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Geisinger Health Plan ranks high on America's Best Health Plans list

Excellent care, patient satisfaction, customer service boost results

Geisinger Health Plan and Geisinger Gold have been named among top ranked commercial and Medicare health plans in the region according to the U.S. News & World Report/ National Committee for Quality Assurance (NCQA) America's Best Health Plans 2007 list. Both Geisinger Health Plan and Geisinger Gold were ranked in the top 15 percent of health plans in the nation.

"The new rankings are a result of our approach to provide state-of-the-art health-care benefits, exceptional member service, combined with an excellent network of physicians and hospitals," says Richard Gilfillan, M.D., president and CEO of Geisinger Health Plan. "It's great to be recognized as one of the top health plans. Our goal is to be the best in the nation and this moves us dramatically forward."

"We're thrilled with the new ranking. For 22 years we've been dedicated to working with physicians and hospitals to provide superior health-care coverage to the residents in the counties we serve," says Duane



Davis, M.D., vice president and chief medical officer of Geisinger Health Plan. "That we've now been recognized as the best in the region is a wonderful testimony to both our employees and participating medical colleagues."

Geisinger Health Plan

Geisinger Health Plan was 33 out of 250 ranked commercial plans. This is the third year that Geisinger Health Plan has been ranked in America's Best Health Plans listing. Geisinger Health Plan's ranking is based on several measures from the Healthcare Effectiveness Data and Information Set (HEDIS®), a report on performance in preventive measures and treatment of chronic conditions.

Geisinger Health Plan scored well in several HEDIS measures, including #1 in the nation for providing beta-blocker treatment to members for six months following a heart attack. The Health Plan was also ranked among the top ten percent of health plans in the nation for four additional measures: well-child visits for children in the first 15 months; adolescent immunizations for measles, mumps and rubella, hepatitis B and chicken pox; use of appropriate medications for adolescents with asthma age 10 to 17; and annual monitoring of people with heart conditions, high blood pressure and seizures.

In addition, members' access to care and overall satisfaction scores, calculated by the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), were factored into the ranking. The Health Plan's accreditation status of "Excellent" from NCQA was the final factor in determining the ranking.

Geisinger Gold

Geisinger Gold was 19 out of 151 ranked Medicare plans. The Medicare health plan rankings

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Important information for providers

2008 Provider Formulary now available

Participating providers were recently mailed copies of the 2008 Provider Formulary, which contains information for both commercial and Gold plans.

We have made significant changes to our formularies in the past two years, and your input into those changes was very important. We are committed to providing value and choice wherever feasible, and we ask you to focus on **treating to target** in 2008, especially for diabetes, hypertension, asthma and cholesterol.

Please consult our online Formulary search at thehealthplan.com for additional product information, including up-to-date listings.

Your Provider Relations Representative is also available to provide further assistance or training on the Formulary booklet.

Formulary updates

The following medications have been deemed non-formulary and will require prior authorization for all benefits (commercial and Gold):

Exforge
Veramyst
Xyzal

Commercial updates

- Effective April 14, 2008, Allegra-D will require prior authorization for the traditional benefit and will move to Tier 3 for the tiered benefit. Existing traditional benefit users will still have coverage without prior authorization. Current tiered users will pay Tier 3 copay. New traditional benefit users who request Allegra-D coverage after April 14 will need to follow the formulary exception process.
- Zyrtec-D and Claritin-D are available OTC for members to purchase and will not be covered by any pharmacy benefit.
- Prilosec 40 mg update for members with the traditional pharmacy benefit: The generic form of Prilosec,

omeprazole, is not available in 40 mg capsules, but is available in 20 mg capsules. Due to the generic availability of Prilosec 20 mg, effective April 14, 2008, Prilosec 40 mg will no longer be covered unless prior authorization is obtained. If you have any members currently using Prilosec 40 mg capsules, please consider switching them to an equivalent dose using omeprazole 20 mg capsules.

- Subutex and Suboxone will be excluded from coverage under the prescription drug benefit upon member's renewal, beginning April 1, 2008.
- Effective April 1, 2008, Neupogen and Neulasta will require prior authorization for the traditional and triple tier benefits. Existing users will not require authorization. New users after this date will need to follow the formulary exception process.

Commercial and Gold update

- Zyrtec will now be available over-the-counter (OTC). Therefore, Zyrtec will no longer be covered for members who received a prior authorization for this non-formulary product in the past.

Our searchable Formulary database is updated regularly for all lines of business at thehealthplan.com. The Pharmacy Department is also available to assist with any questions at (800) 988-4861, Monday through Friday from 8:30 a.m. to 5 p.m.

Outpatient referral forms submission process

Geisinger Health Plan must receive referrals directly from PCPs within 5 days of issuance. You may fax or mail referrals to:

Geisinger Health Plan
100 North Academy Avenue
Danville, PA 17822-3227
Fax: (570) 271-7883

PCPs are encouraged to provide a copy of the referral to the member for their visit to the specialist. Referrals can also be sent directly to specialists.

Specialists can verify referral authoriza-

tions online in the Provider Service Center.



Please contact your Provider Relations Representative for with any questions, or Provider Service Center registration information.

Geisinger Gold information available

As a reminder, information on Geisinger Gold plan offerings for Medicare beneficiaries can be found online in the Provider Information Center at thehealthplan.com.

Private-fee-for-service plans allow members to use any provider that accepts Medicare and the Health Plan's payment terms and conditions. The complete Terms and Conditions, as well as other important PFFS information, is available online.

2008 member ID cards

GEISINGER HEALTH PLAN [®]		HMO	
XXXXXXXXXXXXXXXXXXXXXXXXXXXX28	PCP Copay	\$15	
ID #: xxxxxxx09	Spec Copay	\$25	
Medical Record #: xxxxxx08	ER Copay	\$100	
Primary Care: xxx05	Rx Copay	\$10/20/50	
xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx37	Rx Deductible	\$100 single	
Office #: xxx-xxx-xxxx			
Tel-A-Nurse #: xxx-xxx-xxxx			
www.thehealthplan.com			
Please call Geisinger Health Plan at 570-271-8760; 1-800-447-4000 or TDD Hearing Impaired at 1-800-447-2833 immediately upon hospitalization or if you have any questions concerning your coverage.			
To access Mental Health and Substance Abuse services, please call 1-888-539-7972.			
Members with prescription benefit questions call 1-800-988-4861 or 570-271-5873.			
To access Chiropractic services call American Specialty Health at 1-800-678-9133.			
General Information: Geisinger Health Plan 100 N. Academy Avenue Danville, PA 17822-3029		Mail Medical Claims to: Geisinger Health Plan P.O. Box 8200 Danville, PA 17821-8200	
Benefit Code: xxxxxxx8 Issue Date MM/DD/YYYY		 	
Pharmacists call 1-800-522-7487 for pharmacy benefit information.			

For 2008, member ID cards will display PCP, SCP and ER copays, as well as prescription drug cost sharing (except for Gold), on the front of the card. The benefit code has been moved to the back. The Benefit Code Guide is available in the Provider Service Center at thehealthplan.com. Members will receive new ID cards through April as plans renew for 2008.

The Group Code has been removed from cards and is not required for claim submissions.

HRAs, HSAs offer low-cost health care options

Faced with the challenge of increased premiums, most employers are asking health plans for ways they can maintain great health insurance coverage for their employees, as well as balance rising premium costs.

One option employers use to balance premium costs is selecting a health insurance plan design that has higher out-of-pocket expenses for their employees. However, employers are then confronted with ways to minimize the “sticker shock” (i.e., \$3000 deductible) facing employees.

Geisinger Choice PPO is pleased to offer a solution to employers in the form of health savings accounts (HSAs) and integrated health reimbursement arrangements (HRAs).

How an HSA works

- Employee owns the HSA.
- Employer offers a health insurance plan that meets federal guidelines as an HSA-compatible qualified high deductible health plan.
- Employee has the option of opening an HSA and decides how much to contribute, up to allowed annual amount.
- Employer may choose to contribute to account, but isn't required to do so.
- Employee can use funds to pay for any qualified medical expenses as defined by IRS code 213d.

- Account contributions give employee pre-tax savings and may earn interest that is tax-free. Disbursements from the HSA are tax-free when used for medical expenses.
- If HSA funds aren't used before the benefit year ends, amounts in the account carry over and can be used for future qualifying expenses. The account is also portable if the employee changes jobs.

How an HRA works

- Employer owns the HRA.
- Employer offers health insurance coverage, typically with out-of-pocket expenses for employees (i.e., deductible, coinsurance, etc.).
- Employer creates an HRA for each employee and contributes a specified amount to the HRA (e.g., 50% of the deductible).
- Employee uses HRA funds to pay for qualified expenses, as defined by the employer, such as copayments, coinsurances and deductibles.
- If HRA funds aren't used before the benefit year ends, the employer may allow funds to be carried over to the following year.

What providers need to know

- Increased member cost-sharing (such as higher deductibles and coinsurance) is a growing trend; don't assume patients have first-dollar coverage.
- A member's identification card most likely does not reflect if he or she has an HRA or HSA.
- Providers should continue to verify eligibility, benefits and cost-sharing amounts by contacting the applicable Customer Service Team or online through the Provider Service Center.
- HRA members may have a debit card to access their account. Providers can accept this debit card the same as any other credit or debit transaction.
- File your claims for all Health Plan members directly with the Health Plan. We'll adjudicate the claim and provide an explanation of payment (EOP) indicating any amount owed by the member.
- If the member does not pay out-of-pocket expenses at the time of service, the member may submit a claim to the HRA or HSA administrator, who may reimburse providers directly.

For more information on the Health Plan's consumer driven options, please contact your Provider Relations Representative.

NPI compliance deadline May 23

On or before May 23, 2008, all electronic claims submitted require National Provider Identifiers (NPI) only and no legacy identifiers. Electronic claims submitted after May 23, 2008, with legacy identifiers will be rejected.

We ask each provider to check their billing software and/or billing company to make sure NPI numbers, both individual and organizational, are being included in the appropriate locations on all electronic claims.

We are identifying providers who currently bill with matching NPI enumeration and will request that the use of legacy identifiers be discontinued. Your office may have already received a communication to this effect; if not, please do not discontinue using legacy identifiers until your office has been advised to do so. This will help ensure proper payment and claims processing.

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.

Merck and Company TPA update

Effective January 1, Merck and Company members are enrolled in a direct access HMO plan. Primary care and specialty care office visits carry a \$15 copay, and inpatient admissions are \$200 per admission. Prior authorizations are required for certain services, including certain radiology services through NIA.

Online tools available

Provider Service Center offers easy access to information

The Provider Service Center is available at thehealthplan.com. Registered providers can access:

- Real-time member eligibility data
- Detailed benefit plan information, including cost-sharing amounts
- Current authorizations for Health Plan members
- Current explanations of payment (EOP)
- Comprehensive information on claim status, history and payments
- Medical and pharmaceutical policies

For more information about the Service Center, including registration instructions, please contact your Provider Relations Representative or visit the Provider Information Center at thehealthplan.com.

Radiology precertification at radmd.com

All Health Plan members, regardless of plan type, receiving an outpatient MRA, MRI, CT/PET scan or nuclear cardiology service need precertification through National Imaging Associates, Inc. (NIA).

It is the responsibility of the ordering provider to request precertification by contacting NIA at (866) 305-9729 or via radmd.com. Rendering providers should confirm authorization approval prior to rendering MRA, MRI, CT/PET scan or nuclear cardiology services by verifying authorization information on radmd.com.

Please note: MRA, MRI, CT/PET scan or nuclear cardiology services rendered in the emergency room, observation or inpatient setting do not require precertification through NIA.

If you have questions, please contact your Provider Relations Representative.

Submit claims electronically

Electronic claim submission allows health care providers to bill with decreased delay and costs. Electronic billing streamlines the billing process and proves to be more accurate. Further, electronic billing reduces your paperwork burden and allows office staff to handle other important tasks.

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 thehealthplan.com/GHPCCommon/new_privacy/privacy_claim_submission.cfm for more information and to complete the Health Plan's EDI Submission Form.

Reimbursements now available by EFT

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 contact you to explain 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 (570) 271-5846 if you have any questions.

Group and non-group benefit changes

Benefit changes for commercial group and non-group plans will soon be available online in the Provider Service Center at thehealthplan.com.

Some examples of changes include:

- Medically necessary wart removal by either a PCP or podiatrist is now a covered benefit
- Appropriate copays will apply when annual gynecological exams are performed by either a PCP or a specialist
- Chantix and generic Zyban (smoking cessation drugs) are now covered benefits

The complete list of changes will be available online soon. Non-group changes are effective April 1, 2008. Group changes are effective May 1, 2008, upon a group's renewal. Changes will be communicated to members upon renewal of their plans.

If you have any questions or need assistance with any online tools, please call 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

Communicating denials of coverage

Providers requesting precertification of services through the Health Plan's Medical Management Department will receive both telephonic and written notification of determination of coverage. Communication and documentation of denials are provided to both the provider and the member within the time frames designated by the regulatory bodies.

Written notification of denials include the following:

- Principle reason(s);
- Reference to the benefit provision, guideline or protocol which support the denial;
- Clinical rationale;
- Explanation of the appeal/grievance/complaint procedure;
- Availability of the benefit provision, guideline, protocol, etc., that was used.

Providers should discuss denials of coverage with members so they understand why the service was denied, as well as what options are available for alternative care. Members should also be advised that they have the right to appeal any decisions made by the Health Plan regarding their coverage, and should refer to their benefit documents for the most recent information regarding member rights.

Medical management statement

The Health Plan would like to inform providers that medical management decisions are based upon appropriateness of care and that over- or underutilization of care and services has a potential negative effect on quality.

Decision making is based only on appropriateness of care, service and existence of coverage.

The Health Plan does not specifically reward practitioners or other individuals conducting utilization review for issuing approvals or denials of coverage or services.

The Health Plan does not offer incentives for medical management decision makers that encourage decisions that might result in underutilization.

Quality Improvement information available

If you would like information on the Health Plan's Quality Improvement (QI) Plan, please call the QI department at (570) 271-5108. This plan is also included in the most recent Participating Provider Guide (Dev. 8/05) or online at thehealthplan.com.

Accessibility of primary care services

The Health Plan requires PCPs and/or primary care sites to meet the following minimum standards for accessibility of primary care services for members:

PCP Accessibility	Health Plan Standards
Emergency services	Seen immediately by PCP or designee (in office or emergency room, if appropriate).
Urgent care services	Appointment with PCP or designee within twenty-four (24) hours from the date of the initial request.
Routine care appointments	Appointment with PCP or designee within twenty-one (21) days from the date of the initial request.
Preventive care appointments	Appointment with PCP or designee within forty-two (42) days from the date of the initial request (well-child checks, physicals, etc.).
24-hour availability	PCPs should be available 24 hours a day/7 days a week.
Non-business hour access	The answering service or device should answer 100% of the time. Answering devices, if utilized, will provide caller with the PCP or designated covering PCP's telephone and/or pager number, including emergency instructions.
Appointment wait time	PCP or designee should see a Member within thirty (30) minutes of scheduled appointment time.

HMO and PPO member rights and responsibilities

Member rights

1. Members have the right to timely and effective redress of complaints, appeals and grievances.
2. Members have the right to health maintenance literature and material about Geisinger Health Plan and its services, practitioners and providers for their use, written in a manner which truthfully and accurately provides relevant information so that it is easily understood by a person of average intelligence.
3. Members have the right to be treated with respect and recognition of their dignity and right to privacy.
4. Members have the right to obtain from their plan physician, unless it is not medically advisable, current information concerning their diagnosis, treatment and prognosis in terms that they can reasonably be expected to understand.
5. Members have the right to be given the name, professional status, and function of any personnel providing health services to them.
6. Members have the right to give their informed consent before the start of any procedure or treatment.
7. Members have the right to a candid discussion of appropriate or medically necessary treatment options for their condition regardless of cost or benefit coverage.
8. Members have the right to participate with practitioners in decision making regarding their health care.
9. Members have the right to be advised if a health care facility or any of the providers participating in their care propose to engage in or perform human experimentation or research affecting their care or treatment. A legally responsible party on their behalf may, at any time, refuse to participate in or to continue in any experimentation or research program for which they have previously given an informed consent.
10. Members have the right to refuse any drugs, treatment or other procedure offered by Geisinger Health Plan or its providers to the extent permitted by law and to be informed by a physician of the medical consequence of the subscriber's refusal of any drugs, treatment or procedure.
11. Members have the right to have all records pertaining to their medical care treated as confidential unless disclosure is necessary to interpret the application of their contract to their care or unless disclosure is otherwise provided for by law.
12. Members have the right to all information contained in their medical records unless access is specifically restricted by the attending physician for medical reasons.
13. When emergency services are necessary, members have the right to obtain such services without unnecessary delay.
14. Members have the right to make recommendations



15. Members have the right to be informed of these rights and responsibilities regarding the member's rights and responsibilities policies.

Member responsibilities

1. Members have a responsibility to know their primary care physician and site, and nearest participating hospital.
2. Members have a responsibility to contact their primary care physician for all medical care except in the case of emergencies.
3. Members have a responsibility to be prepared when talking with the doctor.
4. Members have a responsibility to attempt to schedule appointments with the same primary care team each time.
5. Members have a responsibility, if admitted to a non-participating hospital, to contact the Plan or their PCP to arrange for transport when their condition has stabilized.
6. Members have a responsibility to identify themselves as a Health Plan member whenever they call or visit their doctor.
7. Members have a responsibility to offer information their doctor or other health care providers need to care for them and to follow the instructions or guidelines they receive from their provider, such as taking prescriptions as directed.
8. Members have a responsibility to participate in understanding their health problems and developing mutually agreed upon treatment goals.

Policy and clinical 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

New Policies

The following have been added:

- Hip resurfacing arthroplasty (MP186)
- Selective internal radiation therapy (MP208)
- Rhinophototherapy (MP194)
- Endovascular repair of intracranial aneurysm (MP211)

Revised Policies

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

- Medical benefit policy development (MP05)
- Virtual colonoscopy (MP132)
- Balloon brachytherapy for breast cancer (MP120)
- Work hardening and work conditioning (MP108)
- Chelation therapy (MP81)
- Non-invasive mechanical treatments for low back pain (MP77)
- Oral health (MP38)
- Non-invasive testing for heart transplant rejection (MP168)
- Visual field testing (MP49)
- Nocturnal enuresis alarm (MP06)
- Neuromuscular electrical stimulation (MP01)
- Intracranial percutaneous transluminal angioplasty (MP184)

Annual Reviews

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

- Thermography (MP163)
- Lung volume reduction surgery (MP60)
- Adult cardiac MRI (MP160)
- Donor human leukocyte antigen typing (MP79)
- Prothrombin time home testing

(MP157)

- Continuous passive motion (MP158)
- MR ultrasound ablation of uterine fibroids (MP166)
- Implantable and semi-implantable hearing aids (MP135)
- Retinal prosthesis (MP169)
- Salivary hormone testing for menopause (MP162)
- Phototherapy for seasonal affective disorder (MP105)
- Lysis of epidural adhesions (MP138)
- Gastric electrical stimulation (MP134)
- Pulsed electrical stimulation for treatment of osteoarthritis (MP149)
- Therapeutic listening (MP119)
- Massage therapy (MP126)
- Lysis of epidural adhesions (MP138)
- Mindstreams cognitive health assessment system (MP191)
- Anodyne infrared therapy (MP142)
- Chemosensitivity and chemoresistance assays (MP185)
- Pet scan (MP02)
- Sensory integration therapy (MP177)
- Pectus deformity surgery (MP50)
- Quantitative sensory testing (MP118)

Pharmaceutical

Revised Policies

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

- MBP14.0 Meningococcal vaccine
- MBP59.0 White blood cell stimulating factors (Neupogen®, Neulasta®) **(requires prior authorization)**

Annual Reviews

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

- MBP1.0 Coordination of medical benefit and pharmaceutical use
- MBP13.0 Viscosupplementation
- MBP38.0 Clolar (continues to require prior authorization)
- MBP36.0 Abraxane (continues to require prior authorization)
- MBP32.0 Kepivance (continues to require prior authorization)

- MBP18.0 Fabrazyme (continues to require prior authorization)
- MBP34.0 Vitrasert (continues to require prior authorization)
- MBP29.0 Elitek (continues to require prior authorization)
- MBP26.0 Oxaliplatin (continues to require prior authorization)
- MBP28.0 Ontak (continues to require prior authorization)
- MBP7.0 Aldurazyme (continues to require prior authorization)

Clinical Guideline Update

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

- Adult and pediatric immunizations
- Colorectal cancer screening
- Osteoporosis
- Pediatric ADHD
- Alcohol abuse and alcoholism
- Fall prevention ^{NEW}
- Non-surgical treatment of urinary incontinence ^{NEW}

The complete list of clinical guidelines is available online at thehealthplan.com. Providers are encouraged to contact their Provider Relations Representative for assistance in accessing the guidelines online or to request printed versions. Comments can be sent to Phillip Krebs at 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:

- Pharyngitis
- Pediatric otitis media with effusion
- Adult and pediatric immunizations

Your feedback is encouraged and appreciated. Comments should be sent to Phillip Krebs, Medical Management 32-18, or by e-mail to pkrebs@thehealthplan.com. Please provide your feedback by May 30, 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

HPM50

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Geisinger Health Plan ranks high on America's Best Health Plans list

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were based on several HEDIS quality measures released by the Centers for Medicare and Medicaid Services (CMS). Geisinger Gold scored particularly well in measures related to diabetes care, breast cancer and persistence of medications.

In addition, Geisinger Gold's "Excellent" Accreditation from NCQA was factored into the final ranking.

For more information on NCQA, CAHPS® or Quality Compass®, please visit NCQA's Web site at www.ncqa.org or contact Amy Bowen, Public Relations Coordinator, at (570) 271-8135.

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