



GHP recognizes practices for role in U.S.News & World Report ranking

More than 130 practice sites were recently presented plaques in recognition and appreciation of their efforts which contributed toward GHP's national ranking in the U.S.News & World Report/National Committee for Quality Assurance (NCQA) America's Best Health Plans 2008-09 list.*

Geisinger Health Plan and Geisinger Gold are the top-ranked commercial and Medicare health plans in Pennsylvania and among the top five commercial and Medicare health plans in the nation. Primary care physicians, such as Dr. Thomas, have a direct impact on improving patient outcomes by practicing preventive health. One way is by using the Member Health Alerts Web tool which is a free, patient registry designed by the Health Plan to assist busy primary care offices in identifying patients who require certain preventive services. The use of this tool has a direct correlation between increasing quality patient care, which drives improved patient behavior and health, and reduced medical expenses.

To learn more about the Member Health Alerts program and how you can enroll, please visit the Provider Information Center online at thehealthplan.com, or contact your Provider Relations Representative.

*U.S.News & World Report/NCQA America's Best Health Plans 2008-09. America's Best Health Plans is a trademark of U.S.News & World Report.



Dr. Linda Thomas, center, is a primary care physician at Scranton Temple Residency Program Faculty Services in Lackawanna County, which was one of the GHP practices that were recently presented a plaque by the Provider Service staff in recognition and appreciation of their efforts which contributed toward Geisinger Health Plan's national ranking in U.S.News & World Report. Also pictured are GHP staff Kim Winssock, left, and Seana Juda.

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You can also visit www.thehealthplan.com/providers_us/medical.cfm to sign up.

Important information for providers

Medical record documentation standards

To assure quality medical records throughout the Health Plan's provider network, the Quality Improvement (QI) Department audits completion of medical records as a component of the QI program. These audits have identified three particular areas with low rates of compliance:

- Usage of a current health maintenance sheet for patients seen three or more times
- Usage of a current immunization record for patients seen three or more times
- A prominently displayed Advanced Directive

Annual reviews are completed on a random sample of 10% of the currently participating primary care physicians (PCP) in the Health Plan provider network. A list of Health Plan members with a clinic visit to these providers in the past six months is produced.

If the compliance rate is below 85%, the PCP is asked to submit an action plan for improvement within 60 days.

A re-audit is performed within six months of receiving the action plan. A score of 85% or a 10% improvement from the previous score is acceptable. If this requirement is not met, another action plan is performed within 60 days and a six month audit is again required.

The Health Plan maintains minimum standards for written medical record documentation to enhance insured individual care through the consistent documentation of the insured individual care process and the improvement of communication between caregivers, which occurs via the medical record. The Centers for Medicare and Medicaid Services (CMS) recommends all providers include Advanced Directives in the medical record. The Health Plan's medical record guidelines can be found in

the Participating Provider Guide.

Contact for claims questions

All questions regarding a specific claim should be directed to the appropriate Customer Service Team. They may be contacted either by telephone or via the secure messaging feature within the Provider Service Center. The Customer Service Team can better assist you with your claim questions due to:

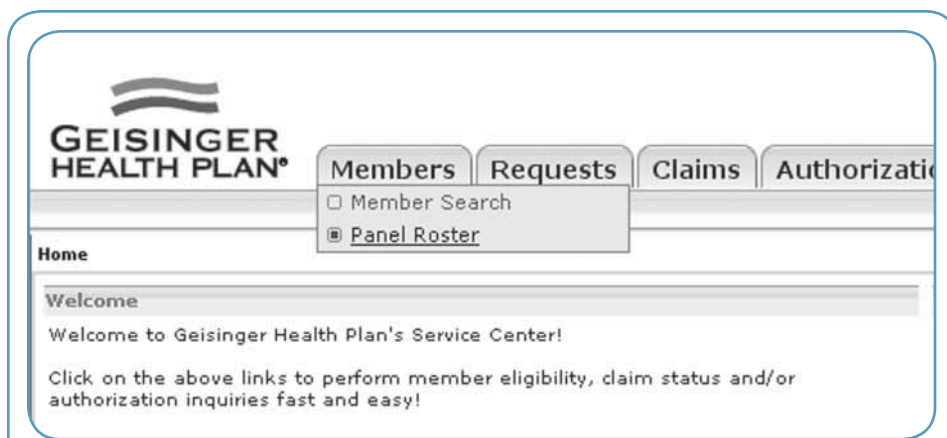
- Direct access to claim processors and adjusters
- Availability of a representative to your office during business hours (Monday through Friday, 8 am – 5 pm for Gold and PPO, 8 a.m. to 6 p.m. for HMO and PPO with referral)
- IVR system for claim status information available now on all

Customer Service Team toll-free numbers

Please continue to contact your Provider Relations Representative for questions on policies, procedures and general Health Plan education.

New clearinghouse available

The addition of Relay Health as a clearinghouse for 835 transactions and claims submissions is just another step toward the Health Plan's goal of providing you with a full array of on-line services that will streamline your business. More tools and resources, such as on-line referrals, are currently in development. Stay tuned. For more information, log onto the Provider Service Center or contact your Provider Relations Representative.



Membership listing available online

Many providers have already enrolled and use the Health Plan's Provider Service Center to determine member eligibility, member cost sharing, referrals and claim information. Also, many primary care offices use the online membership listing/roster to identify membership assigned to their practice. Beginning in October 2009, we will no longer automatically distribute membership listing/rosters to each primary care office. We encourage you to use the Provider Service Center to obtain these listings. If you are unable to obtain a listing online, please contact your Provider Relations Representative.

We are also in the final stages of developing our online referral entry and claim appeal tools. To assist providers, we encourage you to use the secure e-mail feature to correspond with Customer Service regarding questions on claims.

Should you report CPT Category II Codes?

Many physicians have inquired regarding the acceptance of Current Procedural Terminology (CPT) Category II codes. These codes are intended to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures and that have an evidence base as contributing to quality patient care. The Centers for Medicare and Medicaid Services accept these codes as a component to their Physician Quality Reporting Initiative (PQRI). Providers are encouraged to use Category II codes in accordance with CPT guidelines. It is anticipated the use of Category II codes will decrease the need for record abstraction and chart reviews, which reduces administrative burden on physicians, hospitals and other health care professionals.

We welcome your adoption of reporting all Category II Codes in any applicable areas and prefer the following situations are reported with CPT II Category Codes:

Category	CPT Codes (Screening Test Only)	CPT II Category Codes (Screening and Result)
Cholesterol Management for Patients with Cardiovascular Conditions - LDL Level Control	80061, 83700, 83701, 83704, 83721	3048F (LDL-C less than 100 mg/dl), 3049F (LDL-C 100-129 mg/dl), 3050F (LDL-C 130mg/dl or higher)
Hypertension - Blood Pressure Control (<140/90 mm Hg)	Report normal service provided in addition to CPT2	3074F (systolic blood pressure less than 130 mm Hg), 3075F (systolic blood pressure less than 130-139 mm Hg) 3078F (diastolic blood pressure less than 80 mm Hg), 3079F (diastolic blood pressure less than 80-89 mm Hg)
Diabetes - HbA1c Level Control	83036, 83037	3044F (hemoglobin A1c (HbA1c) level less than 7%), 3045F (hemoglobin A1c (HbA1c) level 7-9%), 3046F (hemoglobin A1c (HbA1c) level greater than 9%)
Diabetes - LDL Level Control	80061, 83700,83701, 83704, 83721	3048F (LDL-C less than 100 mg/dl), 3049F (LDL-C 100-129 mg/dl), 3050F (LDL-C 130mg/dl or higher)
Diabetes - Blood Pressure Control (<130/80 mm Hg)	Report normal service provided in addition to CPT2	3074F (systolic blood pressure less than 130 mm Hg) 3078F (diastolic blood pressure less than 80 mm Hg)
Nephropathy Screening Test	82042, 82043, 82044, 81456	3060F (positive microalbuminuria test result documented and reviewed), 3061F (negative microalbuminuria test result documented and reviewed)

Similar to the PQRI program requirements, providers would report \$0.00 associated with the charge amount for each Category II Code. We also recommend you follow the reporting/billing guidelines associated with the PQRI program related to how, when and where to report Category II Codes on your hard copy and/or electronic claim encounters. For your assistance, www.cms.hhs.gov/PQRI provides specifics on Medicare's PQRI program and reporting requirements. Or, you may contact Tami Miller, Director Provider Relations, at 570-271-7403.

Claim coding reminders

Spinal garment coding

Effective October 1, 2009, claims submitted for a spinal garment made primarily of elastic material under the following HCPCS codes must include a GY modifier. If the spinal garment is made primarily of non-elastic material (e.g., cotton or nylon) or has a rigid posterior panel, a CG modifier (policy criteria applied) must be added. The Health Plan reserves the right to edit these services for compliance with stan-

dard coding and benefit limitations.

Elastic spinal garment codes requiring modifiers: L0450, L0454, L0621, L0625, L0628.

Claim coding reminder

In order to avoid claim denials, quantities billed must match the CPT code description. For example:

- 11200 – For the removal of 1 to 15 fibrocutaneous tags, the reported quantity should be 1.

- 66984 – Extra capsular cataract removal with insertion of intraocular lens prosthesis. When billed with Modifier 55, the quantity reported should be 1 and not the number of post-op days.
- D9220 – Deep sedation, first 30 minutes, should be a quantity of 1, not 30.

Take a moment to check your systems or claims to ensure proper quantities are reported. This will increase your revenue return and reduce claim denials.

Important information for PCP offices

The Health Plan encourages you to follow Healthcare Effectiveness Data and Information Set (HEDIS®) guidelines 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. In addition, consistent cooperation in fulfilling these standards can result in cash incentives for you!

Acute bronchitis

According to the Centers for Disease Control and Prevention (CDC), increasing resistance to antibiotics is one of the most important issues in health care today. The guidelines released by The American College of Physicians- American Society of Internal Medicine (ACP-ASIM) do not recommend antibiotic treatment for individuals presenting with uncomplicated acute bronchitis who are otherwise healthy. 8 in 10 antibiotics prescribed for acute respiratory infections in adults are unnecessary, according to CDC prevention guidelines. Inappropriate antibiotic use contributes to bacterial resistance to antibiotics and represents wasted health care resources.

Member health alerts

Are you looking for a way to keep track of your patients who need certain preventive health screenings or clinical tests? The Health Plan has created your personalized member health alerts, accessible for free online at thehealthplan.com. It's easy to use and downloads to a printable format in seconds. Offices have found success using the alerts to ensure labs are ordered for diabetics or to keep track of well visits for patients. For more information on member health alerts, contact your Provider Relations Representative. They can help schedule a demonstration for your office.

Controlling high blood pressure

According to the American Heart Association, one in three adults has high blood pressure. Although effective treatment options are available, 65 percent of Americans with hypertension are untreated or undertreated. People with normal blood pressure live an average of five years longer than those with hypertension. The seventh report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure recommends a goal of <140/90 mm Hg or <130/80 mm Hg for patients with diabetes and chronic kidney disease. For your reference, the Health Plan maintains a hypertension treatment policy, available online at thehealthplan.com.

Glaucoma screenings

Glaucoma is a leading cause of blindness in the United States. It is estimated that over 4 million Americans have glaucoma, but only half of those know they have it because the vision loss is unnoticeable, and usually painless, in the early stages of the disease. Screening and diagnosis of glaucoma is clinically important for early detection and treatment to prevent and delay damage. Routine eye exams should be performed to increase early identification of glaucoma.

LifeScan is preferred glucose meter

Geisinger Health Plan has a preferred provider arrangement with LifeScan, Inc., to provide blood glucose meters to diabetic patients. Commercial or Gold patients are eligible for one free Lifescan meter every two years with a prescription filled at a Health Plan network pharmacy. The meter models included are: One Touch Profile, One Touch Basic, Surestep, Fast Take, One Touch Ultra, One Touch Ultra II and One Touch Ultra Mini. Note: The Ultra Smart meter is NOT covered. No precertification is required for LifeScan, Inc. meters.

Although the copay or cost-share for test strips varies depending on the member's benefit plan, the corresponding Lifescan Test Strips are covered for glucose testing up to five times per day. Greater testing frequencies require prior authorization. All non-Lifescan strips require prior authorization.

Software for downloading the patient's testing results from the meter to an office PC is available from Lifescan to enhance disease monitoring.

The Health Plan's Diabetes Program assists with case management for diabetic patients. This program uses the American Diabetes Association's Clinical Practice Recommendations and Staged Diabetes Management®. To refer a Health Plan member to the Diabetes Care Program, call (800) 833-6355 or (570) 271-8763, Monday through Friday, 8 a.m. to 4:30 p.m.

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. 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. More details will be available in future issues of Briefly.

New and revised policies are effective October 1, 2009. Authorizations can be generated prior to October 1.

*Coverage requires prior authorization (PA)

New medical policies

MP 229 Prolozone Therapy

- Homeopathic injection technique proposed to treat musculoskeletal and joint pain
- Considered experimental, investigational and unproven based on the lack of peer-reviewed, published medical literature.

*MP232 Autism Spectrum Disorder Evaluation and Medical Management

- Prior Authorization requirements may apply
- Communicates the medical necessity criteria for the evaluation and management of autism spectrum disorders (ASD)

MP233 Platelet Rich Plasma Gel

- Proposed as an adjunct to standard treatment for a number of indications including wound care for the treatment of diabetic ulcers and venous stasis ulcers, bone augmentation and fusion, tendonitis, and plantar fasciitis.
- Considered experimental, investigational and unproven based on the lack of peer-reviewed, published medical literature.

New pharmaceutical policies

*MBP 70.0 Mozibil (plerixafor)

- Prior Authorization is required
- Hematopoietic stem cell mobilizer that inhibits the receptors that act as anchors holding the cells to the bone marrow.

MBP 71.0 IV Ketamine

- Considered experimental, investigational or unproven for the treatment (including “ketamine coma”) of complex regional pain syndrome, reflex sympathetic dystrophy and other chronic neuropathic pain disorders

Revised medical policies

*MP 02 PET Scans

- Prior Authorization is required
- Additional indications added

*MP 180 Gene Expression Profiling for Breast Cancer Treatment

- Prior Authorization is required
- Updated language in indication section in regards to hormone receptors

MP 48 Ablation Therapies for the Treatment of Benign Hypertrophy

- Added exclusion in regards to High-Intensity Focused Ultrasound Ablation

MP153 Long Term Acute Care (LTAC)

- Revised Indications for LTAC
- Revised Minimum Requirements section
- Added General Criteria for Discharge from LTAC section

Revised pharmaceutical policies

*MBP 13.0 Viscosupplementation

- Added Synvisc and Synvisc 1 as preferred agents.
- Preferred agents (Euflexxa, Synvisc, and Synvisc 1) do NOT require prior authorization. All other agents (including Orthovisc®, Supartz™, and Hyalgan®) continue to require authorization.

Annual policy reviews

Policies which are reviewed annually,

and which remain unchanged at this time, continue to be available online at thehealthplan.com.

Retired Policies

- MP 47 Stretta procedure for GERD

Clinical Guideline Update

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

- Asthma
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Heart Failure
- Tobacco Cessation

The complete list of clinical guidelines is available online at thehealthplan.com. Please contact your Provider Relations Representative 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:

- Alcohol Abuse and Alcoholism
- Osteoporosis
- Pediatric ADHD
- Colorectal Cancer Screening
- Fall Prevention
- Non-surgical Treatment of Urinary Incontinence
- Treatment of Hepatitis C

Your feedback is encouraged and appreciated. Comments should be sent to Phillip Krebs, Medical Management 32-20, or by e-mail to pkrebs@thehealthplan.com. Please provide your feedback by Nov. 15, 2009.

Formulary updates

Commercial

Drugs Deemed Formulary:

Xenazine (3) *,t
Trilipix (2)
Avodart (2)

Drugs Deemed Non-Formulary:

Vimpat (3) *,t
Toviaz (3) *,t
() = tier

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

** = quantity limits apply

Gold

Gold Formulary Additions:

Xenazine, Vimpat: Added to Tier 3 of the \$0 Deductible Rx formulary and to Tier 2 of the Standard Rx formulary. Prior authorization is required.

Trilipix and Avodart: Added to Tier 2 on both the \$0 Deductible Rx formulary and the Standard Rx formulary

Gold Medications Deemed Non-Formulary:

Toviaz

Specialty Vendor Update

The Health Plan has recently approved the following changes to the Specialty Vendor Pharmacy Program, effective October 1, 2009:

Cimzia, Cerezyme, Raptiva, Ventavis, Remodulin, and Nplate will be available through the program. Prior authorization will be required where applicable and a maximum 34-day supply will be dispensed.

Promacta and Hycamtin (oral) have been added to the list of drugs available exclusively through the program. Prior authorization will

be required where applicable and a maximum 34-day supply will be dispensed.

The Specialty Pharmacy Vendor Drug Request Form is available in the Provider Information Center online at thehealthplan.com and can be faxed to the Pharmacy Department at (570) 271-5610.

Propoxyphene update

The FDA has issued safety warnings involving the risk of overdose, loss of balance resulting in falls, and in some cases death from frequent use or high doses of propoxyphene products. Effective November 1, 2009, all propoxyphene products including Darvocet, Darvocet-N, Darvon, Wygesic, and all other brand name or generic medications containing propoxyphene, will be removed from Geisinger Gold formularies.

We currently cover similar medications in the same cost-sharing tier that include: acetaminophen with codeine, tramadol, tramadol with acetaminophen, and NSAIDs with choline magnesium salicylate, diclofenac, diclofenac extended release, diflunisal, etodolac, etodolac extended release, fenoprofen, flurbiprofen, ibuprofen, indomethacin, indomethacin sustained-release, ketoprofen, ketorolac, meclizemate, meloxicam, nabumetone, naproxen, naproxen sodium, oxaprozin, piroxicam, salsalate, sulindac, tolmetin and EC-naproxen.

As a prescriber, should you feel that a propoxyphene product is the best therapeutic choice for your patient, an exception request should

be submitted to the Health Plan for review. Please visit www.thehealthplan.com/providers_us/medical.cfm for information on how to submit an exception request. Thank you for your cooperation.

Zostavax reminder

Since January 1, 2008, the Centers for Medicare and Medicaid (CMS) have required that Zostavax be paid for as a Part D benefit. This includes both the vaccine itself and the administration of it. The Health Plan cannot reimburse claims as of January 1, 2008. Providers can choose any of the below options for Zostavax:

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

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

Why patients choose Geisinger Gold

Annually, Medicare Advantage Organizations, like Geisinger Gold, evaluate their benefit designs and costs associated with their product portfolio. As the market changes, products and benefits also fluctuate. Many Pennsylvanians join Geisinger Gold due to the premium costs, benefit designs and the availability of their physicians and hospitals. We encourage you to learn about our Gold products in order to assist with any questions your patients may have.

Many Medicare beneficiaries develop chronic health conditions during their senior years. As a physician-led organization, Geisinger Gold understands this progression. We've developed programs that support chronic health conditions and provide the necessary staff, resources and reimbursement to compensate the health care needs of these individuals.

President Obama has recently highlighted Geisinger Health System as a model for health care reform, referring to GHP's Health Navigator (formerly known as Medical Home) and ProvenCare™. In just three years, medical homes sites have demonstrated a quality of life change in many of their Geisinger Gold patients. They've also reduced unnecessary hospital readmissions and centralized patient care around the primary care physician and his or her team.

These medical home sites are truly successful due to the staff and physicians dedicated to improving patient care. We encourage all primary care sites to learn more about the services Geisinger Gold offers.

The list below highlights benefits you and your patients would gain from Geisinger Gold:

Primary Care Offices

- Incentive paying from \$2 to \$4 per member per month for achievement of key HEDIS© and efficiency measures, such as extended office hours and decreased emergency room utilization.

Continuing Medical Education update

Did you know Geisinger Health System offers Continuing Medical Education (CME) courses in our provider community? Courses are available for doctors, nurses, pharmacists, social workers, imaging technologists, physician assistants, nurse practitioners, dietitians, athletic trainers, counselors, psychologists and occupational therapists. The CME office recently received a six-year certificate of accreditation from the Pennsylvania Medical Society to sponsor CME for physicians. The following accrediting bodies have approved Geisinger Health System to offer continuing medical education credits:

- Pennsylvania Medical Society (PMS)

- Fee-for-service reimbursement designed to compensate practices for all services provided
- Patient-centric disease registries which identify children, adults and seniors who are eligible for preventive services as well as annual tests, such as A1c's and LDLs.
- Health care managers who provide telephonic disease education and support to Gold patients in the office, in their home or by telephone.
- Comprehensive network of participating specialty physicians, full service community hospitals and centers of excellence for intense health care conditions.
- Web-based access to member eligibility, cost sharing, benefits and claim status. We also offer 24/7 access to this information via an Interactive Voice Recognition (IVR) system, which is available on all Customer Service toll-free numbers.
- Dedicated Provider Relations staff who can assist practices with any questions or concerns.

Programs available to Gold members

- Health Management and Case Management programs intended to provide extra support to members with certain chronic conditions
 - Fitness center benefits
 - Discounts on health and wellness programs and products
- If your patients would like more information about Geisinger Gold, including how to enroll in a plan, they can contact (800) 631-1656

Please contact your Provider Relations Representative with any questions. Your representative will also be visiting your practice to review our programs and services. Thank you for your continued support of Geisinger Gold and our members.

- Pennsylvania State Nurses Association (PSNA)
 - American Council on Pharmaceutical Education (ACPE)
 - The Commission of Dietetic Registration (CDE)
 - National Board for Certified Counselors (NBCC)
 - American Society of Radiologic Technologists (ASRT)
 - The American Occupation Therapy Association (AOTA)
 - National Athletic Trainers Association Board of Certification (BOC)
 - American Psychological Association (APA)
- To learn more about CME options, go to www.geisinger.org/professionals/education/CME.

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

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

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What you need to know about Health Reimbursement Arrangements

Some employer groups have decided to choose a Health Reimbursement Arrangement (HRA) to help deal with increased premium costs. With an HRA the employer funds an account to pay for their employees' out-of-pocket expenses, such as deductibles. If at the end of the benefit year the funds are not used, the employer can either take back the unused funds or allow the employee to carry them over to the following year.

Not only is the HRA a financial benefit for the employee and the employer, but also for the provider. If funds remain in the HRA account, the provider is guaranteed timely payment directly from ConnectYourCare. If your office receives payment directly from ConnectYourCare, be sure to apply the payments to the correct patient account. Multiple patient payments may be included in each ConnectYourCare payment. When you collect a deductible, ask your patient if they have an HRA, which may pay all or a portion of the deductible. It is still your patient's responsibility to make sure their HRA is managed and their portion of their bill is paid.

If you have any questions or would like to verify if your patient has an HRA, call Geisinger Health Plan's Customer Service Team at 800-504-0443.

