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Guidelines for coding diabetes

Diabetes mellitus is one of the most common diseases seen in Medicare beneficiaries. It can also be one of the most challenging conditions to code properly due to its complexity and resultant complications and manifestations.

It is important that each of the ICD-9-CM diagnosis codes be reflected in the medical record documentation. Proper coding and supporting documentation are necessary to facilitate proper payment.

To help physician offices address these challenges, the CMS and the National Center for Health Statistics (NCHS) have provided the following guidelines for coding and documenting diabetes and its complications.

Please remember, codes must be chosen based solely on documentation. If the condition is not documented, then do not code for it.



Most common diabetic condition

Diabetic mellitus code- diagnosis code 250

The following fifth-digit subclassification is for use with category 250:

- 0 type II or unspecified type, not state as uncontrolled (fifth-digit 0 is for use for type II patients, even if the patient requires insulin)
- 1 type I (juvenile type), not stated as uncontrolled
- 2 type II or unspecified type, uncontrolled (fifth-digit 2 is for use for type II patients, even if the patient requires insulin)
- 3 type I (juvenile type), uncontrolled

Without mention of complications	Diabetes with ketoacidosis	Diabetes with hyperosmolarity	Diabetes with other coma
250.0X	250.1X	250.2X	250.3X
Diabetes with renal manifestations	Diabetes with ophthalmic manifestations	Diabetes with neurological manifestations	Diabetes with peripheral circulatory disorders
250.4X	250.5X	250.6X	250.7X

Use the applicable fifth digit from above. Additional diagnosis codes, such as 250.8X and 250.9X can be used to identify other specified manifestations or unspecified complications. Refer to the most current ICD-9-CM manual for clarification.

Medical and pharmaceutical policy updates

New medical policies

- **MP 230 Outpatient Pulmonary Rehabilitation**
 - Limited to 36 visits per benefit period
 - Coverage is considered medically necessary for insured individuals with moderate to severe chronic obstructive pulmonary disease (COPD) when qualifying criteria is met.
- **MP 231 Radiofrequency Facet Joint Denervation**
 - Percutaneous procedure in which select afferent nerve fibers are selectively destroyed in an effort to eliminate pain.
 - Coverage is considered medically necessary for insured individuals with intractable cervical or lumbar pain when specific criteria are met.
 - The Health Plan does not provide coverage for pulsed radiofrequency facet joint denervation as a treatment for any indication because it is considered experimental, investigational and unproven.
- **MP 235 Total Facet Arthroplasty**
 - Refers to the implementation of a spinal prosthesis to restore posterior element structure and function as an adjunct to neural decompression.
 - The Health Plan does not provide coverage for Total Facet Arthroplasty as a treatment for any indication because it is considered experimental, investigational and unproven.
- **MP 236 Immune Cell Function Assay for Transplant Rejection**
 - Proposed as a method to detect cell mediated immunity in patients undergoing immunosuppressive therapy post solid organ transplant.
 - In addition, proposed as a means of predicting possible transplant rejection prior to solid organ transplantation.
 - The Health Plan does not provide coverage for Immune Cell Function Assay for Transplant Rejection as a treatment for any indication because it is considered experimental, investigational and unproven.
- **MBP 72.0 Treanda® (bendamustine)**
 - **Requires Prior Authorization through Medical Management Department**
 - Considered medically necessary for the treatment of the following conditions when qualifying criteria are met:
 - Chronic Lymphocytic Leukemia
 - Non-Hodgkin's Lymphoma
 - Mantle Cell Lymphoma

Revised medical policies

- ***MP 21 Dorsal Column Stimulation**
 - **Requires Prior Authorization through Medical Management Department**
 - Revised to exclude coverage for use of Dorsal Column Stimulator in the cervical spine.
- ***MP 38 Oral Health**
 - **Prior Authorization through Medical Management Department is required for the following:**
 - Orthognathic surgery (including, but not limited to mandibular and maxillary osteotomies.
 - Extraction of teeth, alveoplasty, and excision of tori
 - The use of deep sedation or general anesthesia to perform oral surgery when done in a hospital or ambulatory surgical center
 - Exclusions revised to exclude coverage for the following:
 - Chin implants (genioplasty, metoplasty)
 - Orthognathic surgery for correction of unaesthetic facial features regardless of whether they are associated with psychological disorders
 - Orthognathic surgery for correction of temporomandibular joint disease or myofascial pain disorder.
- ***MP 56 Management of Excessive Skin and Subcutaneous Tissue**
 - **Requires Prior Authorization through Medical Management Department**
 - Indication and exclusion language more clearly defined for those insured individuals for which coverage is not explicitly excluded.
- **MP 97 Genetic Testing for BRCA 1 and BRCA 2 Testing**
 - Indications revised to be consistent with current National Comprehensive Cancer Network (NCCN) guidelines.
- **MP147 Artificial Intervertebral Disc**
 - Indications added for the use of artificial intervertebral discs in the cervical spine

Revised pharmaceutical policies

- ***MBP 22.0 Xolair® (omalizumab)**
 - **Requires Prior Authorization through Medical Management Department**
 - Recommended dosing schedule added to the policy
 - Formulary alternatives Advair and Maxair added

The medical and pharmaceutical policy updates are also available on thehealthplan.com

Medical and pharmaceutical policy updates

- *MBP 40.0 Orencea® (abatacept)
 - **Requires Prior Authorization through Medical Management Department**
 - New indication for Juvenile Idiopathic Arthritis added

Retired policies

The following Medical Policy has been removed:

- MP103 Collagen Crosslink Analysis

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.

Medical policies

- MP 01 Neuromuscular electrical stimulation
- MP 06 Nocturnal Enuresis Alarm
- MP 60 Lung Volume Reduction Surgery
- MP 77 Non-invasive Mechanical Therapy for Back Pain
- MP 81 Chelation Therapy
- MP 51 Vagus nerve Stimulation
- MP 53 Cochlear Implant
- MP 56 Management of Excessive Skin and Subcutaneous Tissue
- MP 83 Hydrophilic Contact Lenses
- MP 95 Craniosacral Therapy
- MP 103 Collagen Crosslink Antigen
- MP 105 Phototherapy for SAD
- MP 108 Work Hardening/Conditioning
- MP 113 Electrical Stimulation Wound Heal
- MP 119 Therapeutic listening
- MP 123 HDR temp brachytherapy
- MP 126 Massage therapy
- MP 128 Essure tubal sterilization
- MP 132 Virtual colonoscopy

- MP 138 Lysis of epidural adhesions
- MP 142 Anodyne infrared therapy
- MP 149 Pulsed electrical stimulation for osteoarthritis
- MP 158 Continuous passive motion
- MP 160 Cardiac MRI
- MP 162 Salivary hormone testing for menopause and aging
- MP 164 Laser therapy for acne
- MP 168 Breath testing for heart transplant rejection
- MP 169 Retinal prosthesis
- MP 171 Clinical guideline development, implementation and review process
- MP 177 Sensory integration therapy
- MP 186 Total hip replacement
- MP 191 Computerized cognitive health assessments
- MP 194 Rhinophototherapy
- MP 195 Functional magnetic resonance imaging
- MP 204 Nasal and sinus surgery
- MP 205 Advance molecular topographic genotype
- MP 210 Endometrial ablation
- MP 219 Percutaneous neuromodulation therapy
- MP 222 Intradiscal biaculoplasty
- MP 223 Functional anesthetic discography
- MP 224 Topical oxygenation
- MP 225 Circulation tumor cell testing

Medical benefit pharmaceuticals

- MBP 4.0 IVIG
- MBP 9.0 Campath
- MBP 22.0 Xolair
- MBP 25.0 Bexxar
- MBP 53.0 Eraxis
- MBP 54.0 Solaris
- MBP 61.0 Flolan
- MBP 62.0 Remodulin IV

Clinical guideline update

The following clinical guidelines have been recently updated and approved for use by participating providers:

- Alcohol abuse and alcoholism
- Pediatric ADHD
- Colorectal cancer screening
- Fall prevention
- Non-surgical treatment of urinary incontinence

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:

- Treatment of hepatitis C
- Pediatric otitis media with effusion
- Adult and pediatric pharyngitis

Your feedback is encouraged and appreciated. Comments should be sent to Phillip Krebs, Medical Management 32-34, or by email to pkrebs@thehealthplan.com. Please provide your feedback by May 14, 2010.

Commercial and Gold Formulary updates

Commercial

Drugs deemed Formulary

Multaq (2)
Provigil (3)*,t
Lyrica (2)
Savella (2)
Banzel (3)*,t
Celebrex (3)

Drugs deemed Non-Formulary

Renvela (3)*,t
Effient (3)*,t
Rapaflo (3)*,t
Onglyza (3)*,t
Cimzia (3)*,t
Simponi (3)*,t
Nuvigil (3)*,t
Nucynta (3)*,t
Sabril (3)*,t
Saphris (3)*,t
Voltaren Gel (3)*,t
Flector Patch (3)*,t
Cymbalta (3)*
Uloric (3)*,t

() = tier

* = requires prior authorization under the non-tiered benefit

t = requires prior authorization under the tiered benefit

** = quantity limits apply

Commercial Formulary changes:

- Aricept and Lovenox are moving from tier 3 to tier 2 for the Triple Choice pharmacy benefit.
- Human Growth Hormone Update: Effective April 1, 2010 the preferred human hormone agents will be Genotropin and Norditropin. A prior authorization is required and cost sharing will be as specified in the member's drug rider. Other human growth hormone products will require a prior authorization as well, but will require failure on the preferred agents where appropriate first. Existing users of non-preferred agents will not be grandfathered and will be contacted by the Health Plan regarding the transition. Members and providers continue to be required to utilize the Health Plan's Specialty Vendor Program to acquire these products.

Gold

Gold Formulary additions/changes:

- **Multaq**– added to the third tier of the \$0 Deductible RX formulary and added to the second tier Standard RX formulary
- **Provigil, Sabril, Saphris, Votrient, Savella, Banzel, Renvela**– added to the third tier of the \$0 Deductible RX formulary and added to the second tier of the Standard RX formulary (prior authorization required)
- **Lyrica**– added to the second tier of the \$0 Deductible RX formulary and the second tier of the Standard RX formulary (prior authorization removed)
- **Celebrex**– added to the third tier of the \$0 Deductible RX formulary and added to the second tier of the Standard RX formulary (prior authorization removed)
- **Cymbalta**– added to the third tier of the \$0 Deductible RX formulary and added to the second tier of the Standard RX formulary (prior authorization removed)

Gold Medications deemed Non-Formulary (prior authorization required):

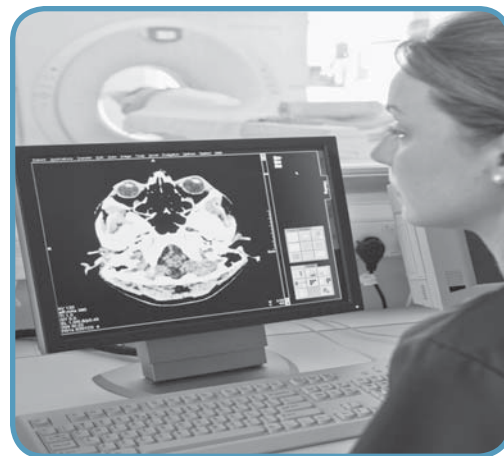
Effient, Rapaflo, Onglyza, Cimzia, Simponi, Nuvigil, Nucynta, Voltaren Gel, Flector Patch, Uloric

Are CT Scans always necessary?

Although technological advancements in diagnostic imaging, including those that involve ionizing radiation, have improved health outcomes for patients, the tremendous increase in the number of CT scans and other nuclear imaging studies (1) have raised concern about the cumulative exposure of the population to ionizing radiation. The likelihood that the risk of cancer acquired from exposure to radiation is dose related (1,2). To put the dosage into perspective, a whole body CT scan gives a dose of ionizing radiation approximately equivalent to 100 x-rays.

When ordering a diagnostic study, please consider exploring an alternate diagnostic test, especially for children or those patients with a history of CT scans. It will be many years before the medical community will fully understand the impact associated with such scans. Now is the time to weigh the benefits and risks of such studies.

In the not too distant future we will begin to track the cumulative exposure of patients to ionizing radiation and report back to ordering physicians to assist them in weighing these risks and benefits when ordering these diagnostic tests. In many cases these tests are medically appropriate. We do not intend coverage for tests to be denied on the basis of cumulative exposure.



References:

1. American College of Radiology White Paper on Radiation Dose in Medicine 2007
Available at: www.acr.org
2. Beir VII: Health Risks from Exposure to Low Levels of Ionizing Radiation
Available at: dels.nas.edu

Chiropractic updates for PEBTF Geisinger Gold members

PEBTF now offers Geisinger Gold as an option to its members. PEBTF Gold members have a limit of 15 chiropractic visits without a plan of care and the chiropractic services must be through a participating provider.

To initiate a plan of care and to obtain authorization for additional visits **beyond the 15 visits**, please contact the medical management department at (800) 544-3907.

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. We also appreciate your support in encouraging patients to receive needed immunizations and screenings.

We will conduct our annual chart reviews in March and April. With your help, we hope to have another successful HEDIS® year.

CMS annual audit

Annually, the Centers for Medicare and Medicaid Services conducts audits on Medicare Advantage plans to ensure the claims data submitted to CMS is supported by the medical record. This audit requires the Health Plan to obtain a copy of the medical record to demonstrate to CMS the diagnosis reported on the claim is actually present in the medical record.

In anticipation of this year's audit, physicians/providers are asked for their cooperation with these requests in a timely way. The audit will allow a six week collection process. Results of the audit will be shared with physicians/providers as a training opportunity. We appreciate your cooperation in this audit process

Code amputation annually

Often a prior amputation may be overlooked as an applicable diagnosis to report during a patient encounter. However, coding prior amputations annually helps support services and potential benefits.

Coding Clinic states that one of the reasons to use a V diagnosis code is to show "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 and may effect 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. The amputation status codes are never used as a Principal or first code on any claims, these codes can only be used as a secondary code.

Other amputee diagnosis codes you may find appropriate to code are:

V49.7	Lower limb amputation status (requires a 5th digit)
V49.70	Unspecified level
V49.71	Great toe
V49.72	Other toe(s)
V49.73	Foot
V49.74	Ankle
V49.75	Below knee
V49.76	Above knee
V49.77	Hip

Health Plan information and resources at your fingertips

The Health Plan Web site offers simple tools and information to help you provide medical care for members. Here are just some of the features and resources on thehealthplan.com:

- See an overview of the different plans we offer or browse Health Plan medical policies and clinical guidelines
- Find information about pre-certification requirements and download a prior authorization form
- Consult our online Formulary when prescribing medications
- Review our Participating Provider Guide and recent Operations Bulletins
- Login to view your Physician Utilization and Provider Profile Reports.
- Check your Physician Quality Summary (PQS) star rating to determine your eligibility for cash incentives
- Use the Member Health Alert tool to improve your PQS rating by examining a list of Health Plan members that require preventive screenings
- Register for the Provider Service Center for access to the Health Plan member's eligibility and benefit information as well as claims status and authorization inquiries



We are continually working to ensure that thehealthplan.com is an asset to you and your practice. Our focus is on creating and developing the online tools and resources that allow you to focus on your patients.

GHP 2010 group benefit changes

Group benefit changes effective April 1, 2010, upon the group's renewal

Changes to the Subscription Certificate and Schedule of Benefits:

- Well-child visits for children up to age 21 will not require a copayment. If additional services such as lab work or diagnostic tests are provided during the visit, or if a specific medical condition is treated, these services may incur a charge.
- Vision and hearing screenings conducted at the member's primary care site will not require a copayment, deductible or coinsurance.
- Copayment for select high-cost injectable drugs will increase from \$50 to \$75. The out-of-pocket maximum for these drugs will increase from \$1,200 to \$1,500 per benefit period. Call the pharmacy customer service team at (800) 988-4861 for a list of these drugs. The following drugs have been added to the list of select high cost injectable drugs that require a copayment:
 - Aldurazyme (laronidase)
 - Arranon (nelarabine)
 - Eligard (leuprolide)
 - Erbitux (cetuximab)
 - Firmagon (degarelix)
 - Ixempra (ixabepilone)
 - Mozobil (pleriafor)
 - N-Plate (romiplostim)
 - Ontak (denileukin diftitox)
 - Reclast (zoledronic acid)
 - Simponi (golimumab)
 - Supprellin LA (histrelin)
 - Torisel (temsirolimus)
 - Treanda (bendamustine)
 - Trelstar (triptorelin)
 - Velcade (bortezomib)
 - Viadur (leuprolide)
 - Vivaglobin (sub q immune globulin)

Geisinger Choice Short Term PPO

Geisinger Health Plan is pleased to introduce Geisinger Choice Short Term PPO, designed for those seeking coverage for a limited period of time or for those requiring a stop-gap solution, such as people who are non-COBRA eligible or between jobs, new hires with a waiting period, early retirees, or students terminating from their parents' plan. Choice Short Term PPO works just like our current PPO direct access plans; there are no referrals and members are not required to select a PCP upon enrollment. The member may choose one specific benefit period no less than 31 days and not exceeding 180 days. Choice Short Term PPO was made available to prospective members February 1, 2010.

Dual eligibles and cost sharing

Providers are reminded that members who are eligible for both Medicare and Medicaid benefits may not be held financially liable for Medicare Part A and B cost sharing when the state is responsible for such amounts, according to the Medicare Improvements for Patients and Providers Act (MIPPA). Geisinger Gold Secure 1 is a Special Needs Plan for Medicare beneficiaries who are also eligible for Medicaid. Gold Secure 1 claims may return a cost sharing amount through your Explanation of Payment notice; however, the explanation of BU states—Gold Secure— Bill PA Medicaid as Secondary. MIPPA mandates that providers— who do not participate with Medicaid— are prohibited from collecting a member's cost sharing amount, when Medicaid is liable this amount. Additionally, some members enrolled in Geisinger Gold Classic, Preferred and Open may also be eligible for Medicaid. If you have question about dual eligible enrollment and how it may affect a member's cost sharing responsibility, contact the Geisinger Gold customer service team at (800) 498- 9731.



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

HPM50 js March 2010 1/18/2010

Health Plan policies and procedures available online

The Health Plan Participating Provider Guide (10/08) is available online at thehealthplan.com. You may also request a copy of the full guide, or select sections, by calling your Provider Relations Representative.

The Participating Provider Guide includes important Health Plan policy and procedure information, including:

- Member rights and responsibilities (HMO, PPO and Gold)
- Medical management information (communicating denials of coverage, how we make medical management decisions, and more)
- Quality Improvement information
- Privacy information
- Minimum standards for medical record documentation

