GHP Family Participating Provider Orientation

Geisinger

Disclaimer

- This presentation is not intended to be all inclusive.
- All information is fully delineated in the GHP Family provider manual, which may be amended from time to time by written correspondence and can be found online at www.ghpfamily.com.

About GHP Family

GHP Family is an insurance plan that provides healthcare coverage to residents of Pennsylvania who are eligible for Medicaid.

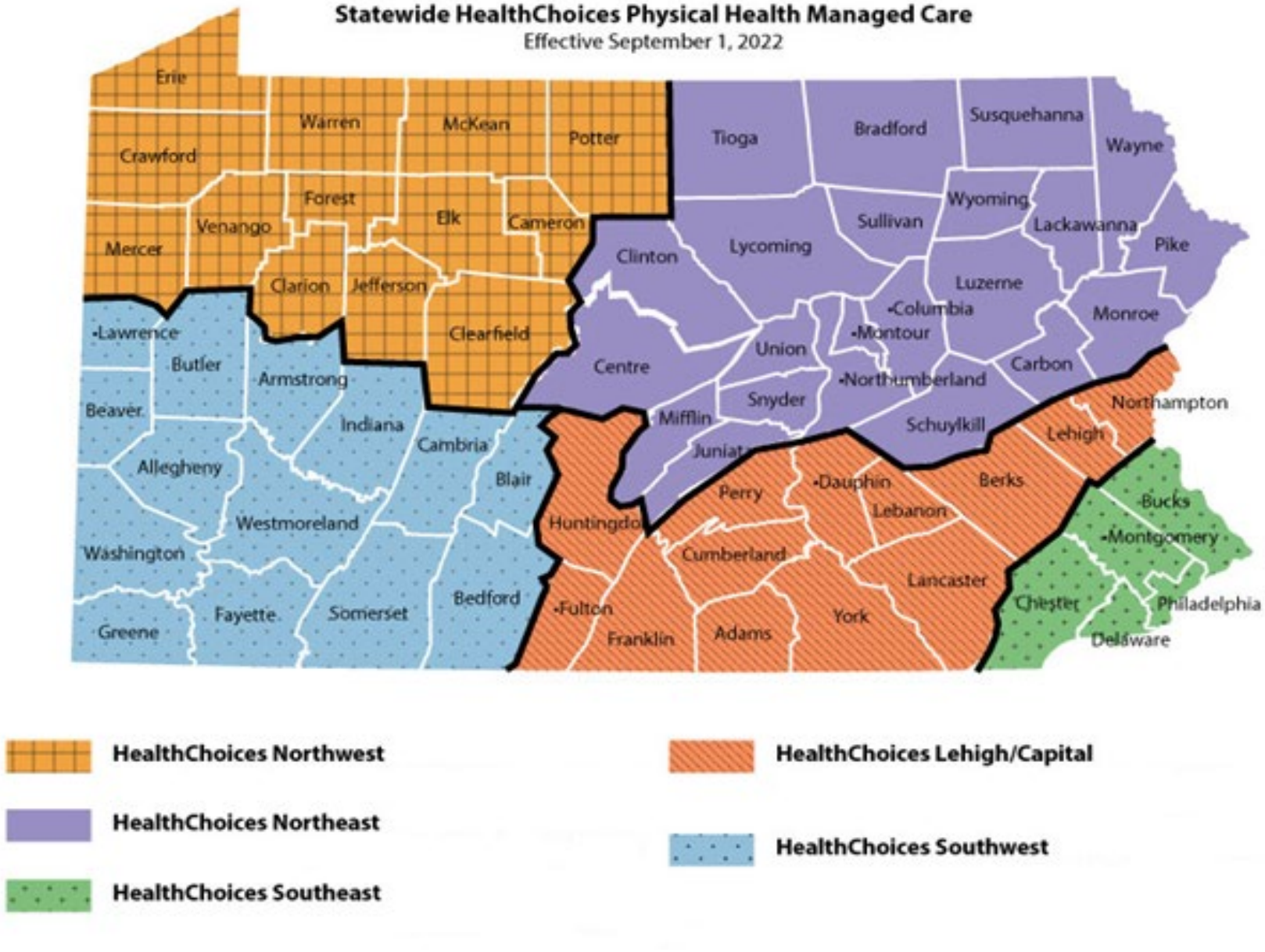
Geisinger Health Plan currently serves more than 200,000 Medicaid members.

Geisinger Health Plan Medicaid coverage will be available to Medicaid-eligible recipients statewide beginning Sept. 1, 2022, as part of an expansion of HealthChoices, Pennsylvania's Medical Assistance managed care program.

All Medical Assistance recipients are required to choose among the managed care health plans available in their region. Those who do not choose a managed care health plan will be assigned one.

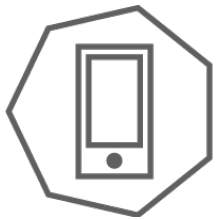
GHP Family serves all of PA

- Geisinger Health Plan offers quality, comprehensive coverage for all eligible Medical Assistance recipients, statewide.
- Each year, nearly 250,000 members throughout Pennsylvania choose GHP Family for our high-quality Medicaid plan.



Communications

Where to find news and resources



Online

- Provider portal on NaviNet
- For Providers section of GHP Web
- For Providers section of GHP Family

Guides, bulletins, forms

- Participating provider guide
- GHP Family provider manual
- Operations bulletins
- Forms

Newsletter

- Look for our monthly provider update on NaviNet
- Provider Updates Geisinger Health Plan

Who to call

- View our list of helpful telephone contacts

Enrollment

- Eligibility is determined by the Pennsylvania Department of Human Services (DHS)
- MA consumers must contact PA Enrollment Service to choose a new PH plan or change from one PH plan to another. Please direct consumers to contact PA Enrollment Services by:
    - Going to PA Enrollment Services (enrollnow.net)Opens In A New Window or
    - Using the mobile app called PA Enrollment Services (available through the Apple store or Google Play) or
    - Calling 1-800-440-3989 (TTY: 1-800-618-4225) and select Option 6 to speak with a representative. Hours of operation are Monday through Friday, 8 a.m. to 6 p.m.

Cultural competency

Cultural competency presentation

DHS defines Cultural Competency as: The ability of individuals 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 healthcare delivery to diverse populations. Title III of the Americans with Disabilities Act (ADA) states that public accommodations, including healthcare provider sites, must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability.

Fraud and Abuse

Prevent and Recognize FWA

Fraud – An intentional deception or misrepresentation made by an individual/entity that knows or should know the deception or misrepresentation could result in some unauthorized benefit to himself/herself or some other person(s) entities.

Waste – The over-utilization of services that often results in the misuse of recourses or unnecessary costs.

Abuse – Abuse refers to practices that are not consistent with accepted and sound medical, fiscal or business practice.

Oversight, Laws and Regulations

Federal and State (OIG, HHS, DOJ, CMS, AGO, DHS, MFCS).
Exclusion Statute, False Claims Act, Anti-kickback Statute, Whistleblower Protection Act.

Reporting FWA

Geisinger Health Plan is committed to a policy of zero tolerance for fraudulent insurance costs.
Providers can report suspected FWA directly to the DHS Provider Compliance Hotline at (866) DHS-TIPS.
GHP and DHS maintain strict confidentiality concerning providers who report FWA.

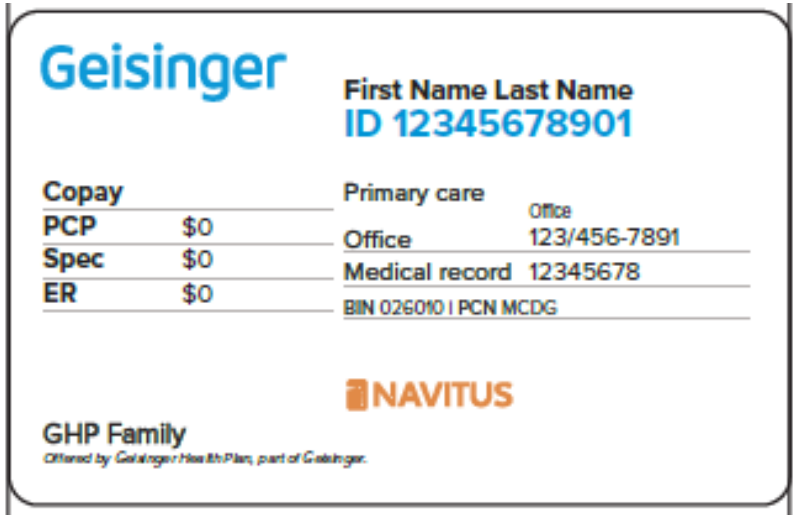
Member Appeals and Provider Disputes

Detailed information on Member Complaints, Grievances, and DHS Fair Hearing Process can be found in the GHP Family Provider Manual and the GHP Family Member Handbook.

The Provider Manual is available on the Provider Service Center at www.ghpfamily.com

Member identification

- Each member is issued an identification card similar to this example.



- Providers should always verify benefits and coverage prior to rendering services.

Member Eligibility

Eligibility can be verified the following ways:

- NaviNet at www.navinet.navimedix.com
- GHP Family Customer Service at (855) 227-1302
- PROMISe Online at http://promise.dpw.state.pa.us
- PA Medical Assistance Eligibility Verification System (EVS) Telephone Line (800) 766-5387 using Member's ID card and PA Access Card information.
- GHP Family members are entitled to certain covered services under the Medical Assistance Program of the Commonwealth of Pennsylvania.
- GHP Family also offers additional benefits outside the Medical Assistance Program.

Provider Office Standards:

Primary Care Physician Scheduling Procedures:

Emergent Care	Immediately or referred to the ER
Urgent Care	Within 24 hours
Routine Care	Within 10 business days of the member's call

Specialty Care Provider Scheduling Procedures:

Emergent Care	Immediately or referred to the ER
Urgent Care	Within 24 hours
Routine Care	Within 15 business days of the member's call

- Member wait times for PCPs should not be more than thirty (30) minutes for a routine care appointment.
- Providers are required to conduct affirmative outreach whenever a member misses an appointment.

Mental health and substance abuse

- PCPs and all non-behavioral health practitioners are encouraged to recommend behavioral health services to GHP Family 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.
- Refer to the GHP Family Provider Manual for more information.

How to request prior auth and precert

- Ordering/admitting provider is responsible for obtaining authorization
- Verify member's eligibility and benefits
- Prior auth is required when GHP is secondary
- Complete necessary form(s) with all the required fields and submit as directed
- Forms are available on NaviNet or the *For Providers* section of the GHP web

Prior authorization and precertification

- The admitting or ordering physician/facility is responsible for obtaining prior authorization or precertification.
- All requests for prior authorization/precertification by Geisinger Health Plan medical management should be submitted by the admitting or ordering participating provider. Make requests by phone, fax or mail:

  Geisinger Health Plan
  Medical Management Department 30-20
  100 North Academy Avenue
  Danville, PA 17822
  Phone: 800-544-3907
  Fax: 570-271-5534

- Please refer to the Prior Authorization/Precertification list available on NaviNet for a complete list of services requiring prior authorization or precertification.

Cohere Health – Online authorization portal

You'll benefit from a streamlined and collaborative online authorization experience that offers evidence-based care suggestions, faster approval and instant authorization in some cases! *Geisinger Health Plan Medical Management will continue to review requests and retain ultimate authority over medical necessity determinations.*

Authorize the following services through Cohere:

- Home health and hospice
- Outpatient therapy services
- Chiropractic services
- Outpatient services (see prior auth list), including DME
- Musculoskeletal services
- Interventional pain management
- Cardiology services

Coming Soon! *Inpatient Services-check for updates on Navinet.*

Check our prior authorization PriorAuthList.pdf (geisinger.org) list frequently so you always know which services require authorization submission through Cohere. Register for Cohere today!

Look for upcoming GHP/Cohere virtual townhall through MS Teams. Those will be posted on Navinet.

HealthHelp prior authorization

GHP requires prior authorizations through HealthHelp for the following services: high-end radiology.

The process improves quality, reduces cost of care and ensures members receive clinically appropriate and medically necessary services.

All requests for applicable tests and procedures will go through HealthHelp, except services rendered in an emergency or inpatient setting.

A Complete list of associated procedure codes requiring authorization can be found at www.healthhelp.com/Geisinger.

Visit the For Providers section of Geisinger Health Plan's website for more information or to register for online learning opportunities hosted by HealthHelp.

Ordering DME through Tomorrow Health

We work with Tomorrow Health to streamline ordering and access to home medical equipment supplies (DMEPOS) for GHP members. Tomorrow Health coordinates amongst the DMEPOS suppliers in GHP's existing network to ensure patient orders are handled with accuracy, speed and exceptional service. Tomorrow Health's platform is free to use, and any DMEPOS supplier is welcome to join.

Resources for ordering providers

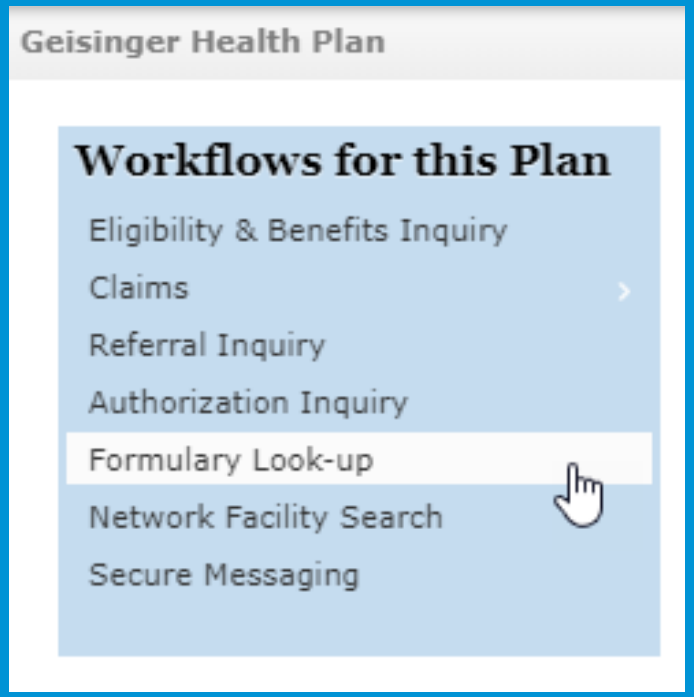
- Watch a short demo video of the ordering process.
- Contact providers@tomorrowhealth.com or call us at **844-402-4344** to speak with a member of our provider account management team or receive training for your team.

Resources for DME suppliers

- Apply to receive new orders for GHP members. All DME suppliers must have an account with Tomorrow Health.
- Reach out to DMEpartners@tomorrowhealth.com with any questions.

Formulary lookup

The formulary lookup tool on NaviNet allows you to see how a particular member's benefits apply to certain drugs, as well as other pharmacy-related information.



Pharmacy

Requesting prior authorization and/or a formulary exception is the responsibility of the prescribing provider.

How to request prior auth or exception:

- Submit a formulary exception/prior authorization request through PromptPA online portal: ghp.promptpa.com
- Complete and fax the Formulary Exception/Prior Authorization Form available on NaviNet
- Call the pharmacy department: **800-988-4861**
- GHP-Family-Medical-Drug-PA-List.pdf (geisinger.org)

Pharmacy

- Outpatient Prescription Drug Coverage includes the use of the statewide preferred drug list (PDL), GHP Family formulary and network pharmacies.
- Multi-tiered prescription benefit levels generate member cost sharing based upon the type of medication prescribed.
- Tier Explanation:
    - Brand – mostly single source, includes specialty drugs
    - Generic
    - OTC – certain OTCs covered at retail pharmacy when prescription is provided by physician

Pharmacy prior authorization process

GHP Family follows the statewide Preferred Drug List (PDL). The statewide PDL is a list of preferred drugs developed by the Department of Human Services' (DHS) Pharmacy and Therapeutics Committee. Medications not on the PDL follow the GHP Family formulary. View the Statewide Preferred Drug List (PDL).

GHP Family's pharmacy department maintains a process by which providers can:

- Request prior authorization for medications designated in the statewide PDL or GHP Family formulary as requiring such. Drugs that require a prior authorization are designated in the GHP formulary with a "PA" indicator.
- Request a formulary exception for specific drugs, drugs used for an off-label purpose, and biologicals and medication(s) not included in the statewide PDL or GHP Family formulary.

GHP Family specialty drug program

Specialty Drug Process

- A list of specialty medications is available on the website.
- Prescribing physicians must fax a completed Specialty Prescription Referral Form and, when applicable, a PA form (forms can be found on the pharmacy forms web page).
- Upon request for PA and/or the receipt of a completed Specialty Prescription Referral Form, GHP will:
  - Verify member eligibility and perform authorization review, if required.
  - Notify the prescribing physicians of the approval or denial within applicable regulatory time frames.
- GHP reimburses the pharmacy vendor directly for the medication it distributes.
  - Participating providers will not be reimbursed for medications obtained through the pharmacy vendor.
- Medication requests will be shipped according to the prescribing physician's instructions.

Coordination of Benefits

- GHP Family acts 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 these services, 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.
- It's 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.
- Providers cannot balance bill members.

“Right from the Start” maternal health program

- GHP Family’s “Right from the Start” maternal health program is the name of our “Healthy Beginnings Plus” program.
- This program is designed to serve the GHP Family member throughout her pregnancy, from early identification, through the prenatal experience and post-partum follow-up.
- Communication with the obstetrical provider is emphasized from the first identification of pregnant status.
- The OBNA form should be completed with pregnancy determination.
- OBNA form is part of the GHP Family Pay-for-Quality Program.
- Refer to the GHP Family Provider Manual for more detailed information on this process.
- Obstetrical needs assessment form: https://obcare.optum.com

EPSDT billing guide/training

GHP Family EPSDT guidelines

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) 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 primary care providers (PCPs) who provide services to Members under the age of twenty-one (21) are required to provide comprehensive health care, screenings, and preventive services. GHP Family requires Participating PCPs to provide all EPSDT services in compliance with federal and state regulations and periodicity schedules.

Special Needs Unit

- The Special Needs Unit (SNU) is a dedicated resource for the unique needs of GHP Family members classified as having a special need.
- The Special Needs Unit (SNU) can be used as a resource for Providers, Members, and Caregivers to assist with the management of Members with Special Needs.
- The SNU will work collaboratively to provide Case Management services through its Proven Health Navigator Case and Health Management program.
- GHP Family Special Needs Unit: **855-214-8100**

Electronic claims resources

Visit our *Claims and e-transactions* page for more information.

EDI

Electronic Data Interchange (claim submission)

- Use GHP Payer ID **75273** when submitting claims via AllScripts, Change Healthcare or Relay Health.

EFT

Electronic Funds Transfer (claim payment)

- Register with InstaMed.
- Claim payments will be directly deposited into your bank account.

EOP

Electronic Explanation of Payment (claim remittance)

- Received online through InstaMed.

Paper claims submission

Format:

- CMS1500 or UB04
- Electronic or paper claim submission is accepted.

CMS1500 paper claim tips:

- Individual NPI number and taxonomy required in box 24J
  - *For FQHC/RHC use group NPI and taxonomy in box 24J*
- Servicing facility location NPI number required in box 32A
- Organizational NPI number required in box 33A
- DHS Promise enrollment is required and must match what is billed

Paper claims address:

P.O. Box 160

Glen Burnie, MD 21060

Timely filing requirements

Initial submission must be received within:

180 days from the date of service for outpatient claims

180 days from the date of discharge for inpatient claims

Previously paid or denied claims may be resubmitted and must be received within:

365 days from the date of service

Claim Research Request Form (CRRF)

When to use a CRRF

- *No prior auth denial* (failure to precert services) – Only when there is a compelling reason why the provider failed to precert, and the dispute is within timely filing guidelines.
- Claim edit denials – Be sure to check the claim edit box on the CRRF form and attach supporting documentation.
- Timely filing denials – Only when there is a compelling reason for why the provider failed to submit timely.

When NOT to use a CRRF

- Claim retractions – Providers should initiate through customer service or secured message via web.
- Information on a **denied claim** needs to be corrected – Providers should resubmit the corrected claim through their normal claims submission process.
- Not on fee schedule denials – Questions related to provider contracts or fee schedules should be directed to your provider account manager.
- Timely filing denials – If no compelling reason exists (COB claims are not subject to timely filing).

Replacement claim billing

A replacement claim is billed when a specific claim needs to be entirely replaced with new claim information. The original claim is considered null and void and is completely replaced by the information on the replacement claim submission and must be submitted 60 days from the date of the first EOP of the original claim.

When to submit a replacement claim

- Changing previously submitted diagnosis codes.
- Changing member data, except for the member ID.
- Changing the billed amount on the original claim.
- Changing previously submitted procedure codes.
- Adding services in addition to data corrections to the original claim.
- When you are within timely filing.

When NOT to submit a replacement claim

- The claim is **beyond** timely filing – submit a CRRF.

For the following reasons below - recommend using XX8 to void original claim and submit new claim (use in box 22 on CMS 1500 form on or as bill type on UB).

- The billing NPI number is changing.
- You are making a correction to the subscriber ID.

Reportable conditions

Providers are required to ensure that reportable conditions are appropriately reported in accordance with PA Code, Title 28, Chapter 27. A list of reportable diseases can be obtained by visiting the Pennsylvania Department of Health website at:

Reportable Diseases (pa.gov)

For healthcare practitioners and healthcare facilities, all diseases are reportable within 5 work-days, unless otherwise noted.

Have a claims issue?

GHP's Provider Care Team answers the call

Call 1-844-447-7768 (1-844-GHP-PROV) to connect with a dedicated claims resolution representative. Here is how you benefit:

- Shorter hold times when calling.
- Faster claims issue resolution; expected turn-around times provided when necessary.
- Claims issues are logged and tracked through resolution; no more repeat calls.
- Complete resolution follow up; GHP will close the loop to ensure your needs are met.
- One number to contact; no need to call your GHP account manager with claims questions.
- Tracking numbers are provided for your secure message requests through NaviNet.

GHP Family Pay-for-Quality program

- Pay-for-Quality Program encourages and promotes the focus of exceeding standard quality of care for GHP Family members.
- The Pay-for-Quality program is available to Primary Care specialties (Family Practice, Internal Medicine/Pediatrics, Internal Medicine, and Pediatrics) and the specialty of Obstetrics and Gynecology.
- Physicians are rewarded for performing well on specific HEDIS measures.
- Details can be found in the P4Q manual available on NaviNet

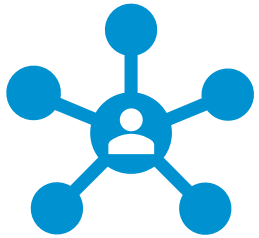
Demographic updates

Types of updates

- **Add** – will allow you to add a provider or location
- **Change** – will permit you to indicate changes to an existing provider's profile, office location, TIN, etc.
- **Both** – will let you make both additions and changes on one form
- **Term** – will allow you to initiate a provider termination or remove a practice location
- **Upload documents** – this feature permits you to attach existing documentation of your changes and supply comments

Visit the *For Providers* section of our website or look for the *Practice Information Change Form* under *Resources* on the right navigation bar on NaviNet. Fill out a few required fields to verify your identity, then select the type of update you want to make.

Provider Account Manager



Your Provider Account Manager is available to Assist you with any of the following issues:

- Virtual or On-site education offered to your staff
- GHP Family Pay-for-Quality information
- Navinet training
- Policy questions

Your Provider Account Manager can be reached by calling (800) 876-5357.

Thank you

Geisinger