Provider Manual

July 2014

Updated April 1, 2015

The policies and procedures set forth in this provider manual are administered for Christiana Care Quality Partners by Geisinger Health Options, the third party administrator. The phrase "The Health Plan" may be used throughout this document in reference to Geisinger Health Options as the third party administrator.

Participating Provider Manual

The Participating Provider Manual, as may be amended from time to time, is incorporated by reference to the Agreement. The Manual is designed for use by, and applicable to, all Participating Providers, who in accordance with the terms and conditions set forth in their respective Agreements, provide Covered Services to Members.

Please contact your designated Provider Relations Representative if you have questions concerning the information within this Manual.

For purposes of the Participating Provider Manual:

- Geisinger Health Plan or Geisinger Health Options shall be referred to as the "The Health Plan"

Overview of CCHS as a Payor Partner

SECTION 1: GENERAL INFORMATION

Section 1: General Information

Overiew of CCHS as Payor Partner

The following pages within this Section contain information regarding the product lines offered by CCQP. A detailed description, including the terms and conditions of the Member's benefit coverage for a particular product line may be found in the Member's applicable Benefit Document. Individuals must meet the eligibility requirements as set forth in the applicable Benefit Document to be enrolled as a Member. Register for the Health Plan's online Provider Service Center at https://www.thehealthplan.com/cchs/index.cfm toview a Member's detailed eligibility and benefit information.

Mental health and substance abuse services are coordinated through OptumHealth Behavioral Solutions at (888) 839-7972.

Questions about a Member's eligibility, claims, benefit coverage or the Grievance and Complaint procedures can be addressed online by registering for the Health Plan's Provider Service Center at https://www.thehealthplan.com/cchs/index.cfm.

Questions may also be directed to: Customer Service
(844) 568-5229
TTY/TDD 711 for the hearing impaired
Monday through Friday, 8 p.m.-4:30 p.m.

Copayment, Coinsurance and Deductibles

A Member's financial liability for certain Covered Services may be determined by reviewing the front of a Member's ID card. You may also register for the Health Plan's online Provider Service Center at www.thehealthplan.com/providers_us/servicecenter.cfm to view a Member's detailed eligibility and benefit information. When a Member's benefit structure denotes financial liability in the form of a Copayment, such liability typically applies to evaluation and management services performed in the following setting: office, consultation, preventive medicine and emergency department. Additionally, certain Members may have a per day or per visit Copayment responsibility for certain services such as; outpatient rehabilitative services, outpatient radiology tests, home health services, ambulance services and outpatient surgery.

Participating Providers should access the Provider Service Center at https://www.thehealthplan.com/cchs/index.cfm and review a Member's benefit document or the Health Plan's online Explanation of Payment (EOP) to appropriately determine a Member's financial liability.

Membership Identification

Sample Identification Cards are available for your reference online at
http://www.christianacare.org/documents/qualitypartners/CCQP-Sample-ID-Card.pdf

Each Member is issued an Identification Card as well as a unique identification number at the time of enrollment. The identification number appears in the left mid-section of the front of the Identification Card and should be readily available when contacting the applicable Customer Service Team with questions specific to Members' benefits. The reverse side of the Identification Card should be reviewed for additional information. All Identification Cards include the following information:

- Product type or plan design (e.g. HMO or no-referral) is indicated in the upper right corner of the Identification Card.
- **Green marbled:** Geisinger Health Options Third Party Administrator (TPA) product Members. The self-funding Employer's logo or company name appears in the upper left corner. For example, the CCQP or applicable provider network's logo will appear in this location.

Employers, Groups or Members may enroll or disenroll from the Health Plan throughout the calendar year. Participating Providers can access the Provider Service Center at www.thehealthplan.com to confirm a Member's eligibility online. Members are instructed to present their Identification Card whenever they seek medical care. A newly enrolled Member should present a copy of their enrollment form as verification of enrollment until their Identification Card is received.

Customer Service Teams available for enrollment confirmation:
Geisinger Health Plan's IVR (Interactive Voice Response) system is available for provider use, 24 hours a day, 7 days a week. Our Customer Service Representatives are available to assist you during normal business hours listed below.

Customer Service
(Claims, Member Benefits & Eligibility)
Christiana Care Health System/TPA
(844) 568-5229
TTY/TDD 711 for the hearing impaired
Monday – Friday, 8 a.m. - 4:30 p.m.

TPA Responsibilities

CCQP partners with Geisinger Health Plan as the TPA for self-funded employer Christiana Care HealthSystem. Through and in collaboration with Geisinger Health Plan, CCQP shall be respoinsisble for the following:

Health Plan will:

- Adjudicate and pay Clean Claims within 30 days of receiving a Clean Claim.
- Orient Participating Providers to the CCQP/Geisinger policies and procedures.
- Provide ongoing communication about any changes to the CCQP/Geisinger policies and procedures and other operational issues that will affect the provision of services to Members.
- Provide administrative services to Members including, but not limited to, processing Member's Complaints, Grievances and appeals; communicating CCQP/Geisnger Health Plan policies; distributing Identification Cards, Member handbooks, and making available a listing of Participating Providers.
- Provide assistance to membership through the Customer Service Teams or Tel-A-Nurse Service.
- Assure availability and accessibility of adequate Participating Health Care Providers in a timely manner, enabling applicable Members to have access to quality care and continuity of health services.
- Consult with Participating Health Care Providers in active clinical practice regarding professional qualifications and if additional Health Care Providers need to be included in the Network.
- Ensure that Member have the right to access Emergency Services twenty-four (24) hours a day, seven (7) days a week and provide reasonable payment or reimbursement for Emergency Services.
- Ensure Health Care Services, when Medically Necessary, are available twenty-four (24) hours a day, seven (7) days a week.
- Ensure that there are Participating Health Care Providers who are physically accessible to people with disabilities and can communicate with Members with sensory disabilities in accordance with Title III of the Americans with Disabilities Act of 1990.
- Not penalize or restrict a Participating Health Care Provider from discussing:
    a) The process that the Health Plan or any individual, partnership or entity contracting with the Health Plan uses or proposes to use to deny payment for a Covered Service; and
    b) Medically Necessary and appropriate care with or on behalf of a Member, including information regarding the nature of treatment; risks of treatment; alternative treatments; or the availability of alternate therapies, consultation or tests; and
    c) The decision of the Health Plan to deny payment for a Covered Service.
- Not use any financial incentives that compensate a Participating Provider for providing less than Medically Necessary and appropriate care to a Member.
- Ensure that a Member's Protected Health Information (PHI) is adequately protected and remains confidential in compliance with all applicable federal and state laws and regulations and professional ethical standards.
- Not exclude, discriminate against or penalize any Participating Provider for their refusal to allow, perform, participate in or refer for Health Care Services, when the refusal of the Participating Provider or the Health Plan is based on moral or religious grounds.
- Not be responsible for Covered Services provided to a Member following the date of termination of the Agreement with a Participating Provider when the Participating Provider has been terminated for cause, including breach of contract, fraud, criminal activity or

posing a danger to a Member, or the health, safety or welfare of the public as determined by the Health Plan.

- Maintain policies and procedures that allow for individual Medical Necessity determinations.
- Allow the Participating Provider to consider a Member's input into the Participating Provider's proposed treatment plan, irrespective of coverage; potential and known side effects of treatment and planned/proposed management of symptoms. Examples may include: a) education of Members regarding their health care needs and b) sharing findings of history and physical examinations.
- Ensure that Health Care Services are provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.
- Ensure that Participating Providers who maintain a current drug enforcement agency (DEA) certificate shall receive a Formulary, which includes procedures that describe the process to be used to obtain coverage of a drug that is an exception to the Formulary.
- In the event Health Plan suspends or terminates the Agreement between the Health Plan and a Participating Provider physician, Health Plan will provide suspended or terminated Participating Provider physician written notice of the following: (i) the reasons for the action, including, if relevant, the standards and profiling data used by Health Plan to evaluate the Participating Provider physician and the numbers and mix of such physicians needed by Health Plan, and (ii) the affected physician's right to appeal the action, process, and timeline for requesting a hearing. Participating Providers that are excluded from participating in the Medicare program shall not be afforded the opportunity to appeal a suspension or termination action by Health Plan.

Protected Health Information

The Health Plan will ensure that Members and Participating Providers receive communication that informs them of the Health Plan policies and procedures regarding the collection, use and disclosure of Members' Protected Health Information. Communication will include the five (5) following criteria:

- Health Plan's routine uses and disclosure of PHI. The Health Plan uses and discloses PHI in connection with Members' treatment, to make payment for Health Care Services and for Health Plan's health care operations.
- Uses of Authorizations. Special authorizations are required by Delaware law to permit disclosures of certain highly sensitive personal information. In certain situations, consistent with applicable regulations or laws, the Health Plan will request Members' written authorization before using or disclosing identifiable health information. Except for the treatment, payment and health care operations, the Health Plan will not use or disclose Members' PHI unless the Member has signed a form that allows the Health Plan to do so.
- Access to PHI. Members have the right to look at or get a copy of their PHI in a designated record set (i.e. medical/billing record) in accordance with all applicable laws pertaining to access of PHI.

- Internal Protection of Oral, Written and Electronic PHI across the Organization. The Health Plan has procedures in place to prevent unauthorized access to Members' PHI, which includes employees' signed statements in which they have agreed to protect Members' confidentiality, using computer passwords to limit access to Members' PHI.
- Protection of Information Disclosed to Plan Sponsors or Employers. The Health Plan may release Members' PHI to a plan sponsor or Employer, provided the plan sponsor or Employer has certified that the information provided will be maintained in a confidential manner and not used for employment related decisions or for other employee benefit determinations or in any other manner not permitted by law.

Participating Providers can access the Health Plan's entire Privacy Notice online at www.thehealthplan.com/cchsor a paper copy may be obtained by contacting your Provider Relations Representative.

Disease Management Programs

CCQP, in collaboration with Geisinger, offers care coordination and disease management programs to assist Members with chronic conditions.
Case management nurses provide the following services and programs:

Coordinate Care After Discharge
Case Managers contact Members with certain health conditions, including heart failure and pneumonia, after a hospital, rehabilitation or Skilled Nursing Facility admission. The purpose of the contact is to be sure that Members are taking medications as prescribed, have a return appointment with their Primary Care and/or Specialty Care provider and to review other important issues.

Complement the Care Provided by the Primary (PCP) and/or Specialty Care Provider (SCP)
The Community Case Manager works with the Member and the PCP/SCP to assist Members in the community with chronic health/social problems. The Community Case Manager also provides monitoring and education to help Members better manage the following health conditions:

Adult and Pediatric Asthma
Education is a key factor in the Asthma Care Program. Community Case Managers work with Members and their families to help them understand and manage asthma triggers and symptoms.

Chronic Kidney Disease (CKD)
The purpose of the CKD program is to improve the coordination of appropriate services with a PCP or nephrologist (kidney specialist) for Members with kidney disease. Members learn about the importance of proper nutrition, medications, blood pressure control, and receive other important health care information from a Community Case Manager.

Heart Failure
An ongoing combination of education and follow up by a Community Case Manager teaches Members the importance of medications, diet, and life-style habits to improve the management of heart failure.

Chronic Obstructive Pulmonary Disease (COPD)
The Chronic Obstructive Pulmonary Disease (COPD) Program helps Members with COPD to better manage the condition. Information about tobacco cessation, pulmonary function testing, medication management and life-style modification is provided by a Community Case Manager.

Diabetes
Members in the Diabetes Care Program work with a Community Case Manager who provides education on topics including diet, medications, routine foot care and ways to improve blood sugar control. The Community Case Manager also coordinates services for Members such as eye exams and kidney screenings. This combination of education and coordination of care assists Members in taking control of diabetes.

HeartWise
Managing risk factors and promoting proper medication management is the focus of the HeartWise program for Members with heart disease. Cholesterol and blood pressure management are key aspects of the program. Community Case Managers also provide education about diet and exercise strategies, and work with providers to coordinate recommended therapies.

Hypertension
A Community Case Manager assists Members in learning what they can do to control blood pressure and reduce the risk of developing other health problems that can result from poorly controlled blood pressure.

Osteoporosis Prevention and Management
This program provides education to women and men at risk for osteoporosis, as well as those who have already been diagnosed. A Community Case Manager outlines steps to prevent osteoporosis and to reduce the risk of complications during education sessions provided in the office or by telephone.

Tobacco Cessation
In the Tobacco Cessation Program, professional support is provided by Community Case Managers through phone, individual or group counseling over the course of five sessions. The program goal is to help break the addiction to tobacco products such as cigarettes, pipes and smokeless tobacco, and help Members quit.

To refer a Member to a Disease Management Program, or to learn more about a specific Disease Management Program, Participating Providers should visit the Health Plan's Provider Information Center at www.thehealthplan.com or contact:

Case Management Department

Monday through Friday, 8 a.m. to 4:30 p.m.
(800) 883-6355 or (570) 271-8763

Disease Management Program Development
The Case Management administrative staff conducts an analysis of the disease under consideration prior to the development of a disease management program. The following criteria are evaluated:

1. Disease prevalence.
2. Disease complexity.
3. Potential for reducing complications, improving quality.
4. Current cost of managing the disease.
5. Existence of an evidence-based clinical guideline to assist practitioners in the management of the disease.
6. Value to the Member and the Health Plan if the program is implemented.

The Case Management team determines the need for a specific disease management program based upon the criteria listed above and submits a proposal to the Health Plan's Medical Management/Administrative Committee for review and approval. Actively practicing practitioners are participating members of disease management teams and assist in the development, implementation, and monitoring of new and established health management programs.

Practitioner Program Content
The design of all disease management programs includes: evidence-based clinical guidelines, Member identification, passive or active enrollment, stratification, interventions based on stratification level, practitioner decision support and evaluation of program effectiveness.

Evidence-based clinical guidelines are a core component of all disease management programs. Board certified specialty and/or primary care practitioners are involved in the review and approval of evidenced-based guidelines.

Clinical guidelines are reviewed every two years or when the appropriate guideline team, the Health Plan's Guideline Committee and the Quality Improvement Committee make recommendations. Primary care practitioners are involved in the development and review of new disease management programs through their participation as health management committee members. The Health Plan's Case Management Department and the accompanying teams are responsible for program content that is consistent with current clinical practice guidelines.

Evidence-based guidelines are posted online at www.thehealthplan.com, and announcements are made in the publication Briefly to inform practitioners of their availability. Printed copies or electronic PDF files are available upon request for practitioners who do not have Internet access by contacting the Health Plan's Case Management Department at (800) 883-6355.

Identification of Members who will benefit from Case Management disease management programs is accomplished through claims analysis using standard clinical specifications from criteria such as the Health Plan Employer Data & Information Set (HEDIS). Member

identification is also facilitated by direct Referrals from Health Care Providers, the Member and/or family, and from various Health Plan departments including Medical Management, Customer Service, Appeals, and Quality Improvement.

Passive/active enrollment
All Members with a disease-specific diagnosis are identified by claims analysis and/or HEDIS criteria and mailed a disease-specific informational newsletter. Selected Members are informed of their enrollment in the program and have the opportunity to "opt out" by contacting the Health Plan's Care Coordination department. Members that do not opt out are considered passive enrollees.

All passive enrollees receive disease-specific informational newsletters each year to increase their knowledge of disease self-management. Each newsletter also encourages the Members to become "active" enrollees in the disease management program.

A Member becomes actively enrolled in the appropriate disease management program when the Member contacts the Health Plan's Case Management department directly, is referred by a Health Care Provider or a Health Plan department, or accepts an invitation extended by the Health Plan's Care Coordination Department (through disease-specific Member newsletters or direct Member invitation by letter or phone as the result of claims analysis information). A Community Case Manager reviews the Referral information and contacts the Member to either schedule an office appointment with the nurse or to arrange to routinely communicate with the Member telephonically. After the Member's verbal and/or written consent for participation is obtained, the Member is actively enrolled in the appropriate program.

Risk stratification
The Community Case Manager stratifies active Members based on clinical criteria according to low, moderate or high risk. For example, Members enrolled in the Congestive Heart Failure program are stratified according to the American College of Cardiology (ACE). Members with diabetes are stratified using glycosolated hemoglobin (A1c) control and the presence of risk factors.

Interventions
The degree of intervention is based on the Member's risk stratification. For example, a Member classified as low risk will receive a minimum of one (1) program informational newsletter each year, self-management education, a plan of care, and one or more follow-up office or phone appointments. A Member with a high-risk stratification will receive these interventions in addition to more frequent office/phone visits and Referrals for necessary specialty or case management services.

Practitioner decision support
The Case Management decision support model includes evidence-based clinical guidelines (previously described), Case Management nursing staff, the plan of care, and the Practitioner Quality Feedback Report. The program is designed for actively practicing primary care practitioners.

The Case Management nursing staff is key to providing collaborative "real time" decision support to primary care practitioners. The nurses follow internally developed education pathways that complement the clinical guideline. The education pathways provide a framework for self-management education and the recommended laboratory/diagnostic studies.

The plan of care includes information regarding the Member's self-management of their condition, special considerations or exceptions, review of medical test results, management of co-morbidities, collaborative goal-setting and problem-solving, medication review, and preventive health monitoring. The plan of care is reviewed and discussed by the practitioner and Community Case Manager in person, by phone, or through an electronic medical record messaging process.

Additional decision support information is mailed to Participating Providers annually from the Case Management administrative staff in the form of a letter accompanied by the Practitioner Quality Feedback Report.

The involvement of the practitioner is integral in the design of program content for all Care Coordination disease management programs. Practitioner participation ensures program content is appropriate for the actively practicing primary care practitioner. All primary care practitioners are surveyed annually in order to elicit feedback regarding the program(s).

Evaluation of program effectiveness
Program effectiveness is measured by conducting a pre-and post-analysis of pertinent clinical measures, annual Member/practitioner program satisfaction surveys and pre- and post comparisons of services utilized by Members in the programs.

Practitioner's rights
Practitioners who care for Members have the right to:

1. Obtain information regarding Case Management disease management programs and services in conjunction with the Health Plan as outlined herein; and
2. Obtain information regarding the qualifications of the Case Management staff; and
3. Obtain information regarding how the Case Management staff facilitates interventions via treatment plans for individual Members; and
4. Know how to contact the Community Case Manager responsible for managing and communicating with their patients; and
5. Request the support of the Case Management nursing staff to make decisions interactively with Members regarding their health care; and
6. Receive courteous and respectful treatment from Case Management staff at all times; and
7. File a complaint when dissatisfied with any component of the Case Management programs by contacting the Case Management Department at (800) 883-6355.

Preventive Health Program

The Health Plan strives to keep Members healthy through a preventive health program. Members are informed and encouraged to take advantage of preventive health measures such as immunizations, breast and cervical cancer screenings and diabetic eye exams. The Health Plan

continually expands this program in order to ensure that more Members will receive recommended preventive health measures. Current initiatives include:

- Childhood immunizations
- Adolescent immunizations
- Cervical cancer screening
- Breast cancer screening

Program Goal: The goal of the program is to educate and encourage Members to have the recommended preventive services and to encourage communication between Participating Providers.

How the Program Works: Nurses employed by the Health Plan will be communicating with Members or their PCPs concerning those Members needing preventive services. If the Member has not received the recommended service, the Member is educated on its importance and is encouraged to call their Primary Care Site. In some cases the Health Plan will schedule the services for the Member. If the Member has received the preventive service, information pertaining to the date and location of the provided service is obtained for reference.

For more information on preventive health services, visit the Health Plan's Provider Information Center at www.thehealthplan.com or contact the Health Plan's Quality Improvement (QI) department at (570) 271-5108.

Departments Available for Assistance

Case Management Department

The Case Management Department is available to assist Participating Providers and Members with its various disease management programs. Clinical guidelines for each of these programs are available on the Health Plan's Web site, www.thehealthplan.com.

To refer a Member into a Disease management Program, or to learn more about a specific Disease management Program, Participating Providers should contact the Case Management Department.

Case Management Department
Monday through Friday, 8 a.m. to 4:30 p.m.
(800) 883-6355 or (570) 271-8763

Customer Service Teams

Customer Service Teams (CSTs) are comprised of customer service representatives who process Member enrollment, claims, and respond to Member and Health Care Provider inquiries. The Health Plan makes every effort to assure that Members will be well informed and able to participate in decision making for their health care needs and benefits. Most Member questions stem from: i) the need for a clear definition of benefits, ii) an understanding of the role of managed care, and iii) the access process to obtain necessary medical care. Responsibilities of the teams include:

- Responding to Members' questions about their Health Plan coverage and protocol for accessing medical care.
- Resolving Members concerns and coordinating the Complaint, Grievance and appeals processes, as they are mandated through Governmental Agencies.
- Promoting Member education.
- Processing all Health Care Provider claims and Member enrollment/disenrollment activity.
- Conducting follow-up calls to assure Member satisfaction.
- Reviewing trends to determine areas that may require Member education.

Most inquiries can also be addressed by visiting the Health Plan's Website, www.thehealthplan.com/cchs, where a multitude of online tools and resources are available at the click of a button.

Customer Service Teams:
Geisinger Health Plan's IVR system is available for provider use, 24 hours a day, 7 days a week. Our Customer Service Representatives are available to assist you during normal business hours listed below.

Customer Service
(Claims, Member Benefits & Eligibility)
Christiana Care Health System/TPA
(844) 568-5229
TTY/TDD 711 for the hearing impaired
Monday – Friday, 8 a.m. - 4:30 p.m.

Medical Management
(Pre-Certification & Prior Authorization)
(844) 369-2618 or (570) 214-2469
Fax: 844-620-3286
Monday – Friday 8 a.m. – 5 p.m.

Pharmacy Department
(800) 988-4861 or (570) 271-5673
Fax: (570) 271-5610
Monday – Friday, 8:30 a.m. - 5 p.m.

Durable Medical Equipment (DME) Management Department

The DME Management Department, a division of the Health Plan's Medical Management department, is responsible for precertification of outpatient DME services. DME Participating Providers are required to initiate precertification of outpatient DME services through the DME Management Department prior to rendering such services. Prosthetic and Orthotic Devices are not considered DME. Participating Providers should contact the DME Management Department with questions related to outpatient DME.

DME Management Department
Monday through Friday, 8 a.m. to 4:30 p.m.
(866) 248-1972 or (570) 271-7127; fax: (570) 271-7171

Home Health/Hospice Management Department

The Home Health/Hospice Management Department, a division of the Health Plan's Medical Management department, is responsible for precertification and coordination of Home Health Services, which include hospice, home skilled nursing, home infusion, home rehabilitative therapy and home phlebotomy services. The Home Health/Hospice or home phlebotomy Participating Provider should contact the Home Health/Hospice Management Department when such services are required. The Home Health/Hospice Management Department will verify Member's eligibility, benefit limits and coordination of benefit (COB) upon receipt of a Home Health Referral Form. Participating Providers should contact the Home Health/Hospice Management Department with questions related to Home Health/Hospice Services.

Home Health/Hospice Management Department
Monday through Friday, 8:30 a.m. to 4:30 p.m.
(877) 466-3001 or (570) 271-5506; fax: (570) 271-5507

Medical Directors and Quality Improvement (Q.I.) Nurses

The Health Plan uses Medical Directors, in addition to the Vice President Chief Medical Director, to serve the needs of the Network and the Members. Medical Directors are also practicing Participating Providers. The Health Plan believes Medical Directors should remain close to clinical practice in order to understand the effect managed care has on a physician practice. The Health Plan maintains an on-duty and on-call schedule assuring Medical Director availability twenty-four (24) hours a day, seven (7) days a week.

The Medical leadership of The Health Plan works closely with CCQP administration and the Clinical Operations Committee of CCQP Board of Managers in order to determine any unique Medical Management approaches associated with CCQP. Broadly, the medical management components are as follows:

- Inpatient Care – all such services do require prior authorization through the Health Plan;
- Outpatient Procedures – certain services within this category require prior authorization through the Health Plan. A list of these services can be found by clicking on this link.
- Medical Pharmaceuticals – Aside from the prescription drug plan, medications that fall under the medical plan (often infused or injected medications) are not subject to prior authorization. Instead, the Clinical Operations Committee of CCQP will evaluate utilization and cost trending throughout the year. This retrospective review will be performed to assure members and the self-funded employer client that access and use are most effective, efficient and optimal.
- Medical and Cardiac Imaging - While high-end imaging for Quality Partner patients will not require pre-authorization, Quality Partners will promote a physician-implemented initiative to ensure appropriate use of imaging. As part of this initiative, physician's may occasionally receive a phone call from one of the Quality Partners

Radiology providers to discuss exam appropriateness or to consider an alternate, possibly more appropriate exam. The ordering physician will have the final decision on what imaging exam is utilized. We expect that over time, collaborative physician-implemented best practices and utilization norms will evolve around high-end imaging within Quality Partners.

- Rehabilitation Services – Physical therapy and occupational therapy provided to CCQP members are subject to prior authorization for visits in excess of visit number twelve. The rehab provider, and not the ordering clinician, is responsible for this ongoing clinical justification for services.

Outpatient Radiology

While high-end imaging for CCQP members will not require pre-authorization, CCQP will be promoting a physician implemented initiative to ensure the appropriate utilization of imaging. As part of this initiative, ordering physicians may occasionally receive a telephone call from one of the CCQP Radiology providers to discuss exam appropriateness or to consider an alternate, possibly more appropriate exam. The ordering physician will have the final decision on what imaging exam is utilized. It is anticipated that over time, collaborative physician implemented best practices and utilization norms will evolve around high end imaging within CCQP.

This imaging utilization appropriateness review will be guided by industry-accepted criteria established through the American College of Radiology (ACR) or other sources as deemed applicable. This review will initially be in place for imaging studies performed through Christiana Care only.

This process shall apply to the following non-emergent medical and cardiac imaging services:

- MRI/MRA
- CT/CTA
- Nuclear Stress Tests
- Stress Echo

Benefits of this radiologic review

- Improved patient care and satisfaction.
- Cost savings through a direct reduction in the inappropriate use of diagnostic radiology services.
- Physician-friendly process as all reviews happening "behind the scenes" and any discussion regarding the intended test or study is handled local physician to local physician.
- real-time monitoring of radiation dose exposure and management (applies to studies performed within Christiana Care facilities).

Outpatient Rehabilitative Therapy Management Department

The Outpatient Rehabilitative Therapy Management Department, a division of the Health Plan's Medical Management department, is responsible for the precertification of outpatient physical, speech and occupational therapy services.This precert process will be initiated, as described below, after the member has already received 12 therapy sessionsThe Participating Provider of outpatient rehabilitative services is responsible for initiating precertification through the Outpatient Rehabilitative Therapy Management Department. Participating Providers can contact the Outpatient Rehabilitative Therapy Management Department with questions related to outpatient rehabilitative therapy services.

Outpatient Rehabilitative Therapy Management Department
Monday through Friday, 8:30 a.m. to 4:30 p.m.
(800) 270-9981 or (570) 271-5301; fax: (570) 271-5302

Provider Relations

Provider Relations acts as the primary liaison between the Network, CCQP and Geisinger Health Plan. Each Participating Provider has a specific Provider Relations Representative assigned to their practice or facility. Provider Relations' primary focus is to enhance Participating Provider satisfaction and retention and to ensure a long-term partnership between CCQP and each Participating Provider.

Your Provider Relations Representative will offer to schedule an initial orientation with your practice to review the Health Plan's policies and procedures, product lines, benefit information, and other standard operating procedures. Some such session may be offered individually, while others may be conducted in large group session enviroments. Periodic telephonic or on-site visits will also be scheduled to review changes in products or services, as well as financial or utilization reports.

Your Provider Relations Representative should be contacted immediately to discuss any changes related to your practice, including tax identification number, remittance address, business name or the addition or termination of a physician/clinician.

Christiana Care Quality Partners
Provider Relations Team
Monday through Friday, 8:30 a.m.-5 p.m.
302-623-7959
qualitypartners@christianacare.org

Pharmacy Department

The Health Plan's Pharmacy Department is available to assist Participating Providers and Members with pharmacy-related questions. A list of drugs, known as a Formulary, is developed to optimize patient care through the rational selection and use of drugs, and to ensure quality prescribing practices. The Formulary is a culmination of efforts by the Geisinger Health Plan Pharmacy & Therapeutics (P&T) Committee.

Medications in each therapeutic class are reviewed with respect to safety, efficacy, currently available agents and cost-effectiveness for Members. The most appropriate agents are then selected for inclusion in the Formulary. Maintenance of the Formulary is ongoing as the P&T Committee continually reviews new medications and information concerning existing medications.

Specific information available through the Pharmacy Department includes, but is not limited to:

- Information related to new drugs, or existing Formulary products
- Formulary status
- Drug manufacturer pharmaceutical recall
- Information on pharmacy benefits for specific Members
- Answers to questions regarding prescription coverage, or quantity limitation
- Additional benefits; such as, mail order and applicable pharmacy Rider
- The precertification process for certain Formulary or restricted drug
    - Drugs requiring precertification and their associated criteria can be found in the precertification section of the Formulary booklet or in the Provider Information Center section of the Health Plan's Web site at www.thehealthplan.com/providers_us/index.cfm. Participating Providers may also refer to information included under "Formulary Precertification and Formulary Exception Process" included in the Precertification Requirements section of this Manual.
- Status or submission of requests for additions to the existing Formulary can be faxed or mailed to:

Fax: (570) 271-5673
Mail: Geisinger Health Plan Pharmacy Department
100 North Academy Avenue
Mail Code 30-45
Danville, PA 17822

Written and verbal inquires pertaining to whether a specific medication, either included or excluded from the then-current Formulary, will be responded to within applicable regulatory timeframes by the Health Plan Pharmacy Department. Please refer to the Precertification Requirements section of this Manual for the complete process.

Pharmacy Department Representatives
Monday through Friday, 8:30 a.m. to 7 p.m.
(800) 988-4861 or (570) 271-5673; fax: (570) 271-5610

Tel-A-Nurse

Tel-A-Nurse is a valuable health information service featuring a twenty-four (24) hour, seven (7) days a week nursing hotline for Members. Tel-A-Nurse is provided free to Members and is staffed by licensed registered nurses who are available to answer health related questions. An additional service available through Tel-A-Nurse is an audio library, which provides more than 200 recorded health topics that a Member may listen to or request a brochure on at any time.

Tel-A-Nurse: (877) 543-5061

Medical Management Department

The Medical Management Department encourages and facilitates the use of the most appropriate level of care providing Medically Necessary services to Members. The Medical Management Department utilizes nationally recognized guidelines as well as internal medical benefit policies and other resources to guide precertification, prior authorization, Concurrent Review, and retrospective review processes in accordance with the Member's applicable Benefit Document and eligibility. The Medical Management Department is available to assist Participating Providers with:

- Precertification of planned inpatient, rehabilitative and skilled level of care admissions
- Concurrent Review of all admission information
- Notification processes related to Intermediate level of Care admissions and discharges
- Precertification of non-emergent ambulance transportation services
- Requests related to services requiring Health Plan precertification
- Requests related to medical policy criteria, Medical Management processes, or provider appeals
- Requests to speak with a Health Plan Medical Director

The decision-making process for authorization of Health Care Services is based on Medical Necessity using clinical, psychosocial and access/availability information for each case. A Medical Director renders any denial of coverage on the basis of Medical Necessity.

Medical Management Statement

Participating Providers are reminded that utilization criteria is available upon request. Participating Providers may request a copy of the applicable criteria as part of the utilization decision phone conversation, by fax or U.S. mail or through discussion with the respective Health Plan Medical Director. Complete criteria can be reviewed at the Health Plan's home office located in Danville, Pa. Written requests should be submitted to the Medical Management Department, 100 N. Academy Ave., Danville, Pa 17822-3220.

Medical Management
(Pre-Certification & Prior Authorization)
(844) 369-2618 or (570) 214-2469
Fax: 844-620-3286
Monday – Friday 8 a.m. – 5 p.m.

Health Plan Web Site Information

The Health Plan is continually working to improve the capability of its World Wide Web site, www.thehealthplan.com, which affords Participating Providers a plethora of online information, resources and tools.

Registration process

Because certain provider information is secured, Participating Providers must enter specific identification information as part of the registration process, in order to access all sections of the Web site. The following Participating Providers information is required:

- Health Plan provider number.

- Date of birth.
- Social security number.
- Medical license number and State of licensure.

After successfully entering this information, Participating Physicians will be able to establish a user ID and password immediately to complete the registration and login process.

Some online tools and resources may require additional registration criteria. Please contact your Provider Relations Representative with any questions regarding the Health Plan's Web site and online services.

Provider Information Center

A provider's access includes, but is not limited to:

- An up-to-date version of the Health Plan's Provider Formulary, searchable by both therapeutic category(s) and individual drug.
- A search of the CCQP/Geisinger provider Network, which is updated nightly.
- CCQP Provider ManualOperations Bulletins.
- Provider newsletters.
- Disease management program descriptions.
- Case management program description.
- Clinical guidelines.
- Online CME courses.
- Precertification list.
- Laboratory Utilization Report.
- Physician Utilization Activity Report.
- Pharmacy Utilization Report.
- Member Health Alerts.
    - A Web tool that is designed to assist Primary Care Practices in identifying Members who are eligible for certain preventive services or quality metrics associated with the pay-for-value program (i.e. mammograms and colorectal exams). Each PCP or their office personnel will be able to access a listing of Members who, based on claim data, are due for the services listed. These services should be performed by a Participating Provider and may be eligible for Member cost sharing. As you begin scheduling services for these Members, your Member Health Alerts listing will automatically be updated based on claim and medical record data received by the Health Plan. As you may be aware CCQP contains a payment mechanism for preventive services and other quality improvement measures. By utilizing the Member Health Alert list, you can positively influence your quality data.
- Pay-for-Value Program.

Pay-for-Value (P4V) for PCPs is designed to measure and monitor specific criteria selected by Quality Partners for each PCP with sufficient data. Adherence to these principles generally results in the delivery of high quality, medically appropriate health care services, as well as Member satisfaction. Incentive payments are available to high scoring providers. This is a pay-for –value initiatice: providers are rewarded for scoring well on the quality categories within the program.

Provider Service Center
The Provider Service Center is available at www.thehealthplan.com.
Registered Participating Providers can access:

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

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

Electronic Explanation of Payment (EOP) (835 Transaction)
Electronic EOP is a quick and easy way to verify the accuracy of claim payment. To request electronic Explanation of Payment (EOP), please complete and submit the Electronic Explanation of Claim Payment Provider Enrollment Form, attached in Section 10 of this Manual and available online at www.thehealthplan.com/providers_us/eeop.cfm, to:

Geisinger Health Plan
PNM Operations/EDI Enrollment 32-20
100 North Academy Avenue
Danville PA 17821-3020

Once your enrollment form has been received, we will contact you to begin set up.

Electronic Claim Submission
Electronic claim submission allows Health Care Providers to bill with decreased delay and costs. It streamlines the billing process and proves to be more accurate. Electronic billing also reduces your paperwork burden and affords office staff the time to handle other important tasks.

Please refer to the section of this Manual entitled "Reimbursement and Claims Submission" for more information or visit www.thehealthplan.com/bottomnav/edi.cfm to complete the Health Plan's EDI Submission Form online.

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

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

Please note: Paper explanation of payment (EOP) will continue to be generated and distributed by mail; however, no checks will accompany the EOP.

EFT payments can start in as little as two weeks. You will be notified prior to this occurring. EFT payments for all line of businesses except Third Party Administrator (TPA) are processed on Mondays (except bank holidays). TPA transfers will be made when funded. This is the same as without EFT.

Section 2: Referrals

Verification of Eligibility and Benefit Limit

Prior to coordinating Health Care Services, a Member's eligibility and benefits should always be verified. Providers can use the online Member eligibility verification tool on the Health Plan's Provider Service Center at www.thehealthplan/providers_us/servicecenter.cfm or contact the Health Plan Customer Service Team corresponding to the Member's product type to verify eligibility and benefits:

Geisinger Health Plan's IVR system is available for provider use, 24 hours a day, 7 days a week. Our Customer Service Representatives are available to assist you during normal business hours listed below.

Customer Service
(Claims, Member Benefits & Eligibility)
Christiana Care Health System/TPA
(844) 568-5229
TTY/TDD 711 for the hearing impaired
Monday – Friday, 8 a.m. - 4:30 p.m.

Medical Management
(Pre-Certification & Prior Authorization)
(844) 369-2618 or (570) 214-2469
Fax: 844-620-3286
Monday – Friday 8 a.m. – 5 p.m.

Pharmacy Department
(800) 988-4861 or **(570) 271-5673**
Fax: (570) 271-5610
Monday – Friday, 8:30 a.m. - 5 p.m.

CCQP Program through CCHS:
This program entitles the Member to self-refer or directly access Health Care Services in or out-of-Network without PCP Referral.

Section 3: Precertification Requirements

Precertification Requirements

Precertification is the Health Plan's response to information presented relating to a request for specified Health Care Services.

Precertification does not guarantee a Member's coverage or Health Plan payment.

A Member's coverage is pursuant to the terms and conditions of coverage set forth in a Member's applicable Benefit Document Please contact the Customer Service Department (CST) for verification of precertification requirements (contact information available on following page).

A Member is not financially responsible for a Participating Provider's failure to (i) obtain precertification, or (ii) provide required and accurate information to the Health Plan. Copayments, Coinsurance and/or Deductibles are the financial responsibility of the Member, when applicable.

Precertification Determination and Communication Process

Precertification may be performed by Health Plan Medical Management staff, or through delegated vendor relationships. Delegated vendors may review services such as, but not be limited to, mental health and radiology.

Precertification staff, which includes appropriate practitioner reviewers, utilize nationally recognized medical guidelines as well as internally developed medical benefit policies, individual assessment of the Member, and other resources to guide precertification, Concurrent Review, and retrospective review processes in accordance with the Member's eligibility and benefits.

Upon submission of required information, the Precertification staff will provide verbal and written notification of determination of coverage in accordance with regulatory timeframes.

As it relates to urgent Concurrent Review approvals, the Health Plan has an understanding with Participating Providers that, once approval has been given it remains in effect until the Health Plan notifies the provider otherwise. This means that as Concurrent Review of care is ongoing and the case continues to meet criteria for approval, the Health Plan does not provide repeated notices of approval. Participating Providers will be notified every time a Concurrent Review results in a denial.

Participating Providers are verbally notified of any medical review denial(s) and are offered the opportunity to discuss adverse decision(s) directly with an appropriate practitioner reviewer who made the initial determination; or reviewer available at a time convenient for the Participating

Provider. The Participating Provider's request to discuss the determination is required to occur within one (1) Business Day of the Health Plan's verbal denial notification in order to meet stringent regulatory timelines for the generation of denial notices.

The Participating Provider has the opportunity to supply additional supportive information for discussion. In most cases, a decision will be rendered during the telephone discussion. The Participating Provider will then be notified of the determination in writing within timeframes specified by product type, and if denied, information regarding the right to appeal the determination shall be included.

Participating Providers are encouraged to notify the Member of a Health Plan's decision within the same Business Day of the decision notification from the Health Plan to the Participating Provider. It's important that any discussion regarding a Health Plan's decision be documented in the Member's medical record and should include key components, such as contact person/Member's name, date of notification, Health Plan's decision, alternative plan of care, if applicable and Member's appeal opportunities.

Contact the Medical Management Department at the number listed above for a listing of delegated vendors and contact numbers.

Verification of Eligibility and Benefit Limit

Prior to coordinating Health Care Services, a Member's eligibility and benefits should always be verified through the online Provider Service Center at www.thehealthplan.com/providers_us/servicecenter.cfm or by calling the applicable Customer Service Team.

Customer Service
(Claims, Member Benefits & Eligibility)
Christiana Care Health System/TPA
(844) 568-5229
TTY/TDD 711 for the hearing impaired
Monday – Friday, 8 a.m. - 4:30 p.m.

Medical Management
(Pre-Certification & Prior Authorization)
(844) 369-2618 or (570) 214-2469
Fax: 844-620-3286
Monday – Friday 8 a.m. – 5 p.m.

Pharmacy Department
(800) 988-4861 or **(570) 271-5673**
Fax: (570) 271-5610
Monday – Friday, 8:30 a.m. - 5 p.m.

The Customer Service Team telephone number is printed on the reverse side of each Member Identification Card.

1) Inpatient Hospitalization

Requests for precertification of a planned inpatient Hospital admission is the responsibility of the admitting Participating Provider.

Please note:

- For mental health and substance abuse precertification, refer to the reverse side of the Member's Identification Card for the applicable mental health and substance abuse vendor's name and telephone number or contact the applicable Customer Service Team for further assistance.
- For inpatient rehabilitation admissions, refer to the Section titled "Inpatient Rehabilitation Admissions" within this Manual.
- Observation services expected to exceed 23 hours also require precertification.
- Copayments, Coinsurance and/or Deductibles are the financial responsibility of the Member, when applicable.

Hospitals should verify authorization has occurred by contacting either the admitting Participating Provider or the Health Plan's Medical Management Department.

Requesting Precertification

Prior to a planned inpatient admission to a Hospital Provider, the admitting Participating Provider is responsible for initiating precertification by contacting the Medical Management Department anytime at the telephone number listed below.

Medical Management
Phone: (844) 369-2618 or (570) 214-2469
Fax: 844-620-3286

Inpatient admissions excluded from precertification:

- Emergency inpatient admissions, which may be an (i) admission from an emergency room that results in a direct admission, (ii) a direct admission from an ambulatory surgery center or (iii) an admission directly from a physician's office.
- An inpatient admission to a Hospital Provider where the Health Plan is secondary to another payer who requires precertification and authorization has been obtained from the primary carrier. However, notification for Concurrent Review is required.
- A full term pregnancy with intent to deliver, either vaginal or cesarean section
  Please note: Any other planned inpatient Hospital admission during the course of pregnancy requires precertification.
- A transfer from one Participating Hospital Provider to another Participating Hospital Provider where the first inpatient admission was precertified and/or followed by Health Plan Concurrent Review for the same level of care.
- Retrieval of a Member from a non-participating facility to a Hospital Provider through the Health Plan's out-of-Network retrieval process. Transfer may only occur at such time when the Member's condition has stabilized and the Member can be transported safely to a Hospital Provider without suffering detrimental consequences or aggravating the Member's condition.

- Observation Services furnished by a Hospital Provider in an outpatient setting that include the use of a bed and periodic monitoring by a Hospital Provider's nursing or other staff and does not exceed a maximum of twenty-three (23) hours in duration.

Planned Inpatient Admission: Precertification for a planned inpatient Hospital admission is required no less than two (2) Business Days prior to the planned date of admission.

Please note: Planned admissions to an acute rehabilitation facility or rehabilitation unit within a Hospital are considered inpatient Hospital admissions and are subject to the precertification requirements listed in the Section titled "Inpatient Rehabilitation Admission" within this Manual.

Observation Services: Precertification is required for Observation Services expected to exceed twenty-three (23) hours.

Information Required when Requesting Precertification

The following information should be readily available when the admitting Participating Provider initiates the request for precertification:

Demographics: Member's name, Health Plan Member identification number, admission date, admitting Participating Provider's full name, name of Hospital Provider with requestor's name, fax number and telephone number.

Reason for Admission: All pertinent diagnosis and applicable diagnosis code (referred to as "ICD-9-CM Code")
Procedure Scheduled, if applicable: procedure to be performed, procedure codes, and date scheduled (if available)

- **Severity of Illness Indicators:**
  - Clinical Findings
  - Pertinent Imaging /ECG Findings
  - Pertinent Laboratory Findings
- **Intensity of Service Indicators:**
  - Pertinent Treatment/Medication Ordered, including frequency of administration
  - Discharge Planning/Case Management/Social Service's Assessment and Plan

Authorization Notification Process

Upon receipt of required information, the Medical Management Department will provide verbal and written notification of the determination of coverage. Notification shall occur within applicable regulatory or NCQA time frames, whichever is more rigorous. Notification shall include information on the Participating Provider's right to appeal any determination of coverage. Providers should refer to Section 6 of this Manual entitled "Provider Administrative Rights" for more information.

An inpatient admission to a Participating Provider determined clinically inappropriate by the Medical Director will be paid at an appropriate alternate level of care or denied completely. Medical Director determinations are in accordance with individual Member's needs, characteristics of the local delivery system, applicable medical criteria and clinical expertise. At

the time of a denial, the Participating Provider is verbally notified of the option to speak with a Medical Director regarding such denial.

Concurrent Review

Participating Providers are required to initiate Concurrent Review telephonically with the Medical Management Department within one (1) Business Day of an inpatient admission at (844) 369-2618. Each inpatient admission is subject to the Concurrent Review process.

During Concurrent Review, a determination of continued coverage and a subsequent assigned Concurrent Review date will be provided by the Medical Management Department staff. The following information will be discussed during the initial Concurrent Review:

- verification of admission date and attending physician
- current inpatient care needs
- plan of care
- overall goals and anticipated length of stay (if known), and
- discharge planning

2) Inpatient Rehabilitation Admissions

Request for precertification of an inpatient rehabilitation admission is the responsibility of the admitting Participating Provider.

Please note:

- Precertification is not required when the Health Plan is secondary to another payer who requires precertification and authorization has been obtained from the primary carrier. However, Concurrent Review is required.
- Copayments, Coinsurance and/or Deductibles are the financial responsibility of the Member, when applicable. *Please note*: This may be a limited benefit.

Requesting Precertification

Inpatient rehabilitation admissions are required to be precertified no less than two (2) Business Days prior to the planned date of admission.

Submit the "Inpatient Rehabilitation Precert Worksheet" (Contact the Health Plan by phone or check online for form availability) via fax to (570) 271-5534.

The Health Plan will only accept the Inpatient Rehabilitation Precert Worksheet as appropriate fax precertification request documentation. Utilization of the Inpatient Rehabilitation Precert Worksheet will ensure the Health Plan receives all applicable information. No other forms or alterative fax processes will be accepted unless mutually agreed upon by the Health Plan in advance.

The Inpatient Rehabilitation Precert Worksheet must be legible and all areas applicable to the admission must be completed. The Health Plan will be unable to accurately process incomplete or illegible worksheets, which may result in unnecessary denials.

Participating Providers are required to notify the Health Plan within one (1) Business Day of an inpatient rehabilitation admission that occurred during non-business hours utilizing the fax process listed above. The Medical Management Department will complete a clinical review and authorize or deny the admission retrospectively pursuant to the Member's condition at the time of the admission.

Authorization Notification Process

Upon receipt of required information, the Medical Management Department will provide verbal and written notification of the determination of coverage. Notification shall occur within applicable regulatory or NCQA time frames, whichever is more rigorous. Notification shall include information on the Participating Provider's right to appeal any determination of coverage. Providers should refer to Section 6 of this Manualentitled "Provider Administrative Rights" for more information.

An inpatient rehabilitation admission to a Participating Provider determined clinically inappropriate by the Medical Director will be paid at an appropriate alternate level of care or denied completely. Medical Director determinations are in accordance with individual Member's needs, characteristics of the local delivery system, applicable medical criteria and clinical expertise. At the time of a denial, the Participating Provider is verbally notified of the option to speak with a Medical Director regarding such denial.

Concurrent Review

Participating Providers are required to contact the Medical Management Department within one (1) Business Day of an inpatient rehabilitation admission at (800) 544-3907 option 2 to verify admission and establish the next review date. Each rehabilitation admission is subject to the Concurrent Review process, including instances where a case rate/MS-DRG may apply.

During Concurrent Review a determination of continued coverage and a subsequent assigned Concurrent Review date will be provided by the Medical Management Department staff. The following information will be discussed during the initial Concurrent Review:

- current inpatient care needs
- plan of care
- overall goals and anticipated length of stay (if known), and
- discharge planning

3) Skilled Level of Care Admissions

SNF or Hospital Providers accepting skilled admissions are responsible for requesting precertification. Precertification must be requested no less than one (1) Business Day prior to admission; requests made after 3 p.m. may be pended to the next Business Day.

Please note:

- A three (3) day Hospital stay is not required by the Health Plan prior to a skilled admission.
- Specialty consultative, surgical, and evaluation/management services provided in the skilled or Intermediate level of Care setting do not require an Outpatient Referral Form to be issued by a Member's PCP.

- Precertification is also required when the Health Plan is not the Member's primary insurance coverage.
- Copayments, Coinsurance and/or Deductibles are the financial responsibility of the Member, when applicable.

Requesting Precertification

Precertification for a skilled level of care admission is required no less than one (1) Business Day prior to the planned date of admission.

Please note: Any skilled level of care admission request received after 3:00 p.m. on weekdays may pend until the next Business Day.

Medical Management Department
Precertification line is available 24 hours/day, 7 days/week
Phone: (844) 369-2618 or (570) 214-2469
Fax: 844-620-3286

SNF or Hospital Providers are required to notify the Health Plan within one (1) Business Day of a skilled level of care admission that occurred during non-business hours (Monday through Friday 4:30 p.m. to 8:00 a.m)., or on a weekend or Holiday (New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day and Christmas Day).

The Medical Management Department will complete a clinical review, and authorize or deny the admission retrospectively pursuant to the Member's condition at the time of admission.

Information Required when Requesting Precertification

The information below should be readily available when the accepting SNF or Hospital Provider initiates the request for precertification:

- Demographics: Member's name, Health Plan identification number, admission date, admitting Participating Provider's full name, SNF or Hospital Provider with requestor's name, fax number and telephone number.
- Reason for Admission: objective, subjective findings, and Member's primary diagnosis.
- Clinical Findings: current functional status and rehabilitative therapy evaluations or recommendations (if known).
- Previous Clinical Findings: level of functioning and anticipated disposition (if known).
- Anticipated plan of care.

Authorization Notification Process

Upon receipt of required information, the Medical Management Department will provide verbal and written notification of the determination of coverage. Notification shall occur within applicable regulatory or NCQA time frames, whichever is more rigorous. Notification shall include information on the Participating Provider's right to appeal any determination of coverage. Providers should refer to Section six 6 of this Manualentitled "Provider Administrative Rights" for more information.

A skilled level of care admission to a Participating Provider determined clinically inappropriate by the Medical Director will be paid at an appropriate alternate level of care or denied completely. Medical Director determinations are in accordance with individual Member's needs, characteristics of the local delivery system, applicable medical criteria and clinical expertise. At the time of a denial, the Participating Provider is verbally notified of the option to speak with a Medical Director regarding such denial.

Concurrent Review of a Skilled Admission

Initial Concurrent Review: SNF or Hospital Providers are required to initiate Concurrent Review with the Medical Management Department staff within two (2) Business Days of the skilled admission. All skilled admissions will be subject to the Concurrent Review process, including SNF admissions where the Health Plan is not the Member's primary insurance coverage, as well as a Member who transfers from one SNF or Hospital Provider to another SNF or Hospital Provider. During Concurrent Review, a determination for continued coverage at the appropriate level of care and a subsequent assigned Concurrent Review date will be provided by the Medical Management Department staff.

The following Member information will be discussed during the initial Concurrent Review:

- Verification of admission date and attending physician.
- Current skilled needs to include skilled nursing and/or therapies.
- Rehabilitative therapy evaluations and plan of care (if appropriate), and
- Overall goals and anticipated length of stay (if known).

Subsequent Concurrent Review: Subsequent Concurrent Review is required to occur telephonically with the assigned Medical Management Department staff.

The following Member information will be discussed during each subsequent Concurrent Review:

- Skilled nursing or therapy updates including quantitative progress toward goals (nursing notes, therapy notes or logs may be requested by the UM Department staff).
- A plan of care with anticipated disposition and estimated length of stay.

The Medical Management Department staff will authorize continued coverage as deemed Medically Necessary, confirm level of care and establish the date for next review. In most cases, it is expected that all subsequent Concurrent Reviews will occur weekly by telephone.

Notification Process for Member Discharge from Covered Services

When it has been determined that a Member's needs no longer meet skilled criteria and skilled nursing care will be terminated, the Participating Provider (referred to hereafter in this section as the "Provider of Care") is required to inform Health Plan of termination of skilled services no later than two (2) days prior to the Member's Covered Services terminating. This communication shall include the issuance of the then current "Notice of Non-Coverage (NONC)" (Contact the Health Plan by phone or check online for form availability)

If the Member's services are expected to be fewer than two (2) days in duration, the Provider of Care should notify the Health Plan at the time of admission.

If a Member and/or the Member's family, authorized representative, physician and/or provider is dissatisfied (whether known or anticipated) with an impending discharge, the Health Plan should be notified immediately.

Financial Liability for Non-Compliance with Member Discharge Process

The Provider of Care may be subject to financial liability for continued Covered Services rendered to a Member as a result of non-compliance with the requirements for delivery of the denial notice in accordance with applicable regulations. Such liability may not be imposed upon the Member.

SNF Services Requiring Coordination

- **Monthly Confirmation of Member Status:** SNF or Hospital Providers accepting skilled and/or non-skilled (Intermediate Care) admissions are required to submit, by facsimile, a completed "Monthly Report of Member Status" form (Contact the Health Plan by phone or check online for form availability) to the Medical Management Department at (844) 369-2618. The "Monthly Report of Member Status" form is required no later than the FIRST day of the month. The summary information submitted on the "Monthly Report of Member Status" form is mandatory.
- **Hospice Election:** The SNF or Hospital Provider is required to notify the Health Plan's Home Health/Hospice Management Department at (877) 466-3001 immediately upon a Member's decision to invoke their Hospice benefit. Notification should also be made to the Health Plan's Medical Management Department at (844) 369-2618.
- **Infusion Therapy Services:** Participating Providers are encouraged to refer to their Agreement for specific information regarding the reimbursement inclusions/exclusions for infusion therapy services. Questions regarding infusion therapy services should be reviewed during the Concurrent Review process with the Medical Management Department.
- **Mental Health and Substance Abuse Services:** Participating Providers may assist Members in obtaining authorization and coordinating mental health and substance abuse services. Refer to the reverse side of the Member's Identification Card for the applicable mental health and substance abuse vendor's name and telephone number or contact the applicable Customer Service Team for further assistance.
- **Outpatient Rehabilitative Therapy Services:** Participating Providers are encouraged to refer to their Agreement for specific information regarding the inclusion/exclusion of outpatient physical, occupational or speech therapy services for Members originally admitted under a skilled level of care, but no longer meeting skilled criteria or who have exhausted their skilled level of care benefit.

A Participating Provider with an Agreement which includes outpatient physical, occupational and speech therapy services should refer to the section of this Manual titled "Outpatient Physical, Occupational and Speech Therapy Services" for specific instruction regarding the Health Plan's policy and procedure for coordinating outpatient rehabilitative therapy services.

Precertification of outpatient physical, occupational and speech therapy services is the responsibility of the rehabilitative Participating Provider (or designee) rendering the service.

Such precertification services for rehabilitation care is required upon visit number thirteen (13) and greater for a given member.

Notification of a Non-Skilled Admission

Prior to a non-skilled admission and again upon discharge of a Member, SNF or Hospital Provider accepting the admission is required to notify the Medical Management Department.

4) Home Health/Hospice, Home Infusion and Home Phlebotomy Services

Referrals for Home Health/Hospice Services and/or home phlebotomy services are the sole responsibility of the rendering Home Health/ Hospice Provider or home phlebotomy Participating Provider.

Please note:

- Certain Home Infusion services may require precertification. Providers should contact VITALine Pharmacy Services at (800) 527-6249 or fax a Referral to (570) 271-5843.
- Precertification is also required when the Health Plan is not the Member's primary insurance coverage.
- Copayments, Coinsurance and/or Deductibles are the financial responsibility of the Member, when applicable.

Home Health/Hospice Services Referral Process

When a Member requires home care services, a Participating Provider should issue a written or verbal order to the applicable home care services Participating Provider. Home Health/Hospice Providers utilize a referral process to initiate the request for additional visits within one (1) Business Day of completion of the admission assessment.

The mechanism utilized by the Home Health/Hospice Provider when initiating a Referral to the Medical Management department's Home Health/Hospice Management Department is the Home Health/Hospice Management Department Referral Form (Contact the Health Plan by phone or check online for form availability). Home phlebotomy Participating Providers should utilize a mutually agreeable form approved by the Home Health/Hospice Management Department when initiating a Referral.

Hospice Election and Notice

When a Member elects Hospice Services, the hospice must complete an election notice. In addition, the hospice must complete a change form when the election is for a patient who has changed an election from one hospice to another. The hospice provider is responsible for submitting all hospice forms to the Health Plan.

When hospice coverage is elected, the beneficiary waives all rights to standard coverage payments for services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an attending physician, which may include a nurse practitioner.

To be covered, Hospice Services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice

care and; a certification that the individual is terminally ill must be completed by the patient's attending physician (if there is one), and the Medical Director. Nurse practitioners serving as the attending physician may not certify or re-certify the terminal illness. A plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care. Certification of terminal illness is based on the physician's or medical director's clinical judgment regarding the normal course of an individual's illness. It should be noted that predicting life expectancy is not always exact.

Completing the Home Health/Hospice Management Department Referral Form

The applicable forms are required to be completed in their entirety and must be submitted prior to rendering services and no later than within one (1) Business Day of completion of the admission assessment. Referrals should be submitted by facsimile to the Home Health/Hospice Network at (570)-271-5507.

Home Health/Hospice Management Department
(877) 466-3001 or (570) 271-5506 fax: (570) 271-5507
Monday through Friday 8:00 a.m. to 4:30 p.m.

Home Health/Hospice Management Department Determination

The Home Health/Hospice Management Department will typically return processed Referral forms to the applicable home care services Participating Provider within one (1) Business Day of receipt of the referral request. In the event additional clinical information or Medical Director review is required to make a determination, the timeframe may be extended. If this occurs, the Home Health/Hospice Management Department will provide verbal or written update to the requesting applicable home care services Participating Provider.

Questions regarding an extension of an existing authorization may be directed to the Home Health/Hospice Management Department.

Concurrent Review Process

Concurrent Review is required on all Home Health Services. The Home Health Provider is required to contact the Home Health/Hospice Management Department Community Case Manager to provide clinical information including a Member's treatment plan. Based on Concurrent Review, a determination of continued coverage will be provided by the Home Health/Hospice Management Department.

Home phlebotomy services are discontinued when concurrent Home Health Services end, unless unique circumstances warrant continued consideration for coverage.

The Home Health/Hospice Management Department utilizes nationally recognized guidelines as well as internal medical benefit policies, and other resources to guide Concurrent Review and retrospective review processes in accordance with the Member's applicable Benefit Document and eligibility.

Home Health/Hospice Provider Responsibilities

Participation in Scheduled Home Health/Hospice Provider Meetings: Home Health/Hospice Provider meetings are scheduled by the Home Health/Hospice Management Department in regional locations to address changes, concerns and updated information. Home Health/Hospice Providers are expected to have representation at each scheduled Home Health/Hospice Provider meeting.

Home Health/Hospice Providers Participate in Program Development: All Home Health/Hospice Providers are required to periodically participate in the development of new programs as applicable to meet the needs of the Member population served by the Home Health/ Hospice Management Department. Such programs may require specialized care from the Home Health/ Hospice Providers for the program to produce positive quality outcomes. As these programs are developed, the Home Health/Hospice Management Department will release care guidelines to the Home Health/Hospice Providers that should be followed for Health Plan Members.

Discharge Reports of Home Health and Hospice Services: As designated by the Home Health/Hospice Management Department, the Home Health/Hospice Provider will provide verbal or written periodic progress reports to the Home Health/Hospice Management Department for each Member under the Home Health/Hospice Provider's care. In order to provide continuity of care, the Home Health/Hospice Management Department requires a discharge report via fax to the Home Health Hospice Management Department within one week of discharge.

Scope of Services: Home Health Provider

Home Skilled Nursing Services: Care provided in the home by physician-supervised skilled nursing personnel in accordance with recognized nursing standards of practice.

Home Rehabilitative Services: Physical, occupational, and/or speech therapy services provided in the Member's home.

Home Medical Social Services: Any services provided by medical social workers made available by the Home Health Provider to assist the Member or his/her family in coping with a Member's medical condition.

Home Health Aide: Custodial nursing services consisting of care provided in the home by home health aides.

Influenza Vaccination: The influenza vaccination may be administered to "at risk" Members only. A Member is defined as "at risk" if they meet (1) one or more of the following guidelines:

- Member is age fifty (50) or older.
- Member resides in a PCF.
- Member has diabetes, kidney disease or is immunosuppressed.
- Member is a health care worker with direct patient contact.
- Member lives with an "at risk" person as defined above.

Home Phlebotomy Services: Laboratory services for Members meeting homebound criteria as defined by Health Plan.

Programs Available through the Home Health/Hospice Management Department

The Home Health/Hospice Management Department has established the following programs to effectively serve specific populations of Members.

- **Post Partum Early Discharge Home Care:** The Home Health/Hospice Management Department has established specific guidelines for approval of Home Health Services for mothers and infants discharged from the Hospital less than forty-eight (48) hours after a vaginal delivery or less than ninety-six (96) hours after a cesarean section. Time limits and definition of Covered Services are in accordance with Governmental Agency requirements, as applicable.
  Infants requiring follow-up care for elevated bilirubin levels are eligible for Home Health Services provided home phototherapy is being utilized.
  Please note: Home phototherapy should be arranged through a DME Participating Provider. Coverage is subject to the Member's applicable Benefit Document.
- **Congestive Heart Failure (CHF) Home Care:** For the homebound Member confronted with CHF, the Home Health/Hospice Management Department is able to coordinate a standardized teaching and assessment program with Home Health Providers. The Home Health/Hospice Management Department, in collaboration with the Health Plan's Care Coordination Department, ensures continued telephone and/or PCP follow-up.
- **Influenza Vaccinations:** In order to assist the Health Plan in its measurement of HEDIS® statistics, (such as influenza vaccinations for Members age sixty-five (65) and older) the Home Health/Hospice Management Department has developed a method for monitoring influenza vaccines. A Member who obtains an influenza vaccine at a community site such as a local drug or grocery store will commonly receive the influenza vaccine by a Home Health Provider. The Home Health/Hospice Management Department has developed and distributed the Influenza Vaccination Record (Contact the Health Plan by phone or check online for form availability), which is completed by the Home Health Provider when administering the influenza vaccine to a Member. The Home Health Provider will forward the "Influenza Vaccination Record" to the Home Health Management Department for each Member who received the influenza vaccine. The Home Health Management Department is also able to coordinate home administration of the influenza vaccine with Home Health/Hospice Providers, providing the Member meets the established criteria for home administration. As always, if the Member is able to return to the PCP, it is considered the preferred place of administration.
- **Orthopaedic Joint Recovery:** The Home Health/Hospice Management Department has implemented a program for Members undergoing elective joint replacement surgery (i.e., hip, knee). Upon a scheduled operative date, a Home Health visit may be ordered by a Participating Provider to enroll the Member in the joint-recovery home program. One (1) physical therapy home visit is scheduled within seven (7) to fourteen (14) days preoperatively to educate a Member about pain management and exercises, as well as conduct a home safety evaluation. The visit documentation should be faxed as directed within one business day of the pre-operative visit so that it can be utilized for discharge planning. Following the surgery and upon discharge to home, the rendering agency would resume Home Health Services. The Home Health/Hospice Management Department

Community Case Manager will coordinate Home Health Services with the same Participating Provider. Additional Home Health Services will be tailored to the Member's individual needs.

- **Home Management of Deep Vein Thrombosis (DVT):** Through new technology and pharmaceutical alternatives to IV anticoagulation, Members can be instructed in subcutaneous home administration of low molecular weight heparin products. After a first dose administration in a controlled setting, such as the physician office, care can be coordinated for home drug delivery. Education on self-administration will be conducted by a registered nurse from a Home Health Provider.

For more information about any of the above listed programs or recommendations for a new program(s), please contact the Home Health/Hospice Management Department at (877) 466-3001 or (570) 271-5506.

5) Durable Medical Equipment ("DME")

Referrals and Concurrent Review for outpatient DME Services are the sole responsibility of the rendering DME Participating Provider. DME Participating Providers are required to submit the applicable precertification forms to the Medical Management department's DME Management Department within one (1) Business Day of receipt of a DME order even if medical necessity information is not yet available. This includes Urgent Care DME requests (i.e., oxygen) received during the DME Management Department's non-business hours. A coverage decision provided by the DME Management Department is required in advance of release, delivery or purchase of DME, except in the case of after hours or weekend Urgent Care DME requests (i.e., oxygen). Items delivered prior to determination of coverage by the Health Plan require clear and detailed advance notice of potential cost with signature of insured. No reimbursement will be provided for delivery of purchased items without such advance notice and signature.

Please note:

- Precertification is also required when the Health Plan is not the Member's primary insurance coverage.
- Prosthetic and orthotic devices are not considered DME and do not require precertification.
- Copayments, Coinsurance and/or Deductibles are the financial responsibility of the Member, when applicable.

When a Member requires outpatient DME, a Participating Provider should issue a verbal or written order to a DME Participating Provider that includes the following:

- **Member Demographics:** Member's name, primary residence address, telephone number, and Health Plan identification number.
- **Requested DME service/item.**
- **Clinical Findings:** Diagnosis and applicable diagnosis code.
- **Prescribing or ordering Participating Provider name and telephone number.**
- **Anticipated duration of DME need.**
- **Additional clinical information** to support request for DME.

DME Participating Providers are located at www.thehealthplan.com. Participating Providers with questions related to outpatient DME authorization or precertification may contact the Health Plan DME Management Department (DME Management Department) at the following:

DME Management Department
Monday through Friday, 8:00 am to 4:30 p.m.
(866) 248-1972 or (570) 271-7127 Fax: (570) 271-7171

Consignment DME

Consignment DME provided by a non-branch location (i.e., physician office stocked with DME by a DME Participating Provider) are limited to those approved in advance by the DME Management Department. No purchased items with value greater than $100 can be provided on a consignment basis. The scheduled delivery date should be the dispense date appearing on the applicable precertification form(s). Consignment DME provided by a non-branch location is required to be submitted for retrospective review within 30 days of issuance utilizing the applicable precertification form(s). The form must be clearly marked to show "consignment" with clear indication of the date equipment was provided to the Member. Misrepresentation of issue date will result in denial of payment and the Member may not be held liable for payment in these circumstances.

Completing the applicable DME Management Department Precertification Form

All DME Management Department precertification forms are required to be completed and submitted within **one (1) Business Day** of receipt of the written or verbal order issued by a provider, via facsimile to the DME Management Department at (570) 271-7171. Required fields are marked with an asterisk (*).

- **Precertification Form 1:** General Request for DME (Contact the Health Plan by phone or check online for form availability): This form is required to be completed and submitted for each initial precertification request for outpatient DME.
- **Precertification Form 2:** Oxygen/Continuous Positive Airway Pressure (CPAP) Device Request (Contact the Health Plan by phone or check online for form availability): Upon DME Participating Provider's receipt of a written or verbal order issued by a provider for oxygen or CPAP, both the General Request Precertification Form 1, as well as the Oxygen/CPAP Prescription Precertification Form 2 is required to be completed in their entirety. Both precertification forms are required to be submitted by facsimile to the DME Management Department within one (1) Business Day of receipt of the written or verbal order issued by a provider.
  CPAP units must be dispensed with two (2) smart cards. Payment will be denied if this requirement is not met. Patient education material provided by the DME Management Department should be included with every oxygen and CPAP delivery.
- **Precertification Form 3:** Respiratory Assist Device: Upon DME Participating Provider's receipt of a written or verbal order issued by a Participating Provider for respiratory assistance device(s) both the General Request Precertification Form 1, as well as the Respiratory Assist Device Precertification Form 3 (Contact the Health Plan by phone or check online for form availability), is required to complete in their entirety. Both precertification forms are required to be submitted by facsimile to the DME Management

Department within one (1) Business Day of receipt of the written or verbal order issued by a provider.

- **Precertification Form 4**: Multiple HCPCS Code (Contact the Health Plan by phone or check online for form availability): In the event a DME Participating Provider is initiating a request for precertification which has more than four (4) requested DME services, both the General Request Precertification Form 1, as well as the multiple HCPCS Code Form 4, is required to be completed in its entirety.

Both precertification forms are required to be submitted by facsimile to the DME Management Department within one (1) Business Day of receipt of the written or verbal order issued by a provider.

DME Management Department Determination

The DME Management Department will return a processed precertification form(s) to the DME Participating Provider within one (1) Business Day of receipt of the precertification request. In the event additional clinical information or Medical Director review is required to make the determination, the one (1) Business Day timeframe may be exceeded. If this occurs, the DME Management Department will provide verbal or written update to the requesting DME Participating Provider. Additionally, the DME Management Department may request supporting clinical information in order to render a determination. Authorized precertification forms will be returned and include the following: 1) DME by HCPCS code and modifier specificity and 2) quantity of DME and 3) authorized date range of DME, if applicable. For items that are provided on a recurring basis, including but not limited to DME accessories or ostomy and urological supplies, the general rule is that providers may dispense no more than a 3 month supply at any one time. Surgical dressings may be dispensed only one month at a time; less in the early or late course of treatment when needs may change based on an improving or worsening condition or the type of the supply may be expected to change.

Please note: Questions regarding an authorization may be directed to the DME Management Department. Providers must contact the DME Management Department via phone if they have not received a response within one business day, in order to confirm that the precertification form was received. An interactive voice recording (IVR) is in place to accept these calls.

- **Form 6:** Request to Modify Previously Authorized Outpatient DME. In the event a DME Participating Provider requests a modification of an existing DME Management Department determination, a completed Change Form is required and should be submitted to the DME Management Department by facsimile (Contact the Health Plan by phone or check online for form availability). A Change Form may be completed for the following purposes which include, but are not limited to:
    - Return of DME to the DME Participating Provider (i.e., physician order discontinued, Member expired, Member elected hospice benefit, Member voluntary discontinuation; DME Participating Provider should not state, “no longer using”).
    - Actual date of service changed from the initial anticipated delivery date.
    - Change to an initial DME request.

- HCPCS coding change.
- Member identification correction.

- **Form 7:** Extension of an Existing Authorized Outpatient DME (Contact the Health Plan by phone or check online for form availability): DME Participating Providers are required to request an extension of an existing authorization decision, as applicable, prior to the expiration date indicated on the returned original authorized precertification form. This extension request is initiated by the DME Participating Provider via the DME Recertification Form.
  The DME Recertification Form should be completed in its entirety and submitted via facsimile no sooner than 2 weeks before the end of an authorization period, but no later than one (1) Business Day prior to the expiration date.

6) Outpatient Physical, Occupational and Speech Therapy Services

Referrals and Concurrent Review for outpatient rehabilitative Services are the sole responsibility of the rendering Outpatient Therapy Participating Provider. The first eleven (11) visits for outpatient rehabilitative services do NOT require a precertification but do require notification to Geisinger. Member visits in excess of eleven (11) require a physician order and are subject to approval through the precertification process.

Please note:

- An Outpatient Referral Form is not required when ordering outpatient rehabilitative therapy services, however, the completion and submission of Health Plan designated form(s) by the outpatient rehabilitative therapy Participating Provider are required as outlined in this Manual.
- Referral and Concurrent Review is also required when the Health Plan is not the Member's primary insurance coverage or when workers' comp or auto insurance may be primary.
- Co-payments, Coinsurance and/or Deductibles are the financial responsibility of the Member, when applicable.

A Participating Provider should issue a signed written order to an outpatient rehabilitative therapy Participating Provider when a Member requires outpatient physical, occupational and/or speech therapy services. Outpatient rehabilitative therapy Participating Providers can be located in the "Rehabilitation Facility" section of the Health Plan's then current Provider List or at www.thehealthplan.com. Outpatient rehabilitative therapy Participating Providers are required to initiate the Referral within seven (7) calendar days of the initial rehabilitative evaluation by Form A (Outpatient Rehabilitative Therapy Notice) and prescribing physician's order.

Participating Providers with questions related to outpatient rehabilitative therapy authorization may contact the Medical Management department's Outpatient Rehabilitative Therapy Services Management Department (Outpatient Rehabilitative Therapy Services Management Department) at the following telephone numbers:

Outpatient Rehabilitative Therapy Services Management Department
Monday through Friday, 8:00 am to 4:30 p.m.

(800) 270-9981 or (570) 271-5301 Fax: (570) 271-5302

An outpatient rehabilitative therapy Participating Provider is encouraged to begin rehabilitative services upon the initial evaluation of a Member. All rehabilitative visits will apply against the Member's applicable benefit accumulator and are included in the total number of rehabilitative visits authorized by the Rehabilitative Management Department. Requests received seven (7) calendar days beyond the date of service will be denied. The prescribing physician's order for rehabilitative services is required to be faxed to the rehabilitative network with Precertification Form A.

Please note: A maximum of two (2) outpatient rehabilitative visits will be authorized upon receipt of only Section 1 of "Precertification Form A".

Concurrent Review

All services beyond the initial review by the Health Plan will require Outpatient rehabilitative therapy Participating Providers must complete "Precertification Form B" (Contact the Health Plan by phone or check online for form availability) in its entirety and submit via facsimile when additional rehabilitative visits beyond those previously authorized are being requested. Forms without complete visits to date will be considered incomplete. Specific measurements or functional assessments may be requested in order to make a determination of progress toward goals, as well as for determination of ongoing need.

7) Outpatient Radiology and Cardiac Imaging Services

While high-end imaging for CCQP members will not require pre-authorization, CCQP will be promoting a physician implemented initiative to ensure the appropriate utilization of imaging. As part of this initiative, ordering physicians may occasionally receive a telephone call from one of the CCQP Radiology providers to discuss exam appropriateness or to consider an alternate, possibly more appropriate exam. The ordering physician will have the final decision on what imaging exam is utilized. It is anticipated that over time, collaborative physician implemented best practices and utilization norms will evolve around high end imaging within CCQP.

This imaging utilization appropriateness review will be guided by industry-accepted criteria established through the American College of Radiology (ACR) or other sources as deemed applicable. This review will initially be in place for imaging studies performed through Christiana Care only.

This process shall apply to the following non-emergent medical and cardiac imaging services:

- MRI/MRA
- CT/CTA
- Nuclear Stress Tests
- Stress Echo

Other services requiring precertification

The listing of other services requiring precertification can be found on the Health Plan's Web site at www.thehealthplan.com/providers_us/precert.cfm. This listing is subject to change. A minimum of thirty (30) days advance notice is provided to Participating Providers regarding changes to this listing. Please contact the Medical Management Department if you have questions regarding the precertification of a particular service, or refer to our online listing.

Requesting Precertification

Requests for precertification may be submitted by U.S. Mail, telephone or facsimile to:

Geisinger Health Plan
Medical Management Department
100 North Academy Avenue
Mail Code 32/18
Danville, PA 17822
(844) 369-2618 or (570) 214-2426
Monday through Friday 8:00 a.m. to 5:00 p.m.
Fax: (844)620-3286

Information required when requesting precertification

- Demographics: Member's name, Health Plan identification number, admission date (if applicable), date of service, and Provider of service full name, Requesting physician with phone number and fax number.
- Reason for Service: objective and subjective findings.
- Pertinent Treatment/Medication Ordered.
- If request is for utilization of a non-Participating Provider, submission should include specifics as to why the service is not obtainable from a Participating Provider. Any information submitted by hard copy should clearly identify the requestor's name and contact information.
- Submission of photographs and/or medical records.
- Submission of photographs is considered confidential medical record information and should be forwarded to the above address in a sealed envelope labeled "CONFIDENTIAL MEDICAL RECORDS."

Upon submission of required information, the Medical Management Department will provide verbal and/or written notification of determination of coverage relative to the precertification request in accordance with regulatory timeframes.

It is the obligation of the Participating Provider to discuss all treatment alternatives and options with the Member. This should include a discussion of the Health Plan approval process and the importance of identifying the best alternatives for care. The optimal method for accomplishing this is to include the Health Plan in the review process prior to making any arrangements. Failure to follow this process leads the Member and/or the Member's family to having inaccurate expectations.

10) Pharmacy Formulary Precertification and non-Formulary Exception Process

The Health Plan's Pharmacy Department maintains a process by which Health Care Providers can:

- Request precertification for medication(s) designated in the Formulary by an asterisk (*) as requiring such.
- Request a Formulary exception for specific drugs, drugs used for an off-label purpose, and biologicals and medication(s) not included in the Health Plan's then current drug Formulary.

Requesting Precertification

Health Care Providers can initiate such requests by contacting the Pharmacy Department by telephone, fax or written request at the following:

Geisinger Health Plan
Pharmacy Department
100 North Academy Avenue
Mail Code 32-46
Danville, PA 17822
Monday through Friday, 8:30 a.m. to 5:00 p.m.
(800) 988-4861 or (570) 271-5673
Fax: (570) 271-5610

Information required to process the request includes:

- Caller's name and telephone number.
- Member's Health Plan identification number and, if applicable medical record number.
- Prescribing Health Care Provider's name and telephone number.
- The medication requested.
- Supporting clinical rationale, which may include, but is not limited to, relevant pages from the medical record, laboratory studies, prior medication treatment history and other documentation, as determined by the Health Plan to be relevant.

Determination Process

Formulary exception requests will be evaluated and a determination of coverage made utilizing all the following criteria:

- Member's eligibility to receive requested services (enrollment in the plan, prescription drug coverage, specific exclusions in Member's contract).
- Utilization of the requested agent for a clinically proven treatment indication or diagnosis.
- Therapeutic failure, intolerance or contraindication to use of Formulary agent and/or agents designated as therapeutically equivalent.
- Appropriateness of the non-Formulary agent compared with available Formulary agents, including but not limited to:
  a. Safety
  b. Efficacy

c. Therapeutic advantage as demonstrated by head to head clinical trails
d. Meets Health Plan criteria for drug or drug class Formulary exception

The prescribing Health Care Provider will be contacted to review the request and available Formulary alternatives. If an exception is still requested, appropriate medical record documentation and treatment information will be requested verbally and in writing. A due date for the required information (fifteen (15) days from the date of the request) will be included in the verbal and written notifications. When all requested information has been received, it will be attached to a flow sheet for documentation as a pre or post-service request.

- If the requested information is not received within fifteen (15) days, the Health Care Provider will be contacted and a second request for information will be made both verbally and in writing. The date by which the information is required will be included in the verbal and written request.
- If the required information is not received by the due date, a determination of coverage will be rendered based on the information available. Requests for exception are reviewed and a determination of coverage made within a time frame in accordance with the following:
    - When the request for coverage is related to an Urgent Care claim, a determination of coverage will be made within twenty-four (24) hours of receipt of all necessary information.
    - When the request for coverage is deemed to be a pre- service or post service, a determination of coverage will be made within forty-eight (48) hours of receipt of all necessary information.

A Health Plan Pharmacist will perform the initial review of the necessary information and assemble documents necessary to recommend a course of action. A licensed physician shall make the final decision in those instances where a Formulary exception decision results in a denial based on Medical Necessity and appropriateness. Based on the determination of coverage made, one (1) of the following will occur:

If the Formulary exception is approved:

- An electronic override will be entered into the pharmacy claims adjudication system. The Member (or Member's authorized representative) and provider will be notified of the determination of coverage within twenty-four (24) hours of decision being made.
    - At the time of notification, the Health Plan will indicate the coverage provided in the amount disclosed by the Health Plan for the service requested.
- A written confirmation of the approval will be sent to the provider and Member within two (2) days after the determination of coverage is made.
- If the request for a Formulary exception is denied, resulting in an adverse benefit determination, the following will occur:
    1. The Health Care Provider and Member (or Member's authorized representative) will be verbally notified of the adverse determination within twenty-four (24) hours of the decision.
    2. This verbal notification will include instruction on how to initiate a Grievance and/ or Appeal process.

3. The prescribing Health Care Provider will be offered the opportunity to discuss the determination of coverage with a Health Plan Pharmacist or Medical Director.
4. The Member (or Member's authorized representative) and Health Care Provider will be sent confirmation of the adverse benefit determination within two (2) days of the decision being made. The written notification shall include; (1) the specific reason for the determination, (2) the basis and clinical rationale utilized in rendering the determination of coverage, if applicable, (3) any internal policy or criterion applied, if applicable, (4) as well as instructions regarding initiation of the Grievance and/or Appeal process.

Formulary changes are printed in the Health Plan's quarterly newsletter, "Briefly" and are additionally available at www.thehealthplan.com. A minimum of thirty (30) days advance notice is provided to participating physicians regarding Formulary changes, except when the Formulary change is due to the approval or withdrawal of a medication by the Food and Drug Administration.

Medical Benefit Policies

A medical policy is the written description of the Health Plan's position concerning the use or application of a biologic, device, pharmaceutical, or procedure, based on any or all of the following: Medicare guidelines, clinical practice guidelines, nationally accepted standards, and the findings and conclusions drawn from a complete Technology Assessment (TA). Additionally, a medical policy is an informational resource that establishes the Medical Necessity criteria for the biologic, device, pharmaceutical, or procedure. It also functions as an informational resource by describing any special requirements for claims processing.

New and revised medical benefit policies, which include services deemed to require precertification, are communicated in the Health Plan's quarterly newsletter, *Briefly*. *Briefly* is accessible online at www.thehealthplan.com, or a hard copy may be obtained from your Provider Relations Representative. A minimum of thirty (30) days advance notice is provided regarding those services, which have been added to the Health Plan's precertification list. For a current listing refer to the Health Plan web site at www.thehealthplan.com/providers_us/precert.cfm.

Participating Providers with questions about the above medical policies can contact the Medical Management Department at the number listed below:

Medical Management
(Pre-Certification & Prior Authorization)
(844) 369-2618 or (570) 214-2469 Fax: 844-620-3286
Monday – Friday 8 a.m. – 5 p.m.

Services Requiring Provider Coordination

Verification of Eligibility and Benefit Limit
Prior to coordinating Health Care Services, a Member's eligibility and benefits should always be verified through the online Provider Service Center at

www.thehealthplan.com/providers_us/servicecenter.cfm or by calling the applicable Customer Service Team.:

Customer Service
(Claims, Member Benefits & Eligibility)
Christiana Care Health System/TPA
(844) 568-5229
TTY/TDD 711 for the hearing impaired
Monday – Friday, 8 a.m. - 4:30 p.m.

Medical Management
(Pre-Certification & Prior Authorization)
(844) 369-2618 or (570) 214-2469
Fax: 844-620-3286
Monday – Friday 8 a.m. – 5 p.m.

Durable Medical Equipment Network
(866) 248-1972 or **(570) 271-7127**
Monday – Friday, 8:30 a.m.- 4:30 p.m.

Home Health & Hospice Network
(877) 466-3001 or **(570) 271-5506**
Monday – Friday, 8:30 a.m.- 4:30 p.m.

Outpatient Rehabilitative Therapy Network
(800) 270-9981 or **(570) 271-5301**
Monday – Friday, 8:30 a.m. - 5 p.m.

Case Management
(800) 883-6355 or **(570) 271-8763**
Fax: (570) 271-7860
Monday – Friday, 8 a.m.- 4:30 p.m.

Pharmacy Department
(800) 988-4861 or **(570) 271-5673**
Fax: (570) 271-5610
Monday – Friday, 8:30 a.m. - 5 p.m

Outpatient Prescription Drugs

The Health Plan utilizes a Formulary for purposes of Member care through the rational selection and use of medications, and to ensure quality, cost-effective prescribing. The Formulary is developed with the input of practicing physicians and pharmacists. Medications in each therapeutic class have been reviewed for efficacy, safety, and cost. Maintenance of the Formulary is a dynamic process; the Pharmacy and Therapeutics Committee continually review new medications as well as information related to medications currently included in the Formulary.

The Health Plan maintains sole discretion of assigning drugs to tiers and moving drugs from one tier to another. Several factors are considered when assigning drugs to tiers.
These factors include, but are not limited to:

- Availability of a generic equivalent.
- Cost of a drug.
- Cost of the drug relative to other drugs in the same therapeutic class.
- Availability of over-the-counter alternatives.
- Clinical and economic factors.

Please note: A drug may change in tier status without notice due to immediate generic availability.

Non-Formulary medications: The Formulary is designed to meet most therapeutic needs of the population served by the Health Plan. Occasionally, because of allergy, therapeutic failure, or a specific diagnostic-related need, Formulary medications may not meet the special needs of an individual Member. In these special instances, the prescribing physician may make requests to the Health Plan Pharmacy Department for non-Formulary or restricted medications. The prescribing physician will receive written documentation and/or a verbal response from the Health Plan Pharmacy Department regarding the request. Under the triple choice plan, non-

Formulary addition requests: Requests for changes or additions to the Formulary can be made by written request to the Health Plan Pharmacy Department at the address listed below. Any additions or deletions to the Formulary may be found in the publication "Briefly," which is issued quarterly to Participating Physicians.

Mailing address:
Geisinger Health Plan
Pharmacy Department
Internal Mail Code: 32-46
100 North Academy Avenue
Danville, PA 17822
Telephone: (800) 988-4861
(570) 271-5673
Fax: (570) 271-5610

Urgent/Emergency Services

Participating Providers agree to have Medical Services available and accessible to Members, twenty-four (24) hours per day, seven (7) days per week. When the participating clinician is not available and accessible to Member, the provider is responsible for ensuring appropriate arrangements are made for another participating clinician to provide Medical Services to Member

Clinicians may utilize the following to ensure Members have access to medical direction or care:

- an answering service that forwards callers (i.e., Members) directly to the clinician or a designated covering participating clinician for medical direction or care during non-business hours.
- an answering device (i.e. voice mail, pager, answering machine, etc) that provides callers with a pre-recorded message directing the Member on how the clinician or designated covering participating clinician can be contacted for medical direction or care during non-business hours.
- any other delivery method that would provide the Member with direct access to the clinician or designed covering participating clinician with medical direction or care during non-business hours.

Orthotic and Prosthetic Service

An orthotic is a rigid appliance or apparatus used to support, align or correct bone and muscle deformities. Orthotic Devices range from arm slings to corsets and finger splints. They may be made from a variety of materials, including rubber, leather, canvas and plastic. A prosthetic is an appliance or apparatus that replaces a missing body part.

When an orthotic or prosthetic has been determined to be Medically Necessary, the prescribing Participating Provider should verify benefit and eligibility with the applicable Customer Service Team and then issue a written prescription in the Member's name for the applicable device. Written prescriptions issued by a Participating Provider for the Orthotic or Prosthetic Device should be kept on file in the Member's medical record.

Orthotic or Prosthetic Participating Providers are located in "Orthotic or Prosthetic" section of the Health Plan's then-current Provider List or at www.thehealthplan.com.

Behavioral Health and Substance Abuse Services

Participating Providers should refer to the reverse side of the Member's Identification Card for the applicable behavioral health and substance abuse benefit program and telephone number. Inpatient and outpatient behavioral health and substance abuse services may require authorization by the applicable Program. Additionally, Participating Providers may contact the applicable Customer Service Team for assistance during Health Plan's normal business hours.

A listing of the behavioral health and/or substance abuse Benefit Program names and telephone numbers for each Health Plan product or Employer-Sponsored Program in effect at the time of printing this Manualcan be reviewed online at www.thehealthplan.com/providers_us/highlights.cfm or in Section 1 of this Manual titled "Health Plan Identification Cards."

Experimental/Investigational or Unproven Services

Experimental, investigational or unproven services are any medical, surgical, psychiatric, substance abuse or other health care technologies, supplies, treatments, diagnostic procedures, drug therapies or devices that are determined by the Health Plan to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use, or not identified in the American Hospital Formulary Service as appropriate for the proposed use, and are referred to by the treating Health Care Provider as being investigational, experimental, research based or educational; or
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II, or III clinical trial set forth in the FDA regulation, regardless of whether the trial is subject to FDA oversight; or
- The subject of a written research or investigational treatment protocol being used by the treating Health Care Provider or by another Health Care Provider who is studying the same service.

If the requested service is not represented by criteria listed above, the Health Plan reserves the right to require demonstrated evidence available in the published, peer-reviewed medical literature. This demonstrated evidence should support:

- The service has a measurable, reproducible positive effect on health outcomes as evidenced by well designed investigations, and has been endorsed by national medical bodies, societies or panels with regard to the efficacy and rationale for use; and
- The proposed service is at least as effective in improving health outcomes as are established treatments or technologies or is applicable in clinical circumstances in which established treatments or technologies are unavailable or cannot be applied; and
- The improvement in health outcome is attainable outside of the clinical investigation setting; and
- The majority of Health Care Providers practicing in the appropriate medical specialty recognize the service or treatment to be safe and effective in treating the particular medical condition for which it is intended; and
- The beneficial effect on health outcomes outweighs any potential risk or harmful effects.

The Health Plan reserves the right to make judgment regarding coverage of experimental, investigational and/or unproven procedures and treatments. Participating Providers are encouraged to contact the MM Department for precertification review as indicated in the Section of this Manual titled "Other Medical Services Requiring Precertification".

Transplant Services

Members are required to utilize designated transplant centers. Precertification is required for transplant evaluations testing and related services for organ, bone marrow and/or stem cell transplants. Participating Providers should contact the Medical Management Department at **(**844) 369-2618 or (570) 214-2469.

Preventive Services

In accordance with the Patient Protection and Affordable Care Act (PPACA), plans effective on or after September 23, 2010, must cover certain preventive services without any Member cost-sharing. All Health Plan plans* will abide by the PPACA's regulations upon renewal, starting October 1, 2010.

Services requiring coverage:

- Evidence-based services as defined by the United States Preventive Services Task Force (USPSTF) including screenings for diabetes, cholesterol, common cancers, and depression, as well as behavioral counseling for obesity, tobacco, and alcohol misuse. These preventive recommendations also include prescriptions for aspirin to prevent cardiovascular disease, iron supplementation for anemic children, fluoride for preschool children, and folic acid supplementation during pregnancy.
- Immunizations for routine use in children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP).
- Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA) including regular pediatrician visits, developmental assessments, various screenings, counseling, and much more.
- Preventive care and screenings for women supported by HRSA.

For a comprehensive outline of recommended preventive services and links to more detailed information, please visit:
http://www.healthcare.gov/center/regulations/prevention/recommendations.html.

Cost-sharing:
Generally, no Member cost-sharing requirements will be imposed with respect to covered preventive services. Exceptions are as follows.

- Cost-sharing may apply to preventive services rendered by a non-participating provider.
- Cost-sharing may apply to office visits billed separately from the preventive service, or when the preventive service is not the primary purpose of the office visit.
- Cost-sharing may apply to a treatment not described in the regulations even if that treatment results from a preventive service that is.

Please note that the Health Plan may use Medical Management processes to determine coverage of preventive services to the extent that they are not specified in the relevant recommendation or guideline.

Section 4: Reimbursement and Claim Submission

Health Plan Reimbursement

Participating Providers are reimbursed for the provision of Medical Services to Members pursuant to the payment provisions of their Agreement. Participating Providers may collect from Members, amounts for non-Covered Services, Copayments, Coinsurance and/or Deductibles that may be due from Member in accordance with the Member's Benefit Document. A Member's cost sharing amount appears on the Participating Provider's explanation of payment (EOP) generated by the Health Plan in response to reported services. Health Plan reimbursement in conjunction with applicable Member cost sharing amounts for Covered Services constitutes payment in full. The Health Plan will not use any financial incentive that compensates a Participating Provider for providing less than Medically Necessary and appropriate care to a Member. The following information provides an overview of fee-for-service payment methodology used to reimburse Participating Providers. Participating Providers should contact their designated Provider Relations Representative with any questions regarding reimbursement. *Please note:* Health Plan coverage is subject to the Member's eligibility and benefits as of the date of service.

Payment Schedules

Payment schedules are designed to allow competitive reimbursement appropriate to the clinical training, expertise and credentials of Participating Providers. Health Plan payment schedules reflect reimbursement rates for designated CPT®/HCPCS codes and are not a reflection of a Member's benefit coverage. Reimbursement through a payment schedule is determined by the services reported in accordance with the coverage outlined in the Member's Benefit Document. Services determined to be non-covered according to such Benefit Documents are not reimbursable by the Health Plan and are the financial responsibility of the Member.

HIPAA regulations require that the Health Plan accept only valid ICD-9-CM and CPT®/HCPCS codes according to the date of service reported. Participating Providers should reference the applicable current coding manuals associated with the date of service to accurately report acceptable diagnoses and procedure code(s). Due to the potential cosmetic nature or limitation of benefits, certain services and/or procedures represented on the Health Plan's payment schedule(s) may require precertification by the Health Plan. Contact the Medical Management Department at (844) 369-2618 for assistance.

Vaccine Pricing

Vaccine price reviews will be conducted on a quarterly basis. In situations where there are unplanned spikes to drug prices, adjustments will be made to the fee schedule based on a review of actual drug invoices as provided by a representative sampling of the provider community.

Copayments/Coinsurance and Deductibles

Copayment, Coinsurance and Deductible information is listed on the front of the Member Identification Card. Please refer to the "Current Benefit Information" section of the Provider Information Center online at www.thehealthplan.com/providers_us/index.cfm. Participating

Providers can also utilize the Health Plan's Explanation Of Payment (EOP) to accurately determine a Member's financial responsibility. The Health Plan's EOP is also available online to Participating Providers registered for access to the Provider Service Center at www.thehealthplan.com/providers_us/servicecenter.cfm. The Health Plan's EOP will reflect the Member's Copayment, Deductible and/or Coinsurance amounts owed for the services reported. In addition, any service/charge determined to be a Non-Covered Service in accordance with the Member's Benefit Document, will be the Member's financial responsibility.

Participating Providers are required to notify Members of credit balances and/or provide refunds of such credit balances to the Member that were a result of the Participating Provider's collection of amounts not owed by Member for Covered Services.

Claim Submission

Participating Providers are required to submit claims to the Health Plan for all services rendered to Members. Claims must be submitted in accordance with Health Plan's then current claim submission processes, which may be amended from time to time, and are required to be submitted electronically through an approved clearinghouse vendor; or if a provider does not have the capability to submit claim forms electronically, claims may be submitted using a CMS-1500 or UB-04 claim form.

A CMS-1500 or UB-04 claim form is required to include the applicable data elements as listed in this section and current coding conventions, such as the then current CPT® and/or HCPCS Level II procedure codes, revenue codes, ICD-9-CM diagnosis coding to the highest level of specificity, as applicable to the diagnosis, for all services reported.

All paper claims should be submitted to:

Geisinger Health Plan or Claims Administrator
P.O. Box 8200
Danville, PA 17821-8200

Health Plan Explanation of Payment (EOP)

An EOP (Contact the Health Plan by phone or check online for form availability) is returned to Participating Providers listing services reported on the claim form. The Health Plan's payment will be the contractual allowance for Covered Services and will be reflected in the column titled "AMOUNT PAID". The amount paid reflects the contractual allowance less any Member cost-sharing. A Member's cost sharing amount is reflected in the column titled "AMOUNT DED&COPAY". This amount is the financial responsibility of the Member. The column titled "EXPLAIN CODES" represent additional information related to the claim or line item and should be reviewed to determine whether additional action is necessary.

Claim Submission Do's

- Submit 90% or more of your claims electronically to the Health Plan.
- Medical documentation should be attached behind the claim form.
- The primary insurance carrier's EOP should be attached behind the claim form.
- Use the Provider Service Center to determine a claims status.

Claim Submission Don'ts

- Do not attach Health Plan Outpatient Referral Forms to claim forms.
- Do not staple separate claim forms together.

Electronic Claim Submission

Participating Providers should utilize Health Plan's Electronic Data Interchange program (EDI) to submit claims and Member encounter data electronically to Health Plan. In order to receive payment for Medical Services, Participating Provider should forward all claims electronically to Health Plan in a format as may be required by the Health Insurance Portability and Accountability Act ("HIPAA") or other regulation and in accordance with Health Plan's policies and procedures. Participating Providers should use Health Plan's electronic portal as the primary source for obtaining the status of any claim submitted for payment.

Prior to initiating electronic claim transactions with the Health Plan, our Electronic Data Interchange (EDI) Enrollment Form must be fully processed. The EDI Enrollment Form is available on the Health Plan's Website at www.thehealthplan.com; enclosed within this Manual (Contact the Health Plan by phone or check online for form availability); or by contacting your Provider Relations Representative. When the EDI Enrollment Form is completed in its entirety, it should be submitted, either via facsimile or US Mail, to the following:

Geisinger Health Plan
CSST/EDI Enrollment 32-27
100 North Academy Avenue
Danville PA 17821-3227
Fax: (570) 271-5341

When the EDI Enrollment Form has been fully processed, you will receive e-mail notification to begin billing electronically, using your National Provider Identifier (NPI). Formatting specifications are outlined in the Health Plan Companion Guide (also available at www.thehealthplan.com).

The Health Plan has contracted with Emdeon and Relay Health, who receive and send electronic transactions on our behalf. For further information regarding Emdeon, please contact them directly at (800) 735-8254 or online at www.webmdenvoy.com; Relay Health at (800) 527-8133 or online at www.relayhealth.com.

The Health Plan strongly encourages its EDI enrollees to ensure that their claim submission software vendor/billing company has taken all necessary steps to confirm all required data elements are captured and populating in accordance with applicable Health Plan Companion Document.

NPI numbers (type 1 and 2) are required on all electronic claims submissions.

EDI Clearinghouse Reports

Understanding and using clearinghouse reports is crucial for maintaining and managing electronic claims. These reports contain concise information regarding the status of electronic claims, identifying those that are have been accepted and those that need to be resubmitted.

A claim reported electronically is not considered received by Health Plan until it has been accepted into its claim processing system. Please contact Emdeon or Relay Health to receive and review the necessary reports to track your electronic claims and to ensure that they have been submitted and processed properly.

Questions related to the Health Plan's electronic claim submission process and procedures should be directed to your Provider Relations Representative.

Claim Reporting Requirements or Guidelines

The following shall function as an informational resource that describes the Health Plan's requirements for professional and facility type claim submission, processing, and reimbursement. *Please note:* Coding conventions, such as CPT®/HCPCS, ICD-9-CM, revenue codes referenced throughout this Manual are subject to change when published for release by Medicare and/or various organizations. Participating Providers should always utilize the then current procedural codes, as applicable, and the then current ICD-9-CM diagnosis coding to the highest level of specificity, as applicable to the diagnosis, for all services reported.

For Professional Providers

Anesthesiology

CPT ® procedure codes 00100 through 01992 should be used to report the administration of anesthesia.

Anesthesia Participating Providers are required to report the applicable anesthesia procedure code modifier to identify the rendering provider. Anesthesia services reported without the appropriate anesthesia modifiers will be denied. Anesthesia modifiers, include the following:

AA: Anesthesia services performed personally by an anesthesiologist
AD: Medical supervision by a physician: more than four concurrent anesthesia procedures
QK: Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QX: CRNA service: with medical direction by a physician
QY: Medical direction of one CRNA by an anesthesiologist
QZ: CRNA without medical direction by a physician

Please note: The Health Plan does not provide additional reimbursement for physical status modifiers.

Anesthesia

Providers will not receive any additional reimbursement for services reported using qualifying circumstances procedure codes (i.e. 99100, 99116, 99135, 99140). For anesthesiology services related to the extraction of partially or totally bony impacted third molars, report the anesthesiology procedures codes (D9220 and D9221), when applicable.

Anesthesia Base Units

Medicare has assigned base value units to each anesthesia procedure code to reflect the difficulty of the anesthesia service, including the unusual pre-operative and post- operative care and

evaluation. Additional units are not recognized for the Member's age, physical status or unusual risk.

Anesthesia Time
Anesthesia time starts when the anesthesia provider begins to prepare the Member for the induction of anesthesia in the operating room (or equivalent area) and ends when the provider is no longer in personal attendance. An anesthesia provider is defined as a physician who performs anesthesia services alone, a Certified Registered Nurse Anesthetist (CRNA) who is not medically directed or a CRNA who is medically directed.

When reporting anesthesia administration services, the time reported should represent the continuous actual presence of the anesthesiologist or CRNA. The total elapsed time (minutes) should be reported in Block 24G of the CMS 1500 Claim Form.

If the minutes reported grossly exceed the national average for the procedure performed, progress notes are required to be submitted. Reimbursement for anesthesia administration services is based on the base unit value assigned to the procedure code, the total minutes reported and the payment schedule anesthesia conversion factor.

Anesthesia services not solely performed by an anesthesiologist will reflect a 50/50 split in reimbursement. The CRNA will receive 50% of the total reimbursement rate and the anesthesiologist will receive 50% of the total reimbursement rate. Reimbursement will not exceed 100% of the total reimbursement rate regardless of how anesthesia services are rendered. When multiple surgical procedures are performed during a single anesthetic administration, the anesthesia code representing the most complex procedure is reported. The time reported is the combined total for all procedures.

Anesthesia Billing for Canceled Anesthesia
To report canceled anesthesia after the pre-op exam but before the Member is prepared for surgery, providers should report the applicable evaluation and management procedure code.

To report canceled anesthesia after the patient has been prepared for surgery but before induction, providers should report the applicable anesthesia administration code with the appropriate anesthesia procedure code modifier and modifier -53 to indicate the service was discontinued.

To report canceled anesthesia after induction, providers should report the applicable anesthesia administration code with the appropriate anesthesia procedure code modifier and the total elapsed time (minutes).

Assistant at Surgery Services
Report one of the following modifiers as appropriate to the situation:
80 – Assistant Surgeon
81 – Minimum Assistant Surgeon
82 – Assistant Surgeon (when qualified resident surgeon not available)

The Health Plan **does not separately reimburse** physician assistants (PA), nurse practitioners (NP) and/or clinical nurse specialists (CNS) for assistant at surgery services. The Health Plan requests that Participating Providers not submit claims for these provider types. However, if such services must be reported, the following must be present on the claim:

- The supervising physician name must be listed in Field 31 on the CMS1500 Claim Form.
- Modifier –AS must be appended to the services reported as being rendered by a PA, NP or CNS.
- Do not use modifier –80, -81, or –82 to represent non-physician assistant at surgery services.

Consultation

The Health Plan will continue to reimburse appropriately coded consultations for all other Health Plan products. Coding guidelines for reporting consultation codes are as follows:

- A request for a consultation from an appropriate source and the reason for the consultation must be documented in the patient's medical record.
- The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record.
- Communication back to the requesting physician must be by written report and documented in the medical record.
- **History includes**: Must have three (3) of three (3) documented in the progress notes to meet consultation guidelines:
    - HPI – History of Present Illness
    - ROS – Review of Systems
    - PFSH – Past, Family, Social History
- **Examination**: Must document all that is pertinent to the nature of the presenting problem and clinical judgment.
- **Medical decision making**: Must have three (3) of three (3) documented in the progress notes to meet consultation guidelines:
    - Number of diagnosis or treatment options
    - Amount or complexity of data reviewed, including old records, or information from another physician. Reviewing lab and radiology results.
    - Risks of complications and/or morbidity or mortality, including but not limited to: medication(s) ordered, whether you are scheduling surgery, or have performed a minor surgery in the office.

Complete documentation of the patient consultation is required. Without such documentation upon request of the Health Plan, the consults level may be lowered or changed to a different evaluation and management code. CMS has created modifier AI (Principal Physician of Record) to be used to distinguish the physician who oversees the Member's care from all other physicians who may be furnishing specialty care. The modifier should be appended to the evaluation and management procedure code only. There is no reimbursement tied to the AI modifier.

Locum Tenens

Locum Tenens provide temporary coverage when physicians are unavailable, or if a site requires additional staffing. When a locum tenens covers for a Member's designated attending physician,

the services of the locum tenens are to be billed by the designated attending physician. The Q6 modifier is required when reporting services rendered by a locum tenens provider. Field 31 on the CMS1500 Claim Form must reflect the designated physician's name.

Immunizations
Immunizations for the purpose of travel, employment, sports camp, education, insurance, marriage or adoption are generally excluded from coverage as indicated in the Member's Benefit Document(s).

Maternity Care and Delivery
When a solo Participating Provider or participating group practice, which the Participating Provider is a part of, provides the antepartum, delivery and postpartum care, the appropriate "Global OB CPT® code" should be reported on the CMS1500 Claim Form (e.g., 59400, 59510, 59610). *Please note:* Field 24A on the CMS1500 Claim Form is required to indicate the delivery date in both the "from" and "to" Fields.

When **only antepartum care** was provided, follow the guidelines listed below. Do not report antepartum care separately when the Participating Provider is part of a group practice or covering practice that has or will be providing the delivery.

- Services for Members seen by a Participating Provider for seven (7) or more antepartum care visits should be reported with CPT® code 59426 in Field 24D with a unit of one (1) reported in Field 24G on the CMS 1500 Claim Form.
- Services for Members seen by a Participating Provider for four (4) to six (6) antepartum care visits should be reported with CPT® code 59425 in Field 24D with a unit of one (1) in Field 24G on the CMS 1500 Claim Form.

Please note: When reporting CPT® code 59425 or 59426, Field 24A on the CMS1500 Claim Form should indicate the last date the Member was seen by the Participating Provider for antepartum care in both the "from" and "to" Fields. CPT® codes 59425 and 59426 may not be reported more than one (1) time per Member per pregnancy. Individual antepartum care visits must be documented in the Member's medical record.

In accordance with standard CPT® guidelines, if a Member is seen by a Participating Provider for antepartum care less than four (4) times, indicate the appropriate evaluation and management (E&M) code for each individual visit. Report E&M code(s) in Field 24D with a unit of one (1) for each individual date of service in Field 24G on the CMS 1500 Claim Form.

When multiple birth delivery was provided, follow the guidelines listed below. CCQP provides additional reimbursement for multiple vaginal birth deliveries during a single pregnancy. However, antepartum and postpartum care services will be reimbursed one (1) time per pregnancy.

- Vaginal twin delivery coding example: 59400 Twin A-routine obstetric care including antepartum care, vaginal delivery, and postpartum care. 59409-51 Twin B-vaginal delivery only.
- Multiple cesarean birth deliveries should be reported with one of the appropriate CPT® code (e.g., 59510, 59414, 59515) and a unit of one (1) reported in Field 24G on the CMS 1500 Claim Form.

Claims for newborns should be submitted to the Health Plan using the **newborn's member identification number**, not that of a parent.

Appropriate Modifier Usage
Per CPT guideline, a modifier provides the means by which the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. Invalid procedure code and modifier combinations will be denied as such and a corrected claim will be needed to process the service.

J & Q Code Modifier Guideline
HCPCS Level II - J & Q codes are used to report drugs that ordinarily cannot be self-administered and should be reported using the appropriate dosage administered. It is not appropriate to append anatomical site modifiers to these services.

Global versus Technical/Professional Guidelines
Providers should not append the -TC modifier to procedure codes that aptly describe and represent only the technical component of a procedure or service. Also, providers should not append the -26 modifier to procedure codes that aptly describe and represent only the professional component of a procedure or service. Inappropriate reporting of such services with a -TC or -26 modifier will be denied as an invalid procedure code/modifier combination.

Modifier –25 Guidelines
Modifier –25 is used to report a significant separately identifiable evaluation and management (E&M) service that was performed by the same physician on the same day of the procedure or other service. Modifier-25 may be reported with an E&M code on the day a procedural service was performed and the physician indicates the Member's condition required a significantly separately identifiable service from the procedure(s) performed that day or the E&M was above and beyond the usual pre-procedure or post-procedure case that is associated with the procedure(s) performed.

The E&M service may be prompted by the condition or symptom for which the procedure was provided. Different diagnoses are not required for reporting the E&M on the same date as the procedure. Participating Providers are advised that an E&M reported with modifier –25 that has a diagnosis the same as, or related, to the diagnosis reported for the procedure may require medical documentation to support payment. The Health Plan will review and determine the relatedness of the diagnosis codes reported and approve for payment or deny accordingly. Providers are encouraged to submit paper claims with medical documentation when reporting an E&M service with modifier-25 and a procedure on the same date of service **when the diagnosis codes reported are the same or related. Documetnation is not required when the -25 modifier is used in combination with immunization/vaccine administration**.

Medical record documentation should provide clear evidence that the E&M service is above and beyond the exam component inherent to the reported procedure(s) or that the E&M is a significant, separately identifiable service.

If medical documentation does not support the criteria, the E&M service will be denied. Additionally, insufficient documentation (i.e., the E&M level of service reported is not supported

by the medical record, the record does not support that a separate service was provided) will result in denial of the E&M.

Please note: A Member's office visit Copayment is not applicable when a reported E&M service is denied. Additionally, the Health Plan conducts retrospective audits, which may include E&M services reported with modifier-25 on the same day as a procedure when the diagnosis codes are distinct or unrelated.

Modifier –50 Guidelines
Participating Provider rendering bilateral procedures performed during the same operative session should report modifier "-50" following the appropriate CPT® code. The unit reported in Field 24G on the CMS 1500 Claim Form should equal one (1). Health Plan reimbursement for bilateral procedures is calculated using 150% of the Health Plan payment schedule amount, taking into consideration any multiple surgery reduction adjustments.

Multiple Surgical Procedures
When more than one surgical procedure is performed during a single operative session, the full fee schedule payment amount will be made for the primary procedure. All applicable procedures performed during the same operative session are paid at a 50 % reduction. This discount reflects the savings realized by preparing the patient only once and the incremental cost associated with anesthesia, operating and recovery room use, and other services required for the second and subsequent procedures.

New Technology or Unusual and Rare Procedures
Participating Providers should contact the Medical Management Department at (844) 369-2618. to ensure a Medical Necessity review is conducted prior to rendering an unusual, rare or new technological procedure. Pertinent information should include a definition or description of the nature, extent and need for the procedure, and the time, effort and equipment necessary to provide the service. Additionally, the following may be required, complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic/therapeutic procedures, concurrent problems (if known), and follow up care.

Once the procedure is deemed payable, the Health Plan will determine the reimbursement rate according to standard industry reimbursement methodologies.

Outpatient Hyperbaric Oxygen Therapy Services (HBO)
HBO Therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure.

Outpatient claims for HBO therapy are billed using HCPCS code C1300 to indicate a 30-minute session in the hyperbaric oxygen chamber. Facilities should report any surgical procedure for wound care with revenue code 761 (Treatment room) with a corresponding CPT/HCPCS code that represents the surgical procedure in addition to the hyperbaric oxygen services.

Outpatient Rehabilitative Services

Physical medicine/rehabilitation and special otorhinolaryngologic encounter based CPT® codes (i.e. 92507, 97001, 97003) are designed to be reported with one (1) unit per date of service regardless of the length of visit/treatment time.

Outpatient rehabilitative therapy services Participating Providers are required to report the applicable then current modifier to identify the rendering provider. Services reported without the appropriate modifiers will be denied and should be corrected prior to resubmission. Applicable modifiers, include the following:

- GN: Service delivered personally by a speech language pathologist or under an outpatient speech language pathology plan of care.
- GO: Service delivered personally by an occupational therapist or under an outpatient occupational therapy plan of care.
- GP: Services delivered personally by a physical therapist or under an outpatient physical therapy plan of care.

Professional Site of Service Payment Differential
Site of service payment differential is a reimbursement methodology utilized by Medicare and other health insurance payors to maintain equity of reimbursement for certain services when performed in different settings (i.e., physician's office, hospital, ambulatory surgery center, etc.). CCQP may apply this reimbursement methodology to certain services as deemed appropriate.

Routine Non-Emergent Transportation
Participating Providers will receive reimbursement for providing routine non-emergent
Skilled Nursing Care
Participating Providers are required to report the place of service code 31 (skilled nursing facility) or 32 (nursing facility) in Field 24B on the CMS 1500 Claim Form when rendering services to Members in a Skilled Nursing Facility (SNF).

Unattended Electrical Stimulation Therapy
HCPCS codes G0281 and G0283 are required to be utilized when reporting "unattended electrical stimulation therapy" in any setting. CPT® code 97014 is not accepted by the Health Plan for the reporting of "unattended electrical stimulation therapy". In accordance with standard coding guideline, G0282 should be utilized to report wound care services not previously described in G0281. Coverage for such services reported under G0282 are based on the Medical Necessity and/or the benefits specifically outlined in the each Member's applicable Benefit Document(s) and may be considered non-covered.

Unlisted Service or Procedure
At times, a service or procedure may need to be reported as "not otherwise specified", "unlisted" or "unclassified". This distinction occurs when a valid description and code does not exist in the current coding manuals for the service rendered. For example: J3490 "unclassified drugs" is used when a valid drug "J code" has not been established.

In this circumstance, the appropriate "unlisted" or "unclassified" code may be used to report the service provided. Medical documentation is required for each "unlisted" or "unclassified" code reported to the Health Plan. If medical documentation is not submitted, the service reported as "unlisted" or "unclassified" cannot accurately be reviewed for coverage against a Member's

Benefit Document, which may result in an unnecessary denial or delay in reimbursement. Because unlisted/unclassified codes could represent more than one service or procedure, the Health Plan's payment schedules do not include reimbursement rates for "unlisted" or "unclassified" codes. Once the "unlisted" or "unclassified" code/procedure/service is determined to be payable, the Health Plan in combination with CCQP will determine the reimbursement rate according to standard industry reimbursement methodologies.

Vision Services
Participating Providers are required to submit claims with S0620 or S0621 when conducting a routine eye examination and refraction on the same Member on the same date of service with diagnosis 367.0-367.4X, 367.8X or 367.9 in the first diagnosis position on claims. This coding combination is appropriate for all product line Members and required to determine benefit coverage. Please note: X in diagnosis codes above is an indication a 5th digit is required. Refer to the then current ICD-9-CM book for further information.

Eyewear and/or contact lenses as well as any related services rendered to Health Plan Members by Participating Providers must be submitted initially to the Health Plan for reimbursement consideration. Members are responsible for balances above the routine eyewear benefit limit. Providers are encouraged to submit claims electronically and utilize the Health Plan's Provider Service Center (www.thehealthplan.com) to verify benefits and claim status.

Well-Child Office Visits
No Member Copayment is required for well-child office visits. Well-child office visits, through 21 years of age, can be coded by using one of the applicable preventive CPT codes, 99381 to 99385 or 99391 to 99395 with the applicable diagnosis. *Please note*: The CPT code corresponding to the age of the child at the time of the visit should be reported. If you utilize a regular Evaluation and Management code to report the visit, you must also report the appropriate preventive diagnosis code V20.2, V20.31, V20.32 and V70.0.

Wisdom Teeth Extraction
Participating Providers reporting the extraction of partially or totally bony impacted third molars to the Health Plan should utilize HCPCS codes D7230 & D7240. For anesthesiology services related to the extraction of partially or totally bony impacted third molars, report the anesthesiology procedures codes (D9220 and D9221), when applicable.

For Ancillary/Facility Providers

Ambulatory Payment Classifications
Services paid under the outpatient prospective payment system are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, providers may be paid for more than one APC for an encounter.

Ambulatory Surgical Centers
Ambulatory Surgical Centers (ASCs) are reimbursed according to the Medicare approved Ambulatory Payment Classification (APC) code list for ASCs. The Health Plan will not provide reimbursement for services that are not part of the Medicare approved list. ASCs are advised to

monitor all scheduled procedures for compliance with the Medicare approved ASC list. Additionally, ASCs may not balance bill a Member for denials related to this requirement.

Hospital Outpatient Departments
Payment for providers who are reimbursed for hospital outpatient services using the Ambulatory Payment Classifications (APCs) payment methodology will be reimbursed for those services on the Medicare approved APC code list for hospital outpatient departments (HOPDs).

Multiple Hospital Imaging Procedure Payment Reduction
Hospitals will be reimbursed using a multiple procedure payment reduction on the technical component of certain diagnostic imaging procedures. Full payment will be made for the first procedure. Each subsequent procedure performed during the same encounter will be reimbursed at 50 percent. The Explanation of Payment (EOP) will reflect an explanation (EX) code of 8T - Pay-Multiple Radiology Reduction Applied when applicable.

Ambulatory Surgical Services For Outpatient Hospital Reporting
Charges should be combined and reported via revenue code 360, when reporting general ambulatory surgical care services (revenue code 490) and operating room services (revenue code 360).

Case Rate Payments for Readmissions Related to an Original Admission
Inpatient claims for readmission of a Member to the same Hospital Provider less than 31 days from the discharge are subject to review by the Health Plan or its review organization, when it appears the two admissions could be related. If it is determined that the readmission was Medically Necessary and related to the original admission, payment will be adjusted to reimburse a single case rate payment.

Diagnosis Related Group (MS-DRG)
The Health Plan utilizes the applicable MS-DRG software to calculate and assign the appropriate MS-DRG for inpatient acute care claims regardless of payment terms. The Health Plan and/or its designated agent will conduct MS-DRG validation audits to ensure accuracy of the information reported by Participating Providers to retrospectively ensure the accuracy of the payment made to the facility. All requests to provide medical records associated with facilities services must be promptly returned to the Health Plan within the timeline indicated on the request. The Health Plan reimburses certain contracted Hospital facilities on a MS-DRG/case payment basis. In cases where a Member is discharged under any post acute care applicable discharge status code, the case will be considered a transfer. If a case is considered a transfer, then the standard transfer payment methodology will apply to that MS-DRG payment. A select set of MS-DRG's that qualify for the transfer payment will be paid using a unique transfer payment methodology.

Post Acute Care Transfer
Claims reported with any post acute care applicable discharge status code and an average length of stay less than the Geometric Mean Length of Stay (GMLOS) established by Medicare will be considered a Post Acute Care Transfer and one of the following transfer payment methodologies could be applied to the MS-DRG/case rate payment:

Standard Post Acute Care Transfer Payment Methodology:

The application of this methodology is similar to CMS in that the hospital MS-DRG/case rate is divided by the Medicare GMLOS to come up with the per diem payment. The actual hospital payment is made up of two parts, the first day payment and the subsequent day's payment. The first day payment is 2 times the per diem. The subsequent day's payment is calculated by taking the Length of Stay minus 1 times the per diem. The standard transfer payment is then calculated by adding the first day payment to the subsequent day payment. The standard transfer payment is then compared to the contracted MS-DRG/case payment. The hospital will be paid the lesser of the full MS-DRG/case payment or the standard transfer payment.

Unique Post Acute Care Transfer Payment Methodology:
The application of this methodology is similar to CMS in that the hospital's MS-DRG/case rate payment is multiplied by 50% plus a single per diem day for the first day payment. The subsequent day's payment is calculated by taking the Length of Stay minus 1 times 50% of the per diem. The unique transfer payment is then calculated by adding the first day payment to the subsequent day's payment. The unique transfer payment is then compared to the contracted MS-DRG/case payment. The hospital will be paid the lesser of the full MS-DRG/case payment or the unique transfer payment.

Durable Medical Equipment (DME) Services
DME Participating Providers are required to report services with the applicable modifiers. For example: 22 Unusual Procedural Service, NU new equipment (purchased), MS maintenance and service, RR rental rate, UE used rate.

DME Participating Providers submitting hard copy claims to the Health Plan are required to report the full rental period beginning with the start to the end date in Field 24A. Electronically submitted claims should reflect the rental period end date in Field 24A.

Please note: Claims should not be submitted nor will claims be accepted until the rental cycle's end date has passed.

Home Health/Hospice Prior Authorization Number
Home Health/Hospice Providers must submit the precertification number assigned by the Home Health/Hospice Management Department in Field 63 on the UB-04 Claim Form.

Hospice Providers are required to list the hours of continuous care in Field 46 on the UB-04 Claim Form.

Observation Services
Observation Services should be reported using revenue code 762. Revenue codes 760, 761 and 769 are not appropriate for reporting Observation Services to the Health Plan and will not be considered for reimbursement. The applicable units of service (total bed hours) must accompany revenue code 762 to indicate the total number of Observation Service hours rendered. The units of service should be reported in whole hours as follows:

- Partial hours less than or equal to 30 minutes should be rounded down to the nearest hour; and

- Partial hours greater than 30 minutes should be rounded up to the nearest hour.

When reporting Observation Services that were provided to a Member who was subsequently admitted to the same Hospital Provider as the Observation Services, such services are required to be reported using revenue code 762 as described above. Such Observation Services are not separately reimbursed as outpatient services but may be considered as the first day of the inpatient reimbursement.

Outpatient Services Prior to an Admission
Certain outpatient preadmission services furnished by a Hospital (or an entity wholly owned and/or operated by the Hospital) to a Member up to 3 days before the Member's admission are included in the inpatient payment*. If outpatient services are diagnostic or related to the Hospital admission, the services/charges are to be included on the inpatient claim. Services that are subject to the payment window (and covered under the inpatient payment) include all diagnostic services and those non-diagnostic outpatient services that are related to the admission. Maintenance dialysis and ambulance services are excluded.

Never Events/Hospital Acquired Conditions (HAC) / Present on Admission Indicators (POA)
The Health Plan has developed policies that address the quality of care and improve the medical safety of its Members to reduce avoidable medical errors. These policies address Never Events, Hospital Acquired Conditions and the reporting of Present on Admission indicators.

Never Events are defined as rare medical errors such as surgery performed on the wrong body part, leaving a foreign object inside a patient after surgery, or an infant discharged to the wrong person.

Hospital Acquired conditions are defined as conditions which could reasonably have been prevented through application of evidence-based guidelines. These conditions are not present when patients are admitted to a hospital, but present during the course of the stay.

Present on Admission indicators are used to identify a condition that is present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including the emergency department, observation or outpatient surgery, are considered as Present on Admission.

The Health Plan will follow CMS guidelines and process claims in a similar manner and reserves the right to withhold payment or a portion thereof for services associated with a Never Event and/or an HAC. We encourage you to view our medical policies online at the Health Plan's web site, www.thehealthplan.com for additional information on this subject.

CMS1500 Claim Form Data Element Requirements

Please note:

- Each claim is required to include the applicable data elements as listed in this section and current coding conventions, such as the then current CPT® and/or HCPCS Level II procedure codes, revenue codes, ICD-9-CM diagnosis coding to the highest level of specificity, as applicable to the diagnosis, for all services reported.

- Provider's reporting procedures and/or services using an unlisted procedure code should follow the instructions listed under "Unlisted Service or Procedure" located previously in this section of the Manual.
- Report individual charges for each service in Field 24F, 28 and 30. In addition, report the total claim charge and any amounts paid by the subscriber, other insurance payor and any balance due amounts. Be certain the total charge equals the service line charges. The Health Plan denies claims with service lines and/or total billed charges that reflect zero dollar amounts ($0.00).
- Field 24G must have the total number of units (base + time) when reporting anesthesia services.
- The referring provider's NPI number is required in Field 17B and Filed 24J, as applicable, on each CMS1500 Claim Form. The billing provider's NPI number is required in Field 33a, and the service facility's NPI number is required in Field 32a.

The below list identifies required data element fields, as well as the description of the field which should be entered on each CMS Claim Form.

Field 1a:	Member's Health Plan identification number
Field 2:	Member's name (last name, first name, and middle initial) as shown on insurance card
Field 3:	Member's birth date (mm/dd/yyyy) and gender
Field 4:	Subscriber's/Insured's name, if different than Member name in Field 2. If the information is the same for Field 2 and Field 4, enter "same" in Field 4
Field 5:	Member's address (number, street, city, state, zip code and telephone number including area code)
Field 6:	Member's relationship to subscriber/insured
Field 7:	Subscriber's address (number, street, city, state, and zip code, telephone include area code) (insurance card holder's address)
Field 8:	Check appropriate box for Member's marital status and whether employed or a student
Field 9:	Fields 9a – 9d must be completed if the answer to Field 11d is yes.
Field 10a-c:	Check the appropriate box to indicate whether or not employment, auto liability or other accident involvement applies to one or more of the services described in Field 24. Enter the state postal code. Any item checked "YES," indicates there may be other insurance primary to the Health Plan.
Field 11:	Subscriber's/Member policy group number. By completing this Field, the physician/supplier acknowledges that they have made a good faith effort to determine whether the Health Plan is the primary or secondary payor
Field 11a:	Subscriber's/Member's 8 digit (mm/dd/yyyy) date of birth and gender
Field 11b:	Employer's name or school name
Field 11c:	Subscriber's/Member's plan name or program name
Field 11d:	Check the appropriate box to indicate whether or not there is another health benefit plan
Field 12:	The Member or authorized representative must sign and enter the date unless the signature is on file in the physician's/supplier's office.
Field 13:	The insured's or authorized person's signature
Field 14:	Date of current illness, injury, pregnancy

Field 15:	If Member has had same or similar illness, give first date
Field 16:	Dates Member is unable to work in current occupation.
Field 17:	Name of referring or ordering physician or other source
Field 17b:	Referring or ordering provider NPI number
Field 18:	Hospitalization dates related to current services
Field 19:	Enter the start/stop/total (Professional anesthesia claims only)
Field 21:	Member's appropriate diagnosis or nature of illness or injury (relate items 1,2,3 or 4 to Field 24e by line).
Field 23:	Precertification number, as applicable.
Field 24A:	Date of service for the applicable procedure, service or supply. When from and to dates are indicated for a series of identical services, enter the number of days or units in Field 24G.
Field 24B:	Appropriate place of service code. Standard place of service codes only
Field 24D:	Procedures, services, or supplies using the appropriate CPT® code/HCPCS code. When applicable, show the appropriate modifier(s).
Field 24E:	Diagnosis code (ICD-9-CM) reference -Enter the diagnostic code reference number as shown in Field 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service - either a 1, or a 2, or a 3, or a 4.. If a situation arises where two or more diagnoses are required for a procedure code (e.g. Pap smears), the Provider shall reference only one of the diagnoses in item 21.
Field 24F:	Charge for each listed service
Field 24G:	Number of days or units (If only one service or procedure is performed, the number one (1) must be entered)
Field 24J:	Referring or ordering provider NPI number
Field 25:	Participating Provider's federal tax identification number
Field 26:	Member's account number; limited to 20 characters or less
Field 27:	Check the appropriate box to indicated the whether the provider of service or supplier accepts assignment of benefits.
Field 28:	Total billed charges for services or supplies provided
Field 29:	Amount paid
Field 30:	Balance due
Field 31:	Signature and date of physician or supplier including degrees or credentials
Field 32:	Name and address of facility where services were rendered (if other than home or office)
Field 32a:	Service facility's NPI number
Field 33:	Physician's or supplier's billing name, address, zip code, telephone number
Field 33a:	Billing provider's NPI number

UB-04 Claim Form Data Element Requirements

Type of Bill (TOB) Field 4 on a UB-04 Claim Form Participating Providers reporting services on a UB-04 are reminded of the following guidelines. Field 4 is required to contain three (3) digits

identifying the: (1) type of facility where care was provided, (2) type of care being reported, and (3) the sequence of the bill for a specific episode of care.

Please note:

- Each claim is required to include the applicable data elements as listed in this section and current coding conventions, such as the then current CPT® and/or HCPCS Level II procedure codes, revenue codes, ICD-9-CM diagnosis coding to the highest level of specificity, as applicable to the diagnosis, for all services reported.
- Certain data elements listed below may not be applicable to outpatient services, such as: Field 17-41, Field 76, and Field 78.
- CPT®/HCPCS code matrix for outpatient radiology services which require precertification through National Imaging Associations (NIA) is located on the Health Plan's Web site at www.thehealthplan.com/providers_us/radprecert.cfm and in the section of this Manual titled "Precertification Requirements."
- Provider's reporting procedures and/or services using an unlisted procedure code should follow the instructions listed under "Unlisted Service or Procedure" located previously in this Section of theManual .
- Fields 42, 44, 45, 46, and/or 47 must include the necessary information. If these Fields do not contain the necessary information, Participating Providers must utilize an attachment, which includes: Individual date of service, description of service provided, applicable CPT®/HCPCS code, quantity and charge amount.
- Field 82 is required to reflect the ordering provider's information when billing for outpatient diagnostic services The below list identifies required data element fields, as well as the description of the field which should be entered on each UB-04 Claim Form.

Field 1:	Participating Provider's name, complete mailing address and telephone number
Field 3:	Participating Provider's Member control number
Field 4:	Appropriate type of bill alphanumeric code
Field 5:	Participating Provider's federal tax identification number
Field 6:	The beginning and ending dates of the period included on this bill. This can be a single date of service or a range of dates
Field 12:	Member's name
Field 13:	Member's complete address
Field 14:	Member's date of birth
Field 15:	Member's gender
Field 16:	Member's marital status
Field 17:	Date the Member was admitted for inpatient care (MMDDYY)
Field 18:	Hour the Member was admitted for inpatient care
Field 19:	Appropriate admission type code that indicates the priority of the admission
Field 22:	Member's status at the time discharge as indicated in Field 6
Field 23:	Medical record number
Field 24-30:	Applicable condition codes
Field 31:	Appropriate diagnosis related group (MS-DRG) code for inpatient services
Field 32-36:	Appropriate occurrence codes and dates, as applicable
Field 39-41:	Appropriate value codes and dollar amount, as applicable
Field 42:	Appropriate revenue code

Field 43:	Revenue code description
Field 44:	Appropriate CPT®/HCPCS procedure code(s)
Field 45:	Individual date of service for the service provided
Field 46:	Number of units associated with the service provided on a single encounter date
Field 47:	Total charges for the billing period for each revenue code
Field 48:	Total non-covered charges related to the revenue code in Field 42
Field 50:	Payor identification
Field 51:	Participating Provider Health Plan identification number
Field 52:	Release of information certification indicator
Field 54:	Prior payments; payors and Member
Field 55:	Estimated amount due
Field 56:	Participating Provider NPI number
Field 58:	Insured's Name-same as Field 12 Member's name
Field 59:	Member's relationship to insured
Field 60:	Member's Health Plan identification number
Field 61:	Group name
Field 62:	Insurance group name
Field 63:	Treatment authorization codes
Field 65:	Employer name
Field 67:	Principle diagnosis code-include 4th and 5th digit, if applicable
Field 74:	Principle and other diagnosis codes
Field 76:	Attending physician's name and NPI number
Field 77:	Operating physician's name and NPI number
Field 78:	Other physician's name and NPI number
Field 79:	Other physician's name and NPI number
Field 80:	Remarks

Outpatient Hospital Revenue Code Reporting Requirements

Please Note:

- Report services rendered to the highest level of specificity supported by the Member's medical record.
- Failure to submit a CPT®/HCPCS code with the revenue codes listed below will result in denial of that line item.
- The Health Plan requires professional services to be reported on a CMS1500 Claim Form. CPT®/HCPCS codes identifying professional services are denied when reported on the UB-04 Claim Form. For example, the Health Plan does not separately reimburse for clinic charges represented by CPT® codes such as 99201-99499 reported on the UB-04 Claim Form. The cost of such charges is reimbursed to the applicable professional provider as payment in full for Covered Services.

The Health Plan requires a corresponding CPT®/HCPCS code with the following revenue codes for services reported in an outpatient Hospital setting:

260 General IV therapy
261 Infusion Pump
269 Other IV Therapy

274 Medical/Surgical Supplies/Devices- Prosthetic/Orthotic Devices
300-309 Laboratory
310-319 Laboratory Pathological
320-329 Radiology-Diagnostic
330-339 Radiology-Therapeutic
340-349 Nuclear Medicine
350-359 Computed Tomographic (CT) Scans
360-369 Operating Room Services
400-409 Other Imaging Services
410 Respiratory Services-General
413 Respiratory Services-Hyperbaric Oxygen Therapy
420 Physical Therapy-General
430 Occupational Therapy-General
440 Speech-Language Pathology-General
441 Speech-Language Pathology-Visit Charge
450-452,456,459 Emergency Room Services
460-469 Pulmonary Function
470-471 Audiology
480-489 Cardiology
490 Ambulatory Surgical Care-General
499 Ambulatory Surgical Care-Other Ambulatory Surgical Care
510-519 Clinic
520-529 Freestanding Clinic
540 Ambulance-General
545 Ambulance-Air Ambulance
610-619 Magnetic Resonance Technology (MRT)
623 Medical/Surgical Supplies-Surgical Dressings
634 Pharmacy, Erythropoietin (EPO) Less Than 10,000 Units
635 Pharmacy, Erythropoietin (EPO) 10,000 or More Units
636 Pharmacy, Drugs Requiring Detailed Coding
730-739 EKG/ECG (Electrocardiogram)
740-749 EEG (Electroencephalogram)
750 Gastrointestinal Services-General
759 Gastrointestinal Services-Other Gastrointestinal
761 Treatment Room Services
771 Preventive Care Services-Vaccine Administration
790 Lithotripsy-General
799 Lithotripsy-Other Lithotripsy
900-909 Psychiatric/Psychological Treatments
910-911 Psychiatric/Psychological Services
914-919 Psychiatric/Psychological Services
920-929 Other Diagnostic Services
940 Other Therapeutic Services-General
941 Other Therapeutic Services-Recreational Therapy
943 Other Therapeutic Services-Cardiac Rehabilitation
944 Other Therapeutic Services-Drug Rehabilitation
945 Other Therapeutic Services-Alcohol Rehabilitation

949 Other Therapeutic Services
960-989 Professional Fees

Claim Status Inquiry
Participating Providers are encouraged to visit the Provider Service Center at www.thehealthplan.com or contact the applicable Customer Service Team (CST) during the following timelines to determine the status of any claim:

- 30-60 days from initial claim submission: Participating Providers should verify claim status online through the Provider Service Center at www.thehealthplan.com or call the Health Plan's applicable CST; or Health Plan receipt of claim if an EOP has not been received by the Participating Provider within 45-60 days from the initial claim submission. Participating Providers are encouraged to document the date of inquiry as well as the name of the CST representative with whom the inquiry was discussed.
- 60 days from initial claim submission: A duplicate of any initially submitted claim may be resubmitted to the Health Plan when an EOP has not been received by the Participating Provider within 60 days from the initial claim submission; and claim status and/or receipt by the Health Plan cannot be verified through direct inquiry with the applicable CST representative as described above. To expedite this resubmission process, a duplicate of any initially submitted claim may alternatively be transmitted via facsimile. Please note that all claims transmitted via facsimile should be specifically addressed to the attention of the CST representative with whom you have spoken.

Claim Reconsideration Procedure
Participating Providers who wish to file claim reconsideration should utilize the Claim Research Request Form (Contact the Health Plan by phone or check online for form availability) to register the reconsideration. Claim reconsideration is not a Health Care Provider Initiated Grievance.

The Health Plan must receive the Participating Provider's claim reconsideration accompanied by the required documentation related to the claim within sixty (60) days from the date indicated on the EOP. Reconsiderations received after the sixty (60) day filing limit are not eligible for reconsideration and will be returned to the Participating Provider. Additionally, requests for the Health Plan's claim edit rationale must be submitted and received by the Health Plan within sixty (60) days from the date indicated on the initial Health Plan EOP that communicated the claim edit decision.

Claim Research Request Form Process
Completion of a Claim Research Request Form is necessary when requesting reconsideration of a claim for the following:

- Procedure/service denials that are the result of the Health Plan's claim editing software "Deny-Claim Edit."
- Claim payment or denial when a coordination of benefit adjustment is required.
- Claim denial when additional medical documentation is being presented (i.e., miscellaneous code submission).
- Data element correction of an approved/paid service (i.e., Member identification number, date of service, billed charge, or number of units).
- Reconsideration of an incorrect payment or denial.

Completion of a Claim Research Request Form is not required when requesting reconsideration for any of the following reason(s):

- Reconsideration of a claim denial due to a Participating Provider's billing error (i.e., invalid diagnosis code [ICD-9-CM], procedural code [CPT®/HCPCS], revenue code, invalid modifier, invalid place of service code, missing or invalid Participating Provider name and tax identification number [TIN]). These claims can be corrected by the Participating Provider and resubmitted via the provider's usual submission method. Corrections to the Member identification number or date of service require the use of the Claim Research Request Form.
- Request retraction of claim payment (i.e., overpayment, duplicate claim payment, cancelled charge).
- Requesting addition of a CPT®/HCPCS code to the Participating Provider's existing payment schedule. Please contact your Provider Relations Representative.
- Reconsideration of a claim denial for exceeding the timely filing requirement (refer to the "Time Limits" section for applicable claim submission time limits).

Claim Research Request Forms and necessary accompanying documentation must be submitted within sixty (60) days from the date of the Health Plan Explanation of Payment (EOP). Please check off the applicable reason for the reconsideration request as well as including the name and telephone number of the person completing the form. Any reconsideration request submitted without the required documentation or after the sixty (60) day submission period is not eligible for reconsideration and will be returned to the Participating Provider office.

Please note: For electronic claims, a copy of the Emdeon/Relay Health Payer Reject/Unprocessed Claims Report, or vendor equivalent report, should be submitted along with a Claim Research Request Form to the Claims Department. Claim reconsiderations submitted using the Claim Research Request Form will be finalized within forty-five (45) days of receipt. Participating Provider will be notified of the Health Plan's determination via:

- A new EOP with an explanation code; or
- A returned Claim Research Request Form with a brief explanation of the reconsideration denial.

Please contact Customer Service e with any questions regarding the Claim Research Request Form or these instructions. Claim Research Request Forms should be submitted to the following address:

Customer Service
(Claims, Member Benefits & Eligibility)
Christiana Care Health System/TPA
(844) 568-5229
TTY/TDD 711 for the hearing impaired
Monday – Friday, 8 a.m. - 4:30 p.m.

Claims Department
Geisinger Health Plan
PO Box 8200
Danville, PA 17821-8200

Refund Process
When an overpayment on a claim is discovered, we ask that you notify the Health Plan of the overpayment in one of the following ways:

1. Use the online Provider Service Center secure e-mail link, identify the claim number, member ID number, and date of service, as well as basic information regarding the overpayment; or
2. Complete the Claim Research Request form and submit to:
   Geisinger Health Plan, PO Box 8200, Danville, PA 17821; or
3. Contact the Customer Service Team at the toll-free telephone number on the Member's identification card.

An off set to future payment may occur. Further questions regarding this process can be discussed with the Customer Service Team or your Provider Relations Representative. Timely filing guidelines must be followed when resubmitting claims.

Coordination of Benefits
At the time of service, the Participating Provider is responsible for making a reasonable inquiry to determine all applicable health care coverage, including subordinate coverage for the Member. If another insurance carrier is primary to the Health Plan, the Participating Provider is entitled to and responsible for collecting first from the other insurance carrier, amounts covered by the other plan(s), to the extent that the Health Plan or other insurance carrier is subordinate, pursuant to the Member's Benefit Document. Likewise, the Participating Provider recognizes that the Health Plan may be subrogated to a Member's rights of recovery in the event of third party damages and agrees to cooperate with the recovery of third party payments.

Participating Provider agrees that the Health Plan has the right to coordinate benefits as set forth in the Member's application and Benefit Documents. When the Health Plan is a secondary insurance carrier, claims submitted to the Health Plan should include the primary insurance carrier's explanation of payment (EOP) for consideration of coverage not to exceed the contracted Health Plan reimbursement.

Anti-Fraud and Abuse Activities
The Health Plan is committed to a policy of zero tolerance for fraudulent insurance acts that victimize the Health Plan and its' stakeholders. Accordingly, the Health Plan maintains an Anti-Fraud Program. The primary role of the Anti-Fraud Program is to identify suspected fraud and abuse, analyze and evaluate the circumstances, and take appropriate action to ensure the Health Plan and its' stakeholders are not harmed and that any necessary corrective actions are implemented.

What is Fraud and Abuse?
- Generally, deceptions or misrepresentations made by a person or entity that knows or should know that the deception or misrepresentation could result in some unauthorized benefit to himself/herself or some other person(s) or entity(ies) constitutes FRAUD.
- Generally, deception or misrepresentations made by a person or entity that is unaware that the deception or misrepresentation could result in some unauthorized benefit to himself/herself or some other person(s) or entity(ies) constitutes ABUSE.

What is the Participating Provider's Responsibility?
Participating Providers have the responsibility to uphold all contractual requirements, including, but not limited to:

- Prohibiting the submission of false or fraudulent statements and claims related to any of Health Plan's benefit programs.
- Cooperating with Health Plan audits-this may include the exchange of information related to services rendered and/or release of medical record documentation.
- Notifying the Health Plan if the Participating Provider discovers that reimbursement by the Health Plan is not in accordance with the provisions of their Agreement, or that payments made were erroneous.
- Reconciling Member payments with the Health Plan Explanation of Payment (EOP).

It is important that Participating Providers reconcile the EOP with Member accounts. An important element of the EOP includes the section displaying any applicable Member liability (i.e., Copayment, Coinsurance, Deductible). Collecting monies from Members when a Member liability is not displayed on the EOP is inappropriate. Using the EOP is the most effective tool in determining Member liability. If Participating Provider collects monies from the Member and Participating Provider discovers that the payment was not due, Participating Provider must promptly refund the Member.

The Health Plan recognizes that Participating Providers strive to render excellent care and to utilize appropriate billing practices. When questions arise, contact your Provider Relations Representative for clarification. Misunderstandings can lead to unnecessary audits and associated problems.

If you become aware of a fraudulent or abusive insurance act, please contact the Health Plan. You may remain anonymous.

- E-mail at FA@thehealthplan.com
- Call your Provider Relations Representative at (302) 623-7959
- Toll free independent hotline at (800) 292-1627 is available for anonymous reporting
- send written correspondence to:

Geisinger Health Plan Anti-Fraud Program
100 North Academy Avenue
Danville, PA 17822-3220

Additional information regarding Anti-Fraud Program activities can be found at www.thehealthplan.com.

Physician Quality Program

Please refer to the **Physician Quality Program Manual** for all of the details regarding these programs.

Section 5: Credentialing

Credentialing is a systematic approach to the collection and verification of an applicant's qualifications and their ability to meet Quality Partners' criteria. Quality Partners has established credentialing criteria and a process by which providers must satisfy/follow in order to be participating providers. Please refer to **Christiana Care Quality Partners' Credentialing Manual** for full details of the credentialing criteria and process. This document is available upon request from Quality Partners by calling 302-623-7959.

Section 6: Provider Administrative Rights

Provider Administrative Rights

Participating Provider Appeals

In accordance with NCQA standards, treating or attending Participating Providers have the opportunity to speak to an appropriate practitioner to discuss any denial made on the basis of medical necessity.

Health Plan Medical Directors are available to discuss GHP Medical Management denials at (800) 544-3907 or (570) 271-6497 Monday through Friday 8:00 a.m. to 4:30 p.m.

Denial decisions may be rendered by delegated Medical Management (MM) vendors for services such as behavioral health and radiology services. In this instance, the delegated MM vendor will contact the Provider with a phone number and operating hours.

Participating Provider Medical Management Denial Review Procedure

Contingent upon the regulatory mandates of the insurance product, a Participating/Preferred Provider may request a review of a Medical Necessity adverse determination. Insurance products regulated by The Delaware Department of Health and Social Services (HMO and gatekeeper PPO with referral products) allow for appeal of Concurrent Review and other Medical Necessity requests in which the Participating Provider cannot balance bill for denied services, and include the option of an External Review. Other insurance products allow for appeal of all Medical Necessity denials regardless of liability at the Internal Review level only.

Provider Appeal to adverse determinations must:
1. Be submitted to the Medical Management (MM) Department in writing (we recommend submission by fax for Urgent Appeal), and
2. Be received in our office within 60 days from the date on the denial notice, and
3. Indicate urgency of Appeal (Standard or Urgent timeframes) (see definition below), and
4. Include applicable medical documentation to support the Appeal. (It is not necessary to forward a complete medical record.), and

- **Internal Review:** Performed by a Medical Director who has not been involved in the original determination with input of the same or similar specialist as indicated; or
- **External Review:** Performed by an External Review Group (ERG). We will retain a contract with a recognized review body (ERG) for the purpose of offering the Provider the option of review by a Practitioner not otherwise associated with us. The cost associated with this review requires Partial Payment of the fee by the Requesting Provider' prior to initiation of the Appeal. Should the ERG decision reverse the original determination, this payment will be reimbursed to the Requesting Provider; Should the ERG decision uphold the original determination, the: equesting Provider shall be liable for full payment of the ERG fee. The cost for an external review will vary dependent on

the details of the requested service, amount of records to be reviewed; and the timeline for processing. The range of cost will be approximately$225 to $575.

In the event of multiple Providers requesting an Appeal on the same adverse determination, the first request received will initiate the Provider Appeal Process. We will ensure that all applicable information is gathered from other pertinent Providers and included in review of the Provider Appeal. The Decision from either Internal or External Review, based upon information available at the time will be final.

Provider Appeal determination and notification will be made within 30 days of receipt of the Appeal and ERG fee payment if applicable. Urgent Provider Appeal determination and oral notification will be completed within seventy-two (72) hours from confnmed receipt of clinical information, and confirmation of ERG fee payment if applicable. All decisions will be final.

The Appeal should be mailed or faxed to:

Medical Management Department
100 North Academy Avenue
Danville, PA 17822-3218
Fax: (570) 271-5534

Urgent Provider Appeal-*. Requests concerning initial or continued services and, in the opinion of a Health Plan Medical Director, application of the standard timeframe for a provider appeal could seriously jeopardize life; health, or the ability of the Member/Covered Person to regain maximum junction.*

Health Care Providers, (hereinafter called "HCPs"), with written consent of a Member or the Member's legal or authorized representative, may file a written Grievance with the Health Plan. HCPs may obtain written consent from a Member or the Member's legal or authorized representative to pursue a Grievance in lieu of the Member at the time of treatment. The definition of "Member" hereinafter shall include a "Member's legal and/or authorized representative".

HCPs may NOT require a Member to sign a document authorizing them to file a Grievance as a condition of providing a health care service.

Once a HCP assumes responsibility for filing a Grievance, the HCP may not bill the Member for services provided that are the subject of the Grievance until the external Grievance review has been completed or the Member rescinds consent for the HCP to pursue the Grievance.

If the HCP chooses to never bill the Member for the services provided that is the subject of the Grievance, the HCP may withdraw the Grievance with notice to the Member. The consent of the Member to the HCP to pursue a Grievance must be in writing and will be automatically rescinded upon the HCP's failure to file or pursue a Grievance.

Once a HCP has obtained written consent from the Member to file a Grievance, the HCP shall have ten (10) days from receipt of the standard written adverse benefit determination and any decision letter from a first, second or external review process upholding the Health Plan's decision to notify the Member of the HCP's intention not to file a Grievance.

The Delaware Department of Health and Social Services requires that certain elements and statements be included in the written Consent. The Health Plan has a Consent form available for HCP's use that includes all the required elements. HCPs may call the Health Plan at 1-800-447-4000 to request a Consent form, or HCPs may use their own consent that include the elements as listed:

- Name and address of the Member and of the Subscriber, if they are different
- The Member's date of birth
- The Member's Health Plan identification number
- If the Member is a minor, or legally incompetent, the name, address and relationship to the Member of the person who signs the consent for the Member.
- The Health Care Provider's name, address and Health Plan identification number to whom the Member is providing consent to
- The name and address of the Health Plan to which the Grievance will be submitted
- An explanation of the specific service for which coverage was provided or denied to the Member to which this consent will apply
- The followings statements need to also be included in the consent:
    - The Member may not submit a Grievance concerning the services listed in this consent form unless the Member has the right to rescind the consent at any time during the Grievance process.
    - The consent of the Member shall be automatically rescinded if the provider fails to file a Grievance, or fails to continue to pursue the Grievance through the second level review process.
    - The Member, if the Member is a minor or is legally incompetent, has read or has been read this consent form, and has had it explained to his satisfaction. The Member understands the information in the Member's consent form.
    - The dated signature of the Member and the dated signature of a witness.

Section 7: Member Rights and Responsibilities

Commercial Member Rights and Responsibilities

Member rights

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

14. Members have the right to make recommendations regarding the Member Rights and Responsibilities policies.
15. Members have the right to be informed of these rights and responsibilities.

Member Responsibilities

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

Other Member Rights and Responsibilities

TPA Member rights and responsibilities are defined by each Employer. Contact the TPA Customer Service Team for specific details. A Member's Complaint and Grievance Procedure and other Member Benefit information is available online to providers registered for the Health Plan's Provider Service Center at www.thehealthplan.com/providers_us/servicecenter.cfm. Providers can also contact the applicable Customer Service Team below to obtain a copy of the Member's Complaint and Grievance Procedure.

Geisinger Health Plan's IVR system is available for Member use, 24 hours a day, 7 days a week. Our Customer Service Representatives are available to assist you during normal business hours listed below.

Customer Service
(Claims, Member Benefits & Eligibility)
Christiana Care Health System/TPA
(844) 568-5229
TTY/TDD 711 for the hearing impaired

Monday – Friday, 8 a.m. - 4:30 p.m.

Medical Management
(Pre-Certification & Prior Authorization)
(844) 369-2618 or (570) 214-2469
Fax: 844-620-3286
Monday – Friday 8 a.m. – 5 p.m.

Durable Medical Equipment Network
(866) 248-1972 or **(570) 271-7127**
Monday – Friday, 8:30 a.m.- 4:30 p.m.

Home Health & Hospice Network
(877) 466-3001 or **(570) 271-5506**
Monday – Friday, 8:30 a.m.- 4:30 p.m.

Outpatient Rehabilitative Therapy Network
(800) 270-9981 or **(570) 271-5301**
Monday – Friday, 8:30 a.m. - 5 p.m.

Case Management
(800) 883-6355 or **(570) 271-8763**
Fax: (570) 271-7860
Monday – Friday, 8 a.m.- 4:30 p.m. .

Pharmacy Department
(800) 988-4861 or **(570) 271-5673**
Fax: (570) 271-5610
Monday – Friday, 8:30 a.m. - 5 p.m.

Section 8: Additional Participating Provider Responsibilities

Additional Participating Provider Responsibilities

The Agreement between Health Plan and each Participating Provider contains terms and conditions relative to Health Plan operations as well as those required byDelaware Health and Social Services and other Governmental Agencies.

In addition to the provisions set forth in the Agreement, Participating Providers are responsible for the following:

Time Limits

The initial submission of any claim must be received by the Health Plan within one hundred twenty (120) days of the date of service for outpatient claims and/or one hundred twenty (120) days of the date of discharge for inpatient claims, as applicable. Any claim which the Health Plan has previously paid or denied may be resubmitted for reconsideration and must be received by the Health Plan within sixty (60) days from the date of receipt of notification from the Health Plan that the claim was paid or denied. Such time limits are not applicable to claims subject to coordination of benefits when the Health Plan is not the primary carrier.

Non-eligible Claims

Any initial or resubmitted claim received after the time limits identified herein will not be considered a valid claim and will be denied by the Health Plan and is not billable to the Member. Failure to verify claim status or receipt within one hundred twenty (120) days of the date of service and/or one hundred twenty (120) days of the date of discharge for inpatient claims may result in non-eligible claims.

Proper Processing

All claims submitted by Participating Provider to Health Plan for Health Care Services provided to Members under the terms of the Agreement will be subject to editing for compliance with standard coding format including, but not limited to, the Health Plan's right to rebundle to the primary procedure those services determined by the Health Plan to be part of, incidental to, or inclusive of the primary procedure. Health Plan reserves the right to process the claim according to said standards.

Non-Covered Services

Neither Health Plan nor an Employer shall have any obligation to pay for services which a Member is not entitled to benefits under the terms of a valid Benefit Document. Such services are considered Non-Covered Services. Participating Provider shall be solely responsible for collecting payment directly from Members for Non-Covered Services and may at any time bill a Member or former Member for any Non-Covered Services. However, claims denied due to Participating Provider's failure to meet Health Plan's precertification, Concurrent Review and/ or

retroactive review processes are not considered Non-Covered Services and Participating Provider agrees that it will not hold Members liable for payment of such denied claims.

Coordination of Benefits

Upon admission or at the time of service, Participating Provider shall be responsible for making a reasonable inquiry to determine entitlement to benefits under Health Plan, an Employer-Sponsored Program or any other form of healthcare coverage. Should such inquiry uncover or should Health Plan notify Participating Provider of the existence of additional healthcare coverage to include, without limitation, insurance carriers, Workers' Compensation, federal, state, or local government benefit plans, health maintenance organizations or any form of service, indemnity or reimbursement benefit plans ("Third Party Payors"), Participating Provider shall be entitled to and responsible for collection directly from Member or others such amounts also covered by Health Plan, or Employer-Sponsored Programs or such other benefit plans to the extent that Health Plan or an Employer-Sponsored Program coverage is subordinate pursuant to the Benefit Document. Likewise, Participating Provider recognizes that Health Plan or an Employer may be subrogated to a Member's rights of recovery in the event of third party damages and agrees to cooperate with Health Plan and Members in the recovery of third party payments.

Third Party Payments

Upon request, Participating Provider agrees to give assistance to Health Plan for purposes of coordinating benefits with primary carriers. If Health Plan is the primary carrier and its payment does not cover all billed charges, Participating Provider may submit claims to the secondary carrier. If Health Plan is the secondary carrier, it shall pay Participating Provider for Covered Services that were not paid by the primary carrier. However, Health Plan's liability shall not exceed the payment provisions of this Agreement and payment by Health Plan (as a secondary payor) shall be reduced by the amounts received or due from a primary carrier. In the event payments made by Third Party Payors exceed the payment provisions of this Agreement, neither Health Plan nor an Employer, as applicable, will be required to remit payment under the terms hereof and Participating Provider may retain the excess. Nothing contained herein shall restrict or otherwise affect Participating Provider's right or obligations with respect to compensation from other Third-Party Payors at its regular rates.

Provider List

Participating Provider permits the inclusion of its name, address(es) and the names and professional designation(s) of its healthcare professionals in the Health Plan's Participating Provider List(s) for purposes of informing Health Care Providers and prospective and existing Members of the locations, services and Participating Providers available to them. Such list is maintained and distributed by Health Plan and is additionally accessible on the Health Plan's Provider Information Center at www.thehealthplan.com.

Audit

Participating Provider agrees that Health Plan or its respective representative(s) may audit any and all aspects of Participating Provider's performance under this Agreement by reviewing any records or documentation related to such performance. Health Plan agrees to provide written

notification to Participating Provider of its intent to conduct an audit of Participating Provider and/or any of Participating Provider's location(s) under the Agreement. Such audit shall occur during normal business hours at a time mutually agreeable to the parties hereto no later than the fifth (5th) Business Day following Participating Provider's receipt of such written notice from Health Plan. Participating Provider shall cooperate fully with any such audit and provide all records and documentation directly related to the services Participating Provider renders hereunder, subject to appropriate medical records' confidentiality safeguards. Health Plan may, at its sole expense, reproduce any record; however, no original record may be removed from Participating Provider's premises.

Advance Directives

Participating Provider agrees to comply with the Patient Self-Determination Act (Section 4751 of the Omnibus Budget Reconciliation Act of 1990) and state regulations and requirements relating to advance directives as such regulations and requirements are applicable to the Participating Provider. Participating Provider shall document in a prominent place in Member's current medical record whether or not the Member has executed an advance directive.

Compliance with Grievance, Complaint and Appeal Procedures

Participating Provider agrees to adhere to and cooperate with Complaint, Grievance and Appeal procedures in connection with a Health Plan Complaint, Grievance and/or Appeals processes including, but not limited to, state and Federal law, Medicare laws, regulations and CMS instructions and Health Plan procedures.

Participating Provider Locations

Participating Provider shall provide Health Care Services at the location(s) approved by CCQP . Participating Provider shall notify CCQP of any additional location(s) where Participating Provider provides Health Care Services to Members prior to rendering those services to Members at such location(s). Health Plan reserves the right to approve additional Participating Provider location(s) based on, but not limited to, Participating Provider's compliance with the terms and conditions of the Agreement, Health Plan's development of appropriate geographic Participating Provider coverage, as applicable, and Health Plan business need.

Participation through a Group Agreement

Subject to meeting CCQP credentialing and other criteria, an individual provider may participate with CCQP through a partnership, corporate, or other type of business entity agreement in which such entity is deemed to have signatory authority on behalf of the individual provider. If an individual Participating Provider discontinues association with such contracting partnership, corporation or business entity, then the individual provider shall no longer maintain Participating Provider status with CCQP. If the individual provider desires to continue participation in the Network as a Participating Provider, then the provider must enter into a contract directly with CCQP through a separate Participating Provider agreement or group agreement. Provider may or may not be subject to recredentialing. Health Plan will evaluate all provider requests to participate with Health Plan and reserves the right to approve additional providers as Participating Providers based on, but not limited to, Health Plan business need.

Establishment of a Confidentiality Policy

Participating Provider agrees to ensure the confidentiality of a Member's Personal Health Information (PHI) and will establish and maintain a confidentiality policy to assure the appropriate handling of the Member's information and records. Such confidentiality policy shall be in accordance with all state and federal laws pertaining to PHI and confidentiality. Participating Provider agrees to furnish a copy of its confidentiality policy to Health Plan upon request.

Copying of Member Medical Records-Financial Responsibility

In the event Health Plan requests copies of a Member's medical records, either in whole or in part, all charges related to copying the records shall be considered fully compensated pursuant to the payment provisions of the Agreement. The Member will not be responsible for any charges related to the copying of medical records in this instance.
In the event the Member requests copies of his or her personal medical records for reasons other than Member selection/transfer to another Participating Provider, the Participating Provider may administer their standard policy regarding financial responsibility for replicating medical records.

Hospitalization

For Hospital Covered Services Physicians and mid level providers will admit Members to a Participating Provider. Physicians and mid level providers may refer a Member to a non-Participating Provider for Covered Services as may be Medically Necessary and upon the prior approval of the Medical Director, unless otherwise permitted in accordance with the terms and conditions of coverage set forth in the Member's Benefit Document.

Missed Appointments by Members

In the event a Member fails to present for a scheduled appointment, the Participating Provider may collect from the Member the amount owed for a missed appointment charge pursuant to the Participating Provider's current policy, which shall not be discriminatory to Health Plan Members.

The Health Plan will not be responsible to reimburse the Participating Provider for missed appointment charges.

Termination of Physician/Member Relationship

In circumstances when a mutually beneficial physician/Member relationship cannot be attained, the Participating Provider may proceed with formal termination of the physician/patient relationship; however, the Participating Provider may not terminate the physician/patient relationship with any Member on the basis of health status or as otherwise prohibited by applicable laws. CCQP encourages Participating Provider to make every effort to resolve disputes prior to taking any formal action to terminate the relationship. The Participating Provider initiating a physician/Member termination must provide the Member and CCQP (i.e., Provider Relations Representatives) with thirty (30) days prior written notification of the intent to terminate the physician/patient relationship. For thirty (30) days from the date CCQP receives notification, the Participating Provider must continue to provide all routine, urgent and Emergency Health Care Services for the affected Member until the transfer of the Member's care

to another provider occurs. These services need to be available and accessible 24 hours per day and 7 days per week.

Advertising Guidelines

Use of CCQP's name and likeness is permitted only with prior written approval from the CCQP Marketing Department. The Health Plan's Marketing Department limits and controls how, when, and in what context the name and any representations about the Health Plan are employed in any Advertising.

The general Advertising policy for the Health Plan is outlined in the following paragraphs and may be used as a reference.

Definitions: In addition to the definitions set forth elsewhere in this Agreement and/or other sources, the following definitions are applicable to this Manual:

Advertising: Advertising is considered any written, electronic, visual or audio medium created for any person or employer group whose intent is to inform them of the advantages of Health Plan or of authorized services.

Approval, Written or Verbal: Any advertising created and planned for public domain requires prior review and approval by the Health Plan's Marketing Department. Verbal approvals are not given.

Health Plan's Marketing Department: The Director, Manager or designee, employed by the Health Plan Marketing Department whose job is to provide written approval for Advertising.

Advertising That Does NOT Require Approval:

The following Advertising does not require written approval and does not constitute advertising:

Slide presentations designed solely for internal audiences

Slide presentations designed solely for colleagues/peers

Advertising That Requires Approval:

Any Advertising that is not listed above requires submission to the Health Plan for written approval by the Health Plan's Marketing Department. A general guideline for Advertising suggests getting anything in doubt approved before use.

Good Advertising and Level Playing Field:

All are encouraged to follow these general Advertising guidelines:

Approval: If Health Plan approves an advertisement, the following will be provided:

- A copy of the Advertisement with mandatory changes, if any.
- Written confirmation of Health Plan's approval.
- An offer to assist you in ensuring Health Plan's name is used and placed correctly.
- The name of a person in Health Plan's Marketing Department who can assist you by answering questions and/or helping you understand the changes required.

Denial: If Health Plan disapproves an Advertisement, Health Plan will provide a written explanation of the problem with suggestions on how to correct it. Contact the Health Plan's Marketing Department to receive immediate assistance and directions regarding re-submission of the corrected Advertisement. In general, anything that is within the limits of good business practice, is truthful and that requires only minor changes will be approved. Any Advertisement that requires a 20% or more re-write cannot be approved because it no longer resembles the original submission.

Advertising Without Approval:
Pursuant to the terms and condition of the underlying Agreement, use of Health Plan's name, likeness or logo without Health Plan approval constitutes breach of the Agreement.

Accessibility of primary care services will be monitored by Health Plan no less than semi-annually utilizing the "Primary Care Site Access Review Form" (Contact the Health Plan by phone or check online for form availability).

Coverage during PCP/SCP Absence

A PCP or SCP Participating Provider must arrange for another PCP or SCP Participating Provider with appropriate training or specialty to assume such provider's responsibility during an absence. Additionally, the coverage arrangement must be with another Participating Provider who has admitting privileges at a Hospital Participating Provider. No financial costs incurred for such coverage shall be charged directly or indirectly to the Member(s), Employer or the Health Plan.

PCP Practice Acceptance Status Member Limitations

In the event a PCP determines it is necessary to limit their clinical practice to new Health Plan membership as a result of the PCP practice membership capacity, the following conditions are required:

- Advanced written notification of a minimum of thirty (30) Business Days prior to the effective date of the limitation.
- PCP acknowledges that they will continue to accept all current Health Plan membership and will continue to provide Medical Services to assigned Member(s), regardless of a pre-existing physician-patient relationship.
- PCP acknowledges that changing to "accepting existing patients only" status represents that the they will continue to accept all patients who may change to Health Plan coverage and the change will not be published in written Member and/or provider material until next applicable printing, and
- PCP must concurrently establish a limited membership acceptance status with all other managed care plans with which PCP participates.

Minimum Standards for Medical Record Documentation

The Health Plan maintains minimum standards for written and/or electronic medical records and reviews Participating Physicians' (referred to hereafter as "Practitioner") medical records to ensure compliance with these minimum standards.

The standards listed below exist to enhance Member care through, (i) the consistent documentation of the Member care; and (ii) the improvement of communication between caregivers, which occurs via the medical record.

I. Medical record guidelines/content:

1. General: The accurate recording and compilation of diagnoses, treatment, and results of treatment are most important to the practice of medicine, and its successful execution requires the cooperation of the entire health care team.
    a. All pages contain insured individual identification number (including printed information from the EMR)
    b. Biographical and personal data is documented/recorded.
    c. The medical record reflects the total insured individual care by all departments and Practitioners.
    d. All contributors to the medical record bear the common responsibility of insuring that the record is legible, current, and completed within one (1) business day of the visit.
    e. Telephone messages pertinent to medical care and subsequent follow-up, are documented in the medical record. Telephone messages are dated, timed and initialed.
    f. Insured individual's failure to keep appointments and cancellations are documented in the medical record.
    g. There is a separate problem list on each medical record containing a current list of diagnoses, and significant surgeries. Each specialist is responsible for the information pertaining to his or her specialty care.
    h. Medical records have a current, separate health maintenance flow sheet.
    i. Allergies, absence of allergies and adverse reactions are documented in the appropriate location in the medical record
    j. Medical records are required to have a current immunization list.
    k. A current separate medication list is maintained in the medical record.
    l. All clinic notes identify the author of the notes. Each site maintains a sheet with signatures and initials.
    m. Signature stamps are not allowed (reference Centers for Medicare and Medicaid Services regulations).

2. Initial Clinic Visit Documentation:
    a. Date is recorded. Department is recorded, when applicable
    b. Pertinent history and physical is recorded for each problem including chief complaint or purpose of visit, subjective and objective findings.
    c. Diagnostic impression.
    d. Plan- Diagnostic and Therapeutic: Laboratory data ordered, procedures performed or scheduled, medications prescribed, instructions given to the Member, disposition (follow-up).
    e. Allergies, absence of allergies and adverse reactions to medications are documented in the appropriate location in the medical record.
    f. Current separate medication list is initiated when applicable.
    g. Past medical history

h. There must be documentation indicating whether or not an Advance Health Care Directive has been executed for insured individuals age 65 years or older and/or those with serious and/or complex medical conditions. If an Advance Health Care Directive has been executed it must be prominently displayed in the medical record

3. Interval or Follow-Up Clinic Notes Documentation:
    a. Date is recorded. Department is recorded when applicable.
    b. Adequate information is recorded for each problem including chief complaint or purpose of visit, subjective and objective findings.
    c. Diagnostic impression.
    d. Plan- Diagnostic and Therapeutic: Laboratory data ordered, procedures performed or scheduled, medications prescribed, instructions given to the insured individual, disposition (follow-up). Especially note any changes from previous visits.
    e. Update problem lists, medication lists, health maintenance flow sheets, allergies, immunization records, and other applicable documents at each visit, as needed.

4. Provider Orders: Provider orders administered by the office staff are marked as completed.

5. Diagnostics and Consults:
    a. Diagnostic test results, procedures, ancillary services and consults (specialty physician) are reviewed and initialed/signed by the ordering Practitioner.
    b. Follow-up communication and documentation to the insured individual for abnormal results.

6. Other Communications: Other communications received are reviewed and initialed/signed by the primary care giver or his/her designee and filed appropriately. This may include home health reports, hospital discharge reports and physical therapy results.

7. Tobacco/Alcohol/Substance Use: A documented annual assessment of tobacco, alcohol, and other substance use for insured individual age 11 and over.

II. Organization and filing of information in the medical record should have a systematic approach.

1. Medical records are organized and stored in a manner that allows easy retrieval and only allows access by authorized personnel. All insured individual's medical records contain the seven (7) following organizational components: (not necessarily in order listed)
    a. Clinic visit/progress notes
    b. Correspondence
    c. Diagnostics/Procedures
    d. Immunization records

e. Problem lists/Medication lists
f. Other flow sheets
g. Demographics

III. Medical record Accessibility
1. Medical records are easily retrievable at the time of the insured individual encounter.
2. Medical records are available for Health Plan administrative/Quality Improvement purposes (including external review organization needs) to the extent permitted by applicable state and federal laws.

IV. Confidentiality of medical records
1. Participating Practitioners agree to ensure the confidentiality of an insured individual's Protected Health Information (PHI) and establish and maintain a confidentiality policy to assure the appropriate handling of insured individual information and records. Such confidentiality policy shall be in accordance with all state and federal laws pertaining to PHI and confidentiality. All records must be stored securely with access only by authorized personnel who receive periodic training on confidentiality.

V. Standards and Performance goals for Practitioners
1. Standards and Performance goals are monitored through the Ambulatory Medical Record Review process as outlined in the Quality Improvement Department Policy #4 Medical Record Review
   a. A score of 85% or higher is required on the Medical Record Review.
   b. Those scoring below 85% are required to submit an action plan and are subject to a re-audit in six (6) months.
2. Monitoring of Participating Practitioner's medical records is part of the Health Plan's Patient Safety Plan. Specific questions utilized for this purpose include those pertaining to:
   a. Patient identification on chart
   b. Allergies or absence of allergies
   c. History and physical
   d. Return communications, and
   e. Medication lists

Other medical record reviews/studies may be conducted as needed for Quality Improvement purposes with identified separate performance goals.

Health Plan Compliance Program

The Health Plan's Compliance Program is designed to oversee the development, implementation and maintenance of a compliance and privacy program that meets or exceeds federal and state laws and regulations, as well as contractual and accreditation obligations. The Health Plan is committed to ethical and legal conduct that is compliant with all relevant laws and regulations, and to correcting wrongdoing whenever it may occur in the administration of any of our plans. This commitment encompasses our organization and any of the parties that we contract with to

provide services related to the administration of our plans. For more detail on our compliance standards, please refer to our Code of Conduct online at thehealthplan.com.

Who do you contact with compliance questions?
You can contact our Compliance Department at (570) 271-7389.

What do you do if you suspect Fraud, Waste, and/or Abuse?
It is very important for individuals who participate with our plans to report all cases of suspected fraud, waste and/or abuse.

The Health Plan has made available several methods for reporting this information.

- You can call the Health Plan's Fraud and Abuse Hotline at 1-800-292-1627. (Calls to the hotline may be made anonymously)
- You can contact our Chief Compliance Officer at (570) 271-7389.

Defining Fraud, Waste, and Abuse

- Fraud – A deception or misrepresentation made by a person or entity that knows or should know the deception or misrepresentation could result in some unauthorized benefit to himself/herself or some other person(s) or entity(ies).
- Waste – Waste occurs when an act of carelessness in performance and/or lack of training result in otherwise unnecessary repetition of services.
- Abuse – A deception or misrepresentation made by a person or entity that is unaware the deception or misrepresentation could result in some unauthorized benefit to himself/herself or some other person(s) or entity(ies).

Examples of Risks for Fraud, Waste and Abuse
Prescriber Fraud, Waste and Abuse

- *Illegal remuneration schemes*: Prescriber is offered, or paid, or solicits, or receives unlawful remuneration to induce or reward the prescriber to write prescriptions for drugs or products.
- *Prescription drug switching*: Drug switching involves offers of cash payments or other benefits to a prescriber to induce the prescriber to prescribe certain medications rather than others.
- *Script mills*: Provider writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for patients that are not theirs. These scripts are usually written, but not always, for controlled drugs for sale on the black market, and might include improper payments to the provider.
- *Provision of false information*: Prescriber falsifies information (not consistent with medical record) submitted through a prior authorization or other formulary oversight mechanism in order to justify coverage. Prescriber misrepresents the dates, descriptions of prescriptions or other services furnished, or the identity of the individual who furnished the services.
- *Theft of prescriber's DEA number or prescription pad*: Prescription pads and/or DEA numbers can be stolen from prescribers. This information could illegally be used to write prescriptions for controlled substances or other medications often sold on the black

market. In the context of e-prescribing, includes the theft of the provider's authentication (log in) information.

Medicare Beneficiary Fraud, Waste and Abuse Risks

- *Misrepresentation of status*: A Medicare beneficiary misrepresents personal information, such as identity, eligibility, or medical condition in order to illegally receive the drug benefit. Enrollees who are no longer covered under a drug benefit plan may still attempt to use their identity card to obtain prescriptions.
- *Identity theft*: Perpetrator uses another person's Medicare card to obtain prescriptions.
- *Prescription forging or altering*: Where prescriptions are altered, by someone other than the prescriber or pharmacist with prescriber approval, to increase quantity or number of refills.
- *Prescription diversion and inappropriate use*: Beneficiaries obtain prescription drugs from a provider, possibly for a condition from which they do not suffer, and gives or sells this medication to someone else. Also can include the inappropriate consumption or distribution of a beneficiary's medications by a caregiver or anyone else.
- *Resale of drugs on black market*: Beneficiary falsely reports loss or theft of drugs or feigns illness to obtain drugs for resale on the black market.
- *Prescription stockpiling*: Beneficiary attempts to "game" their drug coverage by obtaining and storing large quantities of drugs to avoid out-of-pocket costs, to protect against periods of non-coverage (i.e., by purchasing a large amount of prescription drugs and then disenrolling), or for purposes of resale on the black market.
- *Doctor shopping*: Beneficiary or other individual consults a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.
- *Improper Coordination of Benefits*: Improper coordination of benefits where beneficiary fails to disclose multiple coverage policies, or leverages various coverage policies to "game" the system.
- *Marketing Schemes*: A beneficiary may be victimized by a marketing scheme where a Sponsor, or its agents or brokers, violates the Medicare Marketing Guidelines, or other applicable Federal or state laws, rules, and regulations to improperly enroll the beneficiary in a Part D Plan.

Pharmacy Fraud, Waste and Abuse

- *Inappropriate billing practices:* Inappropriate billing practices at the pharmacy level occur when pharmacies engage in the following types of billing practices:
  - Incorrectly billing for secondary payers to receive increased reimbursement
  - Billing for non-existent prescriptions
  - Billing multiple payers for the same prescriptions, except as required for coordination of benefit transactions
  - Billing for brand when generics are dispensed
  - Billing for non-covered prescriptions as covered items

- Billing for prescriptions that are never picked up (i.e., not reversing claims that are processed when prescriptions are filled but never picked up)
- Billing based on "gang visits," e.g., a pharmacist visits a nursing home and bills for numerous pharmaceutical prescriptions without furnishing any specific service to individual patients
- Inappropriate use of dispense as written ("DAW") codes
- Prescription splitting to receive additional dispensing fees
- Drug diversion

- *Prescription drug shorting:* Pharmacist provides less than the prescribed quantity and intentionally does not inform the patient or make arrangements to provide the balance but bills for the fully-prescribed amount.
- *Bait and switch pricing*: Bait and switch pricing occurs when a beneficiary is led to believe that drug will cost one price, but at the point of sale the beneficiary is charged a higher amount.
- *Prescription forging or altering:* Where existing prescriptions are altered, by an individual without the prescriber's permission to increase quantity or number of refills.
- *Dispensing expired or adulterated prescription drugs:* Pharmacies dispense drugs that are expired, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- *Prescription refill errors:* A pharmacist provides the incorrect number of refills prescribed by the provider.
- *Illegal remuneration schemes:* Pharmacy is offered, or paid, or solicits, or receives unlawful remuneration to induce or reward the pharmacy to switch patients to different drugs, influence prescribers to prescribe different drugs, or steer patients to plans.
- *TrOOP manipulation:* When a pharmacy manipulates TrOOP to either push a beneficiary through the coverage gap, so the beneficiary can reach catastrophic coverage before they are eligible, or manipulates TrOOP to keep a beneficiary in the coverage gap so that catastrophic coverage is never realized.
- *Failure to offer negotiated prices:* Occurs when a pharmacy does not offer a beneficiary the negotiated price of a Part D drug.

<u>Pharmacy Benefit Manager (PBM) Fraud, Waste and Abuse</u>

- *Prescription drug switching:* The PBM receives a payment to switch a beneficiary from one drug to another or influence the prescriber to switch the patient to a different drug.
- *Unlawful remuneration:* PBM receives unlawful remuneration in order to steer a beneficiary toward a certain plan or drug, or for formulary placement. Includes unlawful remuneration from vendors beyond switching fees.
- *Inappropriate formulary decisions:* PBM or their P&T committee makes formulary decisions where cost takes precedence over clinical efficacy and appropriateness of formulary drugs.
- *Prescription drug splitting or shorting:* PBM mail order pharmacy intentionally provides less than the prescribed quantity and does not inform the patient or make arrangements to provide the balance but bills for the fully-prescribed amount. Splits prescription to receive additional dispensing fees.

- *Failure to offer negotiated prices:* Occurs when a PBM does not offer a beneficiary negotiated price of a Part D drug

Section 9: Medical Management and Quality Improvement and Accreditation

Medical Management Plan

The 2011 Medical Management Plan defines and clarifies the structure and function of the Health Services Department. This document provides a definition of authority and accountability for medical management activities within the organization, articulates the scope and content of the Medical Management program, identifies the roles and responsibilities of individuals involved, and outlines the program evaluation process.

The Geisinger Health Plan/Geisinger Indemnity Insurance Company/Geisinger Quality Options (GHP/GIIC/GQO) Medical Management Plan is structured to encompass all product lines including, but not limited to, Commercial HMO/POS, Gatekeeper PPO and Medicare product lines.

Philosophy

It is GHP/GIIC/GQO's philosophy to assure the Medical Management Department is structured to manage the use of resources, and to maximize the effectiveness of care and services provided to Members. The Medical Management Department functions are described below.

Mission

- To respect all Members and strive to respond appropriately to Members' care and service needs.
- To improve the health and quality of life of Members by offering quality, well-coordinated health care education and services.
- To measure, evaluate, report, and implement interventions that improve the health status of members.
- To facilitate the delivery of quality care to members in the most cost efficient manner utilizing the appropriate level of care to meet the clinical need.
- To facilitate the Member appeal, complaint, and grievance process in a manner that is timely, supportive to the member, and guided by the member benefit document.

Goals

The overall goal of the Medical Management Plan is to assure that covered health care services are accessible, medically appropriate and cost effective.

Objectives include:

- To identify processes appropriate for medical management review in order to promote improvement in care delivery.

- To communicate to Providers and Members topics related to optimum use of services.
- To serve as a resource for analysis of reports of the medical management experiences, share with Providers and develop appropriate action plans.
- To encourage a "process improvement" philosophy when addressing medical management issues.
- To conduct an annual review/revision/evaluation of the Medical Management Plan, policies /procedures, and criteria.
- Evaluate new technologies and implement medical policies that reflect current medical practices
- To assure medical appropriateness is the basis for Medical Management (MM) decision- making and to assure financial incentives do not impact denials of coverage or service.
- To provide appropriate, consistent and timely MM decisions using evidenced-based medical criteria and Member benefits.
- To promote the use of mechanisms that assesses consistent adjudication of denials and appeals across all MM decision-makers.
- To assure reasonable access to covered care and service for Members throughout the network.
- To facilitate exchange of information between Medical Management, Case Management, Appeals, Medical Claims Research and Quality Improvement (QI) functions to facilitate process improvement, continuity of care, proactive services, and issue resolution.
- To analyze results of the Provider Satisfaction Survey related to Medical Management functions, identify areas of improvement, and develop any appropriate action plans.
- Comply with all state, federal and accreditation agency requirements.

Authority

Medical Management personnel have the authority to review the medical record of any Geisinger Health Plan Member; to discuss findings with the physician or other providers, and to initiate appropriate actions as directed by the Vice President, Chief Medical Officer or his designee (VP Health Services, Medical Directors/Health Services, and Regional Medical Directors). This authority is documented in the GHP Subscription Certificate.

GHP has the authority to delegate MM activities to another agency. Should the Plan exercise that authority, the Medical Management Department will be responsible to assure the delegated agency is in compliance with the contractual agreement, Plan's policies, and all applicable regulations / standards.

Structure

1. **Key Staff Responsibilities and Activities:**

A. The Vice President, Chief Medical Officer and Vice President of Health Services hold administrative responsibility for the Health Services Department and are involved in program implementation. **(Attachment A – Health Services Organizational Chart)**

* *The Vice President, Chief Medical Officer* is the designated physician for providing clinical leadership in the development, implementation, oversight, continuous improvement and effectiveness of the Medical Management programs. The VP, Chief Medical Officer reports to the Board of Directors, chairs the Medical Management Administrative committee (MMAC) and serves on the Pharmacy and Therapeutics committee, and the Technology Assessment committee among others.
* *The Vice President, Health Services* is the Administrator in charge of overseeing all medical management operations. The VP, Health Services reports to the CMO and serves on MMAC and a multitude of other committees.

B. *The Medical Directors/Health Services and Regional Medical Directors* of the Geisinger Health Plan serve as the designees for the CMO for decisions based on medical appropriateness, authorization of referral to out of network providers, and dialogue with providers related to services and the appeal of MM denials.

* *Medical Director/Health Services/Medical Informatics*- Licensed physician who has leadership responsibility for the Medical Management area related to inpatient and out patient care. Works closely with the VP Health Services and reports directly to the CMO.

* *Medical Director/Health Services*- Licensed physician who has leadership responsibility for the Medical Management area related to patient care. Works closely with the VP Health Services and reports directly to the CMO.

* *Medical Director/VP Pharmacy*- Licensed physician designated as the lead medical authority for all Health Plan activities within the North Central Region and takes a leadership role in relationship building within the region. Also responsible for all Pharmacy activities within the Health Plan. Works closely with the VP Health Services and reports directly to the CMO.

* *Medical Director/Health Services/Proven Health Navigator* Licensed physician designated as the medical team leader for all Health Plan activities within the Western Region and takes a leadership role in relationship building within the region. Also responsible for working with the VP, Health Services to champion the Health Navigator care model. Works closely with the VP Health Services and reports directly to the CMO.

* *Medical Director/Health Services/Quality and Performance* Licensed physician responsible for all activity related to quality of care rendered to Health Plan members and by participating providers. Works closely with the VP Health Services and reports directly to the CMO.

All GHP Medical Directors have authority to make MM decisions including denials. All GHP Medical Directors are board-certified physicians engaged in a variety of clinical specialties. The Medical Directors interact on a regular basis with the MM staff in the processes to support MM decision-making. The MM Professional Staff are licensed in the State of Pennsylvania and are the initial contact for MM decision-making; however, this staff does not issue denials on the basis of medical necessity. All Medical Directors report directly to the CMO.

C. *Behavioral Health Practitioner*: The Regional Medical Director and Regional QI Director of the behavioral health delegated entity; United Behavioral Health (UBH), (or their designee) is responsible for implementing the behavioral health aspects of the MM and QI Programs (in cooperation with the Health Plan VP, Chief Medical Officer). The UBH Medical Director works closely with the Health Plan CMO and the Medical Director/Health Services for overseeing and implementing programs related to Behavioral Health. The Regional Medical Director of UBH participates in both the Behavioral Health oversight committee and the Quality Improvement committee.

D. Medical Management Professional Staff: The professional staff within the Medical Management area includes RN's, LPN's, Occupational, Physical and Respiratory Therapists. All professional staff are licensed in Pennsylvania and have the ability to approve requests based on specified criteria. They can recommend denials based on specified criteria, and those recommendations will be reviewed by a Medical Director for the final decision. All professional staff report to a Director who is a licensed respiratory therapist, and to the Vice President, Health Services who is an RN.

E. *Outpatient Case Management Nursing Staff:* The nursing staff including Disease/Case Management nurses and Medical Home Case Managers, who provide disease management, case management and coordination of care services.

2. Committee Structure (Attachment B)

The following describes the Medical Management Administrative Committee reporting structure and responsibilities:

A. Medical Management Administrative Committee (MMAC) meets monthly.

1. <u>Role</u>

- The MMAC is responsible for functioning as the oversight committee for the Medical Management process and activities. This committee receives and makes recommendations on information and reports received from the subcommittees.

2. <u>Committee/Chairman</u>

- Geisinger Health Plan Vice President, Chief Medical Officer.

Committee is comprised of Medical Directors, VP Health Services, Administrative staff, Medical Management, Case/Disease Management, Pharmacy, Accreditation, Appeals, QI and Provider Network Management etc.

3. *Reports to Geisinger Health Plan Quality Improvement Committee through the Vice President of Health Services at least semi-annually.*

4. *Responsibilities*
   - Review/approval of the Medical Management Plan and Evaluation.
   - Review/approval of MM criteria.
   - Review/approval of Medical Policies.
   - Oversight of Pharmacy & Therapeutics Committee and their activities.
   - Oversight of Physician Advisory Group and their activities.
   - Oversight of Technology Assessment Committee and their activities.
   - Oversight of The Behavioral Health Oversight Committee and their activities related to Medical Management.
   - Oversight of the Medical Management Committee and their activities.
   - Oversight of the MM portion of the Provider/Member Satisfaction Surveys.
   - At least semi-annual report to the GHP Quality Improvement Committee
   - Oversight of any delegated MM activity
   - Technology Assessment Committee reports related to approvals and denials.
   - Oversight of the MM portion of the CAHPS Survey.

5. *Subcommittees of MMAC*

   a. The Medical Management Committee (MMC) meets twice monthly (first and third Monday).

   1. *Role*
      - The MMC is responsible for coordinating operational activities throughout the Health Services department along with operational policy review/approval. MMC is also responsible for an initial review of medical policies and clinical guidelines with recommendations to MMAC.

   2. *Chairperson/Committee membership*
      - Medical Policy/Clinical Guidelines Manager

      Committee is comprised of Medical Directors, Pharmacy, Appeals, Medical Management, Case/Disease Management, Accreditation, Reimbursement and Benefits/Configuration departments.

   3. *Reports to MMAC*

   b. Pharmacy and Therapeutics (P&T) Committee Meets quarterly

1. *Role*
   - The P&T committee is responsible for ensuring that procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals. This committee is also responsible for reviewing new pharmaceuticals for possible inclusion in the formulary/medical benefit determinations.

2. *Chairperson/Committee membership*
   - Vice President, Chief Medical Officer

   Committee is comprised of Medical Directors, Pharmacy representatives, participating physician representation and Manager of Clinical Guidelines. As an adjunct to this committee there are several advisory committees from multiple clinical specialty areas who provide expertise related to specific clinical issues.

3. *Reports to MMAC*

c. Technology Assessment Committee- meets quarterly

1. *Role*
   - Responsible for evaluating new medical technologies and new applications of existing technologies for possible inclusion in the benefit package. This may include medical technologies, behavioral health procedures or other devices. (All new pharmaceuticals/pharmaceutical procedures will be taken through the P&T committee).

2. *Chairperson/Committee Membership*
   - GHP Medical Director, Health Services

   Committee is comprised of up to 17 physicians from multiple specialties, up to 3 lay members and support staff.

3. *Reports to MMC, MMAC, QIC and GHP Board of Directors*

d. Behavioral Health Oversight Committee- meets quarterly

1. *Role*
   - Responsible for oversight of the delegated behavioral health services to include, but not limited to, review of reporting received from the delegated entity and HEDIS data.

2. *Chairperson/Committee membership*
   - Medical Director/ Health Services

   Committee is comprised of Administration, PNM, Pharmacy, Accreditation, QI, Medical Management, Case/Disease Management

along with multiple representatives from the behavioral health vendor, UBH.

3. Reports to MMAC and then QIC

e. Physician Advisory Group (PAG) (Meets electronically on an ad hoc basis)

1. Role

- Responsible for providing input related to clinical, service, administrative or regulatory issues.

2. Chairperson/committee membership

- One of the GHP Medical Directors or any GHP employed designee of the Medical Director

Committee composition includes 5-10 multi-specialty physicians.

3. Reports to MMC and then MMAC

3. Committee Minutes

- Minutes will be generated for all Medical Management Administrative Committee and Sub-committee meetings, with review and approval by each Committee.
- The minutes will reflect the activity, discussion, analysis and recommendations of the committees as well as follow-up and resolution of prior recommendations.
- The minutes will be dated and signed by the chairperson and the recording secretary.

4. Medical Management Plan/Evaluation

The Geisinger Health Plan Medical Management Program is designed to provide the structure and processes for continuously monitoring, analyzing and improving the clinical care and services managed through the Health Services Department. At the beginning of each year (and when necessary) the Health Services Department reviews/revises the Medical Management Plan. The Medical Management Plan defines the mission, goals, structure and scope of the Medical Management, Case/Disease Management, Medical Home and Appeal Departments. The Plan also outlines the committee reporting structure.

An evaluation is conducted annually by the Health Services Department and impacts the forthcoming MM plan. The annual evaluation serves to evaluate the impact of the Medical Management Program. This document describes the activities conducted by the Medical Management Department under the direction of the MMAC and evaluates (by tracking and trending) the effectiveness of these activities. The impact of the program with respect to delivery of services is monitored and evaluated through the following:

- MM Data Reporting
- CAHPS Survey
- HEDIS
- Physician Satisfaction Surveys

The Medical Management Plan and the Medical Management Annual Evaluation are reviewed and approved by the Medical Management Administrative committee, then the Quality Improvement committee, on an annual basis.

5. MM/QI Program Integration

The Medical Management Department plays a vital role in the Quality Improvement Process. The MMAC Committee comprised of Senior Medical Management personnel oversees Medical Management processes and reports directly to the Quality Improvement Committee. The flow of information between departments goes in both directions. Opportunities identified in either area may be shared through multiple methods such as committee meetings and face-to-face interactions and may be the basis of development of a QI activity or change to a MM procedure.

6. Behavioral Health Aspects of the MM Program

Management of behavioral health care is conducted by UBH for Health Plan members. The UBH Regional Medical Director for the St. Louis Care Advocacy Center (CAC) is the designated behavioral health practitioner responsible for providing clinical leadership to the Quality Management Program within the CAC. As such the UBH Regional Medical Director is also responsible for providing clinical leadership to the Health Plan related to all behavioral health activities. More details (including triage/referral/levels of care) are described in the UBH MM program description.

7. Appeal Procedures for Adverse Determinations

The Plan has a formal process for appeals and grievances to meet the standards/requirements of regulatory and accrediting bodies. Policies and procedures have been developed for Member and Provider appeals processes and are managed by the Appeals Department for Member appeals and through the MM department for the Provider appeals. More specific details are described in the associated policies.

8. Delegation of MM (Attachment C-Delegation Agreements)

The Health Plan is accountable for the decisions of any entity to whom a specific MM activity is delegated. Oversight activities include a pre-delegation assessment of the delegate's ability to perform the delegated activities, an annual review of the delegate's performance, review and approval of delegate's MM program description and annual evaluation and review of quarterly reports from the delegated entity to assess the impact of activities on quality and delivery of health care to members. All delegated arrangements are described in the attachment, including NCQA accreditation status.

Scope

"Medical Necessity" or "Medically Necessary" is defined by Geisinger Health Plan as covered services rendered by a health care provider, that the Health Plan determines are:

A. Appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease or injury.
B. Provided for the diagnosis and the direct care and treatment of the member's condition, illness, disease or injury.
C. In accordance with current standards of good medical treatment practice by the general medical community.
D. Not primarily for the convenience of the member or the member's health care provider.
E. The most appropriate source or level of service that can safely be provided to the member. When applied to hospitalization this further means that the member requires acute care as an inpatient due to the nature of services rendered or the member's condition and the member cannot receive safe or adequate care as an outpatient.

The Plan's Medical Management decision process will be supported by evidence-based criteria in order to assure decisions are made in a fair, impartial, and consistent manner.

Review and selection of MM criteria will be the responsibility of the MMAC, with recommendations from the Medical Directors, PAG, MMC and MM staff. The criteria will serve as a guideline, with opportunity for the Medical Director to consider all the factors in a case and determine the decision.

Evidence-based clinical criteria used to support MM decisions will be managed through MMAC using the following process:

- Criteria adoption or revisions will be supported by appropriate clinical evidence.
- Criteria are made available for input from the PAG.
- After review of all input, the MMAC will record their formal vote on acceptance of the criteria;
- The MM Department maintains a policy/procedure to define application of the criteria using clinical and psychosocial information on a given case, including specifics of the local delivery system;
- Criteria will be revised as necessary and reviewed no less than annually;
- Inter-rater reliability testing will be performed and documented at least annually for all nursing, therapy and physician staff involved in the application of the criteria; and
- The provider Manual will provide direction as to how a participating practitioner can avail themselves of the criteria, as defined by an existing vendor copyright.

Data sources which may be used during the decision making process include but are not limited to the following:

Clinical Information from the treating physician such as: patient demographics, diagnosis, requested service, clinical findings, pertinent imaging, pertinent lab finding and pertinent treatment/medications.

In addition, individual needs and local delivery system assessments are considered. These may include age, co-morbidities, complications, progress of treatment, psychosocial situations, home environment and availability of appropriate services in the identified Health Plan service area.

Behavioral Health to include Mental Health and Substance abuse is an integral part of the Medical Management Program. This program is managed by UBH, an accredited MBHO, as a delegated activity. The Health Plan requires routine reporting, which is reviewed at multiple levels, including Behavioral Health Oversight Committee and also the Quality Improvement Committee. Geisinger Health Plan and UBH work cooperatively to assure the best possible outcomes for the member.

1. MM Functions

A. Precertification

Precertification of non-emergency facility admissions must be initiated by the admitting physician or facility through telephone or fax contact with the Medical Management staff at the Plan. The Medical Management staff utilize InterQual® SI/IS clinical guidelines, as a basis for determinations, according to the clinical detail presented to them. The Medical Management Staff will utilize the InterQual® SI/IS guidelines to determine the following:

- Medical necessity of the requested care
- Appropriateness of the service, location and level of care
- Appropriateness of the length of stay
- Assignment of the next anticipated review

Cases failing the InterQual® SI/IS guidelines or not meeting GHP Medical Policy, in the judgment of the nurse, are referred to a GHP Medical Director for final decision. Discussion with the requesting physician and/or an appropriate licensed specialty physician may be included in the decision making process.

Precertification provides an opportunity to intervene when any of the following are identified:

- Potential inappropriate health care services and admissions
- Complex cases appropriate for Case Management
- Discharge planning needs
- Potential quality of care issues
- Members who would benefit from Disease Management Programs.
- Clarification of par provider's availability to provide the service.

Providers are instructed to utilize their this Manual to assist them with the pre-certification process.

Timelines for decision making are as follows:

- Pre service non-urgent (HMO, PPO)—within 15 days of receipt of the request
- Pre service urgent (HMO, PPO)—within 72 hours of receipt of the request
- Pre service non-urgent (Medicare)—within 14 calendar days of receipt of the request
- Pre service urgent (Medicare)—within 72 hours of receipt of the request

The Health Plan has a delegated Outpatient Radiology Prior Authorization Program for certain outpatient radiology services that is managed by National Imaging Associates (NIA). Prior Authorization is required for non-emergent outpatient CT scans, MRI, MRA, PET scan and/or nuclear cardiology services.

B. Concurrent Review

Concurrent Review of acute, subacute, rehab, and SNF admissions are performed by the MM nurses and/or therapists as initiated by the physician or facility of admission. As with precertification, the concurrent review process is supported by InterQual® guidelines and the Plan's Medical Directors. Reviews are conducted by nurses and include the following:

- Evaluation for appropriateness (medical necessity, level of care, length of stay);
- Evaluation and coordination of discharge planning and transitions of care to next point of care (nursing home, home health, rehab, etc);
- Referral to Case Management or Disease Management programs;
- Referral to Transplant Management Nurses; and
- Identification of potential quality of care issues.

The MM nurses and therapists evaluate and participate in discharge planning in conjunction with the facility Medical Management Review nurse, and GHP Complex Case Management Case Managers to facilitate the transition of the Member from an inpatient setting to a less acute setting that is more appropriate to the Member's condition and to coordinate efficient management of benefits. The MM nurses and therapists refer appropriate facility admissions to Outpatient Case Management for assessment and management.

Timelines for decision making are as follows:

- Concurrent urgent (HMO, PPO)—within 24 hours of receipt of the request

C. The Determination of Coverage Process

The Determination of Coverage (DOC) process is coordinated through an LPN Case Manager (or MM RN if the scope is transplant services) in response to pre-service requests from a member or provider for authorization of coverage. The Plan's Medical Directors are consulted in the DOC process and licensed specialty physician input is incorporated as indicated. Any denial, on the basis of medical necessity, is

made by the Medical Director. Determination of Coverage decisions are made considering these factors (other factors may also be used):

- Member's benefit document;
- Member's individual needs
- The Plan's local delivery system available to the Member, participating/preferred provider's ability to provide service, availability of skilled, sub-acute, and home services and coverage of these services;
- NCQA, CMS, and other state and federal regulations;
- Standards of medical practice;
- The Plan's Medical Policies;
- Articles, literature, and research studies;
- Pertinent clinical information from other providers involved in the Member's care; and
- Recommendations from the Geisinger Technology Assessment Committee.

If coverage for the request does not require a medical necessity determination because it is addressed as a specific exclusion within the Member's benefit document, the nurse will generate a notice to the Member identifying the specific contract exclusion.

Timelines for pre-service determinations are noted under Section VI, 1.A.

The nurse coordinates a Member's care needs with both participating and non-participating providers in order to assure continuity of care and optimal outcomes. These nurses work closely with the Case/Disease Management nurses in the management of cases requiring both benefit and Case/Disease Management services, as well as in cooperation with the Transplant management vendor.
A list of services/procedures requiring determination of coverage is maintained by the MM department and is available to providers in their ProviderManual.

D. Retrospective Review

Retrospective Reviews are reviews conducted after services have been provided to the Member. Retrospective review includes a medical necessity evaluation of the care/service provided to the Member, and physician compliance with the MM program requirements. Retrospective review includes consideration of medical criteria, member benefit information, administrative guidelines, and national coding guidelines. The individual needs of the Member as well as local delivery system availability are considered. Retrospective reviews and reconsideration of medical claims denied through claim edit or claim review processes are performed by a Medical Claims Research Coordinator. These reconsideration decisions are based on medical documentation, CPT and ICD-9 coding principles, government regulations, and current contracts along with the aforementioned criteria. The Plan's Medical Directors are consulted for medical necessity evaluation.

Timelines for decision making are as follows:

- Post service (HMO, PPO)—within 30 days of receipt of the request

E. Out of Network Management

The MM professional staff follows the care of Members admitted to a non-participating facility for emergency care. When the clinical case supports the ability of the Member to be safely transported, retrieval to a participating facility may be offered. The nurse in cooperation with the GHP Medical Director and/or triage physician at the Emergency Department of Geisinger Medical Center, Danville, coordinate this transport.

F. Transplant Services

The MM professional staff provides coordination of benefits and case management to members approved or considered for organ and bone marrow transplantation. The GHP Medical Director oversees the transplant process and has ultimate responsibility for any decisions based on Medical Necessity. These decisions are based on the criteria noted as described in the scope section of this document.

G. Discharge Planning:

Health Services nursing staff evaluate and coordinate health services and care to encourage the transition of the patient from an inpatient setting to a less acute setting which is more appropriate to the patient's condition. Health Services staff participate in discharge planning to coordinate efficient management of benefits and coordination of services through discharge.

H. Case Management Process

Geisinger Health Plan Benefit Nurse Coordinators provide limited case management activity in relation to requests for certain out-of-network services that are required by members. Serious and complex medical care needs are referred to case managers for triage into case management/disease management programs.

I. Transition of Care

Members identified as having exhausted a limited benefit are referred to Case Management. These nurses evaluate and assist in transitioning care to any existing alternative resources if available. This is performed through referral to local or state funded agencies, community services and/or other resources.

J. Continuity of Care

The Plan is committed to ensuring the Member's continuity and coordination of care with their provider if the Member is undergoing an active course of treatment for an acute episode of a chronic illness or acute medical condition or if the Member is in the second or third trimester of pregnancy when that provider's participation

agreement is discontinued. The Plan is also committed to a new Member's right to continuity and coordination of care if Member's provider is not participating with the Plan. Certain conditions must be satisfied prior to continuity being approved. These conditions are described in the established Health Plan policy. These conditions are designed to meet the needs of the Member while meeting the requirements of all external regulatory and accrediting bodies.

K. Emergency Services Management

Geisinger Health Plan currently does not deny emergency service claims. All emergency service claims are adjudicated for payment without review for coverage determination.

L. On-site Review Process

On-site review services may be conducted at participating facilities throughout the service areas. Functions include concurrent and retrospective review when applicable. Guidelines have been established for identification of GHP MM staff at the facility, a process for scheduling the review in advance and a process for ensuring GHP staff follow facility rules. This process is described in more detail in the policy. On-site reviews are not currently being conducted.

M. Medical Policy/Technology Assessment

Geisinger Health Plan has a formal mechanism to evaluate and address new developments in technology and new applications of existing technologies for consideration of inclusion in the benefit package. This evaluation is conducted in an effort to keep pace with changes in services which may be available to our membership. This program ensures members have equitable access to safe and effective care. The four elements to be evaluated include:

- Medical Technologies
- Behavioral Health Procedures
- Pharmaceuticals
- Devices

The Medical Policy Manager utilizes resources such as (but not limited to) Geisinger Health Plan Technology Assessment Committee, Hayes Inc. and ECRI Institute Technology Assessment resources, current professional literature reviews, Geisinger Health Plan Medical Directors, pharmacists, and physician consultants/experts. These policies direct informed decisions about medical care within the benefit structure. Once developed, Medical Policies are reviewed and approved by the MMAC. Final approval by the Vice President, Chief Medical Officer is required.

New pharmaceuticals are evaluated through the Pharmacy and Therapeutics committee, using specific criteria.

N. DME, Home Health and Outpatient Rehab Services

Management of services for DME, Home Health, and Outpatient Rehab is directed through the Medical Management Committee.

O. Disease/Case Management Program

1. Disease Management

Please note: 1). Disease/Case Management programs overlap with quality and medical management. The specific DM programs are described in more detail in the QI plan. 2). Case/Disease Management and Medical Home are the Health Plan departments responsible for the coordination and delivery of disease/case management services.

Disease Management is defined as the application and coordination of resources for a population of Members characterized by the presence of a chronic condition (such as diabetes, asthma, or heart failure). Resources are applied across the continuum of care and through the life cycle of disease to achieve optimum levels of wellness. The key words in disease management are "population" and "chronic illness."

The goal of The Plan's Disease Management Program is to promote quality health outcomes relying on Disease Management nurses working in concert with the patient, family, provider and other members of the health care team.

The Disease Management Programs are established utilizing evidence-based Clinical Guidelines (developed from nationally accepted best practice parameters, specialty and practitioner input), Stratification and Assessment Guidelines, and internally developed Intervention Pathways. Members are eligible to receive education by Disease Management nurses to improve self-management skills and individualized support for optimal health outcomes.

The goals of the Disease Management Programs are to:

- Improve self-management skills of Members;
- Promote quality healthcare including appropriate monitoring and treatment strategies;
- Enhance wellness through appropriate preventive screenings;
- Coordinate appropriate utilization of services;
- Facilitate and coordinate appropriate outpatient, inpatient and emergency room utilization, as indicated.

Disease Management Programs involve voluntary participation from the Member. The Health Plan encourages active Member participation in Disease Management through direct mailings, Newsletters (*Member Updates)* and direct communication with Practitioner and Member.

Current Disease Management Programs include:

- Diabetes Care Program
- Adult and Pediatric Asthma Care Program
- Stop Tobacco Use Program
- Osteoporosis Management Program
- Hypertension Program
- Chronic Obstructive Pulmonary Disease (COPD)
- Heart Failure (HF)
- Coronary Artery Disease (CAD)

2. Complex Case Management

Complex Case Management is the coordination of care and services for members with multiple or complex conditions or other special needs. Case Management is a collaborative process of assessment, planning, implementation, coordination, monitoring, evaluation and advocacy for options and services to meet Member's health care needs and to promote appropriate, cost-effective outcomes.

The goals of Case Management include the following:

- To assess Member/family needs and provide access to needed services;
- To coordinate care based on a strong understanding of Member's benefit (in cooperation with MM professional staff);
- To develop a plan of care in conjunction with the member/family and provider, that addresses the specific care needs relevant to the Member and to implement delivery of Case Management services in a timely fashion;
- To involve the Member/family in the formulation of the Case Management plan of care and in the decision making process;
- To focus on continuity of care, minimize care fragmentation and provide a smooth transition between providers and levels of care, especially in the areas of medication reconciliation and coordination of services;
- To maximize the appropriate, efficient, and cost effective utilization of available resources.

A. Nursing Staff

The majority of Case Managers are Registered Nurses licensed in the state of Pennsylvania who provide support services, education, and coordination of care for serious and complex medical cases. The Case Management Program is provided directly to the Member at the practitioner's office at owned or contracted primary care sites and/or telephonically.

The Case/Disease Management staff seeks guidance when managing complicated cases by contacting the on-call Medical Director and working directly with the member's primary/specialty care provider.

3. Proven Health Navigator

   The Health Plan developed and implemented a Proven Health Navigator (formerly Medical Home) program based in primary care sites across the network. The program is designed to improve the quality and efficiency of care based on primary care redesign, onsite case management, team-based care, improved access, QI strategies, care systems management and redesigned reimbursement strategies.

2. Ensuring Appropriate Utilization

Geisinger Health Plan facilitates the delivery of appropriate care and monitors the impact of the medical management program. This process is designed to assist in detecting potential under/over utilization of services. The review consists of examining utilization data against established thresholds and taking appropriate action on identified opportunities for improvement.

Over/under utilization is monitored for the GOLD population using the following HEDIS metrics.

- Inpatient days/1000
- ALOS
- Outpatient visits/1000
- Mental health Ambulatory services

Thresholds are based on the Medicare HEDIS Means, Percentiles and Ratios report, using the 90th and 10th percentiles.

The affirmative statement regarding the MM Decision Making process is distributed to practitioners, providers, employees and members. The statement notes:

- MM decision making is based on (1) the medical necessity and the appropriateness of care and services and (2) the existence of coverage taking into consideration the member's individual circumstances and the applicable contract language contained within the member's benefit document concerning covered services and exclusions.
- The Health Plan does not specifically reward practitioners or other individuals conducting utilization review for issuing approvals or denials of coverage or services.
- The Health Plan does not offer incentives for MM decision makers that encourage decisions that might result in under utilization.

3. Related Medical Management Functions

A. Drug Utilization Review

Drug Utilization Review (DUR) will be managed through the Plan's Pharmacy Department, utilizing the processes and timeframes designated by the PA Department of Health, PA Department of Insurance, NCQA, DOL, and CMS. DUR will include precertification, retrospective review, provider profiling, formulary management, and formulary design. The Medical Directors are consulted for medical necessity issues and denials. Application of new drugs, as well as formulary status decisions will be determined by the Pharmacy and Therapeutics Committee, and then reported to the MMAC.

B. Tel-A-Nurse

Support to members for medical information and advice on a 24/7 basis is provided through the Tel-A-Nurse program. This program is available to all Members through a toll free telephone number.

C. Provider Satisfaction Survey

Provider Satisfaction Survey is utilized by the Plan to survey participating providers and office managers in order to determine areas of strength and to identify opportunities for improvement. Medical Management processes are included in this survey. This survey is conducted on a yearly basis and the results are reviewed at MMC. The results are compared to those from the year before and an action plan is presented to MMAC.

D. Member Satisfaction Survey

Member Satisfaction is measured in several ways. These methods include CAHPS Survey (annual) and post discharge surveys (on-going). These surveys evaluate member satisfaction with the medical management process. The results are presented to the MMAC committee.

E. Notification of Review Determinations

The MM staff provides telephonic and/or written notification of benefit determinations for precertification, concurrent review and retrospective review. Communication and documentation of the denial are provided to both practitioner and Member as designated by the applicable regulatory bodies.

Written notification of adverse determinations (denials) include the following:

- Principle reason(s) in easily understandable language
- Reference to the benefit provision, guideline, protocol etc, which support the denial
- Clinical rationale
- Explanation of the Appeal/Grievance/Complaint procedure
- Availability of the benefit provision, guideline, protocol, etc. that was used.

F. Confidentiality

To ensure Member and practitioner confidentiality, staff training begins during the Medical Management orientation program. Only confidential information required for the purpose of performing Medical Management processes is collected. Access to this information is limited to those employees who have a need to know and/or those employees who have authority to receive such information. On-line confidential information is password protected. This process adheres to the Geisinger Health Plan confidentiality policy.

Medical Management employees sign a confidentiality statement on an annual basis.

G. Hours of Operation

Medical Management regular hours of business are Monday through Friday from 8:00 a.m. to 4:30 p.m. Medical Directors are on duty or on call 24 hours a day, seven days a week to be available for the decision processes regarding the care of the Plan's Members. This process is outlined in the MM Communications Guidelines Policy.

Quality Improvement Plan

Purpose

The Geisinger Health System mission is to enhance the quality of life through an integrated health service organization based on balanced patient care, education, research and community service. Geisinger Health Plan/Geisinger Indemnity Insurance Company/Geisinger Quality Options ("Health Plan") supports the overall mission of Geisinger Health System. The Health Plan Quality Improvement Program provides the structure and processes for continuously monitoring, analyzing, and improving the clinical care and services provided under Health Plan products in order to further that mission.

The Health Plan Quality Improvement program is structured to support all product lines including, but not limited to, Commercial HMO/POS and Gatekeeper PPO. Medicare product lines are described in a separate document.

Goals and Objectives

The following goals and objectives of the QI program (not in any specific order) function to support the concepts of continuous quality improvement.

To promote optimum health care in a managed care environment.

1. To conduct quality improvement activities to improve the quality of clinical care and services provided to members.

2. To identify, through data collection and analysis, provider practice patterns, operational procedures, and other activities where improvement will enhance the quality or efficiency of health care.

3. To conduct the quality improvement program based on identification of activities through methods including, but not limited to, demographic analysis, member feedback, and provider feedback.

4. To prioritize quality improvement activities based on high-volume, high-risk analysis.

5. To implement strong interventions for those activities identified as opportunities for improvement.

6. To conduct analysis of activity results using both a quantitative and barrier analysis methodology.

7. To assess effectiveness of interventions based on re-measurement and follow-up.

8. To promote efficient delivery of health care by evaluating the utilization of primary and specialty services.

9. To regularly assess the availability, accessibility and continuity/coordination of care provided to Geisinger Health Plan members.

10. To provide educational opportunities based on quality improvement findings.

11. To continually strive to further integrate quality improvement into operations.

12. To incorporate behavioral health activities into the QI program through workgroup participation, adoption of clinical guidelines and quality improvement studies/activities.

13. To specify policies and procedures specific to QI activities for the Health Plan.

To enhance our inter-disciplinary approach in the care of and service to Health Plan patients and/or members.

1. To include representatives of the various health care disciplines in the quality improvement process.

2. To involve both contracted and employed practitioners in various aspects of the QI program.

3. To emphasize the importance of a team effort to produce patient satisfaction and continuous quality improvement.

4. To enhance communication among health care team members.

5. To provide input into the organization and content of the Provider Manual .

6. To contribute to the formal orientation of Health Plan providers and practitioners.

7. To involve lay members of the Health Plan in multiple aspects of quality improvement.

8. To assure continuity and coordination of care, including how it relates to Behavioral Health Care and services.

9. To work cooperatively with the delegated entities to promote the highest level of member care and service.

C. To assure initial credentialing of all qualified practitioners and providers and subsequent recredentialing of same, in compliance with regulatory requirements.

D. To assure the maintenance of quality medical records.

1. To provide, through the Provider Manual, guidelines for documentation of medical record information.

2. To facilitate evaluation of quality of care and continuity/coordination of care through routine medical record audits, as defined by GHP policies.

E. To improve satisfaction of Geisinger Health Plan members and providers/practitioners.

1. To obtain member/provider/practitioner feedback through multiple mechanisms including but not limited to:

- Focus groups
- Member concerns/complaints/appeals/grievances
- Member surveys
- Practitioner/Provider feedback surveys

2. To analyze member/provider/practitioner satisfaction data from the above sources, identify opportunities for improvement and implement service improvement activities with strong actions and re-measurement as appropriate.

F. To assure that preventive health services are appropriately provided to members.

1. To target for CQI preventive health measures required for HEDIS and NCQA standards, as well as other measures meaningful to the membership.

2. To educate members about available health promotion, health education and preventive health services

G. To improve patient safety.

1. To educate members regarding clinical safety as it relates to their care.

2. To assess and intervene to improve the continuity and coordination of care and safety through monitoring of return communication between PCPs and Specialists.

3. To monitor physician medical record legibility and documentation to improve safe practices.

H. To serve the cultural and linguistic needs of the membership.

1. To assess the cultural and linguistic needs of the membership through on-line and hard copy surveys and telephone interactions.

2. To employ strategies to meet the cultural and linguistic needs of the membership through telephonic translation services and translation of member materials.

I. To serve members with complex health needs.

1. To serve members with complex health needs as identified in the Case Management policy through the Proven Health Navigator structure and the Case Management team.

Scope of Program

The scope of the quality improvement program is focused on delivering the highest level of quality care and service and to continually enhance member satisfaction. To this end, the comprehensive program uses a wide variety of data and techniques to monitor,

analyze, and evaluate proposed and ongoing improvement activities. Since the inception of the program in 1985, this process has been applied to hundreds of studies, activities, and monitors within the Health Plan. A separate annual QI Work Plan is developed, which details the schedule of activities and tracks progress on these quality initiatives. An Annual Evaluation is also prepared which documents the effectiveness of the QI program and measures how well it is achieving its goals and objectives.

The QI program identifies clinical issues through review of HEDIS and other clinical data results. The QI program identifies service initiatives through member satisfaction surveys, complaint and appeal analysis, monitoring systems and Health Plan operations.

The scope of the QI program is broadly divided into three areas: Clinical programs, Service Initiatives, and Coordinated Activities. QI activities are described in detail in the annual QI Work Plan.

QI activities performed by delegated entities are outlined in the delegated entity's QI plan/workplan/annual evaluations. These documents are reviewed by the Health Plan on an annual basis. Currently this consists of United Behavioral Health (Optum Health) and American Specialty Health Network.

Clinical Programs

Preventive Health Program – The preventive health program is structured to assist physicians in assuring members receive the preventive services they need. Education of members and providers occurs through the publication and distribution of recommended age-specific preventive services in newsletters and on the web site. QI specialists use targeted phone calls and surveys to reach out to members identified as needing services. To ensure the effectiveness of the program, member compliance with recommended health services is measured, mainly using HEDIS methodology. Measurement and improvement activities are wide in range. Examples include; cervical and breast cancer screening, childhood and adolescent immunization, and prenatal care.

Disease and Complex Case Management –The Health Plan develops and implements disease and complex case management programs. Nurses with clinical expertise proactively educate, manage and coordinate care for groups of members with defined chronic conditions. Disease management programs that are ongoing include, but are not limited to: Diabetes, Heart Failure (HF), Chronic Obstructive Pulmonary Disease (COPD), Osteoporosis, Asthma, Coronary Artery Disease (CAD), and Hypertension. Program data is reviewed at least quarterly. Programs and/or processes are revised as indicated by data results, clinical guideline revisions, and staff feedback. The need for additional disease management programs is also evaluated on a regular basis. Complex case management includes post-discharge follow-up of members with targeted conditions and care of members with multiple conditions.

Proven Health Navigator – The Health Plan developed and implemented a Proven Health Navigator (formerly Medical Home) program based in primary care sites across the

network. The program is designed to improve the quality and efficiency of care based on primary care redesign, onsite case management, team-based care, improved access, QI strategies, care systems management and redesigned reimbursement strategies.

Clinical Guidelines – The Medical Policy/Clinical Guidelines Manager leads the development, implementation, and updates to clinical guidelines to assist practitioners and members in the health care decision-making process. Clinical guidelines include but are not limited to: diabetes, sinusitis, asthma, pediatric otitis media, depression, hyperlipidemia in CAD, UTI and Pediatric ADHD. Clinical guidelines are used as the basis for all Health Plan Disease Management programs. The Health Plan systematically assesses performance against several guidelines annually.

Ongoing Clinical Monitors and Studies – Based on data analysis and recommendations from the QIC and other related QI committees/work groups, relevant quality initiatives and monitors are identified for inclusion in the QI program. All departments are responsible for the QI processes (quantitative measurements, implementation of interventions, etc.) relating to these initiatives. Mental Health initiatives are coordinated activities utilizing the Mental Health Carve out company, United Behavioral Health (UBH). Active initiatives include, but are not limited to the following:

- ADHD
- Follow-up After A Hospital Admission for Mental Illness—UBH
- Colorectal Cancer Screenings
- Breast Cancer Screening
- Cholesterol Management after a cardiac event
- Childhood Immunizations

Other initiatives that are continuing activities include, but are not limited to:

- Persistence of Beta Blocker treatment after a heart attack
- Ambulatory Medical Record Review

Behavioral Health Aspects of QI – The Health Plan works in conjunction with UBH to monitor and improve behavioral health services to our members. UBH's Quality Improvement Council, which is chaired by the Vice President of QI, is responsible for promoting the goals and objectives of UBH's QI program. Health Plan direction for these activities is provided by the Behavioral Health Oversight committee and the GHP Quality Improvement Committee led by the Health Plan VP, Chief Medical Officer. Activities being conducted include but are not limited to, follow-up after mental health admission, antidepressant medication management, readmissions within 30 days of discharge from inpatient care and initiation and engagement of alcohol and other drug dependence treatment. A detailed explanation of the behavioral health functions is outlined in the United Behavioral Health (UBH) QI plan, workplan and annual evaluation. These documents are reviewed and approved by the Health Plan's behavioral health oversight committee and Quality Improvement committee annually.

Pharmaceutical Management/Coordination - The Pharmacy Department maintains a closed formulary that is reviewed at least annually. Coordination is ongoing between pharmacy and QI to identify and conduct relevant QI/Pharmacy studies. One pharmacy related activity is asthma control.

Service Initiatives

Access and Availability Standards – Service initiatives include measuring performance against access and availability standards and implementing interventions as appropriate. Access standards have been established by the Health Plan and are monitored on an annual basis. These include access to routine care appointments, urgent care appointments and after hours care. Practitioner availability is also measured on an annual basis. Two standards are used for this measurement; practitioner to member ratio and geographic distribution of practitioners. These findings are then tied into Provider Network Management recruitment plans, as feasible.

Member Satisfaction Initiatives – The QI program uses information including: data from complaints and appeals, member satisfaction surveys (including CAHPS) and telephone interactions to identify activities for improving member satisfaction. Ongoing initiatives include monitoring telephone access standards, tracking complaints and appeals, close monitoring of complaint and appeal turnaround times and member satisfaction survey results analysis. The Service Improvement Committee reviews all of this information separately and in aggregate. Practitioner satisfaction is also assessed through an annual survey. Data is reviewed by the Service Improvement committee along with member satisfaction data to determine similarities/differences. This aggregate analysis is then used for identification of opportunities for improvement.

Patient Safety Activities - Although the Health Plan does not administer direct patient care, the safety of members is vital. Geisinger Health Plan encourages and promotes safety through monitoring of member complaints and appeals, member education, encouraging return communication between practitioners and monitoring medical record legibility and documentation.

Cultural and Linguistic Needs Initiatives- Collecting data on the cultural and linguistic needs of the membership will assist the Health Plan in identifying areas of need.

Other Service Initiatives – Service initiatives identified through data analysis, as opportunities for improvement will be moved forward as service activities.

Coordinated Activities

Over and Under Utilization Monitoring –Geisinger Health Plan facilitates the delivery of appropriate care and monitors the impact through the Medical Management program. This process is designed to assist in detecting potential under/over utilization of services. Areas of focus are identified by relevancy to the Health Plan population in conjunction

with high volume activities. The review consists of examining utilization data and taking appropriate action on identified opportunities for improvement.

Continuity and Coordination of Care Monitoring – The Continuity and Coordination of Care workgroup monitors care and services that members receive across the continuum of care and across the delivery system. Examples include: evaluating the coordination of medical care, taking action to improve the continuity and coordination of care as appropriate, and using medical record audit data to improve practitioner continuity and coordination of care efforts.

Continuity and Coordination of Behavioral Health Care – This is monitored through both UBH and the Health Plan's QI process. Examples include evaluating return communication between primary care and behavioral health care practitioners and assuring follow-up for members who have been discharged from the hospital after a mental health admission.

Credentialing and Recredentialing of Practitioners – The Provider Network Management, Credentialing, Accreditation and QI Departments work closely together to maintain a seamless process for the credentialing and recredentialing of practitioners. The Health Plan re-credentials on a 36 month cycle.

QI Program Structure

The Geisinger Health Plan QI reporting structure brings together work groups and committees within the network to coordinate QI activities across the continuum of care and across the organizations and facilities that deliver care. The Health Plan Board of Directors (the governing body) designates the Health Plan Quality Improvement Committee as the committee to oversee QI activities. As the governing body, the Board of Directors annually approves the QI Plan, QI Work Plan and Annual Evaluation.

The QI structure consists of one main committee (QIC), a number of subcommittees reporting to the QIC, and a number of work groups reporting to subcommittees. Each committee or group keeps minutes that reflect the activity, discussion, analysis, and recommendations/decisions, as well as, follow-up and resolution of prior recommendations. Minutes are dated and signed by the appropriate individual and available at the next meeting.

The following describes the QI reporting structure:

A. **Quality Improvement Committee (QIC):** Meets on a Quarterly Basis.

1. *Role* –Provides direction and oversight to the Quality Improvement process and activities. It receives and acts on reports from subcommittees and work groups.

2. *Chairman* – VP, Chief Medical Officer. (The chair is responsible for administrative management of the Plan's quality improvement activities/program.)

3. *Membership*: **(Attachment A)**

- Chair—Vice President, Chief Medical Officer/Rheumatologist
- President and CEO
- Director, Pharmacy Services
- Vice President, Health Services
- Appeals Manager
- Director Quality Improvement/Appeals
- Director, Case Management/Disease Management
- Director, Medical Management
- Director, Government Programs
- Manager, Provider Credentialing
- Senior Accreditation Coordinator
- Accreditation Coordinator
- Manager, Clinical Guidelines
- Medical Director/VP Pharmacy, Health Plans, North Central Region-Family Practice
- Medical Director, Health Plans, Eastern Region-Family Practice
- Medical Director, Health Plans, Western Region- Family Practice
- Medical Director, Health Services- Pediatrics
- Medical Director, Health Services—Pediatrics
- Medical Director, Health Services
- Practitioners (employed/contracted)
- United Behavioral Health representative, as needed
- Lay member for Commercial Line of Business
- Lay member for Medicare Line of Business

4. Reports to the Health Plan Board of Directors quarterly through the Quality Improvement Committee Chairperson.

5. Responsibilities:

- To establish and approve the Quality Improvement Plan annually.

- To establish and approve the annual Quality Improvement Work Plan.

- To annually review policies and procedures related to QI activities and recommend policy decisions.

- To review and evaluate the results from Quality Improvement activities.

- To review the work and action taken by various Quality Improvement sub-committees and to give advice, direction or recommendations on further action.

- To assist in instituting needed actions, as appropriate.

- To assure follow-up of open items.

- To oversee additional Quality Improvement activities unique to the managed care (Geisinger Health Plan) aspects of care, i.e., appointment access, availability of services, telephone access, HEDIS, clinical guidelines, disease management, care management programs, etc.

- To provide oversight and assure appropriate credentialing activities of practitioners contracted with Geisinger Health Plan.

- To assure practitioner participation in the QI program through committee membership and/or planning, design, implementation or review of activities related to the QI program.

- To review results and approve recommended actions of the Service Improvement Committee based on the Health Plan's satisfaction surveys and other service data such as complaints and appeals.

- To review reports of quality issues and aggregate data on quality issues and provide oversight to recommended actions of the Medical Directors office or Peer Review Committee as applicable.

- To assure linkages between the various committees and departments of the Plan as they relate to quality activities.

- To assure adequacy of the scope of the QI program and documentation of its effectiveness.

- To assure the Plan has appropriate oversight on any delegated activities.

- To assure a planned annual evaluation of the QI Plan, Work Plan and overall QI program is conducted.

B. Sub-Committees of QIC (Attachment B)

1. *Compliance and Privacy Committee*: Meets monthly. Responsible for coordinating and overseeing the implementation and completion of the Compliance Plan, including reviewing and approving policies and procedures relating to compliance and privacy issues. Chair is the Vice President, Legal Services. The Committee is comprised of departmental representation within the Health Plan including legal services, accreditation, health services, etc.

2. *Credentialing Committee*: Meets monthly. This committee is responsible for credentialing and recredentialing of physicians for the Health Plan. Chair is the Health Plan's Western Region Medical Director. The Vice President, Chief Medical Officer is Chairman Emeritus and a permanent committee member. The Health Plans Peer Review Committee is a sub-committee of Credentialing. The Credentialing Committee is comprised of physicians from multiple specialties.

3. T*echnology Assessment Committee*: Meets quarterly. Responsible for evaluation of new medical technologies and new uses of existing technologies for inclusion in the benefit package. Chair is Medical Director, Medical Management. Committee is comprised of up to 17 physicians from multiple specialties, up to 3 lay members and support staff.

4. *Service Improvement Committee*: Meets monthly. Responsible for monitoring and analysis of all Plan satisfaction and complaint data with recommendations taken to and from the HEDIS Steering committee. The committee is also responsible for monitoring access and availability data on a routine basis. Chair is Accreditation Coordinator. Committee is comprised of representation from Clinical reporting, Provider Network Management, Marketing, Health Services and Pharmacy.

5. *Medical Management Administrative Committee*: Meets monthly. Responsible for functioning as the oversight committee for the Medical Management arena. Chair is Vice President, Chief Medical Officer. Committee is comprised of multiple physicians and Administrative personnel within the Health Services, Pharmacy and Provider Network Management departments.

6. *Clinical Guidelines Committee*: Meets monthly. Responsible for overseeing and monitoring clinical guidelines, educating practitioners and members and ensuring quality medical care to be measured against benchmarks. Chair is Medical Policy/Clinical Guidelines Manager.

Committee is comprised of a Medical Director, Provider Network Management, Disease/case management, Accreditation, etc.

7. *Delegation oversight Committee:* Meets monthly. Responsible for overseeing all delegation arrangements and assuring compliance with all applicable external delegation regulations. Chair is Accreditation Coordinator. Committee is comprised of legal services, medical management, pharmacy, customer service, provider network, accreditation and market research.

8. *Minutes:*

- Will be generated for each meeting and approved by the Committee.
- Will reflect the activity, discussion, analysis and recommendations of the Committee, as well as, follow-up and resolution of prior recommendations.
- Will be signed and dated.

9. *Work group structure:*

Work groups are structured to report through the Sub-Committees of the QIC. This provides more direction and oversight of the various activities, which then is reported to the QIC by the sub-committees. Refer to the Committee organizational chart attached as Attachment B.

Quality Improvement and Accreditation Personnel

Role – Operational Staff for the Quality Improvement Program

Vice President, Chief Medical Officer:

The Vice President, Chief Medical Officer is the senior executive responsible for development, implementation and management of the Plan's Quality Improvement program. The Chief Medical Officer has management responsibility for the QI department and the Accreditation department as well as management responsibilities for the Medical Management Program including the MM Staff, Network Management, Health Plan Pharmacy and Disease/case management. The Chief Medical Officer is ultimately responsible for implementation of all aspects of the QI program.

Vice President, Health Services:

The Vice President, Health Services holds administrative responsibility for the Quality Improvement and Accreditation Departments, in conjunction with the Medical Management and Disease/case management Departments. The VP, Health services reports directly to the Chief Medical Officer to coordinate the vision and direction for all Quality Improvement activities.

Behavioral Health Practitioner:

The Regional Medical Director and Regional QI Director of the behavioral health delegated entity, United Behavioral Health, UBH, (or their designee) are responsible for implementing the behavioral health aspects of the QI Program (in cooperation with the Health Plan VP, Chief Medical Officer). The UBH Medical Director and Regional QI Director work closely with the Health Plan CMO and the Behavioral Health Oversight committee for overseeing and implementing programs related to Behavioral Health.
The Regional Medical Director and Regional QI Director of UBH participates in the Behavioral Health oversight committee and the Quality Improvement committee, as needed.

Staff:

1. *Director of Quality Improvement and Appeals* reports directly to the Vice President Health services; functions to facilitate coordination of activities in order to assure successful implementation and ongoing evaluation of processes, which support the QI Plan, QI Work Plan and Annual Evaluation. Responsible for staffing and equipment and overall management of the QI and appeals departments. Interfaces with other operational departments to assure appropriate processes that are critical to quality and service measures.

2. *Geisinger Health Plan Quality Improvement Nurse Manager* reports to the Director of QI and is responsible for coordinating and supporting the Health Plan Quality Improvement activities. The activities include, but are not limited to data maintenance, preventive health initiatives, chart reviews, work group participation, and any relevant education (i.e., Preventive Health, HEDIS) to members and practitioners. There is feedback on all quality improvement activities at the appropriate levels.

3. *Health Plan Senior Accreditation Coordinator:* The Health Plan Senior Accreditation Coordinator works under the direction of the Vice President, Health services, to assure ongoing compliance with all external regulatory standards. The Senior Accreditation Coordinator has responsibility for education of all departments on

an ongoing basis to assure understanding and compliance with applicable standards/regulations.

4. *Health Plan Accreditation Coordinator:* The Health Plan Accreditation Coordinator works under the direction of the Senior Accreditation Coordinator. The Coordinator is responsible for assisting with ongoing compliance with external regulatory standards and education of departments to assure understanding and compliance with applicable standards/regulations.

5. Regional QI Nurses (5)

6. Quality Improvement Specialists (8)

7. QI Service/Data Coordinator

8. HEDIS coordinator

9. Continuous QI Coordinator

Support Staff:

1. Information Technology staff

2. Disease/case management staff

3. Clinical and Operational reporting team staff

4. MM Department

5. Provider Network Representatives

6. Credentialing

Tasks:

1. Responsible for all inventory, tracking and follow-up of Health Plans QI activities. To obtain, assess, and act upon Quality Improvement data, including Quality Improvement Committee minutes and Quality Improvement Plans.

2. To assure completion of chart audits and other data gathering activities required by the Quality Improvement Committee.

3 To attend continuing education programs in Quality Improvement to provide expertise to the Quality

Improvement Committee.

4. To facilitate Quality Improvement accreditation processes and to meet regulatory agency requirements.

5. To meet standards set for compliance with applicable law.

Quality Improvement at Geisinger Health Plan Contracted Facilities

Geisinger Health Plan contracts with multiple facilities. To assure quality care for our members, these facilities/providers are assessed and monitored using established criteria prior to the signing of a contract and at least every three years thereafter.

Delegated Activities

The Health Plan has the ability to delegate activities as described within the NCQA standards. Specific criteria must be met for delegation to occur as described in the Delegation Oversight policy (Attachment D). Specific delegation arrangements are outlined in the attached spreadsheet (Attachment E).

Section 10: Glossary and Acronyms

Glossary

Agreement: The Agreement to provide Health Care Services, together with any attachments, exhibits, applicable Provider Manual(s), Benefit Documents, as amended from time to time and made a part of this Agreement by reference between Participating Health Care Provider or Participating Provider and Health Plan.

Ambulatory Surgical Center: A facility or portion thereof not located upon the premises of a hospital which provides specialty or multi-specialty outpatient surgical treatment. This does not include individual or group practice offices of private physicians or dentists, unless the offices have a distinct part used solely for outpatient surgical treatment on a regular and organized basis.

Ambulatory Surgical Center Provider: An ambulatory surgical center licensed, certified or otherwise regulated under the laws of the state in which it operates, that has an agreement with the Health Plan to provide Covered Services to Members.

Appeal: For a Gold Member, an appeal is a procedure that deals with the review of adverse initial decisions (organization determinations) on the Health Care Services a Member believes he/she is entitled to receive or any amounts that the Member must pay for a Covered Service.

Benefit Document(s): The Subscription Certificate, Schedule of Benefits and any Rider(s) thereto and/or Summary Plan Document which sets forth the terms, conditions and benefits of coverage for Members enrolled in Geisinger Health Plan, Company, Geisinger Quality Options or an Employer-Sponsored Program, as applicable.

Billed Charges: Those charges, determined prior to deduction for discounts and contractual adjustments, which are usually and customarily billed by a provider to all its patients for a particular service, as adjusted from time to time.

Business Day: A day other than Saturday, Sunday or a legal holiday when commercial banks in the State of Delaware are generally open for business.

Medical Management: A method of managing a Member's health care by coordinating care, improving continuity and quality of care in the most efficient manner.

Clean Claim: A claim for payment for a Covered Service which has no defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim. The term shall not include a claim from a Health Care Provider who is under investigation for fraud or abuse regarding that claim.

Clinical Guidelines: Systematically developed statements to assist a provider and patient in making decisions about appropriate health care for specific clinical circumstances.

Coinsurance: A form of cost sharing which requires the Member to pay a portion of the cost of Covered Services. A Coinsurance is a set percentage of this cost.

Company: Shall mean Geisinger Indemnity Insurance Company.

Complaint: A dispute or objection by a Member regarding a Participating Provider; coverage issues, including contract exclusions, limitations and benefits that are not covered; and the operations and\ or management of Health Plan which has not been resolved by Health Plan and has been filed with the Health Plan or Delaware Health and Social Services or Department of Insurance. A Complaint does not include a Grievance.

Concurrent Review: A medical management technique used by managed care organizations to ensure that Medically Necessary and appropriate care is delivered during a Member's hospitalization or other inpatient episode.

Copayment: A form of cost sharing which requires the Member to pay a fixed amount of money for a Covered Service. Copayment amounts are due at the time and place such services are received by a Member, or may instead be subsequently billed by a Participating Provider, at Participating Provider's sole discretion.

Covered Person: An individual eligible to receive Covered Services or other benefits under the terms of the applicable Benefit Documents as the Subscriber or an eligible enrolled family dependent. A Covered Person may also be referred to as a Member.

Covered Service: A Medically Necessary (unless otherwise indicated) service or supply specified in a Member's Subscription Certificate for which benefits will be provided pursuant to the terms of a Subscription Certificate or any Medically Necessary Supplemental Health Services set forth in any Riders supplementing a Subscription Certificate.

Customer Service Team (CST): The Health Plan representatives who can answer Member and Health Care Provider questions and provide information regarding the Health Plan and a Member's Coverage. The telephone number for the Customer Service Team is set forth on the back of the Member's Identification Card.

Deductible: A specific dollar amount that must be incurred and paid by a Member or a Member's family before the Health Plan will assume any liability for all or part of the cost of Covered Services.

Durable Medical Equipment: Equipment designed to serve a medical purpose and which is not generally useful for a Member in the absence of illness or injury, is able to withstand repeated use, is appropriate for use in the home and is not a disposable supply.

Emergency: A medical condition with acute symptoms of severity or severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the Member, or, with respect to a pregnant woman, the health of the Member or her unborn child, in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any organ or body part.

Emergency Services: Any Health Care Service provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Member, or, with respect to a pregnant women, the health of the Member or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Transportation and related Emergency Services provided by a licensed ambulance service shall constitute an Emergency Service if the condition is as described in this definition.

Employer: An employer who has an agreement with Company for the provision of third party administrative services by Company, and access to Health Plan's Network for Employer's health benefits plan(s).

Employer-Sponsored Program: A program established and maintained by an Employer for the purpose of providing its members with health care benefits which may be subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

Formulary: A continually updated list of prescription medications that represents the current covered drugs by Health Plan based upon the clinical judgment of Geisinger Health Plan's Pharmacy and Therapeutics Committee. The Formulary contains both brand name drugs and generic drugs, all of which have been approved by the Federal Food and Drug Administration (FDA).

Formulary Committee: A committee comprised of physicians, pharmacists and administrative staff which makes recommendations regarding Formulary decisions.

Governmental Agency: Shall refer to the Delaware Departments of Insurance or Health and Social Services , the Centers for Medicare and Medicaid Services or other government departments or their respective agents with direct responsibilities to access records for the purpose of quality assurance, investigation of Complaints or Grievances, enforcement or other activities related to compliance with applicable laws and regulations and shall specifically include the National Committee for Quality Assurance, as applicable.

Grievance: A Grievance is a request by a Member or Health Care Provider (with the consent of the Member) to have Health Plan or a certified utilization review entity reconsider a decision

solely concerning the Medical Necessity and appropriateness of a health care service. A Grievance does not include a Complaint. For a, a Grievance is a type of complaint expressing dissatisfaction with any aspect of the Health Plan's or Participating Provider's operations, activities or behavior.
Group: The employer, association, union or trust through which the Subscriber is enrolled.

Health Care Provider: A licensed Hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide Health Care Services under any applicable law including a physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse practitioner, registered nurse, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide behavioral health services.

Health Care Service: Any covered treatment, admission, procedure, medical supplies and equipment, or other services, including behavioral health, prescribed or otherwise provided or proposed to be provided by a Health Care Provider to a Member as deemed Medically Necessary.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): A federal law, as may be amended from time-to-time, including, but not limited to, the following: a) limiting exclusions for pre-existing conditions (as defined under HIPAA); b) prohibiting discrimination against employees and dependents based on their health status; c) guaranteeing renewability and availability of health coverage to certain employers and individuals; d) protecting certain Members who lose Group health coverage by providing access to individual health insurance coverage; and e) regulating the use and disclosure of protected health information.

Health Plan: Shall refer to Geisinger Health Plan, Geisinger Indemnity Insurance Company and Geisinger Quality Options, Inc. collectively.

Home Health/Hospice Provider or Home Health Provider or Hospice Provider: A Medicare-certified agency under agreement with Health Plan which provides: (i) intermittent skilled nursing services and other therapeutic services in a Member's home when Medically Necessary; and when authorized by a Participating Provider unless otherwise permitted in accordance with the terms and conditions set forth in a Member's Benefit Document; and/or (ii) hospice services, as applicable. A Home Health/Hospice Provider or Home Health Provider or Hospice Provider must be Medicare-certified in order to render care to a Gold Member.

Home Health Services: Medically Necessary Health Care Services, which are: (i) rendered in the Member's place of residency by health care personnel; (ii) referred to a Home Health Provider by the Home Health/Hospice Management Department; (iii) provided in accordance with the Member's Benefit Document; (iv) rendered in accordance with a treatment plan established by a Home Health Provider and a Member's physician; or if so required by the terms and conditions of coverage set forth in a Member's Benefit Document, by a Member's physician Participating Provider: and (v) authorized by the Home Health/Hospice Network. Home Health Services may include the administration of Home Infusion, as applicable.

Hospice means a Covered Service rendered by a Preferred Provider who is licensed as a provider of Hospice services in the State of Delaware and is a certified provider of Hospice services under Medicare.

Hospice Services: Medically Necessary Health Care Services which are: (i) referred to a Hospice Provider by the Home Health/Hospice Management Department; (ii) provided in accordance with a Member's Benefit Document; (iii) rendered in accordance with a Plan of Care established by a Hospice Provider and a Member's physician; or if so required by the terms and conditions of coverage set forth in a Member's Benefit Document, by a Member's physician Participating Provider and authorized by the Home Health/Hospice Management Department; (iv) rendered for conditions related to the Terminal Illness; and (v) provided in accordance with the Member's executed advance directive.

Hospital: An institution which: (i) provides diagnostic, surgical and therapeutic services for the diagnosis, treatment and care of injured or ill persons by or under the supervision of physicians; and (ii) is licensed, certified or otherwise regulated to provide such services and to operate as a hospital under the laws of the state in which it operates and/or federal laws, as applicable. The term "Hospital" does NOT include a Skilled Nursing Facility, convalescent nursing home, custodial care home, health resort, spa or sanitarium. A Hospital must be Medicare-certified in order for a Gold Member to receive care at the Hospital.

Hospital Provider: A Hospital that has an agreement with Health Plan to provide Covered Services to Members.

Hospital Services: The Covered Services to be provided by Hospital Provider to Members as set forth in the Agreement.

Identification Card: The card issued by Health Plan to identify Members enrolled in Geisinger Health Plan, Company Geisinger Quality Options, Inc. or an Employer Sponsored Program. Possession of an Identification Card confers no right to Covered Services or other benefits under Health Plan or an Employer-Sponsored Program. To be entitled to Covered Services or benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable premiums under the Benefit Documents have actually been paid; or with respect to an Employer-Sponsored Program, be an enrolled Member on whose behalf all amounts due to Company have been paid by an Employer.

Intermediate Care: A level of care that is less than the degree of care and treatment that Skilled Nursing Facility is designed to provide, but greater than the level of room and board.

Medical Director: The licensed physician designated by the Health Plan to direct the medical and scientific aspects of the Health Plan, and to monitor and oversee the quality and appropriateness of managed health services.

Medically Necessary or Medical Necessity means Covered Services rendered by a Health Care Provider that the Health Plan determines are: (i) appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury; (ii) provided for the diagnosis and the direct care and treatment of the Member's condition, illness, disease or injury; (iii) in

accordance with current standards of good medical treatment practiced by the general medical community; (iv) not primarily for the convenience of the Member, or the Member's Health Care Provider; and (v) the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medical Services or Professional Services: Those services normally provided by a PCP or SCP in the diagnosis and treatment of Members to the extent that they are Medically Necessary and covered under the terms of a Member's applicable Benefit Document. This includes supplies, injections, diagnostic tests and other services and procedures within the scope of the practitioner's professional competence and normal practice.

Medicare (Program): The programs of health care for the aged and disabled established by Title XVIII of the United States Social Security Act of 1965, as may be amended from time to time.

Member: An individual eligible to receive Covered Services or other benefits under the terms of the applicable Benefit Documents as the Subscriber or an eligible enrolled family dependent. A Member may also be referred to as a Covered Person.

Network: The Participating Providers who have entered into a written agreement with Health Plan to provide Covered Services to its Members.

Non-Covered Services: Any service not covered under the terms of a Member's Benefit Document.

Observation Services: Those certain outpatient services furnished by Participating Provider to Members that include the use of a bed and periodic monitoring by Participating Provider's nursing or other staff which are reasonable and necessary to monitor a Member's condition; or to determine the need for a Member's admission to Participating Provider as an inpatient.
Observation Services may be extended beyond twenty-three (23) hours upon advance authorization by the Health Plan Medical Director.

Orthotic Device: A device which is a rigid appliance or apparatus used to support, align or correct bone and muscle deformities.

Participating Health Care Provider or Participating Provider: A physician, medical group, pharmacy, Hospital or other provider of health services, licensed, certified or otherwise regulated under the laws of the state in which it operates, that has an agreement with Health Plan to provide Covered Services to Members.

Payor: An employer, ERISA plan sponsor or trust fund insurance carrier or any other entity that accepts fiduciary responsibility for an established program of health benefits to Payor's

insureds/members, or any other entity which has contracted with Health Plan to use Health Plan's Network.

Policy: The certificate and/or agreement, as may be amended, which sets forth the terms, conditions and benefits of coverage, as awarded by the Health Plan to its Members, as applicable. A Policy may also be referred to as a Subscription Certificate.

Policy Holder: An individual who meets the requirements for eligibility, who has enrolled in the Health Plan, and for whom payment has actually been received by the Health Plan. A Subscriber is also a Member. A Policy Holder may also be referred to as a Subscriber.

Preferred Health Care Provider or Preferred Provider: A Health Care Provider that has an agreement with PPO to provide Covered Services to Members. PPO contracts with a national provider network of professionals and facilities. Preferred Providers within such national preferred provider organization shall not be Preferred Health Care Providers or Preferred Providers unless otherwise provided by the PPO. Please refer to the Provider List or contact the Customer Service Team at the number set forth on the back of the Member's Identification Card for a listing of Preferred Providers.

Protected Health Information ("PHI"): Individually Identifiable Health information (as defined by HIPAA), whether oral or transmitted by electronic media, maintained by electronic media or transmitted or maintained in any form or medium, including demographic information collected from an individual, and a.) created or received by a Health Care Provider, the Health Plan, employer or health care clearinghouse; and b.) relates to the past, present or future physical or mental condition of an individual, as well as the provision of health care to an individual or the past, present or future payment for the provision of healthcare to an individual and (i) that identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Preferred Provider Organization (PPO): Company's Network-based health care program that offers benefits of coverage for certain Covered Services when obtained by a Member, at the Member's option, either in or out-of-Network, subject to the terms and conditions of coverage set forth in the Member's Benefit Document. PPO means Geisinger Quality Options, Inc.

Primary Care Physician (PCP): A Participating Provider physician who, within the scope of the physician's practice; (i) supervises, coordinates, prescribes or otherwise provides Health Care Services to a Member and initiates a Gatekeeper Product Member's Referral for specialty care, as may be required in accordance with a Member's applicable Benefit Document; (ii) maintains continuity of care; and (iii) is so designated by the Health Plan.

Primary Care Site: The medical office, health center, or other facility, or a designated department of a medical facility, staffed by one or more Primary Care Physicians, and designated a Primary Care Site by Health Plan.

Professional Services or Medical Services: Those services normally provided by a SCP in the diagnosis and treatment of Members to the extent that they are Medically Necessary and covered

under the terms of a Member's applicable Benefit Document. This includes diagnostic tests and other services and procedures within the scope of the practitioner's professional competence and normal practice.

Prosthetic Device: A device, which is an externally worn appliance or apparatus, which replaces a missing body part.

Provider List: A published listing (as amended from time to time) provided to Members by the Health Plan which sets forth the names, addresses and telephone numbers of current Providers who have contracted with the Health Plan to provide Covered Services. The current Provider List can be found on the Health Plan's website (www.thehealthplan.com) or obtained by calling the Customer Service Team at the number on the back of the Member's Identification Card.

Referral: An authorization by a Participating Provider (generally a Primary Care Physician) for a Member to be evaluated and /or treated by another Participating Provider, prior to such services being performed.

Rider: A document that sets forth the terms and conditions for coverage of certain Supplemental Health Services in effect for the Subscriber and all family dependents enrolled under the Subscription Certificate.

Schedule of Benefits: A summary of coverage for a Member that identifies the Subscriber, applicable Copayment, Deductible and Coinsurance amounts for Covered Services and any Riders in force of the Benefit Documents.

Self-Referred Service: A Covered Service which is received from a: (i) Participating Provider that have not been delivered, prescribed or authorized in advance by the Member's Primary Care Physician or Medical Director; or (ii) non-Participating Provider without prior authorization by the Health Plan.

Service Area: The counties where Health Plan is licensed to operate by The Delaware Department of Health and Social Services, as may be amended from time to time.

Skilled Nursing Facility (SNF): A facility which: (i) provides inpatient skilled nursing care, rehabilitation services or other related health services; (ii) is licensed, certified or otherwise regulated to provide such services under the laws of the State of Delaware; and (iii) is certified by Medicare. The term Skilled Nursing Facility does NOT include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in activities of daily living.

Skilled Nursing Facility (SNF) Provider: A Skilled Nursing Facility that has an agreement with Health Plan to provide Covered Services to Members.

Skilled Nursing Facility (SNF) Services– Skilled Nursing Facility (SNF) Services are certain Medically Necessary skilled health care services which: (i) consist of comprehensive, inpatient care designed for the medically stable Member who requires skilled nursing or skilled

rehabilitation services as identified by the then current industry-standard medical review criterion in use by Health Plan including, but not limited to, Interqual and Medicare guidelines; (ii) are covered under the terms of a Member's applicable Benefit Document; and (iii) are for Gatekeeper Product Members, when authorized by a Primary care Physician of such Member's Primary Care Site or the Medical Director unless otherwise permitted in accordance with the terms and conditions of coverage set forth in the Member's Benefit Document. SNF Services do not include custodial, convalescent or domiciliary care.

Solicitation: Any conduct by a Participating Provider, its agents, employees, assignees or successors, which may be reasonably interpreted as an attempt to persuade Members, Employers, Groups or others to: (i) discontinue their enrollment with Geisinger Health Plan, Company, Geisinger Quality Options, Inc. and/or an Employer-Sponsored Program but continue to obtain Health Care Services from the Participating Provider; and/or (ii) encourage Members to participate in any other prepaid health plan or program of third party reimbursement.

Specialist: A Health Care Provider whose practice is not limited to primary health care services and who has additional postgraduate or specialized training, board certification or practices in a licensed specialized area of health care.

Specialty Care Provider: A Participating Provider Specialist who provides the necessary evaluation, treatment and follow-up care for Health Plan Members.

Subscriber: An individual who meets the requirements for eligibility, who has enrolled in the Health Plan, and for whom payment has actually been received by the Health Plan. A Subscriber is also a Member. A Subscriber may also be referred to as a Policy Holder.

Subscription Certificate: The certificate and/or agreement, as may be amended, which sets forth the terms, conditions and benefits of coverage, as awarded by the Health Plan to its Members, as applicable. A Subscription Certificate may also be referred to as a Policy.

Summary Plan Document (SPD): An Employer document which sets forth the terms, conditions and benefits of coverage for Members enrolled through an Employer-Sponsored Program.

Supplemental Health Services: Benefits of coverage provided under the Riders listed on the Schedule of Benefits.

Technology Assessment Committee: A committee of clinicians and/or other individuals, which review new or presently non-covered medical equipment, procedures and treatments in order to, among other things, advise the Health Plan on the experimental or non-experimental nature of any equipment, procedure or treatment and/or appropriate coverage status of any equipment, procedure treatment.

Tel-A-Nurse (TANS): A twenty-four (24) hour per day, toll free telephone number for Members to access nurse advice. The toll free telephone number is set forth on Member's Identification

Card. Tel-A-Nurse is not an authorized agent for purposes of coverage determination or appointment scheduling.

Third Party Administrator (TPA): An organization which performs administrative services such as claims processing, claims payment, membership services and utilization review for employee health benefits plans. Company is a TPA for Employers

Urgent Care: Any Covered Health Care Service provided to a Member in a situation, which requires care within twenty-four (24) hours. Urgent Care does not rise to the level of an Emergency as it allows the Member and provider to consider alternative settings of care.

Acronyms

ALJ: Administrative Law Judge
ASC: Ambulatory Surgical Center
ATOD: Alcohol, Tobacco and/or Drugs
CCM: Catastrophic Case Management
CHAP: Community Health Accreditation Program
CHDR: Center for Health Dispute Resolution
CHF: Congestive Heart Failure
CME: Continuing Medical Education
CMN: Certificate of Medical Necessity
CMS: Center for Medicare and Medicaid Services
COB: Coordination of Benefits
COPD: Chronic Obstructive Pulmonary Disease
CPC: Clinical Practice Committee
CPT®: Physician's Current Procedural Terminology
CRDQ: Chronic Respiratory Disease Questionnaire
CRMS: Care Enhance Resource Management System
CST: Customer Service Team
DAB: Department Appeals Board
DEC: Diagnostic Equivalent Category
DHSS: Delaware Department of Health and Social Services
DME: Durable Medical Equipment
DOI: Delaware Department of Insurance
DRG: Diagnostic Related Groups
EDI: Electronic Data Interchange
EOP: Explanation of Payment
ERISA: Employee Retirement Security Income Act of 1974
HAC: Hospital Acquired Condition
HAP: Hospital and Health System Association of Pennsylvania
HEDIS®: Health Plan Employer Data and Information Set
HHS: Health and Human Services
HIPAA: Health Insurance Portability and Accountability Act of 1996
HIPPS: Health Insurance Prospective Payment System
HMO: Health Maintenance Organization
ICD-9-CM: International Classification of Disease, 9th Edition
INR: International Normalized Ratio
JCAHO: Joint Commission on Accreditation of Health Care Organizations
LCM: Large Case Management
LOB: Line of Business
LOS: Length of Stay
MCE: Medical Care Evaluations
MDS: Minimum Data Set
MHAC: Modified Health Assessment Questionnaire

MI: Myocardial Infarction
MMT: Manual Muscle Tone
NCQA: National Committee for Quality Assurance
NOMNC: Notice of Medicare Non-Coverage
OPM: Office of Personnel Management
PCF: Personal Care Facility
PCP: Participating Primary Care Physician
PDCA: Plan, Do, Check, Act
PNM: Provider Network Management
POA: Present on Admission
POS: Point of Service
PPO: Preferred Provider Organization
PRA: Predictive Resource Assessment
PRO: Peer Review Organization
QI: Quality Improvement
QIO: Quality Improvement Organization
QIC: Quality Improvement Committee
RUG: Resource Utilization Group
SCP: Participating Specialty Care Provider
SNF: Participating Skilled Nursing Facility
SPD: Summary Plan Document
TPA: Third Party Administrator
TSI: Transition Systems Inc.
UCR: Usual, Customary, Reasonable Fee
UM: Utilization Management
USPHTF: United States Preventive Health Task Force