GEISINGER HEALTH PLAN FAMILY

Geisinger
HEALTH PLAN

HealthChoices Provider Manual

Revised as of May 2025

The Geisinger Health Plan Family (GHP Family) HealthChoices Provider Manual (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 GHP Family Participating Providers. The Manual supports all applicable federal and state laws, Department of Human Services (DHS) regulations and policies as promulgated through Medical Assistance Bulletins and the specifications of the HealthChoices RFP and HealthChoices Agreement.

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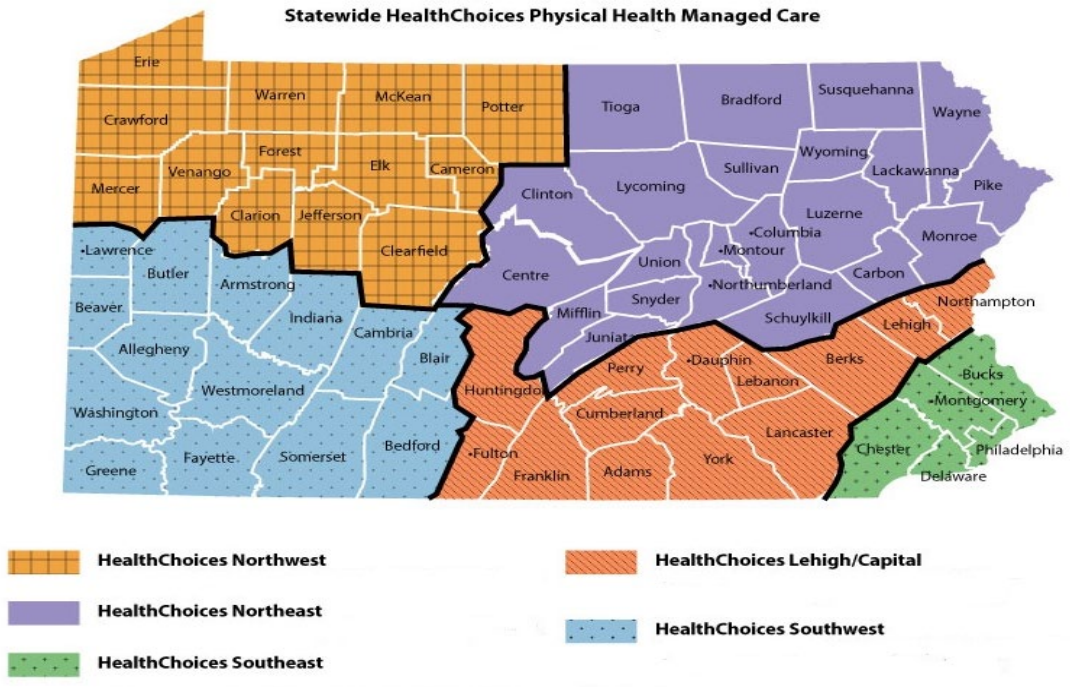
ABOUT GEISINGER HEALTH PLAN FAMILY

Geisinger Health Plan Family (GHP Family) is a Geisinger Health Plan Medicaid managed care plan serving the entire state of Pennsylvania for the HealthChoices managed care program offered to Medical Assistance recipients by the Commonwealth of Pennsylvania, Department of Human Services.

Geisinger Health Plan is recognized as a national leader among managed care organizations and, through GHP Family, brings a physician-led, patient-centered approach to health care delivery for the Medical Assistance enrollees of Pennsylvania. A model for healthcare reform, with documented success in innovative patient management programs and performance-based provider reimbursement, GHP consistently ranks among America's top health plans.

This manual pertains to the participation with GHP Family and the HealthChoices Physical Health Program in the Northwest, Northeast, Southeast, Lehigh/Capital, and Southwest Zones. These 5 zones include all 67 counties in the state of Pennsylvania.

This manual is intended to be used as an extension of the Participating Provider Agreement and a reference guide for Participating Providers and their office staff. While this manual contains basic information about the Commonwealth of Pennsylvania Department of Human Services (DHS) and the Centers for Medicare and Medicaid Services (CMS), providers are required to fully understand and apply DHS and CMS requirements when administering covered services. Please refer to https://www.dhs.pa.gov/ and https://www.cms.gov//.



CONTACT INFORMATION

All paper Claims should be submitted to:

Claims Department
Geisinger Health Plan
PO Box 160
Glen Burnie, MD 21060

Visit us on NaviNet at https://www.navinet.net/ for the following tools:

- Member eligibility and benefits look up
- Prior authorization list, medical policies, and clinical guidelines
- Pay-for-Quality program information

Visit us on Availity at https://apps.availity.com/web/onboarding/availity-fr-ui/#/login for:

- Claims submission
- Claims status inquiry

Providers who only submit paper claims and do not use a clearinghouse can submit claims electronically through Availity. For questions relating to Availity access, visit Availity online at https://www.availity.com/providers/. Go to the Help & Training section or you can call (800) 282-4548.

Call (844) 447-7768 to speak with a Geisinger Health Plan Claims Representative.

ADDITIONAL GHP FAMILY CONTACT INFORMATION

Department	Phone Number [Fax Number]	Hours of Operation
Case Management	(800) 883-6355 or (570) 271-8763 Fax: (570) 271-7860	Monday – Friday 8:00 a.m. – 4:30 p.m.
Customer Care	(855) 227-1302	Monday, Tuesday, Thursday and Friday, 7 a.m. – 7 p.m. Wednesday, 7 a.m. – 8 p.m. Saturday, 8 a.m. – 2 p.m.
Customer Care - Interactive Voice Response (IVR) System	(855) 227-1302	24 Hours/Day, 7 Days/Week
Durable Medical Equipment Network	(800) 883-6355 or (570) 271-8763 Fax: (570) 271-7860	Monday – Friday 8:30 a.m. – 4:30 p.m.

Fraud and Abuse Hotline	(800) 292-1627	24 Hours/Day, 7 Days/Week
Home Health & Hospice Network	(877) 466-3001 or (570) 271-5506 Fax: (570) 271-5507	Monday – Friday 8:30 a.m. – 4:30 p.m.
Medical Management	(800) 544-3907 or (570) 271-6497 Fax: (570) 214-3572	Monday – Friday 8:00 a.m. – 5:00 p.m.
Outpatient Rehabilitation Therapy Network	(800) 270-9981 or (570) 271-5301 Fax: (570) 271-5302	Monday – Friday 8:30 a.m. – 5:00 p.m.
Pharmacy	(855) 552-6028 or (570) 214-3554 Fax: (570) 271-5610	Monday – Friday 8:00 a.m. – 5:00 p.m.
Provider Engagement	(800) 876-5357 or GHPAccountMngt@geisinger.edu	Monday – Friday 8:00 a.m. – 5:00 p.m.
Enhanced Member Supports Unit	(855) 214-8100 Fax: (570) 214-0222 EMSU@thehealthplan.com	Monday – Friday 8:30 a.m. – 5:00 p.m.
TDD for the Hearing Impaired	(800) 654-5988 or 711 for PA Relay services	Monday – Friday 8:30 a.m. – 4:30 p.m. PA Relay Services available 24 Hours/Day, 7 Days/Week

DHS CONTACT INFORMATION

Name	Phone Number	Hours of Operation
DHS HelpLine	(800) 692-7462 TDD: (800) 451-5886	24 Hours/Day, 7 Days/Week
ChildLine (State Child Abuse Registry)	(800) 932-0313	24 Hours/Day, 7 Days/Week
Pennsylvania Department of Human Services (DHS) Office of Medical Assistance Programs (OMAP) Services Line	(800) 537-8862 Press 2 for Providers, then press:	Monday – Friday 8:30 a.m. – 4:30 p.m.

	1 – verify eligibility 2 – pharmacy prior authorization and billing inquires 3 – medical prior authorization and outpatient services 4 – provider enrollment 5 – intense case management 6 – provider service center	
Eligibility Verification System (EVS)	(800) 766-5EVS (5387)	24 Hours/Day, 7 Days/Week
Medical Assistance Provider Compliance Hotline	(866) 379-8477	Monday – Friday 8:30 a.m. – 4:00 p.m.

BEHAVIORAL HEALTH INFORMATION

For referrals to a Behavioral Health Provider, please use the information below which is current as of the published date of this manual.

Behavioral Health Managed Care Organization (BH-MCO)	Counties Served	Website
Community Behavioral Health (CBH)	Philadelphia	https://dbhids.org/about/organization/division-of-community-behavioral-health/

Community Care Behavioral Health Organization (CCBHO)	Adams, Allegheny, Bedford, Bradford, Berks, Blair, Cameron, Carbon, Centre, Chester, Clarion, Clearfield, Clinton, Columbia, Delaware, Elk, Erie, Forest, Greene, Huntingdon, Jefferson, Juniata, Lackawanna, Luzerne, Lycoming, McKean, Mifflin, Montour, Monroe, Northumberland, Pike, Potter, Schuylkill, Snyder, Sullivan, Somerset, Susquehanna, Tioga, Union, Warren, Wayne, Wyoming, York	https://www.ccbh.com/
Magellan Behavioral Health of Pennsylvania (MBH)	Bucks, Lehigh, Montgomery, Northampton, Cambria	https://www.magellanofpa.com/
PerformCare	Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, Perry	https://pa.performcare.org/
Carelon Health of PA, Inc.	Armstrong, Beaver, Butler, Crawford, Fayette, Indiana, Lawrence, Mercer, Washington, Westmoreland, Venango	https://pa.carelon.com/

COUNTY BEHAVIORAL HEALTH CRISIS INTERVENTION INFORMATION

To find the Mental Health/Intellectual Disabilities (MH/ID) Program Offices, including crisis intervention contact information, for a specific county, please refer to: https://www.pa.gov/agencies/dhs/contact/county-mh-id-offices.html.

In the event of a life-threatening emergency, please dial 9-1-1.

National Suicide Prevention Hotline (800) 273-TALK (8255)

MEDICAL ASSISTANCE TRANSPORTATION PROGRAM (MATP)

The Medical Assistance Transportation Program, also known as MATP, provides non-emergency transportation to medical appointments for Medical Assistance Members who do not have transportation available to them. The individual's county of residence will provide the type of transportation that is the least expensive while still meeting their needs. To learn more about MATP, or to find the MATP provider for a specific county, visit PennDOT's website: https://www.findmyride.penndot.pa.gov/fmr-edu/home/transportation-progams/low-income-individuals#header.

PROVIDER RESPONSIBILITIES

GENERAL PROVISIONS

Participating Provider and GHP Family agree to abide by the following General Provisions:

Assignment. The Agreement or any part, articles or sections thereof may not be assigned during the term of the Agreement by any of the parties without the prior written consent of the other party(s), except (i) as may otherwise be provided for in the Agreement and (ii) each party may at any time assign its rights and obligations under the Agreement to any corporation controlled by, in control of or under common control of the assigning party provided, however, it provides the non-assigning party(s) with thirty (30) days prior written notice of said assignment.

Compliance. The parties agree to comply with all applicable federal and state laws and rules including, but not limited to (i) Title VII of the Civil Rights Act of 1964; (ii) The Age Discrimination Act of 1975; (iii) The Rehabilitation Act of 1973; (iv) The Americans With Disabilities Act; (v) other laws applicable to recipients of Federal funds; (vi) Medicare laws, regulations and Centers for Medicare and Medicaid Services ("CMS") instructions; (vii) Patients' bill of Rights in accordance with OPM; (viii) the Genetic Information Nondiscrimination Act of 2008; (ix) Health Insurance Portability and Accountability Act of 1996 (HIPAA); and all other applicable laws and rules. Furthermore, Participating Provider hereby warrants and represents that it shall comply and shall be responsible for requiring any party that it may subcontract with to furnish services to Members to comply with GHP Family's policies and procedures and all other terms and conditions of the Agreement. Additionally, it is hereby disclosed that payments made by GHP Family to related entities, contractors and subcontractors are, in whole or in part, from federal funds received by the GHP Family through its contracts with the Centers for Medicare and Medicaid Services.

Entire Agreement/Amendments/Multiple Originals. The Agreement, together with any attachments, exhibits, or applicable Provider Manual(s), as amended from time to time, set forth the entire Agreement between the parties with respect to the subject matter. Any prior purchase orders, agreements, promises, negotiations, or representations, whether oral or written, not expressly set forth in the Agreement, are of no force or effect. The Agreement shall be executed in multiple originals, one for Participating Provider and the other for GHP Family. The parties agree that the Agreement shall be automatically amended to comply with applicable federal and state laws and regulations; otherwise, the Agreement may not be amended except in writing, signed by the parties.

Exhibits. All exhibits within the Agreement are incorporated by reference and made part of the Agreement as if they were fully set forth in the text of the Agreement.

Governing Law. The Agreement shall be deemed to have been made and shall be construed and interpreted in accordance with the laws of the Commonwealth of Pennsylvania, and the parties hereto agree to the jurisdiction of the Commonwealth of Pennsylvania.

Indemnification. Participating Provider and GHP Family agree to protect, indemnify and hold harmless the other party(s) from and against any and all loss, damage, cost and expense (including attorneys' fees) which may be suffered or incurred under the Agreement as a result of the negligent or intentional acts of the indemnifying party, its employees, agents, consultants or subcontractors. Said indemnity is in addition to any other rights that the indemnified party may have against the indemnifying party and will survive the termination of the Agreement.

Insurance. The parties agree to maintain, at its own cost and expense, insurance coverage as necessary and reasonable to insure itself and its employees and agents in connection with the performance of its duties and responsibilities under the Agreement. Upon request, the parties agree to provide one another with a Certificate of Insurance evidencing said insurance coverage. Participating Provider shall notify GHP Family within ten (10) days of the cancellation or material alteration of such coverage.

Notices. All notices and communications hereunder shall be in writing and deemed given, when personally delivered to or upon receipt when deposited with the United States Postal Service, certified or registered mail, return receipt requested, postage prepaid; a nationally recognized overnight courier, with all fees prepaid; or e-mail addressed as set forth on the first page of the Agreement or to such other person and/or address as the party to receive may designate by notice to the other.

Notification of Incidents. The parties agree to notify the other party(s) within twenty-four (24) hours after the discovery of any incidents, occurrences, claims or other causes of action involving the Agreement. Upon receipt of discovery by any party of any incident, occurrence, claims (either asserted or potential), notice of lawsuit or lawsuit involving the Agreement, said party agrees to immediately notify the other party(s). The parties hereto agree to provide complete access, as may be provided by law, to records and other relevant information as may be necessary or desirable to resolve such matters. This Section shall survive the termination of the Agreement.

Other Parties. The Agreement is solely between the parties hereto and is not intended to be enforceable by any other party or to create any express or implied rights hereunder of any nature whatsoever in any other party.

Partial Invalidity/Interpretation. If any term or provision of the Agreement is determined to be invalid or unenforceable, the remainder of the Agreement will not be affected thereby. The section headings in the Agreement are solely for reference purposes. Participating Provider acknowledges that portions of the Agreement are subject to review by Governmental Agencies and/or their designated representatives, as applicable, and if such Governmental Agencies and/or their designated representatives require any material change to the terms and conditions of the Agreement, Participating Provider agrees to renegotiate the affected terms and conditions upon being notified of such required change by GHP Family.

Promotional Materials. Participating Provider consents to GHP Family's use of its name, address and the names and professional designations of its healthcare professionals in traditional membership and marketing materials. The parties hereto agree not to use the name of or any trademark, service mark or design registered to the other parties or their affiliates or any other party in any additional publicity, promotional or advertising material, unless review and written approval of the intended use shall first be obtained from the releasing party(s) prior to the release of any such material. Said approval shall not be unreasonably withheld by any of the parties. Notwithstanding anything to the contrary in the preceding sentences, GHP Family shall have the right to publish Participating Provider's summary rating as part of GHP Family's Physician Quality Summary Program without obtaining the consent by Participating Provider prior to the release of such rating.

Relationship Among Parties. The parties hereto expressly acknowledge and agree that: (i) GHP Family's duties and responsibilities under the Agreement apply solely to GHP Family Members; (ii) in its capacity as third-party administrator, Company's duties and responsibilities under the Agreement apply to Members of an Employer-Sponsored Program; and (iii) with the exception of (ii) of this Section, Company's duties and responsibilities under the Agreement apply to Company Members. Each party hereto shall be considered independent entities with respect to each other. None of the provisions of the Agreement are intended to create nor shall be deemed or

construed to create any relationship between the parties other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of the Agreement. Neither the parties nor any of their respective agents or employees shall be construed to be the agent, employee, joint Employer or representative of the other. The parties shall not have any express or implied rights or authority to assume or create any obligation or responsibility on behalf of or in the name of the other, except as may be otherwise set forth in the Agreement.

Release of Information. The provisions of the Agreement are confidential and protected from disclosure to any other party unless: (i) otherwise provided for in the Agreement; (ii) disclosure is required by GHP Family, an Employer or Participating Provider to meet any federal, state or local rule, law or regulation; or (iii) any party hereto engages a third party for purposes such as quality assurance or auditing.

Unforeseen Circumstances. In the event either party's operations are substantially interrupted by war, fire, insurrection, the elements, earthquakes, acts of God or, without limiting the foregoing, any other cause beyond the control of the affected party (including the GHP Family no longer meeting all material requirements imposed on GHP Family by Federal or State law resulting in a significant impact on the GHP Family's operations), the affected party shall be relieved of its obligations only as to those affected portions of this Agreement for the duration of such interruption. In the event that the performance of the affected party hereunder is substantially interrupted pursuant to such event, the other party shall have the right to terminate this Agreement upon ten (10) days' prior written notice to the affected party.

Waiver. Failure of a party to complain of any act or omission on the part of another party shall not be deemed to be a waiver. No waiver by a party of a breach of the Agreement will be deemed a waiver of any subsequent breach. Acceptance of partial payment will be deemed a part payment on account and will not constitute an accord and satisfaction.

PRIMARY CARE PROVIDERS (PCPs)

A Primary Care Provider (PCP) is a specific physician, physician group or a Certified Registered Nurse Practitioner (CRNP) operating under the scope of his/her licensure, and who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating and monitoring other medical care and rehabilitative services and maintaining continuity of care on behalf of the Member. Additional PCP responsibilities include, but are not limited to:

- Providing primary and preventive care and acting as the Member's advocate, providing, recommending, and arranging for care.
- Documenting all care rendered in a complete and accurate encounter record that meets or exceeds the DHS data specifications.
- Maintaining continuity of each Member's health care.
- Communicating effectively with the Member by using sign language interpreters for those who are deaf or hard of hearing and oral interpreters for those individuals with LEP when needed by the Member. Services must be free of charge to the Member. Notice of nondiscrimination and the taglines must be posted in physical locations where Providers interact with the public.
- PCPs are responsible for initiating and coordinating referrals of Members for specialty care and other Medically Necessary services, both in-and out-of-plan. PCPs must monitor the progress of the referred Members' care.
- Maintaining a current medical record for the Member, including documentation, of all the services provided to the Member by the PCP, as well as any specialty or referral services.

- Arranging for Medically Necessary Behavioral Health Services for Members by appropriate referrals to a HealthChoices Behavioral Health – Managed Care Organization (BH-MCO) in accordance with the specifications of the provider agreement.

MEMBER ASSIGNMENT TO PCP

Upon enrollment, Members may choose a PCP for themselves and any other eligible family Members. Any Member who does not select a PCP within fourteen (14) Business Days of enrollment will automatically be assigned to a PCP.

If the Member is dissatisfied with the auto-selection assignment or wishes to change their PCP for any other reason, the Member may choose an alternative PCP at any time by calling Customer Care. GHP Family will promptly grant the request and process the PCP change in a timely manner.

GHP Family manages each PCP's panel to automatically stop accepting new Members after the limit of 1,000 Members has been reached. Upon contracting with GHP Family, if the PCP/PCP Site employs Certified Registered Nurse Practitioners/Physician Assistants, then the Provider/Provider Site will be permitted to add an additional 1,000 Members to the practice's panel. Other exceptions to the 1,000 Member panel policy will be considered on a case-by-case basis. Please contact your GHP Family Provider Account Manager for more information.

Assignment of Newborns

Newborns are immediately enrolled in the program and all Medically Necessary services are provided to newborns. GHP Family makes every effort to identify what PCP/pediatrician the mother chooses to use for the newborn prior to the birth, so that the provider chosen by the parent can be assigned to the newborn on the date of birth.

Hospitals need to notify the Member's County Assistance Office (CAO) as soon as the Member gives birth to ensure that the newborn will be appropriately enrolled in Medical Assistance and in GHP Family. Payment for deliveries will be delayed to the extent that accurate enrollment can be confirmed.

CHANGING PCPS

If a Member is dissatisfied with the auto-selection assignment or wishes to change their PCP for any other reason, the Member may choose an alternative PCP at any time by calling the Customer Care number on the back of their GHP Family identification card. GHP Family will promptly grant the request and process the PCP change in a timely manner. Members will receive a new ID card indicating the new PCP's name.

GHP Family maintains policies and procedures allowing Members to select or be assigned to a new PCP whenever requested by the recipient when a PCP is terminated from the Network or when a PCP change is required as part of the resolution to a Grievance or Complaint proceeding.

In cases where a PCP has been terminated for reasons other than cause, GHP Family informs Members assigned to that PCP within thirty (30) days prior to the effective date of the PCPs termination to allow them to select another PCP prior to the PCP's termination effective date. In cases where a Member fails to select a new PCP, the Member is reassigned to another compatible PCP prior to their previous PCP's termination date, informing the Member of the change in writing.

Please Note: Upon notification from DHS that a Participating Provider is suspended or terminated from participation in the Medicaid or Medicare Programs, GHP family will immediately act to terminate the provider from participation. Terminations for loss of licensure and criminal convictions must coincide with the MA effective date of the action.

SPECIALTY CARE PROVIDERS (SCP)

The PCP is responsible for initiating, coordinating and documenting orders to Specialty Care Providers (SCPs) within the GHP Family Network. Members may request a second opinion from providers within the Network. If there is not a second provider with the same specialty in the Network, Members may request a second opinion from a provider out of Network at no charge to the Member.

SCPs must coordinate with the PCP when Members need an order to see another provider. Upon request, such records must be shared with the appropriate providers and forwarded at no cost to the Member or other providers. SCPs are responsible for obtaining orders from physicians and bringing Members into compliance with medical treatment plans.

Members with a disease or condition that is life threatening, degenerative, or disabling may request a medical evaluation. If evaluation standards are met, Members will receive one of the below:

- A standing order to a SCP for treatment of their disease or condition. If a Member needs ongoing care from a SCP, GHP Family will authorize, if Medically Necessary, a standing order to the SCP with clinical expertise in treating the Member's disease or condition. In these cases, GHP Family may limit the number of visits or the period during which such visits are authorized and may require the SCP to provide the PCP with regular updates on the specialty care provided, as well as all necessary medical information.
- A designated SCP to provide and coordinate both primary and specialty care for the Member. The SCP treating the Member's disease or condition will serve as the Member's PCP, coordinating care and making referrals to other SCPs, as needed.

Please refer to Medical Management & Prior Authorizations section of Manual for more information.

SCP AS PCP

A Member may select a SCP to act as PCP if she/he has a disease or condition that is life threatening, degenerative, or disabling. The SCP as a PCP must agree to provide or arrange for all primary care, consistent with GHP Family preventive care guidelines, including routine preventive care, and to provide those specialty health care services consistent with the Member's special need in accordance with GHP Family's standards and within the scope of the specialty training and clinical expertise. To accommodate the full spectrum of care, the SCP as a PCP also must have admitting privileges at a hospital in GHP Family's Network.

PCPs are responsible for initiating and coordinating referrals of Members for Medically Necessary services beyond the scope of their contract of practice. PCPs and SCPs must monitor the progress of the referred Members' care and SCPs must see that Members are returned to the PCP's care as soon as medically appropriate.

SCP's can contact the GHP Enhanced Member Supports Unit (EMSU) at 855-214-8100.

APPOINTMENT STANDARDS

GHP Family works with providers to outreach to HealthChoices Members concerning appointments for Medically Necessary care, preventive care and scheduled screenings and examinations. Contracted GHP Family providers are responsible to adhere to the appointment availability standards for Members. Providers must monitor the adequacy of their appointment processes and reduce unnecessary emergency room visits.

Appointment Type	Member	Provider Type	Appointment Standard(s)
Emergency Medical Condition	All	PCP	Recipients must be seen immediately or referred to an emergency facility.
Urgent Medical Condition	All	PCP	Appointments within 24 hours
Emergency Medical Condition	All	SCP	Appointments immediately
Urgent Medical Condition	All	SCP	Appointments within 24 hours
Routine	All	PCP	Appointments must be scheduled within 10 Business Days.
Specialty	All	Dermatology Dentist Orthopedic Surgery Otolaryngology Pediatric: • Allergy & Immunology • Endocrinology • Gastroenterology • General Surgery • Hematology • Infectious Disease • Nephrology • Neurology • Oncology • Pulmonology • Rehab • Rheumatology • Urology • Dentistry	Appointments must be scheduled within 15 Business Days.

Specialty	All	All Other Specialty	Appointments must be scheduled within 10 Business Days.
Health Assessment	All	PCP	Appointments must be scheduled within three (3) weeks of enrollment.
Initial Appointment	HIV/AIDs Recipients	PCP or SCP	Appointments must be scheduled within seven (7) days of enrollment unless the Member is already in an active care with a PCP or SCP.
	SSI Recipients	PCP or SCP	Appointments must be scheduled within 45 days of enrollment unless the Member is already in an active care with a PCP or specialist.
Initial Prenatal Care Appointment	Pregnant Recipients	OB/GYN or Certified Nurse Midwife	
	First Trimester		Appointments must be scheduled within 10 Business Days of the Member identified as being pregnant.
	Second Trimester		Appointments must be scheduled within five (5) Business Days of Member being identified.
	Third Trimester		Appointments must be scheduled within four (4) Business Days of Member identified as being pregnant.
	High Risk Pregnancy		Appointments must be scheduled within 24 hours of identification of high risk or immediately if an emergency exist.
EPSDT Screens	Under age 21	PCP	Appointments must be scheduled within 45 days of enrollment unless the child is already under the care of a PCP and current with screens.

GHP Family's appointment availability standards reflect minimum requirements. GHP Family routinely monitors providers for compliance with these standards. Noncompliance may result in the initiation of a corrective action plan or further corrective actions.

PCP WAIT TIMES

Waiting time standards for PCPs require that Members, on average, should not wait at a PCP office for more than thirty (30) minutes for an appointment for routine care. On rare exceptions, if a physician encounters an unanticipated urgent visit or is treating a Member with a difficult medical need, the waiting time may be expanded to one (1) hour. GHP Family monitors compliance with appointment and waiting time standards and works with providers to ensure that these standards are met.

APPOINTMENT NOTIFICATION AND FOLLOW-UP

GHP Family requires that PCP's, Dentists, and Specialists conduct affirmative outreach whenever a Member misses an appointment and to document this in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the Member. Such attempts may include, but are not limited to written attempts, telephone calls, and home visits. At least one (1) such attempt must be a follow up telephone call. Communications with the Member should take the language and literacy capabilities of Members into consideration.

EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services are federally mandated services intended to provide preventive health care to children and young adults (under the age of 21 years) at periodic intervals which are based on the recommendations of the American Academy of Pediatrics (AAP), and the Centers for Disease Control and Prevention (CDC). All PCPs who provide services to Members under age twenty-one (21) are required to provide comprehensive health care, screening, and preventive services. GHP Family requires Network PCPs to provide all EPSDT services in compliance with federal and state regulations and periodicity schedules.

EPSDT screens for any new Member under the age of twenty-one (21) must be scheduled within forty-five (45) days from the effective date of Enrollment unless the child is already under the care of a PCP and the child is current with screens and immunizations. Members with suspected developmental delays under the age of five (5) are required to be referred by their PCP through CONNECT (800) 692-7288 for referral for local Early Intervention Program services.

GHP Family will distribute quarterly lists to each PCP that identify Members who have not had an encounter during the first six (6) months of enrollment or Members who have not complied with EPSDT periodicity and immunization schedules for children. PCPs shall be responsible to contact all Members who have not had an Encounter during the previous twelve (12) months or within the MA appointment time frames. These EPSDT Member lists are also available upon request from GHP Family.

Please reference the most recent periodicity guidelines published on the Pennsylvania DHS Web site at: https://www.dhs.pa.gov/.

SCHOOL-BASED HEALTH SERVICES

School-based health services can play a pivotal role in ensuring children receive the health care they need. PCPs are required, with the assistance of GHP Family, to coordinate and/or integrate into the PCP's records any health

care services provided by school-based health services. GHP Enhanced Member Supports Unit (EMSU) can assist PCPs with the coordination of services among the PCP, parents or guardians, and other providers.

SUSPECTED CHILD ABUSE OR NEGLECT

When the County Children and Youth Agency system notifies GHP Family or a Participating Provider suspects a potential case of child neglect and/or abuse of a HealthChoices Member, GHP Family works with the agency and the Participating Providers to ensure that the Member receives timely physical examinations for the abuse or neglect in accordance with the Child Protective Services Law, 23 Pa. C.S. 6301 et seq. and DHS regulations. If a Participating Provider determines that a mental health assessment is needed, the Participating Provider must inform the Member or the County Children Youth Agency representative of how to access mental health services and coordinate access to these services, when necessary. GHP Enhanced Member Supports Unit (EMSU) can assist providers as necessary to connect with local county agencies to remain compliant with mandatory reporting requirements.

In addition to conducting physical examinations, providers must proactively report suspected abuse and/or neglect of HealthChoices Members. Participating Providers can report abuse to the DHS's ChildLine at: (800) 932-0313; TDD: 866-872-1677. ChildLine accepts calls from the public and professional sources 24 hours/day, 7 days/week. ChildLine provides information, counseling, and referral services for families and children to ensure the safety and well-being of the children of Pennsylvania.

Professionals who have reasonable cause to suspect that a child has been abused are required to file a report. The individual may remain anonymous. Each call to ChildLine is answered by a trained intake specialist who will interview the caller to determine the most appropriate course of action. Actions include forwarding a report to a county agency for investigation as child abuse or general protective services, forwarding a report directly to law enforcement officials or refer the caller to local social services (such as counseling, financial aid, and legal services).

For additional information on how to assist children and families, please visit the Child Welfare Services section of the DHS's Website https://www.dhs.pa.gov/.

REPORTABLE CONDITIONS

In accordance with 28 Pennsylvania Code 27.1 Providers must comply with mandatory reporting requirements for Members with identified communicable diseases. A complete listing of responsibilities and disciplinary actions for failure to comply with said requirements by the Pennsylvania licensing boards can be found at: https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/028/chapter27/chap27toc.html&d=reduce. A quick summary of the provider responsibilities includes requirements to:

- Report an outbreak within 24 hours in accordance with § 27.4 (relating to reporting cases).
- Report a suspect public health emergency or an unusual occurrence of a disease, infection or condition not listed as reportable in Subchapter B (relating to reporting of diseases, infections, and conditions) or defined as an outbreak, within 24 hours, and in accordance with § 27.4.
- Report any unusual or group expression of illness which the Department designates as a public health emergency within 24 hours, and in accordance with § 27.4.

GHP Family will conduct random chart audits on an annual basis to verify compliance with this requirement. For assistance in contacting the designated local county/municipal health department, please contact the Enhanced Member Supports Unit (EMSU).

INFECTION CONTROL MEASURES

GHP Family wants to ensure providers exercise approved and effective infection control practices. The Guide to Infection Control Prevention for Outpatient Settings: Minimum Expectations for Safe Care, produced by the Centers for Disease Prevention can be found at: https://www.cdc.gov/Infectioncontrol/index.html

RETURN COMMUNICATION

Specialty Providers are responsible for providing the Member's PCP with information pertaining to the Member's recent episode of care or treatment after each visit or as often as necessary according to federal and/or state laws. PCPs should accurately file written correspondence in the Member's medical record and review such material to assure coordination of the Member's care.

GHP Family provides the "Obstetrical Needs Assessment Form" (ONAF) and the "Retinal Evaluation/Examination Form" to applicable Participating Providers. Contact your Provider Engagement Liaison for information on these forms.

PCP PRACTICE ACCEPTANCE STATUS AND MEMBER LIMITATIONS

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

- Advanced written notification of a minimum of thirty (30) Business Days prior to 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 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 acceptable printing.
- PCP must concurrently establish a limited membership acceptance status with all other managed care plans with which PCP participates.

REFERRALS

Primary care providers (PCPs) —no longer need to submit referrals for GHP Family patients to see a specialist.
Specialty care providers (SCPs) —no longer need to check for a valid referral from GHP Family patient's PCP to care for your patient.

It's important to remember that prior authorization requirements for certain specialty or out-of-network services remain in effect. Check our prior authorization lists at: https://www.geisinger.org/-

/media/OneGeisinger/Files/PDFs/Provider/PriorAuthList.pdf?la=en, to see which services and medications need to be approved for coverage.

We value the PCP-centered care model, so we'll always ask our GHP Family members to keep their PCP informed about specialty services they receive elsewhere.

DIRECT ACCESS AND SELF-REFERRAL

The following services do not require a referral from the PCP:

- Vision
- Dental care
- Obstetrical and Gynecological (OB/GYN) services
- Chiropractic services may be accessed in accordance with the process set forth in Medical Assistance Bulletin 99-10-12
- Physical therapy services may be accessed in accordance with the amended Physical Therapy Act (63 P.S. 1301 et seq.)

Please Note: To be self-referred, the Member must obtain these self-referred services from GHP Family's Network.

Family Planning Services do not require Prior Authorization or referral. Members may access Family Planning Services from any qualified provider. Family Planning Services include, but are not limited to:

- Health Education
- Counseling necessary to make an informed choice about contraceptive methods
- Pregnancy testing and breast and cervical cancer screening services
- Contraceptive supplies such as oral birth control pills, diaphragms, foams, creams, jellies, condoms (male and female), Norplant, injectables, intrauterine devices, and other family planning procedures
- Diagnostic screens, biopsies, cauterizations, cultures, and assessments
- Members have direct access to OB/GYN services and have the right to select their own OB/GYN provider; this includes nurse midwives participating in GHP Family's Network. They can obtain maternity and gynecological care without prior approval from a PCP. This includes:
    - Selecting a provider to give an annual well-woman gynecological visit
    - Primary and preventive gynecology care
    - PAP smear and referrals for diagnostic testing related to maternity and gynecological care, and Medically Necessary follow-up care
    - Perinatal and Postpartum maternity care

In situations where a new pregnant Member is already receiving care from an out-of-Network OB-GYN SCP at the time of enrollment, the Member may continue to receive services from that SCP throughout the pregnancy and postpartum care related to the delivery.

SUBSTANCE ABUSE AND BEHAVIORAL HEALTH

Many behavioral health disorders such as depression, anxiety and substance abuse often occur in Members who present for medical care. PCPs and all non-behavioral health practitioners are encouraged to recommend behavioral health services to Members when deemed appropriate. Substance abuse and behavioral health services are available to all GHP Family Members through the Member's local county mental health office or that office's sub-contracted provider. PCP must inform the Member or the County Children and Youth Agency representative how to access these mental health services and coordinate access to these services, when necessary. To refer GHP Family Members for these services, please reference the behavioral health contact information table in the Contact Information section of this manual for county, provider, and contact details. Members may also self-refer.

MEDICAL MANAGEMENT & PRIOR AUTHORIZATIONS

MEDICAL MANAGEMENT PLAN

The Medical Management Plan defines and clarifies the structure and function of the Medical Management 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.

A copy of the complete MM Plan can be requested from GHP Family's Medical Management Department.

MEDICAL MANAGEMENT STATEMENT

Participating Providers are reminded that utilization criteria are 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 Medical Director. Criteria can be requested in writing from the Medical Management Department at:

Medical Management Department
100 N. Academy Ave.
Danville, Pa 17822-3220.
Phone: (800) 544-3907 or (570) 271-6497; Mon. through Fri., 8 a.m. to 5 p.m.
Fax: (570) 214-3572

QUALITY MANAGEMENT PLAN

The Geisinger Health System's mission is to enhance the quality of life through an integrated health service organization based on balanced patient care, education, research, and community service. GHP Family supports the overall mission of Geisinger Health System. The GHP Family Quality Management (QM) Plan provides the structure and processes for continuously monitoring, analyzing, and improving the clinical care and services provided under GHP Family products to further that mission.

The scope of the QM Plan is comprehensive in nature, allowing for improvement, and is consistent with the DHS's goals related to access, availability, and quality of care.

A copy of the complete QM Plan can be requested from your Provider Engagement Liaison.

POPULATION MANAGEMENT PROGRAMS

GHP Family's Case Management Department offers Population Management Programs for Members across the healthcare continuum including Case Management and Disease Management programs to assist Members with chronic conditions.

GHP Family's Case Management Department engages patients as part of a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality and cost-effective outcomes.

Providers may contact GHP Enhanced Member Supports Unit (EMSU) at 855-214-8100.

GHP's Family Case Management Department is responsible for the delivery of Case Management/Disease Management programs to Insured Individuals. GHP Family provides the following services and programs:

Case Management

Case Managers work in collaboration with the PCP to manage patients with complex co-morbid conditions. The Case Manager completes a comprehensive assessment and prioritizes the patient's needs that allows the provider, Member and/or Member representative, and Case Manager to develop a patient centric plan of care and self-management action plan. Post discharge transitions of care are integral to this patient centered model and include medication reconciliation, confirmation that services are in place (i.e., home health and durable medical equipment), and that there is adequate social support in place. Case Managers facilitate a five (5) to seven (7) day follow-up appointment with the PCP as this is essential to the continuity of care.

For advanced illness, case managers will facilitate palliative care, home health and hospice referrals and the Physician Orders for Life-Sustaining Treatment (POLST) form, if appropriate. Contact your Provider Engagement Liaison for a supply of this form. Advanced directives are facilitated for all Members and are discussed further in the Advanced Directives section of this manual.

Heart failure and COPD are progressive conditions that are managed by case managers in collaboration with the PCP/SCP.

Heart Failure

An ongoing combination of education and management that provides patient education and activation, teaching Members the importance of medications, symptom monitoring that includes daily weights and exacerbation management. Diuretic protocols may be implemented as part of the treatment plan that can be initiated by the Member or family, if determined appropriate by the provider. Diet and lifestyle habits are also part of the education process to improve the management of heart failure. Overall effort is to manage the condition and improve the Member's quality of life.

Chronic Obstructive Pulmonary Disease (COPD)

The Chronic Obstructive Pulmonary Disease (COPD) Program helps Members with COPD to better manage the condition through the inclusion of pulmonary function testing, education, medication management and symptom

monitoring including COPD Rescue Kits, if appropriate, in the treatment plan. Information about tobacco cessation and lifestyle modification is provided by a Case Manager.

Complement the Care provided by the PCP and/or SCP

Case Managers/Health Managers work with Members and the PCP/SCP to assist Members in the community with chronic health/social problems. The Case Managers/Health Managers also provides monitoring and education to help Members better manage the following health conditions: The following programs are available for all Members:

Adult and Pediatric Asthma

Education is a key factor in the Asthma Care Program. Nurse Case Managers/ Respiratory Therapists work with Members and their families to help them understand and manage asthma triggers and symptoms and adhere to treatment plans. Case Managers/Health Managers work with Members to educate them about medications, proper use of inhalers, spacers, nebulizers, and peak flow monitoring. The Case Manager/Health Manager collaborates with the PCP/SCP to develop an individualized Asthma Action Plan with the Member.

Chronic Kidney Disease (CKD)

The purpose of the CKD program is to improve the coordination of appropriate services with a PCP or nephrologist for Members with kidney disease. Case Managers/Health Managers provide education about the importance of proper nutrition, medications, blood pressure control, and other important health care information.

Diabetes

Members in the Diabetes Care Program work with a Case Manager/Health Manager who provides education including pathophysiology, medications, dietary management, exercise and other selfcare strategies that will assist Members in taking control of their diabetes. The Case Managers/Health Managers coordinate services for Members that facilitate standards of care and Healthcare Effectiveness Data and Information Set (HEDIS®) measures to ensure quality.

Coronary Artery Disease (CAD)

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

Hypertension

Case Managers/Health Managers assist 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. Education and optimizing a treatment plan are key to “moving a Member to Goal”.

Osteoporosis

This program provides education to women and men at risk for osteoporosis, as well as those who have already been diagnosed. Case Managers/Health Managers outline steps to prevent osteoporosis and to reduce the risk of complications. Case Managers/Health Managers work with providers to facilitate Dexa Scans and appropriate therapy with patients, as appropriate.

Tobacco Cessation (teen and adult)

In the Tobacco Cessation Program, professional support is provided by Case Managers/Health Managers/Wellness Coaches through phone, group, web-based, or individual coaching. The program goal is to help break the addiction to tobacco products such as cigarettes, pipes, and smokeless tobacco, and help Members quit.

Well on Your Weigh (weight management)

Designed for both adults and children, the program focuses on developing a healthy lifestyle rather than dieting. Members work with Case Managers/Health Managers/Wellness Coaches to set manageable goals, eat healthily, and stay active to control their weight long term.

To refer a Member to a Case Management/Disease Management Program, or to learn more about a specific Case Management/Disease Management Program, Participating Providers should visit GHP Family's Provider Information Center at www.ghpfamily.com or contact the Case Management Department at (570) 271-8763 or toll free (800) 883-6355, Monday through Friday from 8:00 a.m. to 4:30 p.m.

DISEASE MANAGEMENT PROGRAM DEVELOPMENT

Case Management conducts an analysis of the disease under consideration prior to the development of a Case Management/Disease Management program. The following criteria are evaluated:

- Disease prevalence
- Disease complexity
- Potential for reducing complications, improving quality of life
- Current cost of managing the disease
- Existence of an evidence-based clinical guideline to assist practitioners in the management of the disease
- Value to the Participating Provider, Member and GHP Family if the program is implemented

Case Management leadership determines the need for a specific Case Management/Disease Management program based upon the criteria listed above and submits a proposal to GHP Family's Medical Management Administrative Committee and Quality Improvement Committee for review and approval. Actively practicing practitioners are participating Members of Case Management/Disease Management teams and assist in the development, implementation, and monitoring of new and established Case Management/Disease Management programs.

PRACTITIONER PROGRAM CONTENT

The design of all Case Management/Disease Management programs includes but is not limited to 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 SCPs and/or PCPs are involved in the review and approval of evidence-based guidelines.

Clinical guidelines are reviewed annually or when the appropriate guideline team, GHP Family's Guideline Committee and the Quality Improvement Committee make recommendations. Identified primary and SCPs are involved in the development and review of new Case Management/Disease Management programs.

GHP Family'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.ghpfamily.com, and announcements are made in the monthly provider update, 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 GHP Family's Case Management department at (570) 271-8763 or toll free (800) 883-6355, Monday through Friday from 8:00 a.m. to 5:00 p.m.

Identification of Members who benefit from Case Management/Disease Management programs is accomplished through Claims analysis using standard clinical specifications from criteria such as the HEDIS®. Member identification is also facilitated by direct referrals from primary and SCPs, the Member and/or family, and from various GHP Family departments including Medical Management, Customer Care, Appeals, and Quality Improvement.

ENROLLMENT AND PATIENT PARTICIPATION

A Member becomes actively enrolled in the appropriate case/disease management program when the Member contacts GHP Family's Case Management Department directly, is referred by a Health Care Provider or a GHP Family department, or accepts an invitation extended by GHP Family's Case Management Department (by letter or phone as the result of Claims analysis information).

A Case Manager reviews the referral information and contacts the Member to explain the case management services and programs available. After the Member's verbal and/or written consent for participation is obtained, the Member is actively enrolled in the appropriate program.

RISK STRATIFICATION

Case Managers stratify active Members based on clinical criteria according to low, moderate, or high risk. For example, Members enrolled in the Heart Failure program are stratified according to the American College of Cardiology (ACC). Members with diabetes are stratified using glycosylated hemoglobin (A1c) control and the presence of risk factors.

PRACTITIONER DECISION SUPPORT

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

Case Managers are key to providing collaborative "real time" decision support to PCPs. The Case Manager follows internally developed education Care Paths (Algorithms) that complement the clinical guidelines. The education Care Paths (Algorithms) are based on national standards and provide a framework for self-management education, the recommended laboratory/diagnostic studies, and targeted clinical goals.

The plan of care is developed using information regarding the Member's self-management of their condition, barriers, special considerations or exceptions, review of medical test results, management of co- morbidities, collaborative goal-setting and problem-solving, medication review, plans for follow-up, and preventive health monitoring. The plan of care is reviewed and/or discussed by the PCP and/or SCP and the Case Manager in person, by phone, via mail, 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 Case/Disease programs. Practitioner participation ensures program content is appropriate for the actively practicing PCP. All PCPs are surveyed annually to elicit feedback regarding the program(s).

EVALUATION OF PROGRAM EFFECTIVENESS

Program effectiveness is measured by conducting 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:

- Obtain information regarding Case Management/Disease Management programs and services in conjunction with GHP Family as outlined herein; and
- Obtain information regarding the qualifications of the Case Management staff; and
- Obtain information regarding how the Case Management staff facilitates interventions via treatment plans for individual Members; and
- Know how to contact the Case Managers/Health Managers responsible for managing and communicating with their patients; and
- Request the support of the Case Manager/Health Manager to make decisions interactively with Members regarding their health care; and
- Receive courteous and respectful treatment from Case Management staff at all times; and
- File a Complaint when dissatisfied with any component of the Case Management/Health Management programs by contacting the Case Management Department at (570) 271-8763, toll free at (800) 883-6355, or the Customer Care team at the number listed on your patient's insurance card.

PRIOR AUTHORIZATION (PRECERTIFICATION)

Precertification is GHP Family's response to information presented relating to a request for specified health care services.

Precertification does not guarantee a Member's coverage or GHP Family payment.

A Member's coverage is pursuant to the terms and conditions of coverage set forth in a Member's applicable benefit document.

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

A complete list of services requiring Prior Authorization is available online: https://www.geisinger.org/health-plan/providers/authorization-forms-and-resources.

PRECERTIFICATION DETERMINATION AND COMMUNICATION PROCESS

Precertification of services may be required and will be performed by GHP Family Medical Management staff, or through delegated vendor relationships. Delegated vendors may review services such as, but not be limited to, radiology, radiation oncology, and dental services.

Precertification staff, which includes appropriate practitioner reviewers, utilizes nationally recognized medical guidelines as well as internally developed medical benefit policies, individual assessment of the Member, and other resources to guide pre-certification, 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 the Member, the Member's PCP, and the prescribing provider with notification of the determination of coverage as expeditiously as the Member's health condition requires; or, at least orally, within two (2) Business Days of receiving the request, unless additional information is needed. If no additional information is needed, GHP Family will mail written notice of the decision to the Member, the Member's PCP, and the prescribing provider within two (2) Business Days after the decision is made.

If additional information is needed to decide, GHP Family will request such information from the appropriate provider within forty-eight (48) hours of receiving the request and allow fourteen (14) days for the provider to submit the additional information. If GHP Family requests additional information, GHP Family will notify the Member on the date the additional information is requested, using the Request for Additional Information Letter template supplied by the Department. If the requested information is provided within fourteen (14) days, GHP Family will make the decision to approve or deny the service, and notify the Member orally, within two (2) Business Days of receipt of the additional information. GHP Family will mail a written notice of the decision to the Member, the Member's PCP, and the prescribing provider within two (2) Business Days after the decision is made. If the requested information is not received within fourteen (14) days, the decision to approve or deny the service will be made based upon the available information and the Member will be notified orally within two (2) Business Days after the additional information was to have been received. GHP Family will mail a written notice of the decision to the Member, the Member's PCP, and the prescribing provider within two (2) Business Days after the decision is made. In all cases, the decision to approve or deny a covered service or item will be made and the Member must receive written notification of the decision no later than twenty-one (21) days from the date GHP Family receives the request, or the service or item is automatically approved.

When Precertification results in a denial of services, as defined in this manual's Glossary, GHP Family will issue a written notice of denial to the Member, and copy the Participating Provider, using the appropriate notice which includes the Member's appeal rights. In addition, the notice will be available in accessible formats for individuals with visual impairments and for persons with limited English proficiency.

CONCURRENT REVIEW DETERMINATION AND COMMUNICATION PROCESS

As it relates to urgent Concurrent Review approvals, GHP Family has a process with Participating Providers that, once approval has been given it remains in effect until GHP Family notifies the provider otherwise. This means

that as Concurrent Review of care is ongoing and the case continues to meet criteria for approval, GHP Family does not provide repeated notices of approval.

When Concurrent Review results in a denial of services, as defined in this manual's Glossary, GHP Family will issue a written notice of denial to the Participating Provider, using the appropriate notice which includes any appeal rights. In addition, the notice will be available in accessible formats for individuals with visual impairments and for persons with limited English proficiency.

Participating Providers are verbally notified of any pending medical review denial(s) and are offered the opportunity to discuss pending adverse decision(s) directly with an appropriate practitioner reviewer making the initial determination, or reviewer available at a time convenient for the Participating Provider. The Participating Provider's request to discuss the pending determination is required to occur within one (1) Business Day of GHP Family's pending verbal denial notification to meet stringent regulatory timelines for the generation of denial notices. The Participating Provider can supply additional supportive information for discussion.

Please note: Depending on whether the Member exercises their appeal rights and the timeframe in which the Member does so, the Member may potentially be liable for payment if the Member chooses to receive a given service after having been informed of the denial determination and before having the service.

Contact Medical Management at (800) 544-3907 or (570) 271-6497, Monday through Friday 8:00 a.m. to 4:30 p.m. or fax (570) 214-3572. Medical Management's IVR system is available 24 hours/day, 7 days/week.

AUTHORIZATION REQUIRED FOR PAYMENT

Any service, with or without an authorization, rendered by a Participating Provider and determined to be clinically inappropriate by the Medical Director will be paid at an appropriate alternate level of care or payment will be 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 an adverse determination, the Participating Provider is verbally notified of the option to speak with a Medical Director regarding such determination. The Provider Appeal process is also available to Participating Providers for claims payment issues.

MEDICAL BENEFIT POLICIES

Medical policy is the written description of GHP Family's position concerning the use or application of a biologic, device, pharmaceutical, or procedure, based on any or all of the following: Regulatory 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 online in the Clinical Policies section, https://www.geisinger.org/health-plan/providers/ghp-clinical-policies; a direct link to the clinical policies page is also sent by email each month. . The provider update is accessible on the GHP plan central page on https://www.navinet.net. A hard copy may be obtained from your Provider Account Manager. A minimum of thirty (30) days' advance notice is provided regarding those services, which have been added to the GHP precertification list. The precertification list can be found at PriorAuthList.pdf.

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

Phone: (800) 544-3907 or (570) 271-6497; Monday through Friday 8:00 a.m. to 4:30 p.m.

Fax: (570) 214-3572

VERIFICATION OF ELIGIBILITY AND BENEFIT LIMIT

Prior to coordinating health care services, a Member's eligibility and benefits should always be verified through:

- DHS Eligibility Verification System (EVS) at (800) 766-5EVS (5387),
- https://www.navinet.net, or
- GHP Family Customer Care Team at (855) 227-1302

Except in an Emergency or as otherwise permitted in accordance with the terms and conditions of coverage set forth in a Member's benefit document, all healthcare services for a Member must be provided by and rendered in a Participating Provider or must be approved in advance by the GHP Family Medical Director.

INPATIENT SERVICES

Requests for precertification of inpatient services (including planned hospital, inpatient rehabilitation, and skilled nursing facility admissions) are the responsibility of the admitting Participating Provider.

REQUESTING PRECERTIFICATION

Providers can request precertification for inpatient services through https://coherehealth.com/provider/resources/ for all GHP Family patients. Cohere offers evidence-based care suggestions, but Geisinger Health Plan Medical Management will still review requests and retain ultimate authority over medical necessity determinations.

Check GHP Family's precertification list frequently at https://www.geisinger.org/-/media/OneGeisinger/Files/PDFs/Provider/PriorAuthList.pdf?la=en to know which services require authorization submission through Cohere.

Visit the Cohere Learning Center at https://coherehealth.zendesk.com/hc/en-us/articles/10169953922327-Out-of-Network-Exceptions for detailed user guides. Registration with Cohere is required to access the learning center. Register with Cohere at https://coherehealth.com/provider/register/.

Cohere uses a team of nurses and doctors to make sure guidance during the request process is medically appropriate and meets clinical guidelines. Here's what happens when precertification is requested online through Cohere:

1. Cohere's consultative request process guides the user through each step, providing patient-specific suggestions that can expedite approval.
2. Requests are immediately relayed to Geisinger Health Plan Medical Management for review. Geisinger Health Plan Medical Management will make a determination in accordance with the Precertification Determination and Communication Process outlined above.
3. Upon approval, the authorization number populates in the portal.

When a request has received a final determination (approved, partially approved, or denied) Cohere will send the submitter a courtesy email notification regarding a change in status of the authorization.

Using Cohere's online portal is the most direct way to manage authorization requests. However, prior authorization can also be requested using print and fax forms at https://www.navinet.net orhttps://www.geisinger.org/health-plan/providers/authorization-forms-and-resources.

INPATIENT ADMISSIONS EXCLUDED FROM PRECERTIFICATION:

- Emergency and/or Urgent Care 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 GHP Family 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: Inpatient hospital admissions unrelated to the course of pregnancy may require precertification.
- A transfer from one hospital Participating Provider to another hospital Participating Provider where the first inpatient admission was pre-certified and/or followed by GHP Family Concurrent Review and has been determined appropriate for an acute inpatient level of care.
- Retrieval of a Member from a non-participating facility to a Participating Facility through GHP Family'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 Participating Facility 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

GHP will only require prior authorization for planned hospital admissions under the following circumstances:

- If any provider/facility involved in a GHP Member's care is considered a non-participating provider with that patient's plan
- If the procedure being performed is an outpatient procedure, but the provider requests an acute inpatient level of care
- If a GHP patient is admitted to an acute inpatient rehabilitation or skilled nursing facility
- If the procedure being performed is a non-covered service under the GHP patient's plan
- If the procedure being performed is a covered service designated as requiring prior authorization on GHP's prior authorization list

If any of the exceptions listed above hold true, prior authorization is required no less than two (2) business days prior to the planned date of admission.

OBSERVATION SERVICES

Precertification is required for observation services expected to exceed twenty-three (23) hours.

NEWBORN NOTIFICATION

Newborn notifications should be faxed to 570-214-0200. Information required from hospital providers to give notice of new births:

- **Mother's information**
  - Mother's name, Member ID number, date of birth and contact information
  - Facility name
  - Reviewer's name and contact information
  - Date of admission
  - Date of Discharge
  - Diagnosis (vaginal or c-section delivery)
  - Attending physician
- **Baby's information:**
  - Mother's name and Member ID number
  - Baby's name, sex, and date of birth
  - Baby's weight and Apgar score
  - Discharge/NICU/Detained
  - Attending physician
  - Baby's primary care physician (if known)

Please note: GHP Family Medical Management staff are available to assist with discharge planning, especially for complex or hard-to-place Members.

SNF SERVICES REQUIRING COORDINATION

- **Hospice Election:** The SNF or hospital provider is required to notify GHP Family'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 GHP Family's Medical Management Department at (800) 544-3907.
- **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 Care Team for further assistance.
- **Laboratory/Pathology Services:** All laboratory/pathology specimens for Members admitted to a SNF/hospital under any level of care must be forwarded to a Participating Provider for analysis.
- **Home Phlebotomy Services:** All phlebotomy services for Members admitted to a SNF/hospital under any level of care must be forwarded to a Participating Provider for analysis.

- **Radiology Services:** All radiology and mobile radiology services, excluding routine chest x-rays, for Members admitted to a SNF must be coordinated with a radiology Participating Provider. A complete listing of radiology Participating Providers can be located at www.ghpfamily.com.

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. Failure to notify GHP Family of a non-skilled admission or discharge may reflect non-compliant behavior and result in GHP Family administrative action.

OUTPATIENT SERVICES

Requests for precertification of outpatient services (including, but not limited to home health and hospice, outpatient rehab, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), therapy and non-emergent ambulance) are the responsibility of the Participating Provider.

REQUESTING PRECERTIFICATION

Request precertification for inpatient services through https://coherehealth.com/provider/resources/ for all GHP Family patients. Cohere uses a collaborative online authorization process that offers evidence-based care suggestions, but Geisinger Health Plan Medical Management will still review requests and retain ultimate authority over medical necessity determinations.

Check GHP Family's precertification list frequently https://www.geisinger.org/-/media/OneGeisinger/Files/PDFs/Provider/PriorAuthList.pdf?la=en to know which services require authorization submission through Cohere.

Visit the Cohere Learning Center at https://coherehealth.zendesk.com/hc/en-us/articles/10169953922327-Out-of-Network-Exceptions for detailed user guides. Registration with Cohere is required to access the learning center. Register with Cohere at https://coherehealth.com/provider/register/.

Cohere uses a team of nurses and doctors to make sure guidance during the request process is medically appropriate and meets clinical guidelines. Here's what happens when precertification is requested online through Cohere:

1. Cohere's real-time consultative request process efficiently guides the user through each step, providing patient-specific suggestions that can expedite approval.
2. Requests are immediately relayed to Geisinger Health Plan Medical Management for review. Geisinger Health Plan Medical Management will make a determination in accordance with the Precertification Determination and Communication Process outlined above.
3. Upon approval, the authorization number populates in the portal.

When a request has received a final determination (approved, partially approved, or denied) Cohere will send the submitter an email notification with authorization status.

Using Cohere's online portal is the most direct way to manage authorization requests. However, prior authorization can also be requested using print and fax forms at https://www.navinet.net or https://www.geisinger.org/health-plan/providers/authorization-forms-and-resources.

Call Cohere at (855) 460-8026 with registration, login and technical issues with the portal. Questions related to determinations, appeals, peer-to-peer and member information should be directed to Geisinger Health Plan at (800) 876-5357.

Ordering DME through Tomorrow Health

GHP is working with Tomorrow Health to provide patients with easier, more convenient, and more affordable access to home medical equipment. Through this program, providers and patients will enjoy a superior DMEPOS experience:

- Free, fast home delivery for your patients
- More on-time starts of care for your patients
- Single point of contact for all GHP DMEPOS orders
- Hands-on support from a team of expert Care Advocates

All GHP DMEPOS orders should be placed through Tomorrow Health. Tomorrow Health will route orders to a DMEPOS provider in the Geisinger network that best suits the patient's needs. Vision services should not be placed through the Tomorrow Health platform. For a full list of HCPCS codes the program covers visit https://home.tomorrowhealth.com/providers

How to place orders

Ordering providers can place orders on behalf of patients using one of the following methods:

- Online form – Complete the HIPAA-compliant order form at https://home.tomorrowhealth.com/providers.
- Phone – Place orders through an expert Care Advocate at 844-402-4344.
- Fax – Access order forms at www.tomorrowhealth.com/referral and follow the instructions to submit via fax.

Supply closets and onsite consignment

Providers who wish to keep their existing supply closet relationships will be able to. However, for the equipment or supplies to be reimbursed by Geisinger Health Plan, referring or ordering providers will need to submit copies of the corresponding prescriptions to Tomorrow Health by fax or online within one (1) business day of dispensing the item(s).

DME Prior authorizations

After the referring/ordering provider sends an order to Tomorrow Health, Tomorrow Health will assist with obtaining the complete information required for requesting prior authorization before sending the order to a DMEPOS provider. Once the DMEPOS provider receives and accepts an order from Tomorrow Health, that DMEPOS provider will still request authorization (if needed) through Cohere.

Contact Tomorrow Health

For general inquiries not related to a specific patient or order, please contact Tomorrow Health:
Ordering Providers: providers@tomorrowhealth.com
DME Providers: dmepartners@tomorrowhealth.com

Requesting a Non-Emergent Ambulance

Prior authorization is required through Cohere for non-emergent ambulance transportation (NEAT). Prior authorization is not required for the following:

- All emergency trips
- All non-emergent trips from hospital to hospital

- All non-emergent trips from ED/hospital to a higher level of care
- All non-emergent trips from ED/hospital to skilled nursing, long-term acute care or inpatient rehabilitation facilities
- All non-emergent trips from ED/hospital to an inpatient behavioral health facility
- All non-emergent trips from ED/hospital to inpatient/home hospice

Register with Cohere at http://www.coherehealth.com/register.

View GHP Family's ambulance transport service medical benefit policy MP017 at https://www.geisinger.org/-/media/OneGeisinger/Files/Policy-PDFs/MP/1-50/MP017-Ambulance-Transport-Service.pdf?sc_lang=en&hash=38341DC562687E36ACF2B996AB64AAF9 for detailed coverage criteria.

Changes to NEAT dispatch process

- Discharge personnel and ordering providers should coordinate directly with medical transport providers.
- Reference the member's prior authorization number supplied by Cohere when coordinating transport.
- Make every effort to use participating ambulance providers when ordering NEAT for GHP members. Find in-network ambulance providers on our provider search page at https://www.geisinger.org/healthsparq. Simply enter your location, search Places by Type and start typing "ambulance". Results will include ambulance provider contact and plan acceptance information.
- If using a participating ambulance provider is unreasonable because of availability or distance, alternate arrangements can be made in the best interest of the member. You can note the reasons for using an out-of-network ambulance provider during the Cohere prior authorization request process.
- Keep in mind that options other than ambulance may be more appropriate depending on the nature of the member's transportation needs (e.g., wheelchair van).
- Member cost-sharing may apply according to member benefits.

Contact us

- Contact Provider Engagement at 800-876-5357 or GHPAccountMngt@geisinger.edu.
- Contact our Medical Management team at 800-544-3907.

Coordinating shift care/private duty nursing services

When a GHP Family Member requires shift care/private duty nursing services, providers and home health agencies should work with GHP Medical Management to ensure a request for review of any new or additional services is completed within one business day of completion of the admission assessment. Each request is reviewed by GHP Medical Management on an individual basis of need. Reference medical benefit policy MP287 at https://www.geisinger.org/-/media/onegeisinger/files/policy%20pdfs/mp/251-300/mp287%20shift%20care for more information and guidelines for medical necessity.

There are several options for requesting authorization and coordinating services so that members in need experience no disruption when obtaining or continuing these services.

For new members already receiving shift care/private duty nursing services:

- Agencies caring for the Member should submit the Shift Care Notification Form within five (5) days of any changes in the status of a member receiving shift care services. Fax form to 570-271-5507. The Shift Care Notification Form can be found at https://www.geisinger.org/health-plan/providers/authorization-forms-and-resources.

- Other providers who become aware of any disruption to shift care/private duty nursing services for new members should contact GHP Medical Management immediately to help coordinate services.
- Agencies who can't accommodate continuing services or discharged Member from services due to staffing issues should call GHP Medical Management immediately to help coordinate services. When notified, GHP Medical Management will work with GHP care coordinators to find available covered services for the Member.

For members in need of shift care/private duty nursing services for the first time (new to shift care):

- Prescribing providers referring Members for initial shift care/private duty nursing services should use the Private Duty Nursing/Shift Care Form to relay patient and provider information to GHP Medical Management. Fax form to 570-271-5507. The Shift Care Notification Form can be found at https://www.geisinger.org/health-plan/providers/authorization-forms-and-resources.
- Prescribing providers do not need an agency to request shift care/private duty nursing services for a member. A referring provider should request authorization and coordination of shift care/private duty nursing services directly from GHP Medical Management. There are two ways to request authorization/coordination directly from GHP Medical Management:
  - Request services through Cohere at https://coherehealth.com/provider/resources/.
  - Request services by submitting the Private Duty Nursing/Shift Care Form. Fax form to 570-271-5507. The Shift Care Notification Form can be found at https://www.geisinger.org/health-plan/providers/authorization-forms-and-resources.
- Agencies who can't accommodate new patients or have discharged members due to staffing issues should call GHP Medical Management immediately to help coordinate services. When notified, GHP Medical Management will work with GHP care coordinators to find available covered services for the Member.
- When a home health agency has been identified as the agency that will staff a new case when initial authorization is received, that agency may assist with the development of the authorization request, and GHP may correspond with that agency for purposes of obtaining all necessary information to support the request, but the requesting prescribing provider must be the one to initiate the authorization request.
- For reauthorization requests, the request may be submitted by either the prescribing provider or the home health agency of record that currently staffs the case.

Outpatient cardiology, MSK and interventional pain management services

Cardiology, MSK, and pain management services that require authorization can be requested through Cohere. Authorization for radiology continues through HealthHelp.

OUTPATIENT RADIOLOGY AND IMAGING

GHP Family works with HealthHelp to establish a consultative authorization process to improve quality, reduce the cost of care and ensure members receive clinically appropriate and medically necessary services. The HealthHelp authorization process will involve:

- Collecting relevant clinical information from the ordering/treating physician's office;
- Reviewing this information alongside the latest evidence-based medical criteria for certain procedures;
- If necessary, providing expert peer consultation on treatment and/or test appropriateness and patient safety. If a requested service does not meet evidence-based guidelines, HealthHelp will facilitate a physician-to-physician conversation with the requesting provider to consider alternatives.

Services that will require authorization

All requests for the tests and procedures listed below need to go through HealthHelp, except services rendered in an emergency or inpatient setting.

- CT
- CTA
- MRI
- MRA
- PET

A complete list of associated procedure codes requiring authorization can be found at https://www.geisinger.org/health-plan/providers/radiology-authorization.

How to request authorization

Ordering physicians can request an authorization for services using one of the following methods:

- **Web:** Complete your request through the online tool at www.healthhelp.com/Geisinger.
- **Fax:** Complete the HealthHelp procedure review request form and fax to **877-391-7294**. For an expedited request, fax to **877-391-7295**.
- **Phone:** Call HealthHelp at **877-391-7293**.

The most efficient method for obtaining an authorization number is through the web. Contact HealthHelp program support at **800-546-7092** if you need assistance setting up web access.

What you need to initiate your prior authorization request

The following information is required for all authorization requests and should be available in the patient's chart:

- Member name and ID number
- Ordering provider name
- Ordering provider telephone and fax numbers
- Member diagnosis or clinical indication
- Test being ordered (CPT code)
- Reason for test
- Member symptoms and duration
- Prior related diagnostic tests

Ordering providers:

- Laboratory studies
- Member medications and duration
- Prior treatments
- Summary of clinical findings
- Member risk factors (primarily applies to imaging requests related to cancer indications including screening)

How to confirm authorization

Ordering providers should confirm authorization before scheduling services. Ordering providers can confirm authorization for radiology services using one of the following methods:

Web: When you submit your request through the web, your authorization will be available immediately online to print.

Fax: When you submit your request via fax, a faxed copy of the authorization will be sent to the ordering provider's office fax number you provided on the form.

Phone: When you submit your request by phone, a HealthHelp client service representative will provide a verbal authorization over the phone. A confirmation will also be faxed to the ordering provider's office fax number provided. When contacting HealthHelp for assistance through their automated phone system, please be sure to have the following information and follow the prompts noted below.

Information needed:

- Member ID Number
    - Member ID Number does not include the suffix
- Member Date of Birth
    - Date of Birth format xx/xx/xxxx
- Member diagnosis and procedure codes
- Transaction ID for any previously submitted authorizations you to obtain details on

The automated phone system will include the following options:

Option 1 – How to submit a request
Option 2 – Check status of an existing request
Option 3 – Initiate a new request

HealthHelp representatives are available Monday–Friday, from 8 a.m. to 6 p.m. Eastern Standard Time. After-hours requests may be submitted by fax or via web portal.

Urgent authorization requests
To submit a Medicaid Expedited request, it must be physician ordered and meet the following criteria as per DHS.

Urgent Care Services — Services furnished to an individual who requires services to be furnished within twenty-four (24) hours in order to avoid the likely onset of an Emergency Medical Condition.

Urgent Medical Condition — An illness, injury or severe condition which under reasonable standards of medical practice, should be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or Emergency Medical Condition. The term also includes services that are necessary to avoid a delay in hospital discharge or hospitalization.
If the service you are requesting meets the above criteria, submit your Expedited Request by fax to GHP Family at 570-214-0211.

Additional resources
HealthHelp will host webinars to familiarize Geisinger Health Plan network providers with the authorization process. The webinars will give a system demonstration with user experience insight on how to appropriately enter procedure requests, along with additional program information — such as the Geisinger procedure code list, support tools and HealthHelp contact information.

Visit For Providers section of Geisinger Health Plan's website at http://geisinger.org/health-plan/providers/radiology-authorization to register for one of the webinars. Additional educational materials and program implementation information — including a list of all procedure codes requiring authorization through HealthHelp — will be available:

- On the For Providers section of Geisinger Health Plan's website at http://geisinger.org/health-plan/providers/radiology-authorization
- Through the Geisinger plan central page on https://www.navinet.net
- On HealthHelp's website at http://www.healthhelp.com/Geisinger

For questions or information regarding general prior authorization policy and procedures, contact a Geisinger Health Plan Medical Management representative at **800-544-3907**.

SPECIALTY PHARMACY PROGRAM

Certain prescription and injectable drugs are covered only through GHP Family's Specialty Network. For more detail and a complete list of drugs and pharmacies available through this program, refer to www.ghpfamily.com or call **855-552-6028**. Medication requests are the responsibility of the prescribing Participating Provider. Unless noted on the list, the use of the Specialty Pharmacy Program is not mandatory if the physician elects to buy the medication and bill GHP Family for the cost or if GHP Family is the secondary payer.

Please note: Prior authorization may be required for certain drugs. Please refer to the section titled "Pharmacy Prior Authorization and Nonformulary/Nonpreferred Exception Process" within this Manual for further information.

Specialty Pharmacy Program Process
To initiate the program, the Participating Prescriber can directly e-scribe or fax the prescription to any of the specialty pharmacies in GHP Family's Specialty network. For a full list of specialty medications and participating pharmacies please visit: https://www.geisinger.org/-/media/OneGeisinger/Files/PDFs/GHP-Family/GHPFamilySpecialtyDrugList.pdf.

For more information, please call 855-552-6028.

OUTPATIENT PRESCRIPTION DRUGS

GHP Family, like other MCOs in Pennsylvania, follow the Statewide Preferred Drug List (PDL) which is developed by the Department of Human Services Pharmacy and Therapeutics Committee.

For those Medications not covered by the Statewide PDL, GHP Family 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.

GHP Family: The GHP Family benefit includes coverage only for prescription and over-the-counter (OTC) drugs listed in the Formulary or Statewide PDL. Formulary and PDL exceptions may be granted on a case-by-case basis.

- Tier 1–Includes Generics. Prior authorization may be necessary.
- Tier 2–Includes Brand name drugs. Prior authorization may be necessary.

The most current Statewide PDL can be found at https://papdl.com/preferred-drug-list and the GHP Family Formulary is available online at www.ghpfamily.com.

Maintenance Medications: Members are eligible to receive a ninety (90) day supply of maintenance medications, excluding those that are considered specialty medications or are controlled substances. For questions about which medications are considered maintenance medications, please call GHP Family Pharmacy services at (855) 522-6082 or (570) 214-3554. Members can receive the 90-day supply of medications from a participating retail pharmacy or a participating mail order pharmacy and will be charged the same copay as a one-month supply.

Non-Formulary/Non-Preferred medications: The Formulary and Statewide PDL are designed to meet most therapeutic needs of the population served by GHP Family. Occasionally, because of allergy, therapeutic failure, or a specific diagnostic-related need, Formulary/Preferred medications may not meet the special healthcare needs of an individual Member. In these special instances, the prescribing physician may make requests to the GHP Family Pharmacy Department for nonformulary, nonpreferred, or restricted medications through the exception process. The prescribing physician will receive written documentation and/or a verbal response from the GHP Family Pharmacy Department regarding the request. Under the GHP Family plan, non-Formulary/non-Preferred medications requiring an exception will be available at the appropriate copayment tier (Tier 1 – generic; Tier 2 – brand).

Formulary addition requests: Requests for changes or additions to the Formulary can be made by written request to the GHP Family Pharmacy Department at the address listed below. Any additions or deletions to the Formulary may be found in the monthly provider update.

Geisinger Health Plan Pharmacy Department
100 North Academy Avenue
Danville, PA 17822-2410

Phone: (855) 552-6028; (570) 214-3554
Fax: (570) 300-2122

PHARMACY PRIOR AUTHORIZATION AND NONFORMULARY/NONPREFERRED EXCEPTION PROCESS

GHP Family's Pharmacy Department maintains a process by which Health Care Providers can:

- Request Prior Authorization for medications designated in the Formulary/PDL as requiring such. Drugs that require Prior Authorization are designated with a "PA" indicator.
- Request an exception for specific drugs, drugs used for an off-label purpose, and biologicals and medication(s) not included in the current drug Formulary/PDL.

REQUESTING PRIOR AUTHORIZATION

Prior authorization forms can be found at: www.ghpfamily.com.

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
Danville, PA 17822-2410

Phone: (855) 552-6028 or (570) 214-3554 Monday – Friday 8:00 a.m. - 5:00 p.m.
Fax: (570) 300-2122

Information required to process the request includes:

- Caller's name and telephone number.
- Member's GHP Family identification number and if applicable medical record number.
- Prescribing Health Care Provider's name and telephone number.
- The medication requested, directions, and number of refills.
- 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 GHP Family to be relevant.

Prior authorization requests will be addressed within twenty-four (24) hours of the request being made. If a claim denies at point of sale because a prior authorization is required, the pharmacist will dispense either a five (5) day supply for new medications or a fifteen (15) day supply for ongoing treatment. This does not apply if the pharmacist determines that taking the medication would put the Member at risk.

Exception Determination Process

Formulary/PDL 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).
- Utilization of the requested agent for a clinically proven treatment indication or diagnosis.
- Therapeutic failure, intolerance, or contraindication to use of Formulary/PDL agent and/or agents designated as therapeutically equivalent.
- Appropriateness of the non-formulary/non-preferred agent compared with available formulary/preferred agents, including but not limited to:
    - Safety
    - Efficacy
    - Therapeutic advantage as demonstrated by head-to-head clinical trials
    - Meets DHS criteria for drug or drug class PDL exception
    - Meets GHP Family criteria for drug or drug class Formulary exception

All requests for prior authorization of a medication will be addressed within twenty-four (24) hours of the request being made.

A GHP Family 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 an 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 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 the request being made.
    - At the time of notification, GHP Family will indicate the coverage provided in the amount disclosed by GHP Family for the service requested.

- A written confirmation of the approval will be sent to the provider and Member within 24 hours of the request being made.

- If the request for a Formulary/PDL exception is denied, resulting in an adverse benefit determination, the following will occur:
    - GHP Family will mail the appropriate denial notice with information on appeal rights and process to the Member (or Member's authorized representative) and copy the Provider, within twenty-four (24) hours of the request.
    - The Member and provider will be verbally notified of the adverse determination within twenty- four (24) hours of the request. This verbal notification will include instruction on how to initiate a Complaint or Grievance.
    - The prescribing Health Care Provider will be offered the opportunity to discuss the determination of coverage with a GHP Family Pharmacist or Medical Director.

The written denial notice and verbal explanation shall include:

- The specific reason for the determination;
- The basis and clinical rationale utilized in rendering the determination of coverage, if applicable;
- Any internal policy or criterion applied, if applicable, and;
- Instructions regarding initiation of the Complaint or Grievance.

Formulary changes are printed in the monthly provider update, available on the GHP plan central page on https://www.navinet.net. A minimum of thirty (30) days advance notice is provided to Participating Providers regarding Formulary changes, except when the Formulary change is due to the approval or withdrawal of a medication by the Food and Drug Administration. The most current Statewide PDL can be found at https://papdl.com/preferred-drug-list.

MATERNAL HEALTH PROGRAM (INCLUDING HEALTHY BEGINNINGS PLUS)

Pregnant Member's coverage includes all Medically Necessary ultrasonography. GHP Family's program entitled "Right from the Start" is designed to serve the GHP Family Member throughout her pregnancy, from early identification, through the prenatal experience and postpartum follow-up. GHP Family's comprehensive approach to assist Members through this life changing event engages many areas of health plan employees, provider offices, and most importantly the Member and caregivers.

GHP Family collaborates with various Community-Based Organizations to provide Home Visiting Programs that are available to all first-time parents and parents/caregivers of children who have been identified as having additional risk factors which may include social, clinical, racial, economic, or environmental factors. The Home Visiting Programs are also available to any infant and the infant's parent/caregiver who requests Home Visiting services. Services are available from the prenatal period and at a minimum through the child's first 18 months of life.

The Home Visiting Programs are innovative, expansive, inclusive programs which provide individualized, strengths-based, and family-focused services. These programs are designed to provide support to parents/caregivers, children, and families to ensure that all needs are addressed, and families are active partners in their care.

EARLY IDENTIFICATION

The process begins with early identification of the pregnancy. GHP Family will attempt to identify Members who are pregnant through a variety of processes including:

- Data extractions including, but not limited to, enrollment files, Chronic Conditions and Specialist Visits reports, positive laboratory testing results, and/or prescriptions filled for prenatal vitamins.
- New Member Calls conducted by the dedicated GHP Family Customer Care Team which asks if the Member or anyone in the household who also has GHP Family is pregnant.
- Direct referrals from Case Managers, providers, or other health plan representatives.
- Claims information indicating pregnancy.
- ONAF Completion received either via fax or secure electronic submission through the provider portal.

A master list of any identified Member who is pregnant will be reviewed by the QI Department. Any Member identified as "high risk" will be referred to the Women's Health and EPSDT Coordinator (or designee) for case management intervention. Following this assessment, any case not deemed "high risk" will be forwarded electronically to the QI Specialist assigned for HEDIS® preventative calls.

QUALITY IMPROVEMENT AND REGULATORY REQUIREMENTS

GHP Family has a strong commitment to quality metrics to improve the overall health of our membership. As such, the Case Managers conduct scheduled outbound calls to high-risk pregnant Members to improve Member compliance with measures including:

- Weeks of pregnancy at time of enrollment and live birth
- Timeliness of physician visit (Measure: percentage of live births that had a prenatal visit within the first trimester or 42 days of plan enrollment)

- Timeliness of postpartum visit (Measure: Postpartum visit within 7-84 days of delivery)
- Cesarean Section for low-risk, first birth women
- Percentage of live births less than 2,500 grams
- Completion of Prenatal Depression Screening and treatment for those who screen positive
- Prenatal screening for smoking and treatment discussion during a prenatal visit
- Screening home environment for smoke

SERVICE DESCRIPTION

Member Assistance with Appointment Scheduling

GHP Family will help the Member obtain a provider visit as needed within twenty-four (24) hours to ten (10) days of notification of the pregnancy as required by the Department, depending on the risk level and trimester. See the table in the *Appointment Standards* section of this manual. GHP Family assists the Member in completing a minimum number of prenatal visits and in completing a follow up visit within 7-84 days postpartum.

Network Access

GHP Family Members have direct access to a Women's Health provider. In the event the Member is transferring from another health plan and the current provider is not in-network, GHP Family will cover maternity care through the course of the pregnancy and postpartum care with the non-participating provider.

High Risk Management

Members are screened for high-risk management by Enhanced Member Supports Unit (EMSU) Case Management staff and referred to Women's Health case management nurses with seasoned experience in high-risk fetal maternal health care as appropriate. Regionally based case management staff will coordinate services with perinatology specialty sites throughout the GHP Family service area. Services include telephonic outreach to ensure timely and continuous provider follow-up, assistance with overcoming barriers to care such as transportation or access to appointments or providing resources to assist with weight management and smoking cessation during pregnancy.

Coordination with Healthy Beginnings Plus

GHP Family encourages expectant mothers to participate with participating Healthy Beginnings Plus providers throughout all 67 Pennsylvania counties. Healthy Beginnings Plus is a program that provides education and assistance to female Members with a goal of a healthy prenatal experience and compliant postpartum follow-up.

Behavioral Health Coordination

The Enhanced Member Supports Unit (EMSU) can assist Members to connect with the assigned Behavioral Health Managed Care Organization (BH MCO) in the Member's county of residence. The BH MCO can assist with concerns during pregnancy including depression or other mental illness conditions.

Physical Health Managed Care Organizations (PH-MCOs) Integrated Care Plan (ICP) Program

The purpose of this program is to capture and monitor the case management activities of the PH/BH-MCOs population of members diagnosed with serious persistent mental illness (SPMI). Geisinger Health Plan Care Management staff will be reaching out to providers to discuss an Integrated Care Plan (ICP) that has components of physical health and behavioral health for GHP members with SPMI.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Management

Post-delivery, GHP Family is committed to facilitate timely access and compliance with recommended visits and vaccination schedules for children under the age of 21. Through a series of telephonic outreach, GHP Family Quality Improvement (QI) nursing staff will review Members at key milestones for well child visits and scheduled immunizations. In the event Members are non-compliant with EPSDT visits, GHP Family will make every attempt to reach the Member/caregiver to facilitate compliance.

MEMBER HEALTH EDUCATION

GHP Family has a robust education strategy to outreach to Members upon identification of pregnancy. Topics include importance of scheduling and keeping prenatal appointments, healthy nutrition, and transportation coordination.

Messaging may be accomplished through mailing print materials, reminder phone calls or cell phone texting depending on the risk stratification of pregnant condition and trimester.

PROVIDER RELATIONS

Education

GHP Family respects the value and contribution of the providers taking care of expectant Members. Communication with the obstetrics provider is emphasized from the first identification of pregnant status. The Obstetrical Needs Assessment place ONAF after Form should be completed with pregnancy determination. Completion and submission of the form is part of the GHP Family Provider Pay for Performance Program.

Communication

GHP Family uses a variety of methods to keep providers up to date with current information to the management of pregnant members including a web-based provider manual, operational bulletins, and visits by Provider Engagement Staff.

COMMUNITY OUTREACH

GHP Family will make efforts to engage local community agencies, school systems, and providers to provide education and assistance in the care of our Members. Venues for health education include area high schools, family planning agencies such as Planned Parenthood, or other organizations dedicated to the care of women.

GHP Family will outreach with community agencies specifically in the top four counties designated for teen pregnancy in the sixty-seven-county service area.

MEMBER REWARDS

GHP Family offers Member rewards to encourage compliance with keeping prenatal and postpartum appointments, and well-child visits. Rewards will be offered to:

- Members who completed one prenatal visit in the first trimester and one prenatal visit in the second trimester. Two visits must be completed to be eligible for a reward.
- Members who experience a live birth and keep their postpartum visit between 7-84 days.

- Members who have had 6 well visits by their 15-month birthday.
- Members who have had 2 additional visits between their 15 – 30-month birthday.
- Members 3 – 17 years of age who have completed one well visit with their primary care physician.

Rewards are provided in the form of a gift card that can be used on food, clothing, over-the-counter medications, and personal hygiene items. Compliance will be determined through claims data. No additional reporting is required of the provider.

REPORTING

GHP Family recognizes the responsibility to comply with the Department of Human Services' reporting requirements specific to the care of women who are pregnant. The following table is a general summary for required reports, including report name, description, frequency, and responsible party.

REQUIREMENTS FOR MEDICAID MATERNITY/PREGNANCY REPORTING

Measure Title	Summary of Measure	Responsible Party	Frequency
Percentage of live births weighing less than 2,500 grams	Live births <2,500 grams as a percent of total live births	Clinical Informatics	Monthly
Perinatal Depression Screening (Pre and postnatal)	Screened for depression during prenatal visit Positive depression screen Positive depression screen who received further evaluation or referral Screened for depression during postpartum visit Positive depression screen Positive depression screen who received further evaluation or referral	Clinical Informatics	Monthly
Prenatal Screening for Smoking and Treatment Discussion during a Prenatal Visit (Smoking and environmental smoke)	Screened for smoking during one of first two visits Screened for smoking during one of first two visits and currently smoke, given counseling/advice or referral Screened for smoking during one of first two visits and quit during pregnancy Screened for environmental tobacco smoke during one of first two visits 5. Screened for environmental tobacco smoke during one of first two visits, given counseling/advice or referral	Clinical Informatics	Monthly

Cesarean Rate for Nulliparous Singleton Vertex	C-section rates for low-risk first birth women	Clinical Informatics	Monthly
Prenatal and Postpartum Care	Percentage of live births that received a prenatal care visit within first trimester or within 42 days of enrollment Percentage of live births that received a postpartum visit between 7 and 84 days after delivery	Clinical Informatics	Monthly
Frequency of Ongoing Prenatal Care	Percentage of deliveries which had the expected number of prenatal visits: <21% of expected visits 21%- 40% of expected visits 41%- 60% of expected visits 61%- 80% of expected visits >=81% of expected visits	Clinical Informatics	Monthly
Weeks of Pregnancy at Time of Enrollment	Percentage of women who delivered a live birth, by the weeks of pregnancy at time of enrollment	Clinical Informatics	Monthly
Maternity Outcome Counts	Provides counts of second and third trimester live maternity outcomes; broken out by recipient group for Cesarean Section (C-section) and Vaginal live births;	Clinical Informatics	Annually
Annual Maternity Utilization	Provides maternity utilization information (discharges, days, and average length of stay) for both Cesarean Section (C-section) and Vaginal live births.	Clinical Informatics	Annually
Annual Newborn Utilization	Provides newborn utilization information (discharges, days, and average length of stay) for both well newborns and complex newborns.	Clinical Informatics	Annually

AUDIT CHECKS

The GHP Family Women's Health Coordinator (or designee) will audit the Members identified with a Live Birth diagnosis against those screened and contacted through the Maternal Health Program on an annual basis. Any discoveries to better understand the variances between Members not identified during pregnancy and those with live birth will be assessed to improve processes for early identification of pregnancy for future implementation.

MEMBER RESTRICTION PROGRAM

DHS's Bureau of Program Integrity manages a centralized Member Restriction Program for all managed care and Fee-for-Service delivery systems. GHP Family maintains a Member Restriction Program that interfaces with the

centralized program and cooperates with DHS. The program identifies, restricts, and monitors Members who have been determined to be abusing and/or misusing Medical Assistance services or who may be defrauding the HealthChoices Program. With the approval of DHS, Members may be restricted to receiving services from a single, designated provider for a period of five years.

GHP Family's Special Investigations Unit monitors and evaluates the utilization of Members who are referred to the Member Restriction Program. Providers will receive notification of Members who are restricted, and restrictions are enforced through the Claims payment system.

GHP Family may not pay for a service rendered by any provider other than the one to whom the Member is restricted, unless the services are furnished in response to an emergency, or a Medical Assistance Member Referral Form (MA 45) is completed and submitted with the Claim. The MA 45 must be obtained from the practitioner to whom the Member is restricted. If a Member is restricted to a provider with your provider type, the EVS will notify you if the Member is locked into you or another provider. The EVS will also indicate all type(s) or provider(s) to which the Member is restricted. Valid emergency services are excluded from the lock-in process. GHP Family obtains approval from DHS prior to implementing a restriction, including approval of written policies and procedures and correspondence to restricted Members.

GHP Family will:

- Refer to DHS's Bureau of Program Integrity (BPI) those Members identified as over utilizing or mis-utilizing health care services.
- Evaluate the degree of Abuse including review of pharmacy and medical Claims history, diagnoses and other documentation, as applicable.
- Propose whether the Member should be restricted to obtaining services from a single, designated provider for a period of five years.
- Forward case information and supporting documentation to BPI for review to determine appropriateness of restriction and to approve the action.
- Upon BPI approval, GHP Family will send notification via certified mail to Member of proposed restriction, including reason for restriction, effective date and length of restriction, name of designated provider(s) and option to change Provider, and instructions for requesting a hearing, with a copy to BPI.
- Send notification of Member's restriction to the designated provider(s) and the County Assistance Office.
- Enforce the restrictions through appropriate notifications and edits in the Claims payment system.
- Prepare and present case at a DHS Fair Hearing to support restriction action.
- Monitor subsequent utilization to ensure compliance.
- Change the selected provider per the Member's or provider's request within thirty (30) days from the date of the request, with prompt notification to BPI through the Intranet provider change process.
- Continue a Member restriction from the previous delivery system as a Member enrolls in the managed care organization, with written notification to BPI.
- Review the Member's services prior to the end of the five-year period of restriction to determine if the restriction should be removed or maintained, with notification of the results of the review to BPI, Member, provider(s) and County Assistance Office.
- Perform necessary administrative activities to maintain accurate records.
- Educate Members and providers to the restriction program, including explanations in handbooks and printed materials.

Members have the right to appeal a restriction by requesting a DHS Fair Hearing. Members may not file a Complaint or Grievance with GHP Family regarding the restriction action. A request for a DHS Fair Hearing must be in writing, signed by the Member and sent to:

Department of Human Services
Office of Medical Assistance Programs of Bureau of Program Integrity
Division of Program and Provider Compliance: Member Restriction Section
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

PROGRAM EXCEPTION PROCESS

Participating Providers may request coverage for items or services that are included under the Member's benefit package but are not currently listed on the Medical Assistance Program Fee Schedule. Participating Providers may also request an exception for services or items that exceed limits on the fee schedule if the limits are not based in statute or regulation. These exceptions should be requested in advance of providing services. To request program exceptions, Participating Providers must follow the GHP Family Prior Authorization process.

ENHANCED MEMBER SUPPORTS UNIT

The Enhanced Member Supports Unit (EMSU) is a dedicated resource for the unique needs of the GHP Family Member. The EMSU is designed to assist GHP Family Members with addressing their special healthcare needs and/or health related social needs to support their overall wellbeing. A special healthcare need may be defined as any physical, mental, emotional, and social health need. The EMSU works collaboratively to provide a unified Case Management service through its Proven Health Navigator Case and Health Management program and collaborative agreements with behavioral health managed care organizations and community agencies. Examples of factors in the determination of a Member with a special health care need and/or health related social needs include, but are not limited to, the following:

- Children with special healthcare needs and/or HRSNs, including those requiring skilled or unskilled home shift care or children in substitute care
- Members with limited English proficiency, or special communication needs due to sensory deficits
- Members with Physical and/or Intellectual/Developmental Disabilities
- Members with HIV/AIDS
- Members with significant behavioral health diagnoses
- Members who require transportation assistance
- Members who require care and/or services of a type or amount that is beyond what is typically required
- Members who require extensive rehabilitative, habilitative, or other therapeutic interventions to maintain or improve their level of functioning

- Members who may require that primary care be managed by a specialist, due to the nature of the Member's condition
- Members with conditions that may result in a higher morbidity without intervention and coordination of care for the individual
- Members who require care and/or services that necessitate coordination and communication among Network Providers and/or Out-of-Network Providers
- Members who require care and/or services that necessitate coordination and collaboration with public or private community services organizations outside the PH-MCO, including organizations that address housing, food, and employment challenges
- Members who require coordination of care and/or services between the acute inpatient setting and other facilities or Community Providers
- Members with conditions that result in the Member requiring assistance to schedule or make arrangements for appointments or services, including arranging for transportation to and from appointments
- Members who require mobility accommodations
- Members with conditions that result in the need for a Member to be accompanied or assisted while seeking or receiving care by an individual who may act on the Member's behalf
- Members who require assistance in discharge planning from an inpatient or long-term care or pediatric residential setting to ensure the member will receive services in the least restrictive environment possible
- Children who are in the custody of Office of Children, Youth and Families (OCYF) or known to have an open case with OCYF
- Members with severe and persistent mental illness
- Members experiencing any condition, event or life circumstance that inhibits the Member's access to any necessary service or support needed to address their medical condition or maintain their current level of functioning
- Members who self-identify as having a special healthcare need and/or health related social need

The EMSU can be used as a resource for Providers, Members and Caregivers to assist with management of Members with special healthcare needs. The EMSU can be reached at (855) 214-8100.

COVERED SERVICES

Members are entitled to certain covered services under the Medical Assistance Program of the Commonwealth of Pennsylvania. Member benefits can be verified online through the GHP plan central page, at https://www.navinet.net or by calling Customer Care. Covered services for Members are represented in the GHP Family Benefit Grid below.

Copays are excluded for services provided to:

- Individuals under 21 years of age;

- Services to pregnant women, including through the postpartum period;
- Services provided to patients in long term care facilities (including ICF/ID and ICF/ORC);
- Services or items provided to a terminally ill individual who is receiving hospice care;
- Services provided to individuals residing in a personal care home or domiciliary care home;
- Services provided to women in the Breast and Cervical Cancer Prevention and Treatment (BCCPT) coverage group; and
- Services provided to individuals of any age eligible under Titles IV-B and IV-E Foster Care and Adoption Assistance.

This is not a full list. Please call GHP Family Customer Care for more information on any of the services below, copayment information, prior authorization information or benefit limit information.

Service		Children	Adults
Primary Care Provider	Limit	No	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: No Referral: No	Prior Auth: No Referral No
Specialist	Limit	No	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: No Referral: No	Prior Auth: No Referral No
Certified Registered Nurse Practitioner	Limit	No	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: No Referral: No	Prior Auth: No Referral No
Federally Qualified Health Center / Rural Health Center	Limit	No	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: No Referral: No	Prior Auth: No Referral No
Outpatient Non-Hospital Clinic	Limit	No	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: Yes Referral: No	Prior Auth: Yes Referral No
Outpatient Hospital Clinic	Limit	No	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: Yes Referral: No	Prior Auth: Yes Referral No
Podiatrist Services	Limit	No	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: No Referral: No	Prior Auth: No Referral No
Chiropractor Services	Limit	No Radiology services received at a chiropractic office are not covered.	No Radiology services received at a chiropractic office are not covered.
	Co-payment	$0	$1
	Prior Authorization / Referral	Prior Auth: No Referral: No	Prior Auth: No Referral No
	Limit	No	No

Service		Children	Adults
Optometrist Services	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: No Referral: No	Prior Auth: No Referral No
Hospice Care	Limit	Respite care may not exceed a total of 5 days in a 60-day certification period.	Respite care may not exceed a total of 5 days in a 60-day certification period.
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: No Referral: No	Prior Auth: No Referral No
Dental Care Services	Limit	See Dental Care Services	See Dental Care Services
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: Yes Referral: No Some procedures require prior authorization	Prior Auth: Yes Referral No Some procedures require prior authorization
Radiology (ex. X-rays, MRIs, CTs)	Limit	No	No
	Co-payment	$0	$1
	Prior Authorization / Referral	Prior Auth: Yes Referral: No Some procedures require prior authorization	Prior Auth: No Referral No
Outpatient Hospital Short Procedure Unit	Limit	No	No
	Co-payment	$0	$3
	Prior Authorization / Referral	Prior Auth: Yes Referral: No Some procedures require prior authorization	Prior Auth: Yes Referral: No Some procedures require prior authorization
Outpatient Ambulatory Surgical Center	Limit	No	No
	Co-payment	$0	$3
	Prior Authorization / Referral	Prior Auth: Yes Referral: No Some procedures require prior authorization	Prior Auth: Yes Referral: No Some procedures require prior authorization
Non-Emergency Medical Transport	Limit	Covered if you live in a nursing home or need specialized non-emergency transportation OR Contact your county MATP provider	Covered if you live in a nursing home or need specialized non-emergency transportation OR Contact your county MATP provider

Service		Children	Adults
	Co-payment	Contact your county MATP provider	Contact your county MATP provider
	Prior Authorization / Referral	Prior Auth: Yes Referral: No Covered Services require prior authorization	Prior Auth: Yes Referral: No Covered Services require prior authorization
Family Planning Services	Limit	No	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: No Referral: No Sterilization procedures require prior authorization	Prior Auth: No Referral: No Sterilization procedures require prior authorization
Renal Dialysis	Limit	No	Adult initial training for home dialysis is limited to 24 sessions per calendar year. Back up visits to the facility limited to no more than 75 per calendar per year.
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: Yes Referral: No	Prior Auth: Yes Referral: No
Emergency Services	Limit	No	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: No Referral: No	Prior Auth: No Referral: No
Urgent Care Services	Limit	No	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: No Referral: No	Prior Auth: No Referral: No
Ambulance Services	Limit	No	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: No Referral: No Non-emergent ambulance services require prior authorization	Prior Auth: No Referral: No Non-emergent ambulance services require prior authorization
Inpatient Hospital	Limit	No	No
	Co-payment	$0	$3 per day/$21 max per admission
	Prior Authorization / Referral	Prior Auth: Yes Referral: No Some admissions require prior authorization	Prior Auth: Yes Referral: No Some admissions require prior authorization

Service		Children	Adults
Inpatient Rehab Hospital	Limit	No	No
	Co-payment	$0	$3 per day/$21 max per admission
	Prior Authorization / Referral	Prior Auth: Yes Referral: No	Prior Auth: Yes Referral: No
Maternity Care	Limit	No	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: No Referral: No	Prior Auth: No Referral: No
Prescription Drugs	Limit	No	No
	Co-payment	See Pharmacy Copay	$1 Generic $3 Brand See Pharmacy Copay
	Prior Authorization / Referral	Prior Auth: Yes Referral: No Some medications require prior authorizations. Refer to the https://papdl.com/preferred-drug-list or www.ghpfamily.com	Prior Auth: Yes Referral: No Some medications require prior authorizations. Refer to the https://papdl.com/preferred-drug-list or www.ghpfamily.com
Enteral/Parenteral Nutritional Supplements	Limit	No	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: Yes Referral: No	Prior Auth: Yes Referral: No
Nursing Facility Services	Limit	MCO responsibility until CHC takes over	MCO responsibility until CHC takes over
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: Yes Referral: No	Prior Auth: Yes Referral: No
Home Health Care including Nursing, Aide, and Therapy Services	Limit	No	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: Yes Referral: No	Prior Auth: Yes Referral: No
Durable Medical Equipment	Limit	There may be limits on some DME	There may be limits on some DME
	Co-payment	$0	$2
	Prior Authorization / Referral	Prior Auth: Yes Referral: No Some DME requires a prior auth	Prior Auth: Yes Referral: No Some DME requires a prior auth

Service		Children	Adults
Prosthetics and Orthotics	Limit	No Flat foot diagnosis is not covered	No Flat foot diagnosis is not covered
	Co-payment	$0	$2 (if copay applies)
	Prior Authorization / Referral	Prior Auth: Yes Referral: No Some services require prior authorization	Prior Auth: Yes Referral: No Some services require prior authorization
Eyeglass Lenses	Limit	No limits, but after 4 standard lenses per year, additional lenses in that year must be prior authorized.	Only covered with diagnosis of aphakia, 4 standard lenses per calendar year.
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: No Referral: No	Prior Auth: No Referral: No
Eyeglass Frames	Limit	No limits, but after 2 standard frames per year, additional frames in that year must be prior authorized	Only covered with a diagnosis of aphakia, 2 standard frames per calendar year.
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: No Referral: No	Prior Auth: No Referral: No
Contact Lenses	Limit	No limits, but after 4 lenses per year, additional lenses in that year must be prior authorized.	Only covered with diagnosis of aphakia, 4 standard lenses per calendar year.
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: No Referral: No	Prior Auth: No Referral: No
Contact Lens Fitting	Limit	Covered when medically necessary	Covered when medically necessary
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: No Referral: No	Prior Auth: No Referral: No
Medical Supplies	Limit	No	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: Yes Referral: No Some medical supplies may require prior authorization	Prior Auth: Yes Referral: No Some medical supplies may require prior authorization
	Limit	No	No
	Co-payment	$0	$0

Service		Children	Adults
Therapy (Physical, Occupational, Speech)	Prior Authorization / Referral	Prior Auth: Yes Referral: No	Prior Auth: Yes Referral: No
Laboratory	Limit	No	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: Yes Referral: No Some laboratory tests require prior authorization	Prior Auth: Yes Referral: No Some laboratory tests require prior authorization
Tobacco Cessation	Limit	No	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Prior Auth: No Referral: No	Prior Auth: No Referral: No

COVERED MEDICATIONS WITH NO COPAY

All Member categories, except General Assistance Members 21 to 65 years of age, do not have a copay for the following groups of medications:

- Antihypertensives (high blood pressure)
- Antidiabetics (high blood sugar)
- Anticonvulsants (seizure)
- Cardiovascular preparations (heart disease)
- Antipsychotics (except those that are controlled substance antianxiety drugs)
- Antineoplastics (cancer drugs)
- Antiglaucoma drugs
- Anti-Parkinson's drugs
- HIV/AIDS drugs
- Naloxone

DENTAL SERVICES

Dental services are covered for children under the age of 21. Additional services will be covered when medically necessary:

Service	Limits	Copayments	Prior Auth
Exams / Check ups	1 every 180 days	$0	No
Cleanings	1 every 180 days	$0	No
Fillings	No limits	$0	No
Fluoride Varnish	6 per calendar year for children under 21	$0	No
Fluoride Topical Application	6 per calendar year for children under 21	$0	No
Bitewings	No limits*	$0	No

Intraoral, complete series	1 per 5 years	$0	No
Panoramic Film	1 per 5 years	$0	No
Sealants	No Limit	$0	No
Anesthesia	No Limit*	$0	Yes
Bony Impacted Teeth	No Limit	$0	Yes
Braces	No Limit*	$0	Yes
Crowns	No Limit*	$0	Yes
Dentures	No Limit*	$0	Yes
Extractions	No Limit	$0	Yes
Periodontal Services	No Limit*	$0	Yes
Root Canals	No Limit*	$0	Yes

***Some services have limitations. Contact a SKYGEN Provider Network Representative for benefit limitations.**

Dental Services for Adults 21 years of age and older:

Service	Limits	Copayments	Prior Auth
Exams / Check ups	1 every 180 days	$0	No
Cleanings	1 every 180 days	$0	No
Fillings	No limits*	$0	No
Fluoride Varnish		Not Covered	
Fluoride Topical Application		Not Covered	
Bitewings	No limits*	$0	No
Intraoral, complete series	1 per 5 years	$0	No
Panoramic Film	1 per 5 years	$0	No
Dental Surgical Procedures	When medically necessary*	$0	Yes
Anesthesia	When medically necessary*	$0	Yes
Crowns	Only covered by an approved BLE*	$0	Yes
Dentures	One partial/full upper and one partial/full lower in a lifetime*	$0	Yes
Extractions	No limits	$0	Yes
Periodontal Services	Only covered by an approved BLE	$0	Yes
Root Canals	Only covered by an approved BLE	$0	Yes

***Some services have limitations. Contact a SKYGEN Provider Network Representative for benefit limitations.**

FAMILY PLANNING SERVICES

Members can choose any provider for family planning services. Covered Family Planning Services include, but are not limited to:

- Medically Necessary abortions only as allowed in MA Bulletin 99-95-09
- Contraceptive implants/injections
- Education/counseling
  - In-office visit with PCP or PCP Obstetrician
  - Tubal ligation/Hysterectomies/other sterilizations for both male and female are covered for all Members over age 20.

Required family planning services forms

When a Participating Provider performs certain family planning services, a federally required form must accompany a Claim for payment, regardless of its mode of transmission (electronically or hardcopy on the CMS-1500 Claim form). The Sterilization Patient Consent Form (MA 31), Patient Acknowledgement for Hysterectomy (MA 30), and the Physicians Certification for an Abortion (MA 3) are forms that are required by the Federal Government. Payment for sterilizations, abortions, and hysterectomies will only be made if the appropriate form(s) are completed and accurate, and the procedures were performed within any time frames specified within the regulations. Appropriate consent form must be received at least thirty (30) days prior to the procedure but not more than 180 days prior to the procedure. Consent forms are available online at Department's website: https://www.dhs.pa.gov/docs/Publications/Pages/Medical-Assistance-Provider-Forms.aspx.

Procedures That May Be Included with a Family Planning Clinic Comprehensive Visit, a Problem Visit or a Routine Revisit:

- Insertion, implantable contraceptive capsules
- Implantation of contraceptives, including device (e.g., Norplant) (once every five years) (females only)
- Removal, Implantable contraceptive capsules
- Removal with reinsertion, Implantable contraceptive capsules (e.g., Norplant) (once per five years) (females only)
- Destruction of vaginal lesion(s); simple, any method (females only)
- Biopsy of vaginal mucosa; simple (separate procedure) (females only)
- Biopsy of vaginal mucosa; extensive, requiring suture (including cysts) (females only)
- Colposcopy (vaginoscopy); separate procedure (females only)
- Colposcopy (vaginoscopy); with biopsy(s) of the cervix and/or endocervical curettage
- Colposcopy (vaginoscopy); with loop electrosurgical excision(s) of the cervix (LEEP) (females only)
- Intensive colposcopic examination with biopsy and or excision of lesion(s) (females only)
- Biopsy, single or multiple or local excision of lesion, with or without fulguration (separate procedure) (females only)
- Cauterization of cervix; electro or thermal (females only)

- Cauterization of cervix; cryocautery, initial or repeat (females only)
- Cauterization of cervix; laser ablation (females only)
- Endometrial and/or endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) (females only)
- Alpha-fetoprotein; serum (females only)
- Nuclear molecular diagnostics; nucleic acid probe, each
- Nuclear molecular diagnosis; nucleic acid probe, each
- Nuclear molecular diagnostics; nucleic acid probe, with amplification; e.g., polymerase chain reaction (PCR), each Fluorescent antibody; screen, each antibody Immunoassay for infectious agent antibody; quantitative, not elsewhere specified
- Antibody; HIV-1
- Antibody; HIV-2
- Treponema Pallidum, confirmatory test (e.g., FTA-abs)
- Culture, chlamydia
- Cytopathology, any other source; preparation, screening, and interpretation
- Progestasert I.U.D. (females only)
- Depo-Provera injection (once per 60 days) (females only)
- ParaGuard I.U.D. (females only)
- Hemoglobin electrophoresis (e.g., A2, S, C)
- Microbial Identification, Nucleic Acid Probes, each probe used
- Microbial Identification, Nucleic Acid probes, each probe used; with amplification (PCR)

Procedures That May Be Included with a Family Planning Clinic Problem Visit:

- Gonadotropin, chorionic, (hCG); quantitative
- Gonadotropin, chorionic, (hCG); qualitative
- Syphilis test; qualitative (e.g., VDRL, RPR, ART) Culture, bacterial, definitive; any other source Culture, bacterial, any source; anaerobic (isolation)
- Culture, bacterial, any source; definitive identification, each anaerobic organism, including gas chromatography
- Culture, bacterial, urine; quantitative, colony county
- Dark field examination, any source (e.g., penile, vaginal, oral, skin); without collection
- Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types
- Smear, primary source, with interpretation; special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala azar, herpes)
- Smear, primary source, with interpretation; wet mount with simple stain for bacteria, fungi, ova, and/or parasites

- Smear, primary source, with interpretation; wet and dry mount, for ova and parasites Cytopathology, smears, cervical or vaginal, the Bethesda System (TBS), up to three smears; screening by technician under physician supervision
- Level IV – Surgical pathology, gross and microscopic examination
- Antibiotics for Sexually Transmitted Diseases (course of treatment for 10 days) (two units may be dispensed per visit)
- Medication for Vaginal Infection (course of treatment for 10 days) (two units may be dispensed per visit
- Breast cancer screen (females only)
- Mammography, bilateral (females only)
- Genetic Risk Assessment

PA VACCINES FOR CHILDREN (VFC) PROGRAM

The Vaccines for Children (VFC) program was created as part of the Federal Omnibus Budget Reconciliation Act (OBRA), Section 1928 of the Social Security Act, in August 1993. The purpose of this program is to improve immunization levels across the U.S. by providing vaccines, at no cost, to enrollment public and private providers. The program is regulated by the Centers for Disease Control and Prevention (CDC) and the National Center of Immunizations and Respiratory Disease (NCIRD).

In October 1994, Pennsylvania began its VFC program under the administration of the Department of Health (DOH), Division of Immunization. VFC vaccines are purchased through CDC contracts by the DOH and are supplied to VFC enrolled providers at no cost.

VFC ELIGIBILITY

Children, birth through 18 years of age (to their 19th birthday), are eligible for VFC vaccines if they meet at least one of the following criteria:

- Are enrolled in Medicaid (including Medicaid managed care plans)
- Have no health insurance
- American Indian or Alaska Native (regardless of insurance coverage)
- Underinsured: A child who has health insurance, but the coverage does not include vaccines; a child whose insurance covers only selected vaccines (VFC eligible for non- covered vaccines only). Underinsured children are eligible to receive VFC vaccine only through a federally qualified health center (FQHC), rural health clinic (RHC) or a state health center (SHC) under an approved deputization agreement.

Children with health insurance that covers vaccines and who fail to meet one of the previously mentioned criteria are not eligible through the VFC program, even when the insurance requires a deductible. There are no income restrictions imposed by the VFC program if the child meets all other enrollment criteria.

INSURED CHILDREN

Children whose health insurance covers the cost of vaccinations are not eligible for VFC vaccines, even when a claim for the cost of the vaccine and its administration would be denied for payment by the insurance carrier because the plan's deductible (high deductible plan) had not been met.

VFC Eligibility Scenario: Child is insured and…	Insurance Status	VFC Eligible
Has not yet met plan's deductible	Insured	No
Plan covers all ACIP recommended vaccines but excludes certain products/ combination vaccines	Insured	No
Plan covers only a portion of the vaccine cost and does not have Medicaid as secondary insurance	Insured	No
Has Medicaid as secondary insurance	Medicaid eligible	Yes
Plan covers only a portion of the vaccine cost and has Medicaid as secondary insurance	Medicaid eligible	Yes
Has not yet met plan's deductible and has Medicaid as secondary insurance	Medicaid eligible	Yes
Has exceeded plan's annually allowed number of provider visits or insurance doesn't cover vaccines	Underinsured - must obtain vaccine through FQHC, RHC, or deputized SHC	Yes
Cannot access health insurance due to being incarcerated	Uninsured	Yes

A Medicaid eligible child is eligible for PA VFC vaccines regardless of if they have a primary health care coverage/insurance plan.

For complete eligibility requirements please visit https://www.health.pa.gov/topics/programs/immunizations/Pages/VFC.aspx.

NEW PROVIDER ENROLLMENT

- Complete and submit the PA Vaccines for Children Program Provider Agreement (PA VFC PPA) by fax to 717-214-7223. Upon receipt of the completed PA VFC PPA, the provider identification number (PIN) will be assigned to your facility.
- A copy of the VFC Provider Handbook will be mailed to your facility. This should be reviewed by the physician(s), office manager, primary and backup VFC contacts prior to the enrollment/training site visit.
- Prepare your office and staff for a site visit to go over the administrative requirements of the program and to ensure proper storage and handling of vaccines when received.
- An immunization nurse from your district will contact you to schedule an enrollment/training site visit to review all aspects of the VFC program, to ensure that the vaccine storage units and thermometers meet the requirements of the CDC and to answer any questions staff may have. This visit takes approximately two hours.
- After completion of the enrollment/training visit, the immunization nurse will notify the PA DOH that your facility has been approved to order and receive VFC vaccines.
- VFC staff will notify the PA Statewide Immunization Information System (PA-SIIS) to provide the primary and back-up VFC coordinators with unique usernames and passwords referred to as “logon credentials.” This will allow staff to order vaccines online, update facility address and list vaccine shipping hours.
- View the video “Keys to Storing and Handling Your Vaccine Supply” and printing credentials from the CDC website. This is required for all new enrollments and reactivations. The video is found at: https://www.youtube.com/watch?v=0atwOngjVQY.

PROVIDER REQUIREMENTS

- Administer VFC program vaccines to VFC-eligible children;
- Retain all VFC documentation including patient eligibility screening records for a minimum of three years;
- Make immunization records available to the PA DOH, upon request and during CDC required site visits;
- Comply with the appropriate immunization schedule, dosage and contraindications established by the CDC’s Advisory Committee on Immunization Practices (ACIP);
- Document and retain parent/guardian/individual refusal/rationale for not having client immunized;
- Provide current vaccine information statements (VIS), maintain records in accordance with the National Childhood Vaccine Injury Act and provide, according to federal law, all vaccine providers must give patients, or their parents or legal representatives, the appropriate VIS whenever a vaccination is given;
- Not to impose a charge for the cost of the vaccine to any eligible patient;
- Not to deny administration of a vaccine to a child due to the inability of the child’s parent/guardian/individual of record to pay an administrative fee;
- Comply with VFC program procedures and requirements; and
- Adhere to all federal and state requirements.

For complete provider requirements including provider annual enrollment and PA VFC compliance site visits please visit https://www.health.pa.gov/topics/programs/immunizations/Pages/VFC.aspx.

PROVIDER RESPONSIBILITIES

- Notify PA DOH regarding:
    - Change in facility name
    - Change in facility address
    - Change in facility telephone or fax number

- Change in primary VFC contact
- Change in back-up VFC contact
- Change in medical director/primary physician

- Staff training:
  - Provide internal training on proper vaccine storage and handling guidelines.
  - Provide internal training on vaccine administration protocols to each new employee at time of employment orientation and review annually.
  - Document these trainings and those who attended as required.

- Developing and maintaining written procedures:
  - Emergency handling procedures
  - Vaccine management plan
  - Vaccine disaster recovery plan

- Twice-daily temperature documentation:
  - Time when temperature was checked
  - Initials of staff checking unit temperature
  - Current, min, and max temperature
  - Corrective action documentation on the temperature log (if needed)

- Vaccine storage and handling:
  - CDC/PA DOH requirements/recommendations
  - Equipment (refrigerators/freezers)
  - Thermometers/digital data loggers
  - Maintenance of cold chain

WITHDRAWING FROM THE VFC PROGRAM

To assure a smooth transition of services, the following steps must be taken should a facility choose to discontinue participating in the PA VFC Program.

- Notify the PA VFC program 30 days in advance at (1-888-646-6864) if the office plans to disenroll.
- Submit a complete inventory of all PA VFC vaccines on-site to include brand, lot number, expiration date and number of doses.
- Submit three months of temperature logs.
- Refer VFC-eligible children to another VFC Provider. If necessary, contact the PA DOH for help finding another VFC provider.

FRAUD, WASTE, AND ABUSE

The PA VFC Program recognizes that a vast majority of VFC providers abide by their legal and professional duties and provide critical health care services to VFC patients every day. The PA VFC Program is committed to safeguarding federally funded vaccines by targeting fraud perpetrators and saving taxpayer dollars while reducing the burden on legitimate providers.

The comprehensive program to prevent and detect fraud, waste and abuse consists of:

- Procedures for the identification of potential fraud, waste and abuse in the PA VFC Program;
- A process to conduct a timely, reasonable inquiry into potential violations of federal and state criminal, civil and administrative laws, rules and regulations; and
- A process to refer potential violations of applicable federal and state criminal, civil and administrative laws, rules, and regulations to law enforcement for further investigation within a reasonable period.

VACCINE MANAGEMENT

- Post a vaccine expiration list on the refrigerator and freezer.
- Check and rotate inventory on a weekly basis.
- Administer shorter-dated vaccines first.
- Notify immunization nurses to assist in relocating vaccines expiring in 90 to 120 days to avoid waste.
- Deplete current single antigen vaccine inventory prior to switching to a combination antigen vaccine.

VACCINES AVAILABLE THROUGH THE PA VFC PROGRAM:

- Diphtheria, Tetanus and Acellular Pertussis (DtaP)
- Haemophilus influenzae type b (Hib)
- Hepatitis A (Pediatric)
- Hepatitis B (Pediatric)
- Human Papillomavirus (HPV)
- Influenza
- Measles, Mumps and Rubella (MMR)
- Meningococcal Conjugate (MCV4)
- Meningococcal B
- Pneumococcal Conjugate 13 (PCV13)
- Pneumococcal Polysaccharide (PPSV23)
- Polio (IPV)
- Rotavirus
- Tetanus and Diphtheria (Td)
- Tetanus, Diphtheria and Acellular Pertussis (Tdap)
- Varicella
- Several Combination Vaccines

In addition, the following non-VFC vaccines are available by request for department approved public providers, including state health centers, county and municipal health departments, federally qualified health centers, rural health clinics and other public providers as approved by the PA DOH:

- Hepatitis A (adult)
- Hepatitis B (adult)
- Human papillomavirus (HPV – adult)
- Measles, mumps and rubella (MMR – adult)
- Meningococcal conjugate (MCV4 – adult)
- Meningococcal B (adult)
- Pneumococcal conjugate 13 (PCV13 – adult)
- Pneumococcal polysaccharide (PPSV23 – adult)
- Tetanus and diphtheria (Td – adult)

- Tetanus, diphtheria and acellular pertussis (Tdap – adult)
- Varicella (adult)

For complete vaccine management instructions please refer to https://www.health.pa.gov/topics/programs/immunizations/Pages/VFC.aspx.

NOTE: As new vaccines or combination vaccines are approved by the FDA, they will be made available by the CDC.

Vaccine Ordering

Vaccine orders are placed online using PA-SIIS or by faxing a PA Department of Health Supplied Vaccine Order, Inventory, and Accountability form to 717-441-3800 or call 1-888-646-6864.

- Order monthly: first through 15th
- Order only one month's supply of vaccine
- Order by number of doses, not packages
- Order according to type of facility (private provider – order only pediatric vaccines; public providers – pediatric and adult)

For complete ordering vaccines instructions and shipping information please refer to the https://www.health.pa.gov/topics/programs/immunizations/Pages/VFC.aspx.

Returning Vaccines

All vaccines, including flu, deemed "returnable non-viable" should be returned within six months following expiration date. However, vaccines that have expired more than six months previously will still be accepted. When requesting a shipping label for the return of vaccines, please allow one to five business days to receive notification. Complete the vaccine return and accountability form for returning all vaccines.
Vaccines may be returned when:

- They are expired and unopened.
- They are stored or handled improperly (must complete incident report)
- A storage unit failure occurs (must complete incident report)
- A power outage occurs (must complete incident report)

For complete returning vaccines instructions please refer to https://www.health.pa.gov/topics/programs/immunizations/Pages/VFC.aspx.

Vaccine Storage and Handling

Any new providers enrolling in the VFC Program will be required to use standalone refrigerators and standalone freezers for vaccine storage. PA DOH-approved household combination units are no longer permitted for new enrollment and/or replacement unit purchases.

PA DOH-supplied vaccine must be stored in one of the following:

- Standalone storage units (medical/pharmaceutical grade is highly recommended);
- Medical/pharmaceutical grade combination units; or
- Household combination unit (refrigerator portion only, must have separate standalone freezer).

For complete storage and handling instructions please refer to https://www.health.pa.gov/topics/programs/immunizations/Pages/VFC.aspx.

Contact Information

Pennsylvania Department of Health (PA DOH) Division of Immunizations
625 Forster St., Room 1026
Harrisburg, PA 17120

Toll Free: 1-888-646-6864
Phone: 717-787-5681
Fax: 717-214-7223
Fax: 717-441-3800 or 717-441-3777

Email: paimmunizations@pa.gov
Website: https://www.dhs.pa.gov/docs/Publications/Pages/Medical-Assistance-Provider-Forms.aspx

ADVANCE DIRECTIVES

The Patient Self-Determination Act of 1990, effective December 1, 1991, requires providers of services and health maintenance organizations under the Medicare and Medicaid programs to assure that individuals receiving services will be given an opportunity to participate in and direct health care decisions affecting themselves and be informed of their right to have an advance directive. An advance directive is a legal document through which a Member may provide directions or express preferences concerning his or her medical care and/or to appoint someone to act on his or her behalf. Advance directives are used when the Member is unable to make or communicate decisions about his or her medical treatment.

Advance directives are prepared before any condition or circumstance occurs that causes the Member to be unable to actively decide about his or her medical care.

In Pennsylvania, there are two types of advance directives:

- Living will or health care instructions
- Appointment of a Health Care Power of Attorney

Providers are required to comply with federal and state laws regarding advance directives (also known as health care power of attorney and living wills), as well as contractual requirements, for adult Members. In addition, GHP Family requires that providers obtain and maintain advance directive information in the Member's medical record.

Requirements for providers include:

- Maintaining written policies that address a Member's right to make decisions about their medical care, including the right to refuse care.
- Providing Members with written information about advance directives.
- Documenting the Member's advance directives or lack of one in his or her medical record.
- Communicating the Member's wishes to attending staff in hospitals or other facilities.
- Not discriminating against a Member or making treatment conditional on the basis of his or her decision to have or not have an advance directive.
- Providing staff education on issues related to advance directives.

GHP Family provides information about advance directives to Members in the Member Handbook, including the Member's right to make decisions about their medical care, how to obtain assistance in completing or filing a living will or health care power of attorney, and general instructions.

For additional information or Complaints regarding noncompliance with advance directive requirements, you can contact:

Pennsylvania Office of Attorney General
Strawberry Square, 16th Floor
Harrisburg, PA 17120
Phone: (717) 787-3391

REIMBURSEMENT & CLAIMS SUBMISSION REIMBURSEMENT/FEE-FOR-SERVICE PAYMENT

GHP Family will reimburse Participating Providers at fee-for-service rates described in the Participating Provider's individual GHP Family Agreement. MA fee-for-service fee schedules can be viewed on the DHS website: https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/ma-fee-schedule.

BILLING INSTRUCTIONS

Medical Assistance Enrollment & PROMISe ID Number Required
All providers who provide services to HealthChoices Members must be enrolled in the Commonwealth's Medical Assistance (MA) program and possess an active PROMISe™ Provider ID to bill for services. For information on how to enroll in PROMISe™ and enrollment forms, please visit the DHS's Web site at: https://www.dhs.pa.gov/providers/Providers/Pages/PROMISe-Enrollment.aspx.

Member Eligibility Verification
A MA Identification Card, titled ***Pennsylvania ACCESS Card***, is an identification card issued by DHS to each MA recipient. The card can be used by MA-enrolled Health Care Providers to access DHS's Eligibility Verification System (EVS) and verify the recipient's MA eligibility and specific covered benefits. Prior to rendering or billing for services, providers should verify each Member's eligibility for benefits through the online eligibility information from the EVS. The EVS offers Medicaid providers the information to make an informed decision prior to rendering a service or item.

The plastic ACCESS Card has a magnetic strip designed for swiping through a point-of-sale (POS) device to access eligibility information through the EVS. The MA recipient's current eligibility status and verification of which MCO they may be participating with can be obtained by either swiping the ACCESS Card or by calling the EVS phone number **(800) 766-5387**.

If a Member presents to a Provider's office and states he/she is a MA recipient, but does not have an ACCESS Card, eligibility can still be obtained by using the Member's date of birth (DOB) and Social Security number (SS#) when the call is placed to EVS.

For more information regarding the EVS and ways to access eligibility data, visit the following: https://promise.dpw.state.pa.us/portal/Default.aspx?alias=promise.dpw.state.pa.us/portal/provider.

In addition to the ACCESS Card, Members will receive a GHP Family identification card upon enrollment with GHP Family. Below is a sample of the GHP Family identification card:

Payment for Medically Necessary Services

In accordance with Pennsylvania Code 55, Chapter 1101, DHS will only pay for Medically Necessary services for covered benefits. DHS defines Medically Necessary services as a service or benefit that is compensable under the MA Program and meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition, or disability.
- The service or benefit will, or is reasonably expected to, reduce, or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, considering both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or on an exception basis, must be documented in writing. The determination is based on medical information provided by the Member, the Member's family/caretaker, and the PCP, as well as any other providers, programs, agencies that have evaluated the Member. All Medical Necessity determinations must be made by qualified and trained health care providers.

DHS has established benefit packages based on category of assistance, program status code, age, and, for some packages, the existence of Medicare coverage or a Deprivation Qualifying Code. Participating Providers are expected to provide services in the amount, duration and scope set forth by DHS and based on the Member's benefit package. GHP Family will ensure that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. GHP Family will not arbitrarily deny or reduce the amount, duration, or scope of a Medically Necessary service solely because of the Member's diagnosis, type of illness or condition.

Provider Billing

GHP Family accepts both electronic and manual Claims submissions. To assist us in processing and paying Claims efficiently, accurately, and timely, GHP Family encourages providers to submit Claims electronically. To

facilitate electronic Claims submissions, GHP Family has developed business relationships with major clearinghouses, including Change Healthcare.

GHP Family receives EDI Claims directly from these clearinghouses, processes them through pre-import edits to ensure the validity of the data, HIPAA compliance and Member enrollment and then uploads them each Business Day. Within 24 hours of file receipt, GHP Family provides production reports and control totals to all trading partners to validate successful transactions and identify errors for correction and resubmission.

Providers can submit paper Claims to GHP Family's designated post office box. Paper Claims are scanned into our system each Business Day.

Claims Department
Geisinger Health Plan
PO Box 160
Glen Burnie, MD 21060

Co-payments

Certain services require a Member co-payment. This amount should be collected from the Member by the provider and deducted from the amount billed to GHP Family.

Providers must submit all Claims whether the Member made full payment. Providers should not deny services to a Member even if the Member has not made full payment of their cost-sharing amounts.

It is important for providers to document on the Claim submitted the amount that the Member paid or the amount the provider has billed to the Member.

Coordination of Benefits/Third Party

GHP Family will act as the primary payer on the following services (unless existing primary coverage is available and known at the time of service):

- Preventive pediatric care (including EPSDT services to children), and services to children having medical coverage under a Title IV-D child support order
- As mandated by DHS, GHP Family will process and pay claims for the services above, even when records indicate GHP Family is the secondary payer to an existing primary plan. GHP Family may initiate subsequent recovery efforts once the primary plan appropriately processes claims for these services.

Providers must always ensure GHP Family receives encounter data for **all** covered services provided to members, even when third party insurance is primary and GHP Family is the payer of last resort; and even when no additional payment from GHP Family is expected.

GHP Family is the payer of last resort on all other services. Providers must bill third party insurance before submitting a Claim to GHP Family. GHP Family will pay the difference between the primary insurance payment and GHP Family allowable amount. Providers cannot balance bill Members.

If the primary insurance carrier denies the Claim as a non-covered service, the Claim with the denial may be submitted to GHP Family for a coverage determination under the Member's program. It is the provider's responsibility to obtain the primary insurance carrier's explanation of benefits (EOB) or the remittance advice for services rendered to Members that have insurance in addition to GHP Family. The primary carrier's EOB or

remittance advice should accompany any Claims submitted for payment. A detailed explanation of how the Claim was paid or denied should be included if not evident from the primary carrier's EOB or the remittance advice. This information is essential for GHP Family to coordinate benefits.

If a service is non-covered or benefits have been exhausted from the primary carrier, the provider is required to get an updated letter every January and July to submit with each Claim. Claims submitted without the EOB for Members where third-party insurance is indicated will be denied in most cases.

In the event a Claim is paid by GHP Family and it is later discovered the Member has other insurance, the payment made to the provider will be recovered by either GHP Family or DHS.

GHP Family will neither unreasonably delay payment nor deny payment of Claims because they involved an injury stemming from an accident such as a motor vehicle accident, where the services are otherwise covered. Those funds under the scope of these Other Resources shall be recovered and retained by the Commonwealth.

If assistance with the billing of third-party payers is required, please contact Provider Engagement at (800) 876-5357.

To prevent denials for coding mismatches, Claims submitted to the primary carrier on a form that differs from GHP Family's requirements should be clearly marked with COB Form Type Conversion.

Timely Claim Submission Requirements

GHP Family requires that Claims be submitted within 180 days from the date of service. Providers have 365 days from the earliest date of service to correct and resubmit Claims if the initial submission was within the 180-day timeframe whether the Claim was denied on the first submission. GHP Family requires Clean Claim submissions for processing.

Claims Payment Timeframes

In compliance with federal regulations applicable to Medicaid managed care plans, GHP Family processes Clean Claims in the following timeframes:

- 90.0% of Clean Claims must be adjudicated within thirty (30) days of receipt
- 100.0% of Clean Claims must be adjudicated within forty-five (45) days of receipt
- 100.0% of all Claims must be adjudicated within ninety (90) days of receipt

These timeframes apply to the HealthChoices Program. Most Claims are processed by GHP Family within ten (10) days of receipt.

National Provider Identifier (NPI)

Any Claims submitted by a provider must follow HIPAA regulations regarding NPI numbers and the new Claim forms. Any Claims received not in compliance will be returned.

Compliance

The CMS-1500 form contains fields for the NPI numbers. Field 17 requires the NPI of the referring physician, if appropriate. Field 24J is available for the NPI number of the provider rendering service(s). Field 32 requires the NPI of the facility location if other than office. Field 33 should be completed with the billing provider's NPI number.

The new UB-04 form requires the NPI number of the billing provider in field 56. The NPIs of the attending physician and the operating physician should be in fields 76 and 77 respectively.

EDI Claims

Your electronic billing vendor should have provided you with the newest version of the software to comply with the NPI requirements. If EDI Claims are rejected, please check with your vendor first. If you are experiencing any issues with EDI Claims, please contact Provider Engagement at (800) 876-5357.

Acceptable Claims Forms

GHP Family requires all providers to use one of the following forms when submitting Claims: A CMS-1500 (formerly HCFA 1500) billing form is used to submit Claims for all professional services including ancillary services and professional services billed by a hospital.

Hospital inpatient and outpatient services, dialysis services, nursing home room and board, and inpatient hospice services must be billed on the UB 04 billing form. GHP Family will not process Claims received on any other type of Claim form.

Completing a CMS-1500

The CMS-1500 (formerly HCFA 1500) billing form is used to submit Claims for all professional services. When submitting a CMS-1500 form, certain fields are required (see CMS-1500 required fields section).

CMS-1500 Documentation

Before submitting a Claim a provider should ensure that all required attachments are included.
All Claims that involve other insurance or Medicare must be accompanied by an Explanation of Benefits (EOB) or a remittance advice that clearly states how the Claim was paid or the reason for payment denial.

Completing the UB 04

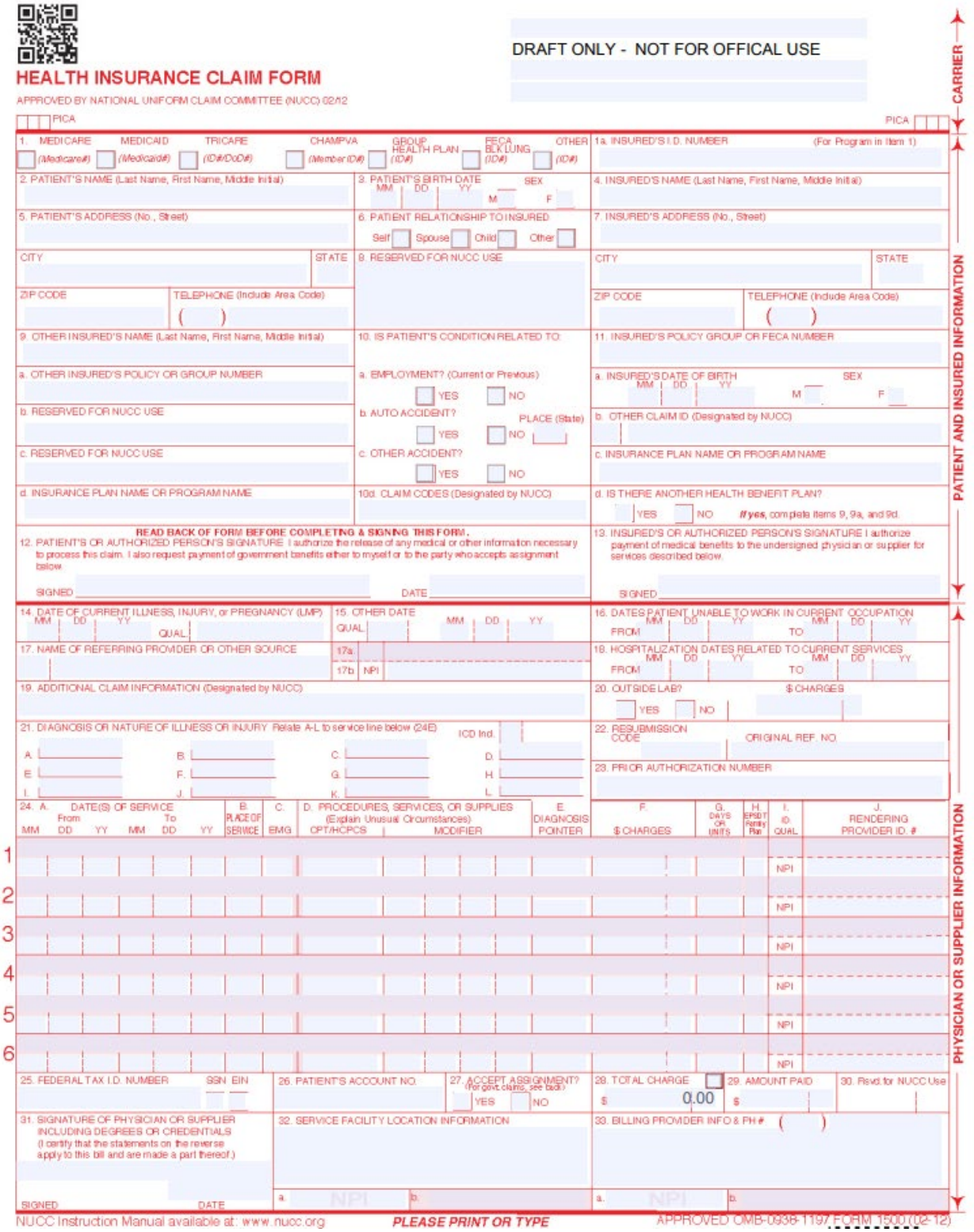
The UB 04 form is used when billing for facilities services including hospital inpatient and outpatient services, dialysis services, nursing home room and board and inpatient hospice service.

UB 04 Documentation

Inpatient, ER and Outpatient hospital Claims above a certain threshold require additional documentation which may include the medical record and an itemized bill.

CMS-1500 REQUIRED FIELDS

Sample form:



DRAFT ONLY - NOT FOR OFFICAL USE

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 0.00

29. AMOUNT PAID $

30. Rsvd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CMS-1500 required fields:

Field #	Required Field Description
1a	Insured's Id Number – 11-digit Geisinger Health Plan Number can be found on the member ID card
2	Patient's name — patient's last name, first name, and middle initial
3	Patient's birth date — patient's date of birth (Month, Day, Year); also, patients' gender
4	Insured's Name – last name, first name, and middle initial of policyholder
5	Patient's address — patient's current address, including city, state, and ZIP code; also, patient's telephone number
6	Patient's relationship to the insured — applicable relationship box marked
7	Insured's address — insured's current address, including city/state/ZIP code; also, insured's telephone number
9	Other Insured's Name – if the patient is covered by another insurance carrier list the insureds Last Name, First Name and Middle Initial
9a	Other Insured's Policy and Group Number – if patient has other insurance listed in box 9, please provider other insured policy and group number
10	Is Patients Condition related to – mark the box if condition is related to employment, Auto Accident, Other Accident
11	Insured's Policy Group or FECA Number – if patient is covered under insured policy, please enter insured's group number
11a	Insured's Date of Birth – (Month, Day, Year); also insured's gender
11d	Is there another Health Benefit Plan – If yes is checked complete box 9, 9a and 9d
12	Patient's or Authorized Person's Signature – Patient has signed release of information from provider
13	Insured's or Authorized Person's Signature – authorize payment of medical benefits
17	Referring Provider Name – First Name and Last Name of referring physician
17a	No longer required
17b	Referring Provider NPI – enter assigned UPIN (Universal Physician Identification Number)
21	Diagnosis or nature of illness or injury – all diagnoses at the time of the encounter for all diagnoses assessed, managed, or treated should be submitted
24A	Date(s) of service (from and to) formatted in month/day/year **NOTE:** DME rental services this is the rental period. Dates cannot overlap any previous or future rental cycles
24B	Place of Service – Standard 2-digit code where services were rendered
24D	Procedures, services, or Supplies – CPT/HCPCS procedure code and modifier if applicate.
24E	Diagnosis Pointer – diagnosis or diagnoses code that apply to services performed at time of visit
24F	Charges — amount charged for service
24G	Days or Units – number of times service was rendered
24J	Rendering Provider ID # - In top box the provider taxonomy code can be billed. In the NPI box the Rendering (Servicing) Provider name and NPI is required. **NOTE:** The Rendering Provider NPI must be an individual NPI and not the group NPI. If the provider is a typical provider type then the DHS Medicaid Provider ID (MPI) is required
25	Federal Tax ID Number – Tax ID of provider rendering the service
26	Patient's Account No – Provider of service account number for patient
28	Total Charges – Total of all service lines billed
29	Amount Paid – Amount paid by Third Party or Patient
31	Signature Of Physician or Supplier Including Degrees or Credentials – Signature of provider rendering services
32	Service Facility Location Information – Facility Name and address where services were rendered. 32a is the NPI of the facility where services where rendered. **NOTE:** Facility Name and NPI is required when billing with POS 19, 21, 22, 23, 24, 31 or 32
33	Billing Provider Info & PH# - Billing Provider name, Address, and phone number. NOTE Box 33 a is the billing provider NPI

ENCOUNTER DATA SUBMISSION

To support timely statutory reporting requirements, we encourage PCPs to submit encounter information within thirty (30) days of the encounter. However, all encounters (Claims) must be submitted within 180 calendar days after the services were rendered or compensable items were provided.

The following mandatory information is required on the CMS-1500 form for a primary care visit:

- GHP Family Member's ID number
- Member's name
- Member's date of birth
- Other insurance information: company name, address, policy and/or group number, and amounts paid by other insurance, copy of EOB's
- Information advising if patient's condition is related to employment, auto accident, or liability suit
- Name of referring physician, if appropriate
- Dates of service, admission, discharge
- Primary, secondary, tertiary and fourth ICD-10-CM diagnosis codes.
- Authorization or referral number
- CMS place of service code
- HCPCS procedures, service or supplies codes; CPT procedure codes with appropriate modifiers
- Charges
- Days or units
- Physician/supplier federal tax identification number or Social Security Number
- National Practitioner ID (NPI) and Taxonomy Code
- Individual GHP Family assigned practitioner number
- Name and address of facility where services were rendered
- Physician/supplier billing name, address, zip code, and telephone number
- Invoice date

Providers should refer to their contracts for documentation requirements and/or to the provider specific billing sections of this manual.

EXPLANATION OF PAYMENT (EOP)

For each Claim that is paid or denied the provider receives a remittance advice (remit). If a Claim is denied, providers receive a remittance advice that summarizes:

- Payment activity for the provider (the provider's account balance, Claims processed, co- payments applied, interest payments or penalties, discounts, the amount recouped if the beginning balance was negative, and the net paid amount)
- The check number
- Denial reasons for Claims or line items denied
- Claims inquiry contact information
- Claims resubmission and reconsideration steps and details of resubmissions
- Appeals process

To access a copy of the EOP including a description of information provided on the remit, please log on to the secure web portal at http://www.instamed.com/eraeft.

CLAIMS RESUBMISSION

Claims may be resubmitted for two reasons; (1) to submit a corrected Claim or; (2) to submit a previously submitted Claim to which additional information has been attached. When resubmitting a Claim, providers need to indicate on the Claim whether it is a corrected Claim or a resubmitted Claim with appropriate supporting documentation.

- Submit a corrected Claim or a request for reprocessing a Claim within the contracted timely filing guidelines.
- Corrected or resubmitted Claims that do not require supporting documentation may be submitted through GHP Family Electronic Data Interface (EDI) vendors.
- Corrected or resubmitted Claims that require supporting documentation must be submitted on paper to the GHP Family Claims processing center or be submitted electronically using the online CRRF appeals via https://www.navinet.net.

GHP FAMILY PAY-FOR-QUALITY PROGRAM

GHP Family's Pay-for-Quality program was initiated to encourage and promote the focus of quality care for GHP Family Members. The Pay-for-Quality program is available to physicians in primary care (i.e., Family Practice, Internal Medicine, and Pediatrics) and Obstetrics and Gynecology. Each specialty within primary care is considered separately. Additionally, qualifying PCPs meeting measurement thresholds for each applicable category are eligible for reimbursement through the Pay-for-Quality incentive payment.

Physicians are rewarded for meeting and exceeding certain clinical measurement categories. The Pay-for-Quality program is not meant to be a static measurement system and will remain flexible to meet changing clinical practices and quality requirements.

More information about the Pay-for-Quality program (including the GHP Family Pay-for-Quality Manual) is available online at https://ghpfamily.com or https://www.navinet.net. Your Provider Account Manager is also available to work with you in meeting Pay-for-Quality measurement criteria to maximize your incentive.

MEMBER RIGHTS & RESPONSIBILITIES

GHP Family Members have the right:

- To be treated with respect, recognizing their dignity and need for privacy, by GHP Family staff and network providers.
- To get information in a way that they can easily understand and find help when they need it.
- To get information that they can easily understand about GHP Family, its services, and the doctors and other providers that treat them.
- To pick the network health care providers that they want to treat them.
- To get emergency services when they need them from any provider without GHP Family's approval.
- To get information that they can easily understand and talk to their providers about their treatment options, risks of treatment, and tests that may be self-administered without any interference from GHP Family.
- To make all decisions about their health care, including the right to refuse treatment. If they cannot make treatment decisions by themselves, they have the right to have someone else help them make decisions or make decisions for them.

- To talk with providers in confidence and to have their health care information and records kept confidential.
- To see and get a copy of their medical records and to ask for changes or corrections to their records.
- To ask for a second opinion.
- To file a Grievance if they disagree with GHP Family's decision that a service is not medically necessary for them.
- To file a Complaint if they are unhappy about the care or treatment they have received.
- To ask for a DHS Fair Hearing.
- To be free from any form of restraint or seclusion used to force them to do something, to discipline them, to make it easier for the provider, or to punish them.
- To get information about services that GHP Family or a provider does not cover because of moral or religious objections and about how to get those services.
- To exercise their rights without it negatively affecting the way DHS, GHP Family, and network providers treat them.
- To create an advance directive.
- To make recommendations about the rights and responsibilities of GHP Family's members.

GHP Family Members have the responsibility:

- Provide, to the extent they can, information needed by their providers.
- Follow instructions and guidelines given by their providers.
- Be involved in decisions about their health care and treatment.
- Work with their providers to create and carry out their treatment plans.
- Tell their providers what they want and need.
- Learn about GHP Family coverage, including all covered and non-covered benefits and limits.
- Use only network providers unless GHP Family approves an out-of-network provider, or they have Medicare.
- Get a referral from their PCP to see a specialist.
- Respect other patients, provider staff, and provider workers.
- Make a good-faith effort to pay their co-payments.
- Report fraud and abuse to the DHS Fraud and Abuse Reporting Hotline.

CONFIDENTIALITY & PRIVACY OF GHP FAMILY MEMBER MEDICAL RECORDS & PROTECTED HEALTH INFORMATION (PHI)

GHP Family follows the regulations in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) including the HITECH Act of 2009. This law protects the privacy of Member medical records and health information. GHP Family also follows all other state and federal regulations regarding privacy of medical records and health information. A Member's medical record and other information (which includes information relating to HIV/AIDS, substance abuse and behavioral health treatments) received by GHP Family will be kept confidential (private) as required by law.

MEDICAL RECORD TRANSITION UPON CHANGE OF PCP OR PLAN

When a Member changes PCPs, GHP Family will facilitate the transfer of his/her medical records or copies of medical records to the new PCP within seven business days from receipt of the request. In emergency situations, GHP Family will facilitate the transfer of medical records as soon as possible from receipt of the request.

When a Member changes plans to a new Physical Health Managed Care Organization (PH-MCO), GHP Family will facilitate the transfer of his/her medical records or copies of medical records to the new PH-MCO within seven business days from the effective date of enrollment in the new PH-MCO. In emergency situations, GHP Family will facilitate the transfer of medical records as soon as possible from receipt of the request.

MEMBER COMPLAINTS, GRIEVANCES, AND DHS FAIR HEARINGS

Overview

DHS defines "Complaint" and "Grievance" as two separate and distinct types of issues. Members and their representatives (including providers) may file a Complaint or Grievance if they are not able to resolve issues through informal channels with GHP Family or the DHS. In some instances, Members and their representatives may request a DHS Fair Hearing.

Members may agree to be represented by their health care provider in the filing of a Complaint or Grievance or in the request of a DHS Fair Hearing. Members may also request an expedited review of a Complaint or Grievance. GHP Family will process an expedited Complaint or Grievance if it determines the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint or Grievance process or if a Member's provider with the Member's written authorization provides GHP Family with a certification that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the standard procedures. The provider's written certification for an expedited review must state why the usual timeframe for deciding the appeal would jeopardize the member's life, health, or ability to attain, maintain or regain maximum function and must include the Provider's signature.

For a provider to represent the Member in the conduct of a Grievance, the provider must obtain written consent of the Member. A provider may not require a Member to sign a document authorizing the provider to file a Grievance as a condition of treatment. The consent form must maintain the following elements:

- The Member's name, address, date of birth, and identification number. If the Member is a minor or is legally incompetent, the name address and relationship to the Member of the person who signed the consent.
- The name, address, and GHP Family provider identification number of the provider who is receiving the Member's consent to file a Complaint or Grievance.
- The name and address of GHP Family.
- An explanation of the specific service/item for which coverage was provided or denied to the Member to which the consent will apply.
- The following statement – "I or my representative may not file a Grievance about the service or item listed in this consent form unless I or my representative takes back my consent in writing. I have the right to take back my consent at any time during the Grievance process by telling GHP Family and **[Name of Provider]** in writing that I do not want **[Name of Provider]** to continue the Grievance process for me."
- The following statement – "My consent to have the Provider file the Grievance for me will automatically no longer be in effect if the Provider does not file a Grievance or does not continue with the Grievance through the end of the Grievance review process.
- The following statement – "I or my representative has read, or has been read, this consent form, and have had it explained to me until I understand it. I or my representative understands the information in this consent form."
- The dated signature of the Member, or the Member's representative, and the dated signature of a witness.

A Member who consents to the filing of a Complaint or Grievance by a health care provider may not file a separate Grievance. The Member retains the right to rescind consent throughout the Grievance.

The Appeal Department has the overall responsibility for the management of the Member Complaint and Grievance process. This includes:

- Documenting individual Complaints and Grievances
- Coordinating resolutions
- Maintaining logs and records of the Complaints and Grievances
- Tracking, trending, and reporting data

The GHP Family Appeals Coordinator will serve as the primary contact person for the Complaint and Grievance.

The Appeal Department, in collaboration with the Customer Care Department and Provider Relations Department, is responsible for informing and educating Members and providers about a Member's right to file a Complaint or Grievance or request a DHS Fair Hearing and for assisting Members in filing a Complaint or Grievance or in requesting a DHS Fair Hearing. Members are advised of their Complaint, Grievance and DHS Fair Hearing rights and the Complaint, Grievance and DHS Fair Hearing process at the time of enrollment and at least annually thereafter. Members are provided this information via the Member handbook, Member newsletters and the GHP Family Web site. The information provided to Members includes, but is not limited to:

- The method for filing a Complaint, Grievance or for requesting a DHS Fair Hearing including procedural steps and timeframes for filing each level of a Complaint or Grievance or for requesting a DHS Fair Hearing.
- Notification of Member's rights related to Complaints, Grievances and DHS Fair Hearing, including the right to voice Complaints or Grievances about GHP Family or care provided.
- The availability of assistance from GHP Family with filing a Complaint, Grievance or requesting a DHS Fair Hearing along with GHP Family toll-free number and address for filing Complaints, Grievances or requesting a DHS Fair Hearing.
- Upon request, reasonable assistance with the Complaint, Grievance and DHS Fair Hearing process is provided to Members. This includes but is not limited to providing oral interpreter services and the tollfree number for language assistant services.
- TTY/TDD and sign language interpreter capability. GHP Family staff is trained to respond to Members with disabilities with patience, understanding and respect.

Complaints
DHS defines "Complaint" as a dispute or objection regarding a participating provider or the coverage, operations, or management of GHP Family, which has not been resolved by GHP Family and has been filed with GHP Family or with DOH or PID, including but not limited to:

- a denial because the requested service or item is not a covered service;
- the failure of GHP Family to provide a service or item in a timely manner, as defined by the Department;
- the failure of GHP Family to decide a Complaint or Grievance within the specified time frames;
- a denial of payment by GHP Family after a service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program;
- a denial of payment by GHP Family after a service or item has been delivered because the service or item provided is not a covered service for the Member;
- a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

The term does not include a Grievance.

Grievances
A “Grievance” is a request to have GHP Family or a utilization review entity reconsider a decision solely concerning the Medical Necessity and appropriateness of a covered service. Members or their representatives (including providers) may file a Grievance. A Grievance may be filed regarding GHP Family’s decision to 1) deny, in whole or in part, payment for a service/item; 2) deny or issue a limited authorization of a requested service/item, including a determination based on the type or level of service or item; 3) reduce, suspend, or terminate a previously authorized service/item; 4) deny the requested service/item, but approve an alternative service/item; and 5) deny a request for a BLE. This definition does not include Complaints.

DHS Fair Hearing
A DHS Fair Hearing is a hearing conducted by DHS Bureau of Hearings and Appeals or its subcontractor.

A Member must file a Complaint or Grievance with GHP Family and receive a decision on the Complaint or Grievance before filing a request for a Fair Hearing. If GHP Family fails to provide written notice of a Complaint or Grievance decision within the time frames specified by DHS, the Member is deemed to have exhausted the Complaint or Grievance process and may request a Fair Hearing.

The Member or the Member’s representative may request a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of GHP Family’s first level Complaint decision or Grievance decision for any of the following:

1. the denial, in whole or part, of payment for a requested service or item based on lack of Medical Necessity;
2. the denial of a requested service or item because the service or item is not a covered service;
3. the reduction, suspension, or termination of a previously authorized service or item;
4. the denial of a requested service or item but approval of an alternative service or item;
5. the failure of GHP Family to provide a service or item in a timely manner, as defined by the Department;
6. the failure of GHP Family to decide a Complaint or Grievance within the specified time frame;
7. the denial of payment after a service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program;
8. the denial of payment after a service or item has been delivered because the service or item is not a covered service for the Member;
9. the denial of a Member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

GHP Family Complaint and Grievance Department provides Members with assistance as necessary, including interpreter and translation services, in filing Complaints, Grievances and requests for DHS Fair Hearings. Contact information is:

Geisinger Health Plan Appeals Department
100 North Academy Avenue
Danville, PA 17822-3220
Phone: (866) 577-7733, Opt. 0
Fax: 570-271-7225

GHP Family will accept Complaints and Grievances telephonically via a toll-free telephone number, in writing or by facsimile. If the Member has a sensory impairment, GHP Family will assign a representative to assist that Member throughout the Grievance system process. GHP Family will accept Complaints and Grievances through a

TTY/TDD line, Braille; tape or CD and other commonly accepted alternative forms of communication. If a Member should need a sign language interpreter, GHP Family will provide one at no cost to the Member. Additionally, GHP Family will train its staff to be aware of speech limitations of some Members with disabilities and treat these Members with patience, understanding and respect.

If a Complaint or Grievance is received in a written format (surface mail, facsimile, Braille), it will be forwarded to the Coordinator.

The Coordinator will assign the appropriate category (Complaint or Grievance or DHS Fair Hearing request), level (first, second, expedited or external) and ensure the required timeframe.

GHP Family Member Handbook (Section 8 – Complaints, Grievances, and Fair Hearings)
To view the information on Complaints, Grievances and Fair Hearings in the GHP Family Member Handbook, click here: https://www.geisinger.org/-/media/OneGeisinger/Files/PDFs/GHP-Family/GHP-Family-Member-Handbook.pdf?sc_lang=en&hash=866CA8C0755BE1F1C48E8BFD239C2BAA.

PROVIDER APPEALS AND DISPUTES

GHP Family offers providers 1) an informal and formal dispute process for expressing dissatisfaction with a GHP Family decision that directly impacts the provider and 2) an informal and formal appeals process to request reversal of a denial by GHP Family. The definitions and processes for Provider Appeals and a Provider Disputes are as follows:

Provider Appeal – A request from a Provider for reversal of a denial by GHP Family, about the three (3) major types of issues that are to be addressed in a Provider Appeal system as outlined in the Provider Dispute Resolution System. The three (3) types of Provider Appeals issues are:

1. Provider credentialing denial by GHP Family.
    - If a provider communicates dissatisfaction with a credentialing determination, Credentials Committee, at its next scheduled meeting, will review information provided by the provider and decide. If the provider's credentialing or recredentialing is denied, the provider has thirty (30) Business Days from receipt of notice to file an appeal.

2. Claims denied by GHP Family for Participating Providers participating in GHP Family's network. This includes payment denied for services already rendered by the Participating Provider to the Member.
    - **Informal Process** – All Participating Providers should use the existing Claim Research Request Form (CRRF) process as outlined in the Provider Service Center.

    - **Formal Process** – If a Participating Provider sends another CRRF stating 2nd level appeal, or requests additional review on a previously reviewed CRRF, the Provider Dispute/Appeals Committee (PDAC), will hear all formal Provider Appeals and make a determination within sixty (60) days.

3. Termination of Participating Provider Agreement by GHP Family based on quality of care or service.

Suspension, non-renewal, or termination of Participating Provider's participation initiated by GHP Family entitles the Participating Provider to an appeal hearing upon timely and proper request by the Participating Provider for said appeal for any of the following reasons:

- Business need;
- Breach of Agreement;
- Suspected fraud and abuse;
- Non-compliant behavior that jeopardizes Member satisfaction;
- Temporary sanction, suspension or restriction by Medicare, any licensing board or professional review organization (Organizational Providers only*); and/or
- Failure to immediately notify Health Plan of substantive changes in credentialing information including, but not limited to, adverse licensure actions, termination/cancellation of professional liability insurance or sanctions from billing private, federal or state health insurance programs (Organizational Providers only*).

Participating Providers will have five (5) Business Days from receipt of notice to file a written request for a hearing to appeal suspension, non-renewal, or termination of GHP Family participation. Requests for a hearing shall:

- Specify in detail the reason(s) the Participating Provider wishes to contest the suspension, non-renewal or termination decision;
- Be delivered certified or registered mail to the GHP Family contact who executed the notice to Participating Provider of non-renewal/termination;
- Specify if Participating Provider intends to be represented by an attorney at the hearing;
- Include the name, address, phone, fax and email (if available) of Participating Provider's attorney, if applicable;
- Include a list of the name(s), title(s), address(es) and phone number(s) of any witnesses expected to testify on behalf of Participating Provider at the hearing; and
- Include copies of all additional information Participating Provider wishes to present at the hearing.

Provider Dispute – A written communication to GHP Family, made by a provider, expressing dissatisfaction with a Health Plan decision that directly impacts the provider. This does not include decisions concerning Medical Necessity. Following are the informal and formal process:

Informal Provider Dispute Process – When a written Provider Dispute is received, it will be forwarded to the appropriate department within GHP Family for resolution. The dispute will be researched and responded to within 45 days of receipt. This initial response is considered the informal settlement process for the dispute.

Formal Provider Dispute Process – If a provider disagrees with our initial response and sends in an additional written inquiry within sixty (60) days of incident being disputed, the Provider Dispute/Appeals Committee will hear all formal Provider Disputes and make a determination. Once received, dispute will be reviewed, and a decision will be rendered within sixty (60) days after receipt. GHP Family may request an extension of up to thirty (30) days, if necessary.

GHP Family's Provider Dispute/Appeal Committee includes the following personnel:

- Director, PNM
- Manager, Operations/Reimbursement Services
- Medical Director, Medicaid

- Medical Director (practicing physician) – GHP
- Claims Designee
- Provider Account Manager, PNM

REGULATORY COMPLIANCE

CULTURAL COMPETENCY

Cultural Competency & Interpretive Services for the Disabled and Those with Limited English Proficiency
Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, gender identification, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English.

GHP Family expects contracted providers to treat all Members with dignity and respect as required by federal law. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance, such as Medicaid.

GHP Family policies conform with federal government Limited English Proficiency (LEP) guidelines stating that programs and activities normally provided in English must be accessible to LEP persons. Services must be provided in a culturally effective manner to all Members, including those with Limited English Proficiency (LEP) or reading skills, those with diverse cultural and ethnic backgrounds, those who are deaf or hard of hearing, the homeless and individuals with physical and mental disabilities. To ensure Members' privacy, they must not be interviewed about medical or financial issues within hearing range of other patients.

In compliance with federal and state requirements:

GHP Family makes certain that LEP Members and Members who are deaf or hard of hearing have access to health care and benefits by providing a range of language assistance services at no cost to the Member or the provider. GHP Family offers translation and interpreter services, including sign language interpreters, to providers and Members free of charge. These interpreters are qualified and familiar with medical terminology. The use of professional interpreters, rather than family or friends, is strongly encouraged. GHP offers telephonic interpretation. Providers can make advance arrangements for personal interpreters. Contact your Provider Account Manager or the Customer Care Department to learn more about these services.

- Bilingual staff members are available in the Member services department to assist LEP Members.
- Member Materials, such as the Member handbook, are available in English, Spanish, and each prevalent language as determined by DHS.

GHP Family provides alternative methods of communication for Members who are visually or hearing impaired, including Braille, audio tapes, large print and/or computer diskette. Upon Member request, we will make all written materials disseminated to Members accessible to visually impaired Members. GHP Family must provide sign language interpreters and TTY or Pennsylvania Telecommunication Relay Service for communicating with Members who are deaf or hearing impaired, upon request.

GHP Family must include appropriate instructions on all materials about how to access, or receive assistance with accessing, desired materials in an alternate format.

MAINSTREAMING

Pursuant to their Agreement, GHP Family Participating Providers must not intentionally segregate Members in any way from other persons receiving services.

GHP Family investigates Complaints and takes affirmative action so that Members are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, language, MA status, health status, disease or pre-existing condition, anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

a. Denying or not providing a Member any covered service or access to a participating facility within the GHP Family Network. GHP Family policy provides access to complex interventions such as cardiopulmonary resuscitations, intensive care, transplantation, and rehabilitation when Medically Necessary. Health care and treatment necessary to preserve life must be provided to all persons who are not terminally ill or permanently unconscious, except where a competent Member objects to such care on his/her own behalf.

b. Subjecting a Member to segregated, separate, or different treatment, including a different place or time from that provided to other Members, public or private patients, in any manner related to the receipt of any GHP Family covered service, except where Medically Necessary.

c. The assignment of times or places for the provision of services based on the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, income status, program membership, language, MA status, health status, disease or preexisting condition, anticipated need for health care or physical or mental disability of the participants to be served.

HIPPA AND CONFIDENTIALITY

HIPAA NOTICE OF PRIVACY PRACTICES

GHP Family maintains strict privacy and confidentiality standards for all medical records and Member health care information, according to federal and state standards. Providers can access up-to-date Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices on our website at www.ghpfamily.com. This includes explanations of Members' rights to access, amend, and request confidential communication of, request privacy protection of, restrict use and disclosure of, and receive an accounting of disclosures of Protected Health Information (PHI).

If you need to contact the Privacy Office you may call or write as follows:

Geisinger Privacy Officer
MC 40-38
100 North Academy Ave
Danville, PA 17822
Telephone: 570-271-7360

CONFIDENTIALITY REQUIREMENTS

Providers are required to comply with all federal, state and local laws and regulations governing the confidentiality of medical information including all laws and regulations pertaining to, but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and applicable contractual requirements.

Providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records and confidential provider and Member information, whether oral or written in any form or medium. All "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral is considered confidential PHI.

“Individually identifiable health information” is information, including demographic data, that relates to:

a. The individual’s past, present or future physical or mental health or condition
b. The provision of health care to the individual
c. The past, present, or future payment for the provision of health care to the individual
d. Information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual
e. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number)

Excluded from PHI are employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g.

Providers’ offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of GHP Family.

Release of data to third parties requires advance written approval from DHS, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by Members or releases required by court order, subpoena or law.

MEMBER PRIVACY RIGHTS

Geisinger’s privacy policy assures that all Members are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements. Our privacy policy conforms with 45 C.F.R. (Code of Federal Regulations): relevant sections of the HIPAA that provide Member privacy rights and place restrictions on uses and disclosures of protected health information (§164.520, 522, 524, 526 and 528).

Our policy also assists GHP Family personnel and providers in meeting the privacy requirements of HIPAA when Members or personal representatives exercise privacy rights through privacy request, including:

a. Making information available to Members or their representatives about GHP Family’s practices regarding their PHI
b. Maintaining a process for Members to request access to, changes to, or restrictions on disclosure of their PHI

c. Providing consistent review, disposition, and response to privacy requests within required time standards
d. Documenting requests and actions taken pursuant to a Member Privacy Request
e. Members may make the following requests related to their PHI ("privacy requests") in accordance with federal, state, and local law:
    - Make a privacy Complaint
    - Receive a copy of all or part of their designated record set
    - Request an amendment to their records containing PHI
    - Receive an accounting of health plan disclosures of PHI
    - Restrict the use and disclosure of PHI
    - Receive confidential communications
    - Receive a Notice of Privacy Practices

A privacy request must be submitted by the Member or Member's personal representative. A Member's personal representative must provide documentation or written confirmation that he or she is authorized to make the request on behalf of the Member or the deceased Member's estate. Except for requests for a health plan Notice of Privacy Practices, requests from Members or a Member's representative must be submitted to GHP Family in writing.

PRIVACY PROCESS REQUIREMENTS

GHP Family's processes for responding to Member privacy requests shall include components for the following:

VERIFICATION

If the requester is the Member, GHP Family personnel shall verify the Member's identity; verification examples include asking for the last four digits of Member's Social Security Number, Member's address, and Member's date of birth. If the requester is not the Member, GHP Family personnel shall require an Authorization for Use or Disclosure completed by the Member to verify the requester's authority to obtain the Member's information. If the requester identifies him/herself as a Member's personal representative, GHP Family personnel shall require a healthcare Power of Attorney (POA) or comparable document for a representative to act on behalf of the Member.

REVIEW, DISPOSITION, AND RESPONSE

GHP Family personnel review and disposition of privacy requests shall comply with applicable federal, state, and local laws and regulations, and applicable contractual requirements, including those that govern use and disclosure of PHI. Responses to privacy requests shall conform to guidelines prescribed by HIPAA, including response time standards, and shall include a notice of administrative charges, if any, for granting the request.

USE AND DISCLOSURE GUIDELINES

GHP Family personnel are required to use and disclose only the minimum amount of information necessary to accommodate the request or carry out the intended purpose.

LIMITATIONS

A privacy request may be subject to specific limitations or restrictions as required by law. GHP Family personnel may deny a privacy request under any of the following conditions:

a. GHP Family does not maintain the records containing the PHI

b. The requester is not the Member and GHP Family personnel are unable to verify his/her identity or authority to act as the Member's authorized representative
c. The documents requested are not part of the designated record set (e.g., credentialing information)
d. Access to the information may endanger the life or physical safety of or otherwise cause harm to the Member or another person
e. GHP Family is not required by law to honor the request (e.g., accounting for certain disclosures)

FRAUD AND ABUSE

GHP FAMILY COMPLIANCE PROGRAM

GHP Family is committed to a policy of zero tolerance for fraudulent insurance acts that victimize GHP Family and its' stakeholders. Accordingly, GHP Family maintains a robust Compliance Program. GHP Family'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. GHP Family 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 Geisinger Health Plan's Code of Conduct available online through www.ghpfamily.com.

Geisinger Health Plan policies are available to providers regarding the following:

Information about the False Claims Act established under sections 3729 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements established under Chapter 38 of Title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in Section 1128B(f) [42 U.S.C.A. § 1320a-7b(f)]) can be found at https://www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf.

Provisions regarding Geisinger Health Plan's procedures for detecting and preventing fraud, waste and abuse can be found at https://www.geisinger.org/about-geisinger/corporate/corporate-policies/report-fraud.

DEFINING FRAUD, WASTE, AND ABUSE

Fraud – An intentional 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). The Fraud can be committed by many entities, including GHP Family, a subcontractor, a Provider, a State employee, or a Member, among others.

Waste – Waste occurs when an act of carelessness in performance and/or lack of training result in otherwise unnecessary repetition of services or cost.

Abuse – Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the MA Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the HealthChoices RFP, Agreement, and the requirements of state or federal regulations) for health care in a managed care setting. The Abuse can be committed by GHP Family, a subcontractor, Provider, State employee,

or a Member, among others. Abuse also includes Member practices that result in unnecessary cost to the MA Program, GHP Family, a subcontractor, or Provider.

REPORTING FRAUD AND ABUSE

Providers can report suspected Fraud and Abuse directly to DHS by:

Phone: (866) 379-8477 (Medical Assistance Provider Compliance Hotline)

Online https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Fraud-and-Abuse---General-Information.aspx

Fax: 1-717-772-4655, Attn: MA Provider Compliance Hotline

Mail:
Office of Administration
Bureau of Program Integrity
P.O. Box 2675
Harrisburg, PA 17105-2675

Reported problems will be referred to the Office of Medical Assistance Program's Bureau of Program Integrity for investigation, analysis and determination of the appropriate course of action. GHP Family and DHS maintain strict confidentiality concerning the providers and Members who report suspected Fraud and Abuse.

Suspected Fraud and Abuse can also be reported to GHP Family's Compliance Department by:

Email: fa@thehealthplan.com

Phone: The GHP Compliance Hot Line at 800-292-1627 or call the Customer Care Team at (855) 227-1302.

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

When you report fraud, you may remain anonymous. All reports are kept strictly confidential.

EXAMPLES OF RISKS FOR FRAUD, WASTE AND ABUSE

Prescriber Fraud, Waste and Abuse

a. *Prescribers 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.

b. *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.

c. *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.

d. *Provision of false information*: Prescriber falsifies information (not consistent with medical record) submitted through a prior authorization or other formulary oversight mechanism to justify coverage. Prescriber misrepresents the dates, descriptions of prescriptions or other services furnished, or the identity of the individual who furnished the services.

e. *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. Member Fraud, Waste and Abuse Risks

f. *Misrepresentation of status*: A Member misrepresents personal information, such as identity, eligibility, or medical condition 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.

g. *Identity theft*: Perpetrator uses another person's GHP Family identification card to obtain prescriptions.

h. *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.

i. *Prescription diversion and inappropriate use*: Members 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 Member's medications by a caregiver or anyone else.

j. *Resale of drugs on black market*: Member falsely reports loss or theft of drugs or feigns illness to obtain drugs for resale on the black market.

k. *Prescription stockpiling*: Member 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 noncoverage (i.e., by purchasing a large amount of prescription drugs and then disenrolling), or for purposes of resale on the black market.

l. *Doctor shopping*: Member 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.

m. *Improper Coordination of Benefits*: Improper coordination of benefits where Member fails to disclose multiple coverage policies, or leverages various coverage policies to "game" the system.

n. *Marketing Schemes*: A Member may be victimized by a marketing scheme where a sponsor, or its agents or brokers, violates the marketing guidelines, or other applicable Federal or state laws, rules, and regulations to improperly enroll a MA beneficiary.

o. *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.

p. *Prescription drug shorting:* Pharmacist provides less than the prescribed quantity and intentionally does not inform the Member or make arrangements to provide the balance but bills for the fully- prescribed amount.

q. *Bait and switch pricing*: Bait and switch pricing occurs when a Member is led to believe that drug will cost one price, but at the point of sale the Member is charged a higher amount.

r. *Prescription forging or altering:* Where existing prescriptions are altered, by an individual without the prescriber's permission to increase quantity or number of refills.

s. *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.

t. *Prescription refill errors:* A pharmacist provides the incorrect number of refills prescribed by the provider.

u. *Pharmacy Illegal remuneration schemes:* Pharmacy is offered, or paid, or solicits, or receives unlawful remuneration to induce or reward the pharmacy to switch Member's' to different drugs, influence prescribers to prescribe different drugs, or steer Member's' to plans.

ADDITIONAL EXAMPLES OF FRAUD:

Recipient fraud is defined as someone who receives cash assistance, Supplemental Nutritional Assistance Program (SNAP) benefits, Heating/Energy Assistance (LIHEAP), childcare, medical assistance, or other public benefits while not reporting income, not reporting ownership of resources or property, not reporting who lives in their household, allowing another person to use his or her ACCESS/MCO card, forging or altering prescriptions, selling prescriptions/medications, trafficking SNAP benefits, or taking advantage of the system in any way.

Provider fraud is defined as billing for services not rendered; billing separately for services in lieu of an available combination code; misrepresenting the service/supplies rendered (billing brand-named for generic drugs, upcoding to more expensive service than was rendered, billing for more time or units of service than provided, and billing incorrect provider or service location); altering claims; submission of any false data on claims, such as date of service, provider, or prescriber of service; duplicate billing for the same service; billing for services provided by unlicensed or unqualified persons; or billing for used items as new.

PROVIDER SCREENING OF EMPLOYEES AND CONTRACTORS FOR EXCLUSION FROM PARTICIPATION IN FEDERAL HEALTH CARE PROGRAMS

OVERVIEW

Under both State and Federal law, DHS and GHP Family are generally prohibited from paying for any items or services furnished, ordered, or prescribed by individuals or entities excluded from the MA Program as well as other Federal health care programs. Medicaid providers and managed care entities who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients when those individuals or entities are excluded from participation in any Medicare, Medicaid, or other Federal health care programs are subject to termination of their enrollment in and exclusion from participation in the MA Program and all Federal health care programs, recoupment of overpayments, and imposition of civil monetary penalties.

The amount of the Medicaid overpayment for such items or services is the actual amount of Medicaid dollars that were expended for those items or services. When Medicaid funds have been expended to pay an excluded individual's salary, expenses, or fringe benefits, the amount of the overpayment is the amount of those expended Medicaid funds.

All employees, vendors, contractors, service providers, and referral sources whose functions are a necessary component of providing items and services to MA recipients, and who are involved in generating a claim to bill for services, or are paid by Medicaid (including salaries that are included on a cost report submitted to DHS), should be screened for exclusion before employing and/or contracting with them and, if hired, should be rescreened on an ongoing monthly basis to capture exclusions and reinstatements that have occurred since the last search. Examples of individuals or entities that providers should screen for exclusion include, but are not limited to:

a. Individual or entity who provides a service for which a claim is submitted to Medicaid;
b. Individual or entity who causes a claim to be generated to Medicaid;
c. Individual or entity whose income derives all, or in part, directly or indirectly, from Medicaid funds;
d. Independent contractors if they are billing for Medicaid services;
e. Referral sources, such as providers who send a Medicaid recipient to another provider for additional services or second opinion related to medical condition.

PROCEDURE

To protect the MA Program against payments for items or services furnished, ordered, or prescribed by excluded individuals or entities; to establish sound compliance practices, and to prevent potential monetary and other sanctions, providers should:

1. Develop policies and procedures for screening of all employees and contractors (both individuals and entities), at time of hire or contracting; and, thereafter, on an ongoing monthly basis to determine if they have been excluded from participation in federal health care programs;

2. Use the following databases to determine exclusion status;

    a. **Pennsylvania Medicheck List**: a data base maintained by DHS that identifies providers, individuals, and other entities that are precluded from participation in Pennsylvania's MA Program:

https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/Medicheck-List.aspx.

b. If an individual's resume indicates that he/she has worked in another state, providers should also check that state's individual list.

c. **List of Excluded Individuals/Entities (LEIE)**: data base maintained by HHSOIG that identifies individuals or entities that have been excluded nationwide from participation in any federal health care program. An individual or entity included on the LEIE is ineligible to participate, either directly or indirectly, in the MA Program. Although DHS makes best efforts to include on the Medicheck List all federally excluded individuals/entities that practice in Pennsylvania, providers must also use the LEIE to ensure that the individual/entity is eligible to participate in the MA Program: https://oig.hhs.gov/fraud/.

d. **System for Award Management (SAM)**: a U.S. Government owned and operated free web site containing entity registration records and exclusion records. Exclusion records identify those parties excluded from receiving certain federal contracts, subcontracts, and financial and non- financial assistance and benefits. The SAM exclusions database, located at https://sam.gov/data-services, is the official governmentwide system of records of debarments, suspensions, and other exclusionary actions.

e. **Social Security Administration Death Master File (SSADMF): a Social Security** Administration (SSA) extract of death information on the NUMIDENT, the electronic database that contains SSA records of Social Security Numbers (SSN) assigned to individuals since 1936, and includes, if available, the deceased individual's SSN, first name, middle name, surname, date of birth, and date of death: https://www.ssa.gov/dataexchange/request_dmf.html.

f. **National Plan and Provider Enumeration System (NPPES)**: a CMS run online registry of National Provider Identifier (NPI) numbers: https://nppes.cms.hhs.gov/#/.

3. Immediately self-report any discovered exclusion of an employee or contractor, either an individual or entity, to the Bureau of Program Integrity at https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Provider-Compliance- Hotline.aspx.

   Online Form: https://forms.dhs.pa.gov/dhs-ma-provider-compliance/

   Mail:
   Bureau of Program Integrity
   MA Provider Compliance Hotline
   P.O. Box 2675
   Harrisburg, PA 17105-2675

   Phone: 1-866-379-8477 (includes TTY)

   Fax: 717-772-4655 – Attention MA Provider Compliance Hotline

4. Develop and maintain auditable documentation of screening efforts, including dates the screenings were performed and the source data checked and its date of most recent update; and

5. Periodically conduct self-audits to determine compliance with this requirement.

PROVIDER SELF-AUDIT PROTOCOL

The Pennsylvania MA Provider Self Audit Protocol allows providers to voluntarily disclose overpayments or improper payments of MA funds. The provider self-audit protocol is available on the DHS website at https://www.pa.gov/agencies/dhs/report-fraud/medicaid-provider-self-audit-protocol.html.

GLOSSARY

Abuse — Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the MA Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the RFP, Agreement, and the requirements of state or federal regulations) for health care in a managed care setting. The Abuse can be committed by the GHP Family, subcontractor, Health Care Provider, State employee, or a Member, among others. Abuse also includes Member practices that result in unnecessary cost to the MA Program, the GHP Family, a subcontractor, or Health Care Provider.

ACCESS Card — An identification card issued by DHS to each MA Member. The card must be used by MA-enrolled Health Care Providers to access DHS's EVS and verify the Member's MA eligibility and specific covered benefits.

Actuarially Sound Rates — Rates that reflect, among other elements:

a. the populations and benefits to be covered;

b. the rating groups;

c. the projected Member months for each category of aid;

d. the historical and projected future medical costs expected to be incurred by an efficiently and effectively operated Medicaid managed care program in the respective county/zone;

e. program changes to the extent they impact actuarial soundness of the rates;

f. trend levels for each type of service;

g. administrative costs expected to be incurred by an efficiently and effectively operated Medicaid managed care program, including assessment costs and profit consideration.

Actuarially sound rates are developed using sound methods and assumptions that are reasonably attainable by the Medicaid managed care organizations in the relevant Agreement year and meet the standards of the Actuarial Standards Board.

Adjudicated Claim — A Claim that has been processed to payment or denial.

Affiliate — Any individual, corporation, partnership, joint venture, trust, unincorporated organization or association, or other similar organization (hereinafter "Person"), controlling, controlled by or under common control with the GHP Family or its parent(s), whether such common control be direct or indirect. Without limitation, all officers, or persons, holding five percent (5%) or more of the outstanding ownership interests of GHP Family or its parent(s), directors or subsidiaries of GHP Family or parent(s) shall be presumed to be Affiliates for purposes of the RFP and Agreement. For purposes of this definition, "control" means the possession, directly or indirectly, of the power (whether or not exercised) to direct or cause the direction of the management or policies of a person, whether through the ownership of voting securities, other ownership interests, or by contract or otherwise including but not limited to the power to elect a majority of the directors of a corporation or trustees of a trust, as the case may be.

Agreement — the written binding document between Participating Provider and Health Plan together with any attachments, exhibits, applicable Provider Guide and the Member benefit plan, as amended from time to time and made part of the Agreement by reference.

Appeal (Provider) — A request from a Health Care Provider for reversal of a denial by the PHMCO, with regard to the three (3) major types of issues:

a. Health Care Provider credentialing denial by the GHP Family;

b. Claims denied by the GHP Family for Health Care Providers participating in the PHMCO's Network. This includes payment denied for services already rendered by the Health Care Provider to the Member; and

c. Agreement termination by the GHP Family.

Behavioral Health Managed Care Organization (BH-MCO) — An entity, operated by county government or licensed by the Commonwealth as a risk bearing Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO), which manages the purchase and provision of Behavioral Health Services under an agreement with DHS.

Behavioral Health (BH) Services — Mental health and/or drug and alcohol services which are provided by the BH- MCO.

Business Day(s) — Includes Monday through Friday except for those days recognized as federal holidays and/or Pennsylvania State holidays.

Case Management — Services which will assist individuals in gaining access to necessary medical, social, educational and other services.

Centers for Medicare and Medicaid Services (CMS) — The federal agency within the Department of Health and Human Services responsible for oversight of MA Programs.

Certified Registered Nurse Practitioner (CRNP) — A professional nurse licensed in the Commonwealth of Pennsylvania who is certified by the State Board of Nursing in a particular clinical specialty area and who, while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with and under the direction of a physician licensed to practice medicine in Pennsylvania..

Claim — A bill from a Health Care Provider of a medical service or product that is assigned a unique identifier (i.e., Claim reference number). A Claim does not include an Encounter form for which no payment is made or only a nominal payment is made.

Clean Claim — A Claim that can be processed without obtaining additional information from the Health Care Provider of the service or from a third party. A Clean Claim includes a Claim with errors originating in the GHP Family 's Claims system. Claims under investigation for Fraud or Abuse or under review to determine if they are Medically Necessary are not Clean Claims.

Complaint — A dispute or objection regarding a particular Provider or the coverage, operations, or management of a PH-MCO, which has not been resolved by the PH-MCO and has been filed with the PH-MCO or with PID's Bureau of Managed Care (BMC), including, but not limited to:

- a denial because the requested service or item is not a covered service; which does not include BLE
- the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;
- the failure of the PH-MCO to decide a Complaint or Grievance within the specified time frames;
- a denial of payment by the PH-MCO after a service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program;

- a denial of payment by the PH-MCO after a service or item has been delivered because the service or item provided is not a covered service for the Member; or
- a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

This term does not include a Grievance.

Concurrent Review — A review conducted by the GHP Family during a course of treatment to determine whether the amount, duration and scope of the prescribed services continue to be Medically Necessary or whether any service, a different service or lesser level of service is Medically Necessary.

County Assistance Office (CAO) — The county offices of DHS that administer all benefit programs, including MA, on the local level. DHS staff in these offices perform necessary functions such as determining and maintaining Member eligibility.

Cultural Competency — The ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Denial of Services — Any determination made by the GHP Family in response to a request for approval which: disapproves the request completely; or approves provision of the requested service(s), but for a lesser amount, scope or duration than requested; or disapproves provision of the requested service(s), but approves provision of an alternative service(s); or reduces, suspends or terminates a previously authorized service. An approval of a requested service which includes a requirement for a Concurrent Review by the GHP Family during the authorized period does not constitute a Denial of Service.

Deprivation Qualifying Code — The code specifying the condition which determines a Member to be eligible in nonfinancial criteria.

Developmental Disability — A severe, chronic disability of an individual that is:

a. Attributable to a mental or physical impairment or combination of mental or physical impairments.

b. Manifested before the individual attains age twenty-two (22).

c. Likely to continue indefinitely.

d. Manifested in substantial functional limitations in three or more of the following areas of life activity:
    - Self-care;
    - Receptive and expressive language;
    - Learning;
    - Mobility;
    - Capacity for independent living; and Economic self-sufficiency.

e. Reflective of the individual's need for special, interdisciplinary or generic services, supports, or other assistance that is of lifelong or extended duration, except in the cases of infants, toddlers, or preschool children who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided.

Disease Management — An integrated treatment approach that includes the collaboration and coordination of patient care delivery systems and that focuses on measurably improving clinical outcomes for a particular medical condition through the use of appropriate clinical resources such as preventive care, treatment guidelines, patient counseling, education and outpatient care; and that includes evaluation of the appropriateness of the scope, setting and level of care in relation to clinical outcomes and cost of a particular condition.

Dispute (Provider) — A written communication to a GHP Family, made by a Provider, expressing dissatisfaction with a GHP Family decision that directly impacts the Provider. This does not include decisions concerning Medical Necessity.

DHS — The Department of Human Services (DHS) of the Commonwealth of Pennsylvania.

(DHS) Fair Hearing — A hearing conducted by DHS, Bureau of Hearings and Appeals.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) — Items and services which must be made available to persons under the age of twenty-one (21) upon a determination of Medical Necessity and required by federal law at 42 U.S.C. §1396d(r).

Early Intervention Program — The provision of specialized services through family-centered intervention for a child, birth to age three (3), who has been determined to have a developmental delay of twenty-five percent (25%) of the child's chronological age or has documented test performance of 1.5 standard deviation below the mean in standardized tests in one or more areas: cognitive development; physical development, including vision and hearing; language and speech development; psycho-social development; or self-help skills or has a diagnosed condition which may result in developmental delay.

Eligibility Verification System (EVS) — An automated system available to MA Providers and other specified organizations for automated verification of MA Members' current and past (up to three hundred sixty-five [365] days) MA eligibility, GHP Family Enrollment, PCP assignment, Third Party Resources, and scope of benefits.

Emergency Services — Covered inpatient and outpatient services that: (a) are furnished by a Provider that is qualified to furnish such service under Title XIX of the Social Security Act and (b) are needed to evaluate or stabilize an Emergency Medical Condition.

Encounter Data — A record of any covered health care service provided to a GHP Family Member and includes Encounters reimbursed through Capitation, Fee-for-Service, or other methods of compensation regardless of whether payment is due or made.

Enhanced Member Supports Unit (EMSU) — A unit within the PH-MCO's organization structure established to assist members with addressing their special healthcare needs and/or health related social needs and supporting them with their overall personal well-being.

Enrollment Assistance Program (EAP) — The program that provides Enrollment Specialists to assist Recipients in selecting a PH-MCO and PCP and in obtaining information regarding HealthChoices Physical, Behavioral Health Services, Community HealthChoices long-term services and supports and service Providers.

Family Planning Services — Services which enable individuals voluntarily to determine family size, to space children and to prevent or reduce the incidence of unplanned pregnancies. Such services are made available without regard to marital status, age, sex or parenthood.

Federally Qualified Health Center (FQHC) — An entity which is receiving a grant as defined under the Social Security Act, 42 U.S.C. 1396d(l) or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under the abovementioned sections of the Act.

Fee-for-Service (FFS) — Payment by DHS or GHP Family to Health Care Providers on a per service basis for health care services provided to Members.

Formulary — An exclusive list of drug products for which the Contractor must provide coverage to its Members, as approved by DHS.

Fraud — Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting. Fraud can be committed by many entities, including the GHP Family, a subcontractor, a Health Care Provider, a State employee, or a Member, among others.

GHP Family Coverage Period — A period during which an individual is eligible for MA coverage and enrolled with a GHP Family.

Grievance — A request to have a GHP Family or a utilization review entity reconsider a decision solely concerning the Medical Necessity and appropriateness of a health care service. A Grievance may be filed regarding a GHP Family decision to 1) deny, in whole or in part, payment for a service/item; 2) deny or issue a limited authorization of a requested service/item, including the type or level of service/item; 3) reduce, suspend, or terminate a previously authorized service/item; 4) deny the requested service/item but approve an alternative service/item, and 5) deny a request for a BLE. This term does not include a Complaint.

Health Care Provider — A licensed hospital or health care facility, medical equipment supplier or person who is enrolled in the Pennsylvania MA Program and licensed, certified or otherwise regulated to provide health care services under the laws of the Commonwealth or state(s) in which the entity or person provides services, including a physician, podiatrist, optometrist, psychologist, physical therapist, certified registered nurse practitioner, registered nurse, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, physician's assistant, chiropractor, dentist, dental hygienist, pharmacist or an individual accredited or certified to provide behavioral health services.

HealthChoices Program — The name of Pennsylvania's 1915(b) waiver program to provide mandatory managed health care to Members.

HealthChoices Zone (HC Zone) — A multiple-county area in which the HealthChoices Program has been implemented to provide mandatory managed care to Medicaid Members in Pennsylvania.

HIV/AIDS Waiver Program — A Home and Community Based Waiver Program that provides for Expanded Services to Members who are diagnosed with Acquired Immunodeficiency Syndrome (AIDS) or symptomatic Human immunodeficiency Virus (HIV) as a cost-effective alternative to inpatient care.

Home and Community Based Waiver Program — Necessary and cost-effective services, not otherwise furnished under the State's Medicaid Plan, or services already furnished under the State's Medicaid Plan but in expanded amount, duration, or scope which is furnished to an individual in his/her home or community to prevent institutionalization. Such services must be authorized under the provisions of 42 U.S.C. 1396n.

Medical Assistance (MA) — The Medical Assistance Program authorized by Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq., and regulations promulgated thereunder, and 62 P.S. and regulations at 55 PA Code Chapters 1101 et seq.

Medical Assistance Transportation Program (MATP) — A non-emergency medical transportation service provided to eligible persons who need to make trips to/from a MA reimbursable service for the purpose of receiving treatment, medical evaluation, or purchasing prescription drugs or medical equipment.

Medical Management (MM) — An objective and systematic process for planning, organizing, directing and coordinating health care resources to provide Medically Necessary, timely and quality health care services in the most cost-effective manner.

Medically Necessary— A service, item, procedure, or level of care compensable under the MA program that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, or disability;
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability;
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, considering both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Member — An individual enrolled in GHP Family who is eligible to receive physical and/or behavioral health services under the Medical Assistance (MA) Program of the Commonwealth of Pennsylvania.

Network — All contracted or employed Health Care Providers in the GHP Family who are providing covered services to Members.

OMAP Hotlines — Department phone lines designed to address and facilitate resolution of issues encountered by Recipients and their advocates or Providers according to PH-MCO policies and procedures.

Other Resources — With regard to TPL, Other Resources include, but are not limited to, recoveries from personal injury Claims, liability insurance, first-party automobile medical insurance, and accident indemnity insurance.

Participating Provider — A licensed hospital or health care facility, medical equipment supplier or person who is enrolled in the Pennsylvania MA Program and licensed, certified or otherwise regulated to provide health care services under the laws of the Commonwealth or state(s) in which the entity or person provides services, including a physician, podiatrist, optometrist, physical therapist, certified registered nurse practitioner, registered nurse, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, physician's assistant, chiropractor, dentist, dental hygienist or pharmacist that has a written Provider Agreement with and is credentialed by GHP Family to provide physical health services to GHP Family Members.

Primary Care Practitioner (PCP) — A specific physician, physician group or a CRNP operating under the scope of his/her licensure, and who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating and monitoring other medical care and rehabilitative services and maintaining continuity of care on behalf of a Member.

Primary Care Practitioner (PCP) Site — The location or office of PCP(s) where Member care is delivered.

Prior Authorization — A determination made by the GHP Family to approve or deny payment for a Provider's request to provide a service or course of treatment of a specific duration and scope to a Member prior to the Provider's initiation or continuation of the requested service.

PROMISe™ Provider ID — A 13-digit number consisting of a combination of the 9-digit base NPI Provider Number and a 4-digit service location.

Provider Reimbursement (and) Operations Management Information System electronic (PROMISe™) — A Claims processing and management system implemented by DHS that supports the Fee-for-Service and Managed Care Medical Assistance delivery programs.

Quality Management (QM) — An ongoing, objective and systematic process of monitoring, evaluating and improving the quality, appropriateness and effectiveness of care.

Retrospective Review — A review conducted by the GHP Family to determine whether services were delivered as prescribed and consistent with GHP Family's payment policies and procedures.

School-Based Health Services — An array of Medically Necessary health services performed by licensed professionals that may include, but are not limited to, immunization, well childcare and screening examinations in a school-based setting.

Third Party Liability (TPL) — The financial responsibility for all or part of a Member's health care expenses of an individual entity or program (e.g., Medicare) other than GHP Family.