



## In this Issue

- 2** RADMD clinical authorization; Radiation safety awareness
- 3** Important information for providers
- 5** HEDIS® measures help ensure quality care
- 6** Formulary updates
- 7** Prior authorization list
- 9** Medical and pharmaceutical policy updates
- 11** Accessibility of PCP services
- 12** Provider satisfaction survey results

# Historic bill brings change to health care and health care coverage

A historic \$938 billion health care overhaul that guarantees coverage for uninsured Americans was signed into law in March. The first changes will take effect by the end of September. Most changes would not kick in until 2014.

The bill immediately starts to close the gap in the Medicare prescription drug benefit. Seniors who fall into the “doughnut hole” gap in coverage will get a \$250 rebate this year.

Other changes starting this year include prohibiting health insurance companies from cancelling coverage due to illness and banning lifetime dollar limits on coverage. Insurers also would be prohibited from denying coverage to children because of a pre-existing medical condition. In addition, parents will get to keep adult children on their health plan until they turn 26.

The legislation also has a transition program meant to help sick individuals who are currently uninsured.

Beginning in 2014, the government will provide tax credits to help pay for premiums for working middle-class families with annual incomes up to \$88,000. Medicaid will also be expanded to cover more low-income people.



Thomas Northcut/ Digital Vision/Thinkstock

Starting that same year, health insurance companies could not deny coverage to people in poor health or charge them higher premiums.

Employers aren't required to offer coverage. Tax credits will help smaller companies get and keep coverage for their employees. Companies with more than 50 workers could see hefty fines if just one of their employees gets government-subsidized coverage.

Individuals would be required to carry health insurance, either through an employer or a government program or by buying it themselves. Those who refuse would get fined by the IRS.

Many legal experts say Con-

gress does have the power under the Constitution to require coverage. Attorneys general from 13 states have already filed suit to stop the mandate.

The Congressional Budget Office estimated that the legislation would cut federal budget deficits by an estimated \$143 billion over a decade. More than 30 million people will gain coverage, and by 2016 about 95 percent of eligible working-age adults and their families would have health insurance. Most would buy their coverage through health insurance exchanges, new state-based purchasing pools. Illegal immigrants wouldn't be able to participate.

# Visit RadMD for clinical authorization information

RadMD is a user-friendly, real-time tool offered by National Imaging Associates (NIA) that provides you with instant access to the high-tech imaging authorization and supporting information you need, in an easily accessible Internet format. Whether submitting imaging exam requests or checking the status of ordered exams, you will find RadMD to be an efficient, easy-to-navigate resource.

Both **ordering and imaging providers** can access a range of online tools and associated imaging information on the [www.RadMD.com](http://www.RadMD.com) Web site:

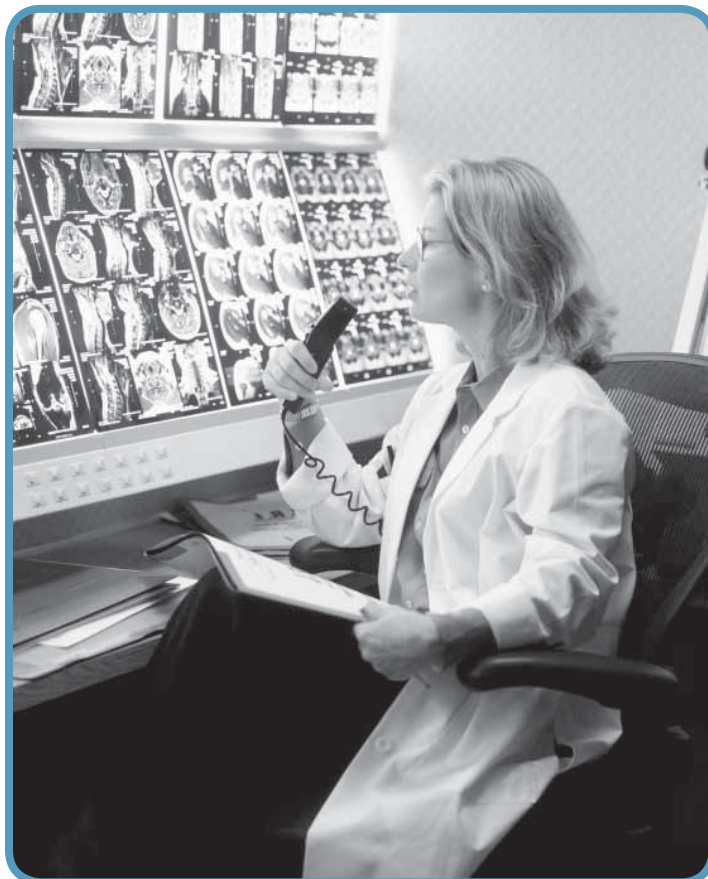
- Secure access to protect your data and your patients' personal health information.
- Up-to-the-hour authorization information, including:
  - Date request initiated
  - Date exam approved
  - Authorization validity period
  - Valid billing codes (CPT®), and more.
- NIA's evidence-based clinical review criteria, our Diagnostic Imaging Guidelines.
- Technical support available if you have questions.

Plus, **ordering physicians** can access a number of key tools:

- Straightforward instructions for submitting exam requests, including the ability to submit multiple requests in the same online session.
- Appropriate ICD code lookup.
- Continuous updates on authorization status.
- Fast authorization decisions available to you online.
- Ease of searching for and selecting convenient imaging facilities.

Additionally, **imaging facilities** benefit from being able to quickly view the approved authorizations for their patients, facilitating prompt service for patients who require imaging procedures.

To get started, simply go to [www.RadMD.com](http://www.RadMD.com), click the



*John Foxx/ Stockbyte/Thinkstock*

New User button and set up a unique user name/account ID and password for each individual user in your office or facility. Your RadMD login information should not be shared. This further protects members' personal health information.

For assistance or technical support, please contact [RadMDSupport@MagellanHealth.com](mailto:RadMDSupport@MagellanHealth.com) or call 1-877-80-RadMD (1-877-807-2363). RadMD is available for authorizations during the hours of 5 a.m. to midnight EST Monday through Friday, and 8 a.m. to 1 p.m. EST on Saturday.

## Radiation safety awareness initiative

The Health Plan will begin a Radiation Safety Awareness Initiative on June 1, 2010 in partnership with National Imaging Associates (NIA), our nationally recognized radiology benefits manager. The goal of this initiative is to improve patient safety by raising awareness regarding radiation exposure.

Cumulative radiation exposure from medical imaging is a rapidly growing patient safety concern. Patients today are exposed to nearly **six times** more radiation from medical diagnostic tests than they were in 1980. The largest con-

tributors to this increase in medical radiation exposure are CT scans and nuclear medicine.

NIA will analyze radiology claims twice a year to identify patients that have reached or exceeded the federal occupational limit for radiation exposure, 50 milliSieverts (mSv).

You will be notified if your patient is at risk upon request of a preauthorization from NIA. Beyond the initial notification, NIA will offer a peer discussion should you want to discuss

*Continued on Page 3*

## Radiation safety awareness initiative

*Continued from Page 2*

the case with another physician and a provider alert letter will also be sent via fax or mail with the authorization or denial letter.

**Please note that your patient's level of radiation exposure will NOT impact the preauthorization or decision-making process for requested imaging studies.**

### **Inclusions and Exemptions**

Modalities that will trigger a radiation exposure warning:

- CT
- PET
- Nuclear Cardiology

### **Tests included in radiation calculation:**

- All ionizing diagnostic imaging tests
- Angiography
- Diagnostic Nuclear Medicine

### **Patients excluded:**

- Patients with cancer diagnosis
- Patients 65 or older

Requests will not be offered a peer-to-peer consultation, but the ordering provider will receive a letter with the written notification of approval or denial

Find more information about radiation exposure on National Imaging Associates Web site at [www.radmd.com](http://www.radmd.com). Look for *Radiation Safety Information* under *Useful Resources*.

NIA is also hosting a webinar on Radiation Awareness on June 22 from noon to 1 p.m. Access information is:

Phone: (888) 251-2909

Access code: 5031888

Web address: <https://www.webmeeting.att.com>

## Summer is a great time to see younger patients

Geisinger Health Plan encourages PCP offices to schedule needed well visits or annual physicals for children and teens during the summer months, when they are more likely to have time for an appointment. This is especially true for college students who may not have a chance otherwise to visit their PCP during the school year.

Well-child visits are a good time to get important immunizations, as well discuss various issues with your patients, such as growth and development, mental health, nutrition and physical activity, and any other concerns.

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***Be sure to let your patients and their parents know there are no copayments for well-child visits, up to age 21!\****

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*\*In-network visits only. If services such as lab work or diagnostic testing are provided during the office visit, or if a specific medical condition is treated, these may incur a charge.*

## Health Plan extends coverage for young adults

In response to an insurance industry request from Health and Human Services Secretary Kathleen Sebelius, Geisinger Health Plan will allow currently eligible dependents to remain on their parents' individual non-group policies up to age 26 beginning June 1. A special letter will be sent to those who are affected, explaining if extended coverage is needed, they can contact the Health Plan prior to the termination effective date. The dependent coverage requirement in the Patient Protection and Affordable Care Act 2010 (PPACA) becomes effective on September 23.

For group plans, Geisinger Health Plan will work with employers who are interested in extending coverage prior to the enactment date.

"We understand the importance and value of health coverage," says Jean Haynes, president and CEO of Geisinger Health Plan. "We are working closely with employers to explore options to preserve our members' coverage."

Young adults who have already aged off their parents' policies and lack coverage through an employer must still wait until the law's provisions actually take effect to get back on. For these individuals, Geisinger Health Plan offers a short-term health insurance plan for individuals including young Americans who may have already lost their coverage. The policy can last anywhere from 31 to 180 days.

## There's a HERO on-call at Geisinger

When members are in need of urgent hospital to hospital transfer, the Health Plan turns to Geisinger Medical Center's HERO (Hospital Emergency Retrieval Officer). The HERO offers 24/7 support to community hospitals in the inter-facility transfer of members when a higher level of care is required. These designated on-call ER/Trauma physicians serve as medical triage, approving urgent transfers to appropriate facilities and communicating transfer details to the Health Plan. The HERO program is essential to the proper approval and steering of members in need of acute urgent care.

The primary contact number to approve a member transfer through HERO is 800-852-7828. For any other issues outside of normal business hours (Monday through Friday from 8:30 a.m. to 5 p.m.) a Health Plan on-call Medical Director can be reached via Geisinger message service at 866-265-7643.

## Utilization and efficiency reports available online

Providers and their office staff can access physicians' utilization and efficiency reports at [www.thehealthplan.com](http://www.thehealthplan.com). These reports, referred to as CRMS, help identify under- or over-utilized patterns. Most physicians find them to be an accurate depiction of their practice patterns. For assistance accessing your report or for questions on the data provided, please contact your Provider Relations Representative.

# Important information for providers

## CHIP members may be eligible for Medical Assistance

Some CHIP members may be eligible for Medical Assistance as a result of their serious health conditions. In accordance with state guidelines, you may be requested to complete and return applicable forms to support a CHIP member's transition to Medicaid which will become the child's primary insurance coverage. For questions or assistance, please contact our CHIP CST team at (866) 621-5235 or (570) 214-9138.

## Correct coding

Don't let incomplete or inaccurate coding rob your practice of appropriate reimbursement. Submitting codes correctly for common conditions like diabetes mellitus can help you avoid denials and assist in monitoring populations with chronic conditions. Remember that all ICD-9-CM diagnosis codes must be reflected in the medical record documentation. Proper coding and supporting documentation are necessary for your payment.

### Diabetes

For diabetes mellitus without mention of complication, code **250.0x**.

If present, complications will generally fall into two categories:

1. Acute metabolic complications (**250.1x – 250.3x**)
2. Chronic complications (**250.4x – 250.8x**)

A denial is likely if you report diabetic mellitus diagnosis code **250.xx** without a fifth-digit sub-classification specifying type and whether the patient's blood sugar level is under control. Be sure to report one of the following fifth-digit codes with diagnosis code **250.xx**:

- **250.x0** - type II or unspecified type, not stated as uncontrolled (fifth-digit 0 is for use for type II patients, even if the patient requires insulin)
- **250.x1** - type I (juvenile type), not stated as uncontrolled
- **250.x2** - type II or unspecified type, uncontrolled (fifth-digit 2 is for use for type II patients, even if the patient requires insulin)
- **250.x3** - type I (juvenile type), uncontrolled

Code **250.9x** for those metabolic complications of diabetes that cannot be assigned elsewhere. Refer to the most current ICD-9-CM manual for clarification.

### Amputations

A prior amputation is often overlooked as an applicable diagnosis to report during a patient encounter. However, coding prior amputations annually helps support patient services. Coding Clinic states that one of the reasons to use a V diagnosis code is to show that "circumstances or problems influence a person's health status but are not in themselves a

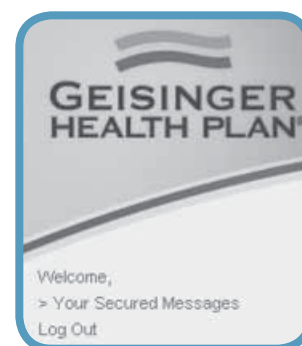
current illness or injury." Adding an amputee status, whether it is an upper or lower limb status, can affect the care given to the patient. For example: Status post (s/p) Below Knee amputation (BKA) - code V49.75 may influence why a patient needed to stay longer after a total knee replacement on the opposite leg. Remember that amputation status codes are never used as the principal code on any claim. These codes can only be used as a secondary code.

## Appealing a claim?

Now your options for appealing a claim extend beyond a telephone call, fax, or mail. Registered users of our Web site can use the secure messaging feature to discuss claims issues with our Customer Service team.

Visit [www.thehealthplan.com](http://www.thehealthplan.com) and sign in with your username and password. Click on "Your Secured Messages" under your username, then click "Compose Message."

Here you can select Claims from the dropdown in the "To:" field and create an e-mail message regarding your claim. Sent messages will be fast-tracked to our Customer Service team which will be happy to work with you until your claim issue is resolved.



## Health Management and wellness

Geisinger Health Plan offers programs for our members with certain chronic health conditions. Specialized nurses, called case or health managers, work with you and your patients to help them better manage their health care needs.

The case/health manager will help educate your patient about their condition, including monitoring of diet, exercise, medications and other lifestyle changes. They can also help coordinate recommended care and services.

The Health Plan offers the following programs:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Stop Tobacco Use
- Hypertension (high blood pressure)
- Heart Failure
- Diabetes
- Heart Disease
- Osteoporosis
- Case Management

For more information, or to recommend a patient for one of these programs, please call (800) 883-6355.

# HEDIS<sup>®</sup> measures help ensure quality care

The Health Plan encourages you to recognize and use the following Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) measures when caring for your patients. Please work with us to meet and maintain these safety and quality improvement goals in pursuit of the highest quality of care for your patients.

Geisinger Health Plan is consistently among the highest-ranked plans in the country. Your assistance is vital to our continued HEDIS<sup>®</sup> success and the continued high-quality service we provide to our members!

## Attention Deficit Hyperactivity Disorder

### Target Population

Children (6-12 years of age) with a new ambulatory prescription dispensed for ADHD

### Criteria

- Facilitate a face-to-face follow-up visit with a practitioner with prescribing authority within 30 days of the initial visit for the prescription; and
- if the child remains on the medication for at least 210 days, two additional follow-up visits should be scheduled with a practitioner within 270 days (9 months) after the initial 30-day period ends.

## Acute Low Back Pain

### Target Population

Health Plan patients with diagnosis of low back pain

### Criteria

Orders for imaging studies for target population within 28 days of diagnosis will be monitored

### Note

Acute low back pain (less than four weeks in duration) is generally a self-limiting condition and most patients recover within a few weeks without the need for imaging studies or aggressive care. Fewer than 1% of radiographs find the cause of a case of low back pain. The Health Plan's acute back pain clinical guideline is available for review online at [thehealthplan.com](http://thehealthplan.com). The Health Plan's medical directors recognize there are valid clinical reasons for ordering imaging studies and encourage proper health care to continue.

## Adult Body Mass Index (BMI)

### Target Population

Health Plan patients 18-74 years of age

### Criteria

Percentage of target population who had an outpatient visit and who had their BMI index documented during the current or previous year.

### Note

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians should screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.

## Cholesterol Management

### Target Population

Health Plan patients 18-75 years of age who are discharged alive for AMI, CABG, PTCA or IVD

### Criteria

Percentage of target population who have an LDL-C screening each year and a controlled LDL level of 100 mg/dL or less.

### Note

The National Cholesterol Education Program's (NCEP) clinical practice guidelines on cholesterol management recommend that for high-risk patients, the overall goal remains an LDL level of less than 70 mg/dL.

## Drugs to be avoided in the elderly

### Target Population

Patients age 65 or older

### Criteria

- Health Plan will monitor target population who have received at least one high risk medication; and
- Health Plan will monitor target population who have received at least two different high risk medications

### Note

Medications which have been found to be potentially harmful in elderly patients are listed at [www.dcri.duke.edu/ccge/curtis/beers.html](http://www.dcri.duke.edu/ccge/curtis/beers.html)

## Potentially harmful drug-disease interactions in the elderly

### Target Population

Patients age 65 or older

### Criteria

- Health Plan will monitor target population who are identified with the following drug/disease combinations:
- A history of falls and a prescription for tricyclic antidepressants, antipsychotics or sleep agents
  - Dementia and a prescription for tricyclic antidepressants or anticholinergic agents
  - Chronic renal failure and prescription for nonaspirin NSAIDs or Cox-2 Selective NSAIDs

# Formulary updates

The 2010 Provider Formulary is available online at [www.thehealthplan.com](http://www.thehealthplan.com) or by calling (800) 988-4861

## Geisinger Gold

### Pharmacy benefit changes

#### Formulary additions

- Arcalyst (rilonacept): Requires Prior Authorization on Tier 2 of the Standard Rx Formulary and Tier 3 of the \$0 Deductible Rx formulary

#### Deemed non-formulary

- Valturna (Aliskiren/Valsartan Tablets): Requires Prior Authorization

### Medical benefit changes:

- Lifescan Brand Meters - \$0 member cost sharing
- Lifescan Brand Strips - 20% member cost sharing, quantity limit of 150 per month (Members of Secure 1 and Secure 3 have \$0 member cost sharing, quantity limit of 200 per month. Applies to new starts only.
- Non-Lifescan Brand Meters and Non-Lifescan Brand Strips: Prior Authorization Required. 20% member cost sharing meters and strips. Applies to new starts only. Same quantity limits apply.

### Nitrofurantoin-Containing Products and Propoxyphene-Containing Products Now Require Prior Authorization

The Beer's Criteria list was created to monitor for potentially inappropriate medication usage in adults 65 years of age and older. In order to effectively provide coverage for safe utilization of these products, Geisinger Health Plan will require prior authorization for certain medications on the list. The most current additions requiring prior authorization are all propoxyphene-containing products and nitrofurantoin-containing products. This means that medications such as Darvocet and Macrobid are no longer covered as part of the Geisinger Gold formularies. For exceptions to be considered, please contact the Pharmacy Department at (800) 988-4861, Monday through Friday from 8 a.m. to 5 p.m.

## Geisinger Health Plan/Geisinger Choice

### Drug Deemed Formulary

Janumet (2)

### Drugs Deemed Non-Formulary

Votrient (3) \*,t,\*\*

Valturna (3) \*,t

Arcalyst (3) \*,t

() = tier

\* = requires prior authorization under the non-tiered benefit

t = requires prior authorization under the tiered benefit

\*\* = quantity limits apply

Effective July 1, 2010 Oxycontin will require prior authorization for new starts and new members. To be exempt from the new

start requirement, a current member must have been receiving Oxycontin for at least 60 days through the Health Plan. New members currently using Oxycontin for greater than 60 days can request continued coverage by having the provider request a prior authorization showing the need for continuity of care. For those newly prescribed Oxycontin, members will be required to have a trial of generic morphine sulfate extended release or show a documented contraindication to such therapy in order to be approved for coverage of Oxycontin. An exception will be made for members who have cancer or are in an end of life situation.

Effective July 1, 2010, injectable anticoagulants (Lovenox, Arixtra) will have a quantity limit of one copay per 14-day supply. Only up to a 14-day supply can be dispensed per fill. They will not be available at mail order.

## Gardasil vaccine not covered for males

Gardasil was recently approved by the Food and Drug Administration for use in males for the prevention of genital warts caused by the human papillomavirus. This indication was thoroughly reviewed by the Geisinger Health Plan Pharmacy and Therapeutics Committee. At this time, the Health Plan will not offer coverage for Gardasil when used in the male population. The decision was based on lack of support from the Advisory Committee on Immunization Practices (ACIP). While ACIP recognizes the use of Gardasil in the male population, it currently is not a recommended vaccination. It is important for providers to know that if a male whom is covered by the Geisinger Health Plan wishes to receive the Gardasil vaccination, payment for the medication is to be provided by the patient. The Health Plan will not reimburse for a Gardasil vaccination administered to a male.

## Gardasil and Cervarix coverage limits for females

The Geisinger Health Plan does cover Gardasil and Cervarix for our female population. Please note, the Health Plan will not reimburse past the recommended three-shot course. Payment for additional shots administered beyond the three-shot threshold will become the responsibility of the provider. If you have any questions about Gardasil (for males or females) or Cervarix, please contact the Geisinger Health Plan Medical Management Department by calling 1-800-544-3907 and selecting option number 2.

## Specialty vendor update

Effective July 1, 2010, the Health Plan's specialty vendor for Lupron Depot will change to Caresite Specialty Pharmacy. Should you choose to utilize this specialty pharmacy vendor for this product, please complete the standard Specialty Vendor Request Form and fax it to the Pharmacy Department Customer Service Team at 570-271-5610.

# Formulary updates

## Health Plan to monitor potential drug misuse

The non-medical use of prescription drugs is a growing problem. Controlled substances, including analgesics, sedative/hypnotics, stimulants and others make up a large percentage of abused drugs. To assist with this problem, Geisinger Health Plan is reviewing pharmacy claims data to analyze potential utilization patterns of concern, specifically multiple pharmacies and providers being used by the same individual for controlled substance prescriptions.

This new program, which began earlier this year, includes informational letters to applicable prescribers. These letters will identify individuals under their care who have had controlled substance prescriptions written by multiple prescribers and filled at multiple pharmacies in the previous quarter. The purpose of the letters is informational only; they do not imply that the individual is inappropriately receiving controlled substances. If the prescriptions are appropriate, the letter may serve as a trigger to discuss the importance of ensuring that all providers are kept aware of

the medications their patient is prescribed. Further, it allows providers to stress the importance of obtaining drugs from one pharmacy whenever possible to enhance the safety and effectiveness of drug therapy.

Please note the following available resources should you receive a letter and desire assistance:

- To determine substance abuse benefits available to your patient you may contact OptumHealth at (888) 839-7972. The majority of Health Plan members have substance abuse benefits through OptumHealth
- To consult with a psychiatrist regarding assessing your patient for possible substance abuse you may contact an OptumHealth Medical Director at (877) 772-6414.

## Fourth tier benefit available

A new fourth tier pharmacy benefit design has been created for commercial lines of business. It offers a new choice for employers to choose when selecting coverage for their employees. For questions about this benefit, please contact the Pharmacy Customer Service team at 1-800-988-4861.

# Services requiring prior authorization

The following list identifies services requiring prior authorization.

To request prior authorization, unless otherwise noted, please contact the Medical Management Department at (800) 544-3907, option 2, or (570) 271-6497, Monday through Friday, 8 a.m. to 5 p.m.

Members may not be held financially liable for a participating provider's failure to obtain prior authorization of the services listed below.

**All drugs newly approved by the FDA should be considered to require prior authorization until such time as they are formally reviewed by the Pharmacy & Therapeutics Committee. Final determinations to require prior authorization for specific drugs will be added to this list as they are made.**

- Actemra® (tocilizumab)
- Any referral to a nonparticipating provider/facility for nonemergency services
- Abraxane® (paclitaxel protein-bound

- particles)
- Advanced Molecular Topographic Genotyping (RedPath Pathfinder TG)
- Acupuncture
- Aldurazyme® (aronidase)
- Alpha 1-Antitrypsin Inhibitor Therapy (Prolastin®, Aralast™, Zemaira®)
- Amevive® (alefacept)
- Any referral(s) to contracted Health Plan providers who require Health Plan authorization/precertification as noted in the then current Health Plan Provider List
- Aralast™
- Aranesp® (darbepoetin)
- Arranon® (nelarabine)
- Arzerra™ (ofatumumab)
- Avastin® (Bevacizumab)
- Bexxa® (Tositumomab and Iodine 131 Tositumomab)
- Bioengineered skin equivalents
- Biofeedback training
- Blepharoplasty
- Blood clotting factors given in a nonemergency outpatient setting

- Botox® (Botulinum toxin Type A)
- Breast Reduction/Reconstruction-unrelated to previous mastectomy for breast cancer
- Carotid Artery Stenting
- Cerezyme® (imiglucerase)
- Cimzia® (certolizumab pegol)
- Clolar® (clofarabine)
- Cochlear Implants
- CT (CAT) Scan (Outpatient/Nonemergency)
- Cubicin® (daptomycin)
- Dacogen® (decitabine)
- Deep Brain Stimulation
- Degarelix®
- Dorsal Column Stimulation
- Durable Medical Equipment (Outpatient)
- Elaprase® (idursulfase)
- Electrical Stimulation to aid bone healing (invasive procedure)
- Elitek® (rasburicase)
- Eloxatin® (oxaliplatin)

*Continued on Page 8*

# Services requiring prior authorization

Continued from Page 7

- Endovenous Radiofrequency Ablation of Varicose Vein
- Epidural Lysis of Adhesions
- Epogen® (erythropoietin)
- Eraxis™ (anidulafungin)
- Erbitux® (cetuximab)
- Erythropoietin Stimulating Agents
- Euflexxa™
- External Counterpulsation Treatment
- Extracorporeal Shock Wave Treatment (ESWT)
- Extraction of teeth, Alveoloplasty and Excision of Tori (limited to extractions that are required prior to organ transplantation, cardiac or radiation procedures)
- Fabrazyme® (agalsidase beta)
- Faslodex® (fulvestrant)
- Fetal Surgery
- Flolan® (epoprostenol)
- Gamma Knife Stereotactic Radiosurgery
- Gene Expression Profiling for Breast Cancer (Onco Type DX)
- Health Care Services associated with Non-covered Services (including but not limited to deep sedation and general anesthesia)
- Herceptin® (trastuzumab)
- Home Health/Hospice and Home Phlebotomy
- Hyalgan®
- Ilaris® (canakinumab)
- Injection Therapies for Back and Radicular Pain
- Inpatient (planned) hospital admissions
- Implanon™ (etonogestrel implant)
- Intensity Modulated Radiation Therapy (IMRT)
- Intravenous (IV) Boniva® (ibandronate sodium)
- Intravenous Immune Globulin (IVIG)
- Ixempra™ (ixabepilone)
- Kyphoplasty
- Leukine® (sargramostim)
- Magnetic Resonance Angiography (MRA) (Outpatient/Nonemergency)
- Magnetic Resonance Imaging (MRI) (Outpatient/Nonemergency)
- Mastectomy for Gynecomastia
- Mental Health and Substance Abuse (Inpatient, Partial Hospitalization and Outpatient)
- Mozobil™ (plerixafor)
- Myobloc (botulinum toxin Type B)
- Myozyme® (alglucosidase alfa)
- Naglazyme® (galsulfase)
- Neulasta® (pegfilgrastim)
- Neupogen® (filgrastim)
- Nuclear Cardiology
- Nonemergency Outpatient Radiology Services (CT, MRI, MRA, PET Scan and/or Nuclear Cardiology services)
- Nplate™ (romiplostim)
- Obesity Surgery
- Ontak® (denileukin diftitox)
- Orenicia® (abatacept)
- Orthognathic Surgery (including, but not limited to mandibular and maxillary osteotomies)
- Orthovisc®
- Panniculectomy, Lipectomy or other excision of excessive skin or subcutaneous tissue
- Percutaneous Lysis of Epidural Adhesions without endoscopic guidance/approach
- Physical, Occupational, or Speech Therapy (Outpatient)
- Positron Emission Tomography (PET) Scan (Outpatient/Nonemergency)
- Prialt® (ziconotide intrathecal infusion)
- Procrit® (erythropoietin)
- Prolastin®
- Proton Beam Radiation
- Reclast® (zoledronic acid)
- Remicade® (infliximab)
- Remodulin® Intravenous
- Restorative or Reconstructive surgical procedures due to their potential cosmetic or limitation of benefit
- Retisert™ (fluocinolone acetonide, intravitreal implant)
- Rhinoplasty as a stand alone procedure
- Rhinoplasty including major septal repair
- Rituxan® (rituximab) for treatment of rheumatoid arthritis
- Sacral Nerve Stimulation (including trial implantation)
- Sclerosing of Varicose Veins
- Septoplasty as a stand alone procedure or septoplasty in conjunction with other planned medically necessary surgeries
- Skilled Level of Care Admission
- Soliris® (eculizumab)
- Stab Phlebectomy for Varicose Vein
- Stelara™ (ustekinumab)
- Stereotactic Radiosurgery
- Surgical Correction of Pectus Deformity
- Supartz™
- Supprelin® LA (histrelin acetate implant)
- Synagis® (palivizumab)
- Synvisc®
- Synvisc One™
- Torisel™ (temsirolimus)
- Transilluminated Powered Phlebectomy (TriVex) for Varicose Vein
- Transmyocardial laser revascularization (Stand alone procedure only)
- Transplant evaluation services (pre-transplant services) and surgical transplantation of organs, bone marrow or stem cells
- Treanda® (bendamustine)
- Tysabri® (natalizumab)
- Unilateral Pallidotomy
- Vagal Nerve Stimulation
- Varicose Vein Ligation
- Varicose Vein Stripping
- Vectibix® (panitumumab)
- Velcade® (bortezomib)
- Vertebroplasty
- Vfend® (voriconazole)
- Virtual Colonoscopy (Outpatient/ Nonemergency)
- Viscosupplementation (Euflexxa™, Synvisc®, Synvisc One™, Hyalgan®, Orthovisc®, and Supartz™)
- Vitrasert® (ganciclovir intravitreal implant)
- Vivitrol® (naltrexone)
- White Blood Cell Stimulating Factors (Neulasta®, Neupogen® and Leukine®)
- Xolair® (omalizumab)
- Zemaira®
- Zevalin® In-111 and Zevalin® Y-90 (ibrutumomab)

# Medical and pharmaceutical policy updates

The following is a summary of new, revised and recently reviewed medical and pharmaceutical policies. Please consult the full text of these policies online at [thehealthplan.com](http://thehealthplan.com). Printed copies are available by contacting your Provider Relations Representative.

In the near future, information on policies and guidelines will be available exclusively online at [thehealthplan.com](http://thehealthplan.com). More details will be available in future issues of *Briefly*.

New and revised policies are effective July 1, 2010. Authorizations can be generated prior to July 1.

\*Coverage requires prior authorization (PA)

## New Policies

### Medical Policies

- **MP 237 Transurethral Radiofrequency Remodeling**
  - Has been proposed to shrink and stabilize the endopelvic fascia, thus improving the support for the urethra and bladder neck.
  - The Plan does not provide coverage for Transurethral Radiofrequency Remodeling as a treatment for any indication because it is considered experimental, investigational and unproven.
- **MP 238 Ocular Blood Flow Tonometer**
  - The device has been proposed to take the intraocular pressure (IOP) and ocular blood flow (OBF) test results together to increase the detection rate for glaucoma when compared to traditional tonometry, which measures only IOP.
  - The Plan does not provide coverage for Ocular Blood Flow Tonometer as a treatment for any indication because it is considered experimental, investigational and unproven.
- **MP 239 Pharmacogenetic Testing for Warfarin Metabolism**
  - Testing for these genotypes has been proposed to detect the common variants in the CYP2C9 and VKORC1 genes and identify patients who require a lower maintenance dose of warfarin and are at an increased risk for bleeding events.
  - The Plan does not provide coverage for Pharmacogenetic Testing for Warfarin Metabolism as a treatment for any indication because it is considered experimental, investigational and unproven.
- **MBP 73.0 Cimzia**
  - Requires **Prior Authorization** through Medical Management Department
  - Considered medically necessary for the treatment of the following conditions when qualifying criteria are met:
    - Physician documentation for a diagnosis of Crohn's disease or rheumatoid arthritis; and
    - Physician documentation of failure on, intolerance to or contraindication to Enbrel and Humira
- **MBP 74.0 Arzerra**
  - Requires **Prior Authorization** through Medical Management Department
  - Considered medically necessary for the treatment of the following conditions when qualifying criteria are met:
    - Prescribed by an oncologist; and
    - Physician provided documentation of the use of Arzerra for an FDA approved indication or a medically accepted indication; and
    - Physician documentation of therapeutic failure on, intolerance to, or contraindication to Campath and fludarabine or Rituxan
- **MBP 75.0 Stelara**
  - Requires **Prior Authorization** through Medical Management Department
  - Considered medically necessary for the treatment of the following conditions when qualifying criteria are met:
    - Physician provided documentation of a diagnosis of rheumatoid arthritis; and
    - Physician provided documentation of a therapeutic failure on, contradiction to or intolerance to
      - Enbrel and Humira; or
      - Remicade
- **MBP 76.0 Actemra**
  - Requires **Prior Authorization** through Medical Management Department
  - Considered medically necessary for the treatment of the following conditions when qualifying criteria are met:
    - Physician provided documentation of a diagnosis of rheumatoid arthritis; and
    - Physician provided documentation of a therapeutic failure on, contradiction to or intolerance to
      - Enbrel and Humira; or
      - Remicade
- **MBP 77.0 Ilaris**
  - Requires **Prior Authorization** through Medical Management Department
  - Considered medically necessary for the treatment of the following conditions when qualifying criteria are met:

*Continued on Page 10*

# Medical and pharmaceutical policy updates

Continued from Page 9

met:

- Physician provided documentation of diagnosis of Cryopyrin-Associated Periodic Syndrome (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) supported by documentation of genetic testing to identify the CIAS1/NLRP-3 gene mutation.
- Must be prescribed by an immunologist, rheumatologist, or allergist.
- Patient must be evaluated by expert in field as chosen by Geisinger Health Plan Medical Director

## Revised Policies

### Medical Policies

- **MP 25 Transcatheter Closure Devices**
    - Requires **prior authorization** through Medical Management for some indications.
    - Exclusion language updated to include transmyocardial transcatheter closure of ventricular septal defects with implants.
  - **MP 38 Oral Health**
    - Requires **prior authorization** through Medical Management for some indications.
    - Indication language more clearly defined for those insured individuals for which coverage of Hospital/ Ambulatory surgical center services are requested.
  - **MP 94 Unilateral Pallidotomy**
    - Removal of **Prior Authorization** requirement
  - **MP135 Osseointegrated Hearing Devices (BAHA Hearing Device)**
    - Formerly titled Implantable and Semi-implantable Hearing Aids
    - Requires **Prior Authorization** through Medical Management Department
  - **MP 197 Janus Kinase (JAK) 2 Testing**
    - Requires **Prior Authorization** through Medical Management Department
    - Revised exclusion section to include age requirements and quantity limits
- ### Medical Benefit Pharmaceutical
- **MBP 56.0 Retisert®**
    - Removal of **Prior Authorization** requirement
  - **MBP 23.0 Velcade®**
    - Requires **Prior Authorization** through Medical Management Department
    - Additional indications added

## Retired Policies

The following Medical Policies have been removed:

- MP08 Medical Policy Assessment Group Operation Guidelines
- MP13 Ambulance Transport
- MP188 Criteria for Home Health Services

## Annual Reviews

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

- MP 05 Medical Policy Process
- MP23 Keratoplasty
- MP 32 Colonoscopy
- MP 33 Varicose Vein Treatments
- MP 34 Foot Orthotic
- MP 37 Home Phlebotomy Program
- MP39 Home Uterine Monitoring
- MP44 Aquatic Therapy
- MP 64 Breast Reconstruction
- MP 68 Reduction Mammoplasty
- MP 69 Ultrafiltration
- MP 73 Deep Brain Stimulation
- MP 76 HH/DME Hyperbilirubinemia
- MP 78 Sexual Dysfunction Therapies
- MP 84 Stereotactic Radiosurgery
- MP 90 Injectable Bulking Agents
- MP 92 Implantable Cardiac Loop Recorder
- MP 99 Breast Implant Removal
- MP 106 Ultrasound in Uncomplicated Pregnancy
- MP 109 Total Body Radiologic Screening
- MP 124 Transpupillary Thermotherapy
- MP127 Prolotherapy
- MP130 Automated Ambulatory BP
- MP136 Alternative Medicine Therapies
- MP165 Treatment of Vestibular Disorders
- MP 174 Exhaled Nitric Oxide for Pediatric Home Use
- MP 172 Microvas Vascular Treatment System
- MP 175 Trigger Point Injection
- MP 176 Meniett Device
- MP 184 Intracranial Percutaneous Transluminal Angioplasty
- MP 189 Computer-Aided Detection Technology
- MP 196 Convection-Enhanced Drug Delivery
- MP198 Pulse Oximetry for Pediatric Home Use
- MP208 Selective Internal Radiation Therapy

Continued on Page 11

# Medical and pharmaceutical policy updates

Continued from Page 10

- MP209 Medical Error Never Events
- MP 211 Endovascular Repair of Intracranial Aneurysms
- MP212 Mist Therapy
- MP 213 Computerized Corneal Topography
- MP 226 Proton Beam Radiation
- MBP1.0 Coordination of Medical Benefit and Pharmaceutical Use
- MBP 7.0 Aldurazyme
- MBP10.0 Zoledronic Acid (Zometa)
- MBP11.0 Botulinum Toxin (Botox®, Myobloc®, Dysport®)
- MBP14.0 Meningococcal Vaccine
- MBP15.0 Zevalin®
- MBP18.0 Fabrazyme
- MBP26.0 Eloxatin®
- MBP28.0 Ontak®
- MBP29.0 Elitek
- MBP32.0 Kepivance
- MBP38.0 Clolar
- MBP42.0 IV Boniva
- MBP48.0 Rituxan
- MBP55.0 Myozyme®
- MBP63.0 Ixempra
- MBP64.0 Arranon
- MBP65.0 Torisel

- MBP66.0 Reclast

## Clinical Guideline Update

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

- Treatment of Hepatitis C

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](mailto: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:

- Chronic Kidney Disease
- Diabetes
- Adult Depression

Your feedback is encouraged and appreciated. Comments should be sent to Phillip Krebs, Medical Management 32-34, or by e-mail to [pkrebs@thehealthplan.com](mailto:pkrebs@thehealthplan.com). Please provide your feedback by October 1, 2010.

## Accessibility of primary care services

In order to best serve Health Plan members, PCPs and/or primary care sites are expected 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 24 hours from the date of the initial request.   |
| Routine care appointments    | Appointment with PCP or designee within 21 days from the date of the initial request.  |
| Preventive care appointments | Appointment with PCP or designee within 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.  |



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

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HPM50 cd June 2010 5/20/10

## Satisfied with service: 2009 provider satisfaction survey results

Our annual satisfaction survey was conducted during the third quarter of 2009 to measure physician satisfaction with Geisinger Health Plan. We would like to thank all of the participating physicians that responded. Your feedback is appreciated.

**Highlights:**

- Overall participating provider satisfaction with the Health Plan remained at 76%.
- Overall satisfaction with our Customer Service Representatives increased to 80% from 72%.
- Overall satisfaction with our Case Management programs increased to 75% from 65%.
- 75% of participating providers reported being satisfied or very satisfied with their Provider Relations Representative.

The Health Plan will continue to analyze survey results to both identify areas of opportunity and continue building on areas of high satisfaction. When you receive an invitation this year to complete the Health Plan's 2010 satisfaction survey, remember that your responses are what drive our provider service initiatives.