved requests will be forwarded to the Specialty Pharmacy Vendor, who will deliver your prescribed doses within four business days.
- While new prescriptions for Pegasys and Peg-Intron will require prior authorization for the traditional and triple tier pharmacy benefits, existing users will not require prior authorization.
- Lucentis will no longer be available to participating providers through the Specialty Pharmacy Program. Providers may continue to "buy and bill" through the medical benefit.
- Ninety-day supplies of medications will no longer be available through the Specialty Pharmacy Vendor Program. The Health Plan has determined that, in many cases, a full 90-day supply is not used by the member, resulting in added cost to the member.
- Prescriptions filled with a Specialty Pharmacy will be limited to a maximum of a 34-day supply for each prescription filled.
- Lupron Depot is not subject to this restriction. Other quantity limits for certain drugs will still apply as appropriate.

Effective June 1, 2008, the intraocular use of Avastin to treat exudative age-related macular degeneration will no longer require prior authorization.

Questions related to the Specialty Pharmacy Vendor Program may be directed to the Health Plan Pharmacy Department (800) 988-4861 or (570) 271-5673.

Part D drugs available as generics

Ambien, Penlac, Toprol XL and Trileptal are now available as generics. Effective May 31, 2008, we will no longer cover the brands of these products for member with our Standard Rx prescription drug plan and Gold Rx 1 prescription drug plan. Prior authorization will be required for the brand-name drugs for members with Standard Rx or Gold Rx 1. The generics will now process on the member's first tier (lowest copay level).

For those members with the \$0 Deductible prescription drug plan or Gold Rx 2 prescription drug plan, brand Ambien, Toprol XL and Trileptal will process on the third tier rather than the current second tier. These members will still be able to obtain the

generics of these products on their first tier.

Lotrel is also now available as a generic. The generic of Lotrel will process on tier 1 of all Gold plans.

Zostavax update

Since January 1, 2008, the Centers for Medicare and Medicaid (CMS) have required that Zostavax be paid for as a Part D benefit. This includes both the vaccine itself and the administration of it. The Health Plan will no longer accept medical benefit claims as of June 1, 2008. Providers will have the following options for Zostavax patients:

- A patient can go to a pharmacy that dispenses and administers the vaccine. This means that the patient would be given a prescription and will need to find a pharmacist that can administer. All billing (vaccine and administration) would occur by the pharmacist.
- A patient can be given a prescription for the vaccine, have it filled at the pharmacy, and return to the office for administration only. Providers would bill the Health Plan only for the administration of the vaccine.
- Providers can sign up for the E-Dispense Portal to bill both the vaccine and its administration. The method would reflect the member's correct Part D copay.

Please contact the Pharmacy Department at (800) 988-4861 if you have any questions.

Formulary updates

Commercial

Medications deemed non-formulary:

Xyrem (3) *,t Neupro (3) *,t
Ventavis (3) *,t, ** Letairis (3) *,t, **
Veregen (3) *,t

Medications deemed formulary:

Twinject (3) ** Levemir (2)
Tricor (2) Revatio (3) *,t, **
Tracleer (3) *,t, **

Existing users of Tracleer and Revatio will not require prior authorization.

() = tier

* = requires prior authorization under the non-tiered benefit

t = requires prior authorization under the tiered benefit

** = quantity limits apply

Gold

Medications deemed formulary:

Kuvan (highest tier, requires prior authorization)
Tricor (2) Levemir (2)

Medications deemed non-formulary:

Letairis Neupro
Remodulin

HEDIS® measures help ensure patient safety

The Health Plan would like participating physicians/providers to be aware of the following Health Plan Employer Data and Information Set (HEDIS®) standards, which promote pharmacy initiatives and in turn aid our members in assuring that their medications are safe and effective.

The majority of current HEDIS measures are “administrative only” measures, which rely entirely on Health Plan claims data, rather than chart audits. When the Health Plan uses claims data, we rely heavily on timely and accurate claims data submitted by our participating providers. It is very important that you submit your claims quickly and accurately.

Rheumatoid arthritis

Rheumatoid arthritis (RA) affects about 1% of the adult population and may result in progressive joint damage, deformity, and disability. Diseases modifying antirheumatic drugs (DMARDs) are used early in the treatment of RA to control symptoms and delay or even possibly stop disease progression.

Measurement

The Health Plan will measure whether adult patients diagnosed with RA have had at least one ambulatory prescription dispensed for a DMARD. The following are considered DMARDs: Humira, Enbrel, Kineret, Remicade, azathioprine, cyclophosphamide, cyclosporine, gold (oral or intramuscular), hydroxychloroquine, leflunomide, methotrexate, minocycline, enicillamine, staphylococcal protein A, and sulfasalazine.

Overuse of antibiotics

Overuse of antibiotics causes the development of antibiotic-resistant bacteria that render many antibiotics ineffective and contribute to serious, difficult-to-treat infections. Cautious antibiotic use can decrease the risk of antibiotic resistance.

Measurement

The Health Plan will measure the potential overuse of antibiotics. Specific antibiotics identified by NCQA for measurement are: quinolones, second-, third-, and fourth-generation cephalosporins, ketolides, azithromycin, clarithromycin, amoxicillin/clavulanic acid, clindamycin, and others.

Common brand names of these antibiotics include: quinolones: Cipro®, Factive®, Levaquin®, Avelox®; second-, third-, fourth generation cephalosporins: Cefzil®, Ceftin®, Lorabid®, Omnicef®, Cedax®, Vantin®, Cefizox®, Ketek®; Zithromax®; Biaxin®; Augmentin®; Cleocin®; Zynox®; Vancocin®.

Annual monitoring of persistent medications

Measurement

The Health Plan will measure members who received at least a 180-day supply of ambulatory medication therapy for the below agents during the measurement year and who had at least one therapeutic monitoring event for the therapeutic agent in the measurement year. In other words, if the member

is on one of the agents listed below, the measure requires that the labs listed below be obtained annually. Agents that should be monitored include:

Drug Name	Lab/Level	Frequency
ACEI/ARBS	K and SCr or BUN	Annually
Digoxin	K and SCr or BUN	Annually
Diuretics	K and SCr or BUN	Annually
Anticonvulsants	Serum Drug Concentration	Annually

Drugs to be avoided in the elderly

The Health Plan will measure 1) the percentage of Gold members who are age 65 or older and have received at least one drug that should be avoided in the elderly and 2) members who received at least two different drugs to be avoided in the elderly. For more information on drugs to be avoided in the elderly, please visit <http://www.dcri.duke.edu/ccge/curtis/beers.html>.

Potentially harmful drug-disease interactions in the elderly

Measurement

The Health Plan will measure the percentage of Medicare members 65 years of age and older who have evidence of the following:

1. A history of falls and a prescription for tricyclic antidepressants, antipsychotics or sleep agents
2. Dementia and a prescription for tricyclic antidepressants or anticholinergic agents
3. Chronic renal failure and prescription for nonaspirin NSAIDs or Cox-2 Selective NSAIDs

Pharmacotherapy management of COPD exacerbation

The Health Plan will measure the percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter between January 1 and November 30 of the measurement year and who were dispensed appropriate medications, which would include:

1. a systemic corticosteroid within 14 days of the event
2. a bronchodilator within 30 days of the event

Cholesterol management for patients with cardiovascular conditions

The Health Plan will measure the percentage of members 18 to 75 years of age who are discharged after acute myocardial infarction, coronary artery bypass graft or percutaneous transluminal coronary angioplasty or who had a diagnosis of ischemic vascular disease to see if they had an LDL screening and an LDL that is at goal (LDL <100 mg/dL).

If you have any questions on the measures listed above, please contact our Pharmacy Department at (800) 988-4861, Monday through Friday from 8:30 a.m. to 5 p.m.

Policy and guideline updates

The following is a summary of new, revised and recently reviewed medical and pharmaceutical policies. The complete text of these policies can be found online at thehealthplan.com or by contacting your Provider Relations Representative.

Medical policies

Annual reviews

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

- Aquatic therapy (MP 44)
- Autologous chondrocyte implantation (MP 115)
- Breast implant removal (MP 99)
- Breast reconstruction surgery (MP 64)
- Chest percussion vest (MP 45)
- Clinical guideline development (MP 171)
- Colonoscopy (MP 32)
- Corneal pachymetry (MP 199)
- Craniosacral therapy (MP 95)
- Deep brain stimulation (MP 73)
- ESSURE hysteroscopic micro-insert tubal occlusion sterilization (MP 128)
- Exhaled nitric oxide for asthma management (MP 174)
- HDR temporary brachytherapy (MP 123)
- Home phlebotomy program (MP 37)
- Implantable cardiac loop recorder (MP 92)
- Injectable bulking agents (MP 90)
- Meniscal allograft transplantation (MP 133)
- Meniett device (MP 176)
- Microvas vascular treatment system (MP 172)
- Morphometric tumor analysis (MP 102)
- Prolotherapy (MP 127)
- Pulse oximetry for pediatric home use (MP 198)
- Reduction mammoplasty (MP 68)
- Routine ultrasound in uncomplicated pregnancy (MP 106)
- Sacral nerve stimulation (MP 91)
- Sexual dysfunction therapy (MP 78)
- Somnoplasty, coblation (MP 40)

- Total body electron beam cat (MP 109)
- Transmyocardial laser revascularization (MP 62)
- Transpupillary thermotherapy (MP 124)
- Treatment of vestibular disorders (MP 165)
- Trigger point injections (MP 175)
- Ultrafiltration (MP 69)
- Unilateral pallidotomy (MP 94)
- Varicose vein treatment (MP 33)
- Vitalstim (MP 131)

Revisions

The following medical policies have been revised with a change to the policy section (e.g., criteria added, removed, or revised).

- Automated ambulatory blood pressure monitoring (MP 130)
- Convection enhances drug delivery (MP 196)
- Criteria for home health services (MP 188)
- Foot orthotics (MP 34)
- Functional MRI (MP 195)
- HH and DME related to hyperbilirubinemia (MP 76)
- Home uterine monitoring (MP 39)
- Interspinous distraction technology (MP 190)
- Intracranial percutaneous transluminal angioplasty (MP 184)
- Tissue engineered skin substitutes (MP 75)
- Transcatheter closure devices for cardiac defects (MP 25)

New policies

The following medical policies have been added.

- Computerized corneal topography (MP 213)
- Endometrial ablation (MP 210)
- Endovascular repair of intracranial aneurysms (MP 211)
- Non-contact low frequency ultrasound for wound management (MP 212)

Retired policies

The following Medical Policies have been removed.

- Actigraphy testing (MP 167)
- Medical director authorization for home infusion services (MP 22)

Pharmaceutical policies

The following policies have been added/updated.

- Alpha 1-antitrypsin inhibitor* (MBP 43.0)
- Avastin* (MBP 30.0)
- Botulinum toxin* (MBP 11.0)
- Cubicin* (MBP 37.0)
- Dacogen* (MBP 46.0)
- Herceptin* (MBP 45.0)
- Velcade* (MBP 23.0)
- VFEND* (MBP 21.0)

*Prior authorization required

Clinical guideline update

The following clinical guidelines have been recently added/updated and approved by the Geisinger Health Plan Quality Improvement Committee for use by participating providers, and have been posted on thehealthplan.com:

- Treatment of hepatitis C
- Adult and pediatric immunizations

The complete list of clinical guidelines is available online at thehealthplan.com. Providers are encouraged to contact their Provider Network Management Coordinator for assistance in accessing the guidelines online or to request hard copy versions. Comments can be sent to pkrebs@thehealthplan.com.

Clinical guideline review

The Health Plan continues to solicit physician and non-physician provider input concerning clinical guidelines. The following clinical guidelines are currently being reviewed:

- Adult depression
- Diabetes
- Chronic kidney disease
- Abnormal cervical cytology

Your feedback is encouraged and appreciated. Comments should be sent to Phillip Krebs, Medical Management, 100 North Academy Avenue, Danville, PA 17822-3218, or by e-mail to pkrebs@thehealthplan.com. Please provide your feedback by Oct. 15, 2008.

Briefly is published quarterly by Geisinger Health Plan, and serves as an informational resource for participating providers and office personnel.

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A copy of this newsletter can also be found at thehealthplan.com

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NIA improves guideline search

National Imaging Associates (NIA) has recently implemented improvements to their clinical guidelines online at radmd.com.

The familiar link on the RadMD Web page called "Clinical Guidelines" will still be used. An improved menu system will help providers find the exact guideline they need.

The new system was developed based on provider feedback. Not every guideline is used for every health plan. This new, dynamic system shows the appropriate guideline, specific to the health plan and the study requested.

Benefit changes available online

Benefit changes to group HMO and PPO plans (effective May 1, 2008) are now available at thehealthplan.com. Benefit changes for non-group HMO plans (effective April 1, 2008) are also available. All changes are effective upon a member's renewal date.

Privacy policies available online

Protecting member and provider privacy is a top priority of the Health Plan. The full text of our privacy and confidentiality policies and procedures can be found online at thehealthplan.com/GHPCommon/new_privacy/privacy_toc.cfm.



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