

Section 3: Precertification Requirements

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Precertification Requirements

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

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

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

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

Precertification Determination and Communication Process

Health Plan Medical Management staff, which includes Medical Directors and the Medical Management Department, utilize nationally recognized medical guidelines such as InterQual,[®] as well as internally developed medical benefit policies, individual assessment of the Member, and other resources to guide precertification, Concurrent Review, and retrospective review processes in accordance with the Member's eligibility and benefits.

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

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

Participating Providers are verbally notified of any medical review denial(s) and are offered the opportunity to discuss adverse decision(s) directly with a Medical Director who made the initial determination; or a Medical Director available at a time convenient for the Participating Provider. The Participating Provider's request to discuss the determination with a Medical Director is required to occur within one (1) Business Day of the Health Plan's verbal denial notification in order to meet stringent regulatory timelines for the generation of denial notices.

The Participating Provider has the opportunity to supply additional supportive information for discussion with a Medical Director. In most cases, the Medical Director will render a decision

during the telephone discussion. The Participating Provider will then be notified of the determination in writing within timeframes specified by product type, and if denied, information regarding the right to appeal the determination shall be included.

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

Medical Management's IVR system is available 24 hours a day, 7 days a week at (800) 544-3907 or (570) 271-6497. You will be prompted to say "precertification" for calls pertaining to acute inpatient precertification. Or say "another reason" if you are calling for something other than acute inpatient precertification. The IVR system also allows you to make multiple precertification requests during the same call.

Verification of Eligibility and Benefit Limit

Prior to coordinating Health Care Services, a Member's eligibility and benefits should always be verified through the online Provider Service Center at www.thehealthplan.com/providers_us/servicecenter.cfm or by calling the applicable Customer Service Team. Providers, acting upon a Referral from the Member's PCP, should contact the Health Plan Customer Service Team corresponding to the Member's product type to verify eligibility and benefits:

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

GEISINGER HEALTH PLAN/COMMERCIAL: (800)-447-4000 (570)-271-8760
Business Hours: Monday – Friday 8:00 a.m. – 6:00 p.m.

GEISINGER HEALTH OPTIONS/PPO: (800)-504-0443 (570)-271-8770
Business Hours: Monday – Friday 8:00 a.m. – 5:00 p.m.

GEISINGER GOLD: (800)-498-9731 (570)-271-8771
Business Hours: Sunday – Saturday 8:00 a.m. – 8:00 p.m.

CHIP, by GEISINGER HEALTH PLAN: (866) 621-5235 (570) 214-9138
Business Hours: Monday – Friday 8:00 a.m. – 6:00 p.m.

PHARMACY: (800)-988-4861 (570)-271-5673
Business Hours: Monday – Friday 8:00 a.m. – 5:00 p.m.
Monday – Friday 8:00 a.m. – 8:00 p.m. for Medicare Part D

MEDICAL MANAGEMENT: (800)-544-3907 (570)-271-6497

Business Hours: Monday – Friday 8:00 a.m. – 4:30 p.m.

TDD for the hearing impaired: (800) 447-2833

Monday – Friday, 8:00 a.m. – 4:30 p.m.

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

1) Inpatient Hospitalization

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

Please note:

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

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

Requesting Precertification

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

Medical Management Department

Precertification line is available 24 hours/day, 7 days/week

(800) 544-3907 (option 1) or (570) 271-6497 (option 1)

Fax: (570) 271-5534

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 the Health Plan is secondary to another payer who requires precertification and authorization has been obtained from the primary carrier. However, notification for Concurrent Review is required.

- A full term pregnancy with intent to deliver, either vaginal or cesarean section
Please note: Any other planned inpatient Hospital admission during the course of pregnancy requires precertification.
- A transfer from one Participating Hospital Provider to another Participating Hospital Provider where the first inpatient admission was precertified and/or followed by Health Plan Concurrent Review for the same level of care.
- Retrieval of a Member from a non-participating facility to a Hospital Provider through the Health Plan’s out-of-Network retrieval process. Transfer may only occur at such time when the Member’s condition has stabilized and the Member can be transported safely to a Hospital Provider without suffering detrimental consequences or aggravating the Member’s condition.
- Observation Services furnished by a Hospital Provider in an outpatient setting that include the use of a bed and periodic monitoring by a Hospital Provider’s nursing or other staff and does not exceed a maximum of twenty-three (23) hours in duration.

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

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

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

Information Required when Requesting Precertification

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

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

Reason for Admission: All pertinent diagnosis and applicable diagnosis code (referred to as “ICD-9-CM Code”)

Procedure Scheduled, if applicable: procedure to be performed, procedure codes, and date scheduled (if available)

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

Administrative Penalty for Failure to Precertify Planned Inpatient Hospital Admissions

In the event an inpatient admission to a Hospital Provider is not precertified and subsequently determined to be clinically appropriate the following administrative penalty shall apply to the admitting Participating Provider and Hospital Provider's reimbursement of Health Care Services.

Health Plan reimbursement will be reduced by fifty percent (50%) for all Health Care Services related to the planned inpatient Hospital admission. This action applies to the Hospital Provider and admitting Participating Provider.

In the event a Member remains in observation which exceeds twenty-three (23) hours, such services beyond twenty-three (23) hours require precertification as described previously. Failure to obtain precertification will result in a denial of all charges, which exceed twenty-three (23) hours.

Authorization Notification Process

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

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

Concurrent Review

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

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

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

Administrative Penalty for Failure of Notification for Concurrent Review

In the event the Hospital Provider has failed to contact the Health Plan to initiate Concurrent Review, an administrative penalty will be applied to the Hospital Provider.

When notification to initiate Concurrent Review occurs while the Member is still hospitalized, but is greater than one (1) Business Day from the date of the admission, Hospital Provider's reimbursement will be reduced by fifty percent (50%) for all Health Care Services related to the inpatient Hospital admission up to the date the Health Plan is notified by the Hospital Provider to initiate Concurrent Review. Reimbursement for Health Care Services via a case rate/MS-DRG (i.e., cardiac or transplant) will be reduced by fifty percent (50%) of the case rate/MS-DRG for the entire admission

Observation Status: In the event a Member is subsequently admitted from observation status, the Health Plan requires notification within one (1) Business Day. Failure to notify the Health Plan will result in the application of the administrative penalty until the date the Health Plan is notified.

2) Inpatient Rehabilitation Admissions

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

Please note:

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

Requesting Precertification

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

Submit the "Inpatient Rehabilitation Precert Worksheet" (see Section 10 entitled "Health Plan Forms") via fax to (570) 271-5534.

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

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

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

Administrative Penalty for Failure to Precertify Planned Inpatient Rehabilitation Admissions

In the event an inpatient rehabilitation admission to a Hospital Provider is not precertified and subsequently determined to be clinically appropriate the following administrative penalty shall apply to the admitting Participating Provider and Hospital Provider's reimbursement of Health Care Services.

Health Plan reimbursement will be reduced by fifty percent (50%) for all Health Care Services related to the inpatient rehabilitation Hospital admission. This action applies to the Hospital Provider and admitting Participating Provider.

Authorization Notification Process

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

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

Concurrent Review

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

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

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

Administrative Penalty for Failure of Notification for Concurrent Review

In the event the Participating Provider failed to contact the Health Plan to initiate Concurrent Review, an administrative penalty will be applied to the Participating Provider.

When notification to initiate Concurrent Review occurs while the Member is still hospitalized, but is greater than one (1) Business Day from the date of the admission, Participating Provider's reimbursement will be reduced by fifty percent (50%) for all Health Care Services related to the inpatient rehabilitation admission up to the date the Health Plan is notified by the Participating Provider to initiate Concurrent Review. Reimbursement for Health Care Services via a case rate/DRG (i.e., cardiac or transplant) will be reduced by fifty percent (50%) of the case rate/DRG for the entire admission.

3) Skilled Level of Care Admissions

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

Please note:

- A three (3) day Hospital stay is not required by the Health Plan prior to a skilled admission.
- Gold Members approved for a skilled admission must be placed in a Medicare certified skilled bed.
- Specialty consultative, surgical, and evaluation/management services provided in the skilled or Intermediate level of Care setting do not require an Outpatient Referral Form to be issued by a Member's PCP.
- Precertification is also required when the Health Plan is not the Member's primary insurance coverage.
- Copayments, Coinsurance and/or Deductibles are the financial responsibility of the Member, when applicable.

Requesting Precertification

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

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

Medical Management Department
Precertification line is available 24 hours/day, 7 days/week
(800) 544-3907 (option 1) or (570) 271-6497 (option 1)
Fax: (570) 271-5534

SNF or Hospital Providers are required to notify the Health Plan within one (1) Business Day of a skilled level of care admission that occurred during non-business hours (Monday through Friday 5:00 p.m. to 8:00 a.m., or on a weekend or Holiday (New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day and Christmas Day)).

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

Information Required when Requesting Precertification

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

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

Authorization Notification Process

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

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

Concurrent Review of a Skilled Admission

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

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

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

- Overall goals and anticipated length of stay (if known).

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

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

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

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

Notification Process for Member Discharge from Covered Services

When it has been determined that a Member's needs no longer meet skilled criteria and skilled nursing care will be terminated, the Participating Provider (referred to hereafter in this section as the "Provider of Care") is required to inform Health Plan of termination of skilled services no later than two (2) days prior to the Member's Covered Services terminating. Medical Management staff will issue the denial notice with signature page to the SNF for delivery to the Member or authorized representative. The Provider of Care is required to obtain the Member's or an authorized representative's signature and date of signature acknowledging receipt of the denial notice. The signature page must be faxed, by the Provider of Care, to the Health Plan within one (1) Business Day of issuing and obtaining the Member's or authorized representative's signature. If the Provider of Care is unable to obtain the Member's signature, an authorized representative may be contacted by telephone. In this case, the authorized representative must be informed of the contents of the notice, the call must be documented, the notice must be signed by the Provider of Care staff and return by fax to the Health Plan.

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

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

If the Gold Member or authorized representative decides to appeal the end of coverage, they must contact the Quality Improvement Organization (QIO) no later than noon on the day before services are to end (as indicated on the NOMNC) to request a review. The QIO for the Commonwealth of Pennsylvania and its telephone number are included on every NOMNC. The QIO will inform the Health Plan and the Provider of Care that the request for review has been received and the Health Plan is responsible for providing the QIO and the Gold Member with a detailed explanation of why coverage is ending. The Health Plan may need to present additional information needed for the QIO to make their decision. The Provider of Care must comply with the Health Plan's request for assistance and provide necessary information within applicable

timeframes. Based on the expedited timeframes, the QIO decision should be rendered and communicated by close of business of the day coverage is to end.

If a non-Gold Member decides to appeal the end of coverage, they must contact the Health Plan Customer Service Team number listed on the back of the insurance card.

Financial Liability for Non-Compliance with Member Discharge Process

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

Administrative Penalty for Failure to Precertify or Perform Concurrent Review of a Skilled Admission

In the event a Provider of Care does not precertify or initiate Concurrent Review and the admission is subsequently determined to be clinically appropriate, the following administrative penalty shall apply to the SNF or Hospital Provider accepting the admission.

Health Plan reimbursement will be reduced by fifty percent (50%) for all Health Care Services related to the skilled admission up to the date that the Health Plan is notified by SNF or Hospital Provider to initiate Concurrent Review. This action applies to SNF or Hospital Provider who accepts the admission.

PCP Management

Members admitted to a SNF or Hospital Provider under a skilled or Intermediate level of Care do not require an Outpatient Referral Form for services rendered in the facility setting, however, for services required outside the skilled or Intermediate Care setting an Outpatient Referral Form issued by a Member's PCP is required.

SNF Services Requiring Coordination

- **Monthly Confirmation of Member Status:** SNF or Hospital Providers accepting skilled and/or non-skilled (Intermediate Care) admissions are required to submit, by facsimile, a completed "Monthly Report of Member Status" form (see Section 10 entitled "Health Plan Forms") to the Medical Management Department at (570) 271-5534. The "Monthly Report of Member Status" form is required no later than the FIRST day of the month. The summary information submitted on the "Monthly Report of Member Status" form is mandatory.
- **Hospice Election:** The SNF or Hospital Provider is required to notify the Health Plan's Home Health/Hospice Management Department at (877) 466-3001 immediately upon a Member's decision to invoke their Hospice benefit. Notification should also be made to the Health Plan's Medical Management Department at 1-800-544-3907.
- **Personal Care Facility:** Medicare standards do not consider a Personal Care Facility (PCF) an institutionalized facility, regardless of a PCF's affiliation with a SNF or Hospital Provider. A PCF is considered an alternative to home living. Excluding Emergency Services and Direct Access Services, Members residing in a PCF require an Outpatient

Referral Form issued by the Member's PCP for Specialty consultative, evaluation and management and surgical services. Detailed information can be found in Section 2 of this Guide titled "Referrals."

- **Infusion Therapy Services:** Participating Providers are encouraged to refer to their Agreement for specific information regarding the reimbursement inclusions/exclusions for infusion therapy services. Questions regarding infusion therapy services should be reviewed during the Concurrent Review process with the Medical Management Department.
- **Mental Health and Substance Abuse Services:** Participating Providers may assist Members in obtaining authorization and coordinating mental health and substance abuse services. Refer to the reverse side of the Member's Identification Card for the applicable mental health and substance abuse vendor's name and telephone number or contact the applicable Customer Service Team for further assistance.
- **Laboratory/Pathology Services:** All laboratory/pathology specimens for Gatekeeper Product Members admitted to a SNF/Hospital under any level of care or PCF, must be forwarded to a Participating Provider for analysis.
- **Home Phlebotomy Services:** Home phlebotomy services for Members residing in a PCF who meet homebound criteria must be coordinated through the Home Health/Hospice Management Department. Please refer to the portion of this section titled "Home Health and Home Phlebotomy Services" for specific information.
- **Outpatient Pharmacy Coverage:** Information in this section only applies to Health Plan Members who do not have a point-of-service benefit, Gold, and certain Geisinger Health Options Members. When a Member's skilled level of care benefit has been exhausted or the level of care has changed to Intermediate Care status, the Member may have outpatient prescription coverage available through their Health Plan Benefit Document. In this circumstance, a Participating Physician must issue all prescriptions for medications. The prescriptions must be dispensed by a pharmacy Participating Provider for coverage under the terms of the Member's Benefit Document. Contact the Health Plan Customer Service Department at the number on the back of the insurance card for questions on benefits and coverage.
- **Radiology Services:** All radiology and mobile radiology services, excluding routine chest x-rays, for Gatekeeper Product Members admitted to a SNF or PCF must be coordinated with a radiology Participating Provider. A complete listing of Radiology Participating Providers can be located at www.thehealthplan.com.
- **Outpatient Rehabilitative Therapy Services:** Participating Providers are encouraged to refer to their Agreement for specific information regarding the inclusion/exclusion of outpatient physical, occupational or speech therapy services for Members originally admitted under a skilled level of care, but no longer meeting skilled criteria or who have exhausted their skilled level of care benefit.

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

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

SNF or Hospital Providers who do not have an Agreement to provide outpatient physical, occupational and speech therapy services must ensure such services are arranged with an outpatient rehabilitative therapy Participating Provider. A listing of outpatient rehabilitative therapy Participating Providers can be located in the then current Provider List or at www.thehealthplan.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. This notification is required due to the Health Plan's reporting requirement for institutionalized Members as regulated by the Center for Medicare and Medicaid Services (CMS) (see Section 10 entitled "Health Plan Forms" for the applicable reporting form).

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

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

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

Please note:

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

Home Health/Hospice Services Referral Process

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

The mechanism utilized by the Home Health/Hospice Provider when initiating a Referral to the Medical Management department's Home Health/Hospice Management Department is the Home Health/Hospice Management Department Referral Form (see Section 10 entitled "Health Plan Forms"). Home phlebotomy Participating Providers should utilize a mutually agreeable form approved by the Home Health/Hospice Management Department when initiating a Referral.

Hospice Election and Notice

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

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

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

Completing the Home Health/Hospice Management Department Referral Form

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

Home Health/Hospice Management Department
(877) 466-3001 or (570) 271-5506 fax: (570) 271-5507
Monday through Friday 8:30 a.m. to 5:00 p.m.

Home Health/Hospice Management Department Determination

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

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

Concurrent Review Process

Concurrent Review is required on all Home Health Services. The Home Health Provider is required to contact the Home Health/Hospice Management Department Case Manager to provide

clinical information including a Member's treatment plan. Based on Concurrent Review, a determination of continued coverage will be provided by the Home Health/Hospice Management Department.

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

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

Administrative Penalty for Failure to Refer Home Health/ Hospice Services and/or Home Phlebotomy Services

In the event Home Health/Hospice and/or home phlebotomy services are provided without notice/justification for Concurrent Review by the Home Health/Hospice Management Department, the applicable rendering Participating Provider may be held financially liable for failure to follow the proper protocols and the Member may not be balance billed.

Notification Process for Gold Member Discharge from Covered Services

When it has been determined that a Gold Member's needs no longer meet Home Health criteria and Home Health services will be terminated, the Home Health Provider (referred to hereafter in this section as the "Provider of Care") is required to inform the Gold Member, in writing, of such termination no later than two (2) days prior to the Gold Member's Covered Services terminating. This communication shall include the issuance of the then current "Notice of Medicare Non-Coverage (NOMNC)" (see Section 10 entitled "Health Plan Forms") by the Provider of Care to the Gold Member. The Provider of Care is further required to obtain the Gold Member's or an authorized representative's signature and date of signature acknowledging receipt of the NOMNC. The NOMNC must be faxed, by the Provider of Care, to the Home Health/Hospice Management Department within one week of discharge from service, regardless of the reason for discharge. If the Provider of Care is unable to obtain the Gold Member's signature, an authorized representative may be contacted via the telephone. In this case, the authorized representative must be informed of the contents of the notice, the call must be documented and the notice must be mailed to the representative. The authorized representative should be instructed to sign and return the NOMNC to the Provider of Care as soon as possible.

If the Gold Member's services are expected to be fewer than two (2) days in duration, the Provider of Care should notify the Gold Member and issue the NOMNC at the time of admission. If the span of time between services exceeds two (2) days, the Provider of Care should deliver the NOMNC no later than the next to the last time that services are furnished. If the member is discharged to another site of care, the NOMNC form should be remarked as such and submitted to the Home Health Management Department as notification of the event.

If the Gold Member and/or the Gold Member's family, authorized representative, physician and/or provider is dissatisfied (whether known or anticipated) with the impending discharge, notify the Home Health/Hospice Management Department immediately.

If the Gold Member or authorized representative decides to appeal the end of coverage, they must contact the Quality Improvement Organization (QIO) no later than noon on the day before services are to end (as indicated on the NOMNC) to request a review. The QIO for the Commonwealth of Pennsylvania and its telephone number are included on every NOMNC. The QIO will inform the Health Plan and the Provider of Care that the request for review has been received and the Health Plan is responsible for providing the QIO and the Gold Member with a detailed explanation of why coverage is ending. The Health Plan may need to present additional information needed for the QIO to make their decision. The Provider of Care must comply with the Health Plan's request for assistance in providing necessary information. Based on the expedited timeframes, the QIO decision should be rendered and communicated by close of business of the day coverage is to end.

Financial Liability for Non-Compliance with Gold Member Discharge Process

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

Home Health/Hospice Provider Responsibilities

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

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

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

Scope of Services: Home Health Provider

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

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

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

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

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

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

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

Scope of Services: Hospice Provider

Payment for hospice agencies is a daily rate for each day a beneficiary is enrolled in the hospice benefit. The daily payments are made regardless of the amount of services furnished on a given day and are intended to cover costs that the hospice incurs in furnishing services identified in patients' care plans. Payments are made based on the level of care required by the beneficiary:

- Routine home care;
- Continuous home care;
- Inpatient respite care; and
- General inpatient care.

Payment for physicians' administrative and general supervisory activities is included in the hospice payment rates. These activities include participating in the establishment, review and updating of plans of care, supervising care and services and establishing governing policies. Where the service is considered a hospice service (i.e., a service related to the hospice patient's terminal illness that was furnished by someone other than the designated "attending physician" [or a physician substituting for the attending physician]) the physician or other provider must look to the hospice for payment.

Claims for all other services related to the terminal illness furnished by individuals or entities other than the designated attending physician will be denied. Such claims include bills for any DME, supplies or independently practicing speech or physical therapists that are related to the terminal condition. These services are included in the hospice rate and paid through the hospice provider.

Hospice Admission Criteria

- Hospice eligibility is determined after the referring physician verifies that Member's life expectancy is less than six (6) months.
- Member chooses to accept Hospice.

- Hospice Services are provided by a Hospice Provider.
- Acknowledgment that Member understands Hospice Services, as outlined in the Hospice Election Form (see Section 10 entitled “Health Plan Forms”).
- Regular Health Plan benefits are waived for care related to the terminal illness diagnosis
- Member agrees to palliative care treatment.

Hospice Discharge

The Hospice Provider will discharge any Member from the hospice program, who, as determined by the Hospice Medical Director and Hospice Provider, no longer meets the hospice admission criteria.

Hospice Forms Description

Hospice form(s) are required to be submitted to the Home Health/Hospice Management Department by facsimile at (570) 271-5507.

The Home Health/Hospice Management Department requires notice of election, revocation, transfer, or death. Standard CMS or provider forms will be accepted.

Programs Available through the Home Health/Hospice Management Department

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

- **Post Partum Early Discharge Home Care:** The Home Health/Hospice Management Department has established specific guidelines for approval of Home Health Services for mothers and infants discharged from the Hospital less than forty-eight (48) hours after a vaginal delivery or less than ninety-six (96) hours after a cesarean section. Time limits and definition of Covered Services are in accordance with Governmental Agency requirements, as applicable.
Infants requiring follow-up care for elevated bilirubin levels are eligible for Home Health Services provided home phototherapy is being utilized.
Please note: Home phototherapy should be arranged through a DME Participating Provider. Coverage is subject to the Member’s applicable Benefit Document.
- **Congestive Heart Failure (CHF) Home Care:** For the homebound Member confronted with CHF, the Home Health/Hospice Management Department is able to coordinate a standardized teaching and assessment program with Home Health Providers. The Home Health/Hospice Management Department, in collaboration with the Health Plan’s Care Coordination Department, ensures continued telephone and/or PCP follow-up.
- **Influenza Vaccinations:** In order to assist the Health Plan in its measurement of HEDIS® statistics, (such as influenza vaccinations for Members age sixty-five (65) and older) the Home Health/Hospice Management Department has developed a method for monitoring influenza vaccines. A Member who obtains an influenza vaccine at a community site such as a local drug or grocery store will commonly receive the influenza vaccine by a Home Health Provider. The Home Health/Hospice Management Department has developed and distributed the Influenza Vaccination Record (see Section 10 entitled “Health Plan Forms”), which is completed by the Home Health Provider when administering the

influenza vaccine to a Member. The Home Health Provider will forward the “Influenza Vaccination Record” to the Home Health Management Department for each Member who received the influenza vaccine. The Home Health Management Department is also able to coordinate home administration of the influenza vaccine with Home Health/Hospice Providers, providing the Member meets the established criteria for home administration. As always, if the Member is able to return to the PCP, it is considered the preferred place of administration.

- **Orthopedic Joint Recovery:** The Home Health/Hospice Management Department has implemented a program for Members undergoing elective joint replacement surgery (i.e., hip, knee). Upon a scheduled operative date, a Home Health visit may be ordered by a Participating Provider to enroll the Member in the joint-recovery home program. One (1) physical therapy home visit is scheduled within seven (7) to fourteen (14) days preoperatively to educate a Member about pain management and exercises, as well as conduct a home safety evaluation. The visit documentation should be faxed as directed within one business day of the pre-operative visit so that it can be utilized for discharge planning. Following the surgery and upon discharge to home, the rendering agency would resume Home Health Services. The Home Health/Hospice Management Department case manager will coordinate Home Health Services with the same Participating Provider. Additional Home Health Services will be tailored to the Member’s individual needs.
- **Home Management of Deep Vein Thrombosis (DVT):** Through new technology and pharmaceutical alternatives to IV anticoagulation, Members can be instructed in subcutaneous home administration of low molecular weight heparin products. After a first dose administration in a controlled setting, such as the physician office, care can be coordinated for home drug delivery. Education on self-administration will be conducted by a registered nurse from a Home Health Provider.

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

5) Durable Medical Equipment (“DME”)

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

Please note:

- Precertification is also required when the Health Plan is not the Member’s primary insurance coverage.

- Prosthetic and orthotic devices are not considered DME and do not require precertification.
- Copayments, Coinsurance and/or Deductibles are the financial responsibility of the Member, when applicable.

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

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

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

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

Consignment DME

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

Completing the applicable DME Management Department Precertification Form

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

- **Precertification Form 1:** General Request for DME (see Section 10 entitled “Health Plan Forms”): This form is required to be completed and submitted for each initial precertification request for outpatient DME.
- **Precertification Form 2:** Oxygen/Continuous Positive Airway Pressure (CPAP) Device Request (see Section 10 entitled “Health Plan Forms”): Upon DME Participating

Provider's receipt of a written or verbal order issued by a provider for oxygen or CPAP, both the General Request Precertification Form 1, as well as the Oxygen/CPAP Prescription Precertification Form 2 is required to be completed in their entirety. Both precertification forms are required to be submitted by facsimile to the DME Management Department within one (1) Business Day of receipt of the written or verbal order issued by a provider.

CPAP units must be dispensed with two (2) smart cards. Payment will be denied if this requirement is not met. Patient education material provided by the DME Management Department should be included with every oxygen and CPAP delivery.

- **Precertification Form 3:** Respiratory Assist Device: Upon DME Participating Provider's receipt of a written or verbal order issued by a Participating Provider for respiratory assistance device(s) both the General Request Precertification Form 1, as well as the Respiratory Assist Device Precertification Form 3 (see Section 10 entitled "Health Plan Forms"), is required to complete in their entirety. Both precertification forms are required to be submitted by facsimile to the DME Management Department within one (1) Business Day of receipt of the written or verbal order issued by a provider.
- **Precertification Form 4:** Multiple HCPCS Code (see Section 10 entitled "Health Plan Forms"): In the event a DME Participating Provider is initiating a request for precertification which has more than four (4) requested DME services, both the General Request Precertification Form 1, as well as the multiple HCPCS Code Form 4, is required to be completed in its entirety.

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

DME Management Department Determination

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

Please note: Questions regarding an authorization may be directed to the DME Management Department. Providers must contact the DME Management Department via phone if they have

not received a response within one business day, in order to confirm that the precertification form was received. An interactive voice recording (IVR) is in place to accept these calls.

- **Form 6:** Request to Modify Previously Authorized Outpatient DME In the event a DME Participating Provider requests a modification of an existing DME Management Department determination, a completed Change Form is required and should be submitted to the DME Management Department by facsimile (see Section 10 entitled “Health Plan Forms”). A Change Form may be completed for the following purposes which include, but are not limited to:
 - Return of DME to the DME Participating Provider (i.e., physician order discontinued, Member expired, Member elected hospice benefit, Member voluntary discontinuation; DME Participating Provider should not state, “no longer using”).
 - Actual date of service changed from the initial anticipated delivery date.
 - Change to an initial DME request.
 - HCPCS coding change.
 - Member identification correction.

- **Form 7:** Extension of an Existing Authorized Outpatient DME (see Section 10 entitled “Health Plan Forms”): DME Participating Providers are required to request an extension of an existing authorization decision, as applicable, prior to the expiration date indicated on the returned original authorized precertification form. This extension request is initiated by the DME Participating Provider via the DME Recertification Form. The DME Recertification Form should be completed in its entirety and submitted via facsimile no sooner than 2 weeks before the end of an authorization period, but no later than one (1) Business Day prior to the expiration date.

Administrative Penalty for Failure to Precertify Outpatient DME

- **Rental DME items:** In the event rented outpatient DME is not precertified within the timeframes established and is subsequently determined to be clinically appropriate by the Health Plan, Health Plan reimbursement for the rental cycle (s) will be prorated to begin on the date the DME Management Department was notified of outpatient DME services. Members may not be held liable for DME Provider’s failure to precertify. If the rental items are determined to be non-covered by the Plan reimbursement will be denied in total and the Member cannot be held liable.
- **Purchased DME items:** In the event outpatient purchased DME is not precertified by the DME Participating Provider, reimbursement will be denied in total. Members may not be held liable for DME Participating Provider’s failure to precertify.

6) Outpatient Physical, Occupational and Speech Therapy Services

Referrals and Concurrent Review for outpatient rehabilitative Services are the sole responsibility of the rendering Outpatient Therapy Participating Provider.

Please note:

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

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

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

**Outpatient Rehabilitative Therapy Services
Management Department**

Monday through Friday, 8:30 am to 5:00 p.m.
(800) 270-9981 or (570) 271-5301 Fax: (570) 271-5302

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

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

Concurrent Review

All services beyond the initial review by the Health Plan will require Outpatient rehabilitative therapy Participating Providers must complete "Precertification Form B" (see Section 10 entitled "Health Plan Forms") in its entirety and submit via facsimile when additional rehabilitative visits beyond those previously authorized are being requested. Forms without complete visits to date will be considered incomplete. Specific measurements or functional assessments may be requested in order to make a determination of progress toward goals, as well as for determination of ongoing need.

Outpatient Rehabilitative Therapy Services Management Department Determination

Whenever possible, the Outpatient Rehabilitative Therapy Services Management Department will return processed form(s) by facsimile to the outpatient rehabilitative therapy Participating Provider within one (1) Business Day of receipt of the Precertification request. In the event additional clinical information or Medical Director review is required to make the determination, the one (1) Business Day timeframe may be exceeded. If this occurs, the Outpatient Rehabilitative Therapy Services Management Department will provide verbal or written update to the requesting outpatient rehabilitative therapy Participating Provider. Additionally, the Outpatient Rehabilitative Therapy Services Management Department may request supporting clinical information in order to render a determination. Outpatient rehabilitative therapy Participating Provider must submit the requested clinical information to the Outpatient Rehabilitative Therapy Services Management Department within than two (2) Business Days of the request. Failure to do so could result in denial of services provided without authorization. Outpatient Rehabilitative Therapy Services Management Department authorization for pediatric Members with a diagnosis of autism, attention deficit hyperactivity disorder, cerebral palsy, developmental delay, Down's syndrome, pervasive developmental disorder, and/or speech and language delay automatically expire on December 31st of the current calendar year. Outpatient rehabilitative therapy Participating Providers should initiate the request for precertification by completing and submitting Section 1 and 2 of the "Precertification Form A" prior to January 1st of the new calendar year.

Notification Process for Gold Member Discharge from Covered Services

When it has been determined that a Gold Member's needs no longer meet outpatient rehabilitative criteria, and comprehensive outpatient rehabilitative therapy services will be terminated, the comprehensive outpatient rehabilitation facility (CORF) Participating Provider (referred to hereafter in this section as the "Provider of Care") is required to inform the Gold Member, in writing, of such termination no later than two (2) days prior to the Gold Member's Covered Services terminating. This communication shall include the issuance of the then current "Notice of Medicare Non-Coverage (NOMNC)" (see Section 10 entitled "Health Plan Forms") by the Provider of Care to the Gold Member. The Provider of Care is further required to obtain the Gold Member's or an authorized representative's signature and date of signature acknowledging receipt of the NOMNC. The NOMNC must be faxed, by the Provider of Care, to the Health Plan within one (1) Business Day of issuing and obtaining the Member's or authorized representative's signature. If the Provider of Care is unable to obtain the Gold Member's signature, an authorized representative may be contacted via the telephone. In this case, the authorized representative must be informed of the contents of the notice, the call must be documented and the notice must be mailed to the representative. The authorized representative should be instructed to sign and return the NOMNC to the Provider of Care as soon as possible.

If the Gold Member's services are expected to be fewer than two (2) days in duration, the Provider of Care should notify the Gold Member and issue the NOMNC at the time of admission. If the span of time between services exceeds two (2) days, the Provider of Care should deliver the NOMNC no later than the next to the last time that services are furnished.

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

If the Gold Member or authorized representative decides to appeal the end of coverage, they must contact the Quality Improvement Organization (QIO) no later than noon on the day before services are to end (as indicated on the NOMNC) to request a review. The QIO for the Commonwealth of Pennsylvania and its telephone number are included on every NOMNC. The QIO will inform the Health Plan and the Provider of Care that the request for review has been received and the Health Plan is responsible for providing the QIO and the Gold Member with a detailed explanation of why coverage is ending. The Health Plan may need to present additional information needed for the QIO to make their decision. The Provider of Care must comply with the Health Plan's request for assistance in providing necessary information within applicable timeframes. Based on the expedited timeframes, the QIO decision should be rendered and communicated by close of business of the day coverage is to end.

Financial Liability for Non-Compliance with Gold Member Discharge Process

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

Administrative Penalty for Failure to Submit Referral/Concurrent Review for Outpatient Rehabilitative Therapy Services

In the event outpatient rehabilitative therapy services are not referred or submitted for Concurrent Review, the outpatient rehabilitative therapy Participating Provider may be held financially liable for failure to follow the proper protocols. Member may not be held liable for provider.

7) Outpatient Radiology Services

Ordering Participating Providers are responsible for requesting precertification of outpatient MRA, MRI, CT Scan, PET Scan, virtual colonoscopy, and/or nuclear cardiology services.

Please note:

- Precertification is also required when the Health Plan is not the Member's primary insurance coverage.
- An Outpatient Referral Form issued by a Member's PCP, in addition to precertification from the Health Plan, may be required in accordance with the Member's Benefit Document.
- MRAs, MRIs, CT Scans, PET Scans and/or nuclear cardiology services rendered in an emergency room, observation and/or inpatient setting do not require precertification.
- TPA self funded Employer Sponsored Programs may individually opt into this precertification program. Contact NIA (www.radmd.com) for precertification requirements by line of business.

- Copayments, Coinsurance and/or Deductibles are the financial responsibility of the Member, when applicable.

Requesting Precertification

The ordering Participating Provider is required to contact the Health Plan's contracted vendor, National Imaging Associates, Inc. (NIA), online through www.radmd.com or toll free at (866) 305-9729, 8:00 a.m. to 8:00 p.m. Monday through Friday to request precertification for an outpatient CT Scan, MRA, MRI, PET Scan and/or nuclear cardiology service.

The ordering Participating Provider is responsible for obtaining precertification from NIA and providing the authorization number to the rendering Participating Provider in advance of an outpatient radiology/imaging service(s).

Urgent/non-emergency outpatient radiology/imaging services scheduled and performed after normal business hours, on weekends or holidays may be conducted by the rendering Participating Provider/facility as requested by the ordering Participating Provider. However, the ordering Participating Provider must contact NIA within (2) Business Days to obtain proper authorization for the outpatient radiology/imaging service, which is subject to the normal review process.

It is the responsibility of the rendering Participating Provider to ensure that precertification through NIA has occurred and an authorization number has been provided for the ordered test prior to the rendering of an outpatient radiology/imaging service. Radmd is the most efficient way to confirm an ordered test has been authorized. Services performed that have not been properly authorized or exceed the authorization period will not be eligible for reimbursement and the Member cannot be balanced billed.

Information required when requesting precertification through NIA:

- Ordering physician's name, office and fax telephone numbers.
- Member's name and Health Plan identification number.
- Requested radiology/imaging service(s).
- Name and address of rendering Participating Provider's office or facility where the service will be performed.
- Anticipated date of service (if known).
- ICD-9 code.
- Third party insurance (if involved).
- Details justifying examination:
 - Symptoms and their duration
 - Physical Exam Findings
- Conservative treatment Member has already completed (i.e., physical therapy, chiropractic or osteopathic manipulation, hot pads, massage, medications).
- Preliminary procedures already completed (e.g., x-rays, CT's, lab work, ultrasounds, scoped procedures, specialist evaluations).
- Reason the study is being ordered (e.g., further evaluation, rule out a disorder, base new treatment, evaluation of current therapy or treatment).

Please be prepared to fax clinical notes, conservative treatment reports, and/or preliminary procedures, if requested. If a case has already been initiated but is pending additional clinical notes, the documentation should be faxed to (800) 784-6864, the number to NIA's Clinical Support Department (CSD) who will attach the notes to the case and route it for appropriate determination.

If it is a new case with no prior initiation, please call (866) 305-9729. Collecting the data NIA needs to address clinical algorithms verbally allows the process to flow more expediently.

Please note: Ordering Participating Providers can initiate authorization for several Members during a single telephone call, which is referred to as "batch authorization".

Authorization Response

Upon submission of all required information, NIA will review criteria according to the services requested and verify Member eligibility. A decision will be provided to the requesting ordering provider verbally and in written form within applicable regulatory timeframes according to a Member's specific product type. A denial notification shall include information on the Participating Provider's right to appeal any determination of coverage.

When a request has been approved the ordering provider will receive an authorization number from NIA, which should be provided to the rendering Participating Provider. An authorization number is valid 60 days from the date of the decision and the authorized service should be completed within this time frame. If the service is not completed during this time frame, NIA should be contacted to ensure the authorization period is reviewed.

Please note: NIA provides a separate authorization number for each outpatient CT Scan, MRA, MRI, PET Scan and/or nuclear cardiology service approved. This includes combination studies conducted during the same visit.

NIA's Web site (www.radmd.com) also provides on-line access to initiate, monitor, and/or track the status of a request for precertification. Rendering Participating Providers are encouraged to register and utilize RadMD to determine the authorization status. Participating Providers without Internet access can contact NIA via the toll free telephone number to verify authorization status.

Clinical Guidelines for Radiology Procedure

The clinical guidelines section of NIA's Web site, located at www.radmd.com/misc_pages/clinical_guidelines.htm, allows Participating Providers to review the most common reasons for requesting certain radiology procedures and to access specific guidelines developed through a scientific process of clinical consensus. These guidelines are approved by NIA and Health Plan Medical Directors and are designed to assist physicians and offices in determining when a specific outpatient CT Scan, MRA, MRI, PET Scan and/or nuclear cardiology service meets NIA/Health Plan's authorization criteria.

Frequently Asked Questions

Question: Which radiology/imaging services require precertification through NIA?

Answer: Outpatient CT Scans, MRAs, MRIs, PET Scans, virtual colonoscopy and/or nuclear cardiology services. Refer to the CPT/HCPCS Code Matrix.

Question: Is precertification required for an outpatient CT Scan, MRA, MRI, PET Scan and/or nuclear cardiology service ordered during an emergency room visit?

Answer: No. It is not necessary for anyone to contact NIA prospectively or retrospectively to authorize an imaging procedure performed during an emergency room visit. However, if the Member is discharged from the emergency room and returns for the outpatient radiology/imaging service, precertification is required.

Question: How are CT Scans, MRAs, MRIs, PET Scans and/or nuclear cardiology services handled when the Member is in observation?

Answer: Radiology/imaging services that occur while the Member is in observation do not require precertification by NIA. Observation stays are expected not to exceed 23 hours in duration.

Question: Can I call The Health Plan directly to obtain precertification for outpatient CT Scans, MRAs, MRIs, PET Scans and/or nuclear cardiology services?

Answer: No. Requests for authorization on outpatient radiology/imaging services need to go through NIA.

Question: What kind of response time can ordering Participating Providers expect when requesting precertification through NIA?

Answer: The best way to increase the possibility of having a request approved at the time of the first call is to have knowledge of the case including:

- the Member's history and diagnosis.
- reason for the outpatient radiology/imaging service.
- results of previous radiology/imaging services; and
- history of medical or surgical treatment(s).

In many cases, especially when the caller requesting the review has all clinical documentation, the request can be authorized during the first phone call. Average calls are completed within 4 1/2 to 5 minutes. Peak call volume occurs between the hours of 11:00 a.m. to 2:00 p.m. EST. In certain cases, the review process can take longer if additional clinical information is required to make a determination.

Question: Can NIA handle multiple authorization requests during a single telephone call?

Answer: Yes. NIA can accommodate multiple authorization during a single telephone call and is available Monday through Friday, 8:00 a.m. to 8:00 p.m. NIA will establish a call back time with high volume ordering providers to handle batch authorization requests.

Question: Why is NIA asking for a date of service when authorizing a procedure? Is authorization required before an outpatient radiology/imaging service is scheduled?

Answer: At the end of the authorization process, the NIA authorization representative asks where the procedure is being performed and the anticipated date of service. The exact date of service is not required. An authorization should be obtained prior to scheduling.

Question: How long is the authorization number valid?

Answer: The authorization number is valid for 60 days from the date of the determination. When a procedure is authorized, NIA will use the decision date as the starting point for the 60-day period in which the procedure must be completed.

Question: What if my office staff forgets to call NIA and then goes ahead to schedule an outpatient radiology/imaging service that requires precertification?

Answer: It is important to notify office staff and educate them about this process. Outpatient CT Scans, MRAs, MRIs, PET Scans and/or nuclear cardiology services rendered without appropriate authorization will not be reimbursed by the Health Plan and the Member must be held financially harmless in accordance with your Agreement.

Question: Can the rendering Participating Provider/facility request authorization through NIA?

Answer: NIA will accept some information from the rendering Participating Provider/facility. However, the ordering Participating Provider is responsible for precertification.

Question: What does the NIA authorization number look like?

Answer: NIA's authorization number is 8 alpha/numeric digits in length (i.e., 0516G123).

Question: Where does the authorization number go on the CMS 1500 and the UB92 Claim Forms?

Answer: The authorization number should be populated in field 23 of the CMS 1500 Claim Form and in field 63 of the UB92 Claim Form. If claims are submitted electronically via 837I or 837P the authorization number should be filled in field 2300 REF02 when REF01=G1.

Question: What happens if a Member is authorized by NIA for only a CT of the abdomen and the radiologist or rendering physician feels an additional study of the pelvis is needed during the same visit?

Answer: The radiologist or rendering physician may proceed with the pelvic study. If this occurs, the rendering provider must contact NIA within 2 Business Days for authorization assistance and should notify the Member's ordering Participating Provider of the additional test performed on the same day, as a matter of appropriate medical procedure. The original ordering Participating Provider should call NIA after the study is provided to proceed with the normal review process to get an additional authorization number.

Question: If NIA denies a precertification request, is there an option to appeal the determination decision?

Answer: If NIA makes the decision to deny the request the ordering Participating Provider will be informed of the applicable appeal process.

Question: What is the toll-free telephone number and hours of operation for NIA's call center?

Answer: You may reach NIA's call center at (866) 305-9729, Monday through Friday, 8:00 a.m. to 8:00 p.m.

Question: Is there a way to bypass the NIA recorded announcement when dialing (866) 305-9729?

Answer: When dialing into the toll-free telephone number, you will hear a 7 second system greeting that identifies the NIA/Geisinger Health Plan Imaging Authorization Service Center. The announcement will instruct you to press option 1 to initiate a new request for authorization on an imaging exam or option 2 for the status of a case that was previously called in for authorization. The announcement will also provide information that emergency procedures do not require prior authorization. The entire greeting may be bypassed by immediately pressing the desired option whenever the announcement starts to play.

CPT/HCPCS Code Matrix for Outpatient Radiology/Imaging Services Requiring Precertification

The CPT/HCPCS code matrix can be found online at the Health Plan’s Provider Information Center (www.thehealthplan.com/providers_us/index.cfm) under ‘Medical Information/Radiology Precertification Program.’ The matrix contains then-current CPT/HCPCS codes that NIA authorizes on behalf of the Health Plan, valid only on the date of publication. A minimum of thirty (30) days advance notice is provided to Participating Providers regarding periodic updates to the NIA matrix. This matrix is designed to assist in the resolution of claims adjudication and claim questions related to those services authorized by NIA. If an outpatient radiology/imaging services is billed under any one of the given codes for that grouping and a valid authorization number has been issued within the date of service validity period, the authorization will apply to all codes listed in the “allowable billed grouping” field.

If a family of CPT/HCPCS codes is not listed in this matrix, an exact match is required between the authorized code and the provider’s reported code. For a current listing of all CPT/HCPCS codes, to link to the NIA web page, and for other information on this topic, refer to the Health Plan web site at www.thehealthplan.com

Please note: Services rendered in an Emergency Room, Observation Room, surgery center or hospital inpatient setting are not managed by NIA.

8) Specialty Pharmacy Vendor Program

Certain prescription and injectable drugs are covered only through the Specialty Pharmacy Vendor Program. For more detail and a complete list of drugs available through this program, refer to www.thehealthplan.com/providers_us/pharmvend.cfm, or call the Health Plan Pharmacy department at (800) 988-4861. Medication requests are the responsibility of the prescribing Participating Provider.

Please note: Precertification may be required for certain drugs. Please refer to the section titled “Other Services Requiring Precertification” within this Guide for further information.

Specialty Pharmacy Vendor Program Process

To initiate the program, the prescribing Participating Provider is required to complete the Health Plan’s Specialty Pharmacy Vendor Request Form and fax it to the Health Plan Pharmacy Department at (570) 271-5610 within **three (3) Business Days** of the Member’s expected medication needs. Telephone orders will not be accepted or processed. The Specialty Pharmacy

Vendor Request Form and other information regarding the Specialty Pharmacy Vendor Program can be found online at the Health Plan's Provider Information Center (www.thehealthplan.com/providers_us/index.cfm) under 'Formulary Information.'

Notification Process

Upon receipt of the Specialty Pharmacy Vendor Program Request Form, the Pharmacy Department will:

- verify the Member's eligibility and benefits.
- review the form to ensure appropriate information has been provided.
- Perform Precertification if required.
- if approved, forward the form to the Health Plan's contracted specialty vendor.

The vendor will process the request and ship the medication to the destination (i.e., provider's office, Member's residence, etc.) identified on the form within forty-eight (48) hours. The entire request and shipment process is expected to take three (3) Business Days or less from receipt of the form.

Pharmacy Department
Monday through Friday, 8:30 a.m. to 5:00 p.m.
(800) 988-4861 or (570) 271-5673
Fax: (570) 271-5610

9) Other Services Requiring Precertification

Please note:

- Precertification is also required when the Health Plan is not the Member's primary insurance coverage.
- An Outpatient Referral Form issued by a Member's PCP, in addition to precertification from the Health Plan, may be required in accordance with the Member's Benefit Document.
- Copayments, Coinsurance and/or Deductibles are the financial responsibility of the Member, when applicable.

Other services requiring precertification

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

Requesting Precertification

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

Geisinger Health Plan
Medical Management Department

100 North Academy Avenue
Mail Code 32/18
Danville, PA 17822
(800) 544-3907 or (570) 271-6497
Monday through Friday 8:00 a.m. to 5:00 p.m.
Fax: (570) 271-5534

Information required when requesting precertification

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

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

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

Administrative Penalty for failure to obtain precertification

In the event precertification is not obtained, the Participating Provider may be held financially liable for failure to follow the proper Health Plan protocol(s).

When Covered Services occur as a result of an out-of-Network Referral, the referring Participating Provider may be financially liable for such out-of-Network Covered Services. However, if a Member self-refers out-of-Network, the Member will be held financially liable.

10) Pharmacy Formulary Precertification and non-Formulary Exception Process

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

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

Requesting Precertification

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

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

Information required to process the request includes:

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

Determination Process

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

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

The prescribing Health Care Provider will be contacted to review the request and available Formulary alternatives. If an exception is still requested, appropriate medical record

documentation and treatment information will be requested verbally and in writing. A due date for the required information (fifteen (15) days from the date of the request) will be included in the verbal and written notifications. When all requested information has been received, it will be attached to a flow sheet for documentation as a pre or post-service request.

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

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

If the Formulary exception is approved:

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

reason for the determination, (2) the basis and clinical rationale utilized in rendering the determination of coverage, if applicable, (3) any internal policy or criterion applied, if applicable, (4) as well as instructions regarding initiation of the Grievance and/or Appeal process.

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

Medical Benefit Policies

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

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

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

Monday through Friday 8 a.m. to 5 p.m.
(800) 544-3907 or (570) 271-6497
Fax: (570) 271-5534

Services Requiring Provider Coordination

Verification of Eligibility and Benefit Limit

Prior to coordinating Health Care Services, a Member's eligibility and benefits should always be verified through the online Provider Service Center at www.thehealthplan.com/providers_us/servicecenter.cfm or by calling the applicable Customer Service Team. Providers, acting upon a Referral from the Member's PCP, should contact the Health Plan Customer Service Team corresponding to the Member's product type to verify eligibility and benefits:

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

GEISINGER HEALTH PLAN/COMMERCIAL: (800)-447-4000 (570)-271-8760

Business Hours: Monday – Friday 8:00 a.m. – 6:00 p.m.

GEISINGER HEALTH OPTIONS/PPO: (800)-504-0443 (570)-271-8770

Business Hours: Monday – Friday 8:00 a.m. – 5:00 p.m.

GEISINGER GOLD: (800)-498-9731 (570)-271-8771

Business Hours: Sunday – Saturday 8:00 a.m. – 8:00 p.m.

CHIP, by GEISINGER HEALTH PLAN: (866) 621-5235 (570) 214-9138

Business Hours: Monday – Friday 8:00 a.m. – 6:00 p.m.

PHARMACY: (800)-988-4861 (570)-271-5673

Business Hours: Monday – Friday 8:00 a.m. – 5:00 p.m.

Monday – Friday 8:00 a.m. – 8:00 p.m. for Medicare Part D

MEDICAL MANAGEMENT: (800)-544-3907 (570)-271-6497

Business Hours: Monday – Friday 8:00 a.m. – 4:30 p.m.

TDD for the hearing impaired: (800) 447-2833

Monday – Friday, 8:00 a.m. – 4:30 p.m.

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 Medical Services for a Gatekeeper Product Member must be provided by and rendered in a Participating Provider or must be approved in advance by the Health Plan Medical Director.

Return Communication

Participating 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.

The Health Plan provides the "Obstetrics/Gynecology Notification of Patient Visit" form and the "Retinal Evaluation/Examination Form" (see Section 10 entitled "Health Plan Forms") to applicable Participating Providers. Contact your Provider Relations Representative for a supply of these forms.

PCP Management of Skilled/Non-Skilled Member Care

Members admitted to a SNF or Hospital Provider under a skilled or intermediate level of care do not require an Outpatient Referral Form for services rendered in the facility setting. However, for

services required outside the skilled or Intermediate Care setting, an Outpatient Referral Form issued by a Member's PCP is required (i.e., outpatient cardiology consultation).

- **Personal Care Facility:** Neither Medicare nor Health Plan standards consider Personal Care Facilities (PCF) as institutionalized facilities, regardless of whether the PCF is affiliated with a SNF or a Hospital Provider. A PCF is considered an alternative to home living.

Therefore, Members residing in a PCF require an Outpatient Referral Form issued by the Member's PCP for specialty consultative, evaluation and management and surgical services, excluding Emergency Services and Direct Access services. Detailed information can be located in the section of this Guide titled "Outpatient Consultative Specialty Referrals."

Outpatient Prescription Drugs

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

The Health Plan offers two prescription drug plans: the "traditional pharmacy benefit" and the "Triple Choice" benefit. Exclusions may differ based on the benefit chosen and are delineated in the Member's prescription drug Rider or Benefit Documents, as applicable. The same quantity limits apply to both plans.

- **Traditional benefit:** The traditional benefit includes coverage only for the prescription drugs listed in the Formulary. Formulary exceptions may be granted on a case by case basis. Members with this benefit pay a set Copayment or Coinsurance for the approved drugs.
- **Triple choice benefit:** The Triple Choice benefit assigns each prescription drug to one of 3 different tiers, each representing a different Copayment amount. Additional drugs, other than those included in this Formulary, may be covered under the Triple Choice plan. The Copayment amount will depend on the Member's prescription drug Rider. The tiers are defined below:
 - Tier 1—Includes most generic drugs and has the lowest Copayment. No precertification is necessary.
 - Tier 2—Includes certain Formulary brand name drugs with no generic equivalent. Precertification may be necessary.
 - Tier 3—Includes certain Formulary brand name drugs with a generic equivalent and non-Formulary brand name drugs. Precertification may be necessary.

The Health Plan maintains sole discretion of assigning drugs to tiers and moving drugs from one tier to another. Several factors are considered when assigning drugs to tiers.

These factors include, but are not limited to:

- Availability of a generic equivalent.

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

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

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

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

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

LIFE Geisinger Advanced Notification/Coordination of Services

LIFE Geisinger participants always require approval prior to receiving non-emergency healthcare services. In order to receive prior approval from GCHS, please contact one of the telephone numbers listed below from 8 a.m. until 5 p.m., Monday through Friday. Twenty-four (24) hour support is available for urgent issues through an on-call process. These numbers are listed on a participant’s LIFE Geisinger identification card.

Scranton: (800) 395-8759
 Lackawanna and Luzerne Counties
 Kulpmont: (866) 230-6465
 Columbia, Montour, Northumberland and Schuylkill
 Counties

GCHS will provide written authorization to the provider in advance of services rendered to a LIFE Geisinger participant.

SilverSneakers® Fitness Program

The SilverSneakers Fitness Program offers certain Gold Product Members a fitness facility membership where they can enjoy low-impact fitness classes and other amenities at no charge. Classes are appropriate for those who exercise on a regular basis as well as individuals who may not have exercised in years. This benefit is available at participating fitness centers without PCP authorization or Referral. Participating Providers are encouraged to remind Gold Members of this benefit and to discuss the positive effects of regular exercise. For a list of Fitness Centers participating with the SilverSneakers Fitness Program contact the Gold Customer Service Team or log on the Health Plan's Web site at www.thehealthplan.com.

Outpatient Laboratory and Radiology Services

Outpatient laboratory and radiology services may be:

- Provided by the Member's PCP.
- Ordered by the Member's PCP without the issuance of a Referral to the Laboratory or Radiology Participating Provider.
- Ordered by a Participating Provider who has received an Outpatient Referral Form issued by the Member's PCP, which indicates "evaluate and treat." Providers are required to utilize a Laboratory or Radiology Participating Provider for such services.
- Ordered by an Participating Provider who has been Directly Accessed by a Member in accordance with the terms and conditions of coverage set forth in their Benefit Document(s).

Please refer to the Health Plan's Participating Provider search at www.thehealthplan.com for a list of laboratory and radiology Participating Providers.

Participating Providers are reminded that when ordering an outpatient MRA, MRI, CT Scan, PET Scan or nuclear cardiology services, precertification is required. Refer to the Section in Guide titled "Outpatient Radiology Services" for additional information.

Urgent/Emergency Services

PCP authorization and/or an Outpatient Referral Form is not required for Emergency Services. However, a Member is directed to discuss their Emergency with their PCP either prior to or following their emergency room visit.

PCP agree to have Medical Services available and accessible to Members, twenty-four (24) hours per day, seven (7) days per week. When the PCP is not available and accessible to Member, the PCP is responsible for ensuring appropriate arrangements are made for another participating PCP to provide Medical Services to Member, in accordance the Health Plan Access and Availability Standards.

PCPs can utilize the following to ensure Members have access to medical direction or care:

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

Participating Provider's specialty services immediately following an emergency department discharge or an inpatient Hospital discharge, whether in or outside the mandatory post-operative period, excluding Direct Access services, require an Outpatient Referral Form (found in section 10 of this Guide) issued by the Member's PCP.

All out-of-Network services immediately following an emergency department discharge or an inpatient Hospital discharge, require precertification.

Orthotic and Prosthetic Service

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

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

An Outpatient Referral Form is not required for an orthotic or prosthetic when ordered by a Member's PCP; or an SCP acting upon a valid Referral issued by a Member's PCP, specifying request for "Evaluate and Treat."

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

Behavioral Health and Substance Abuse Services

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

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

Outpatient Dialysis Services

Outpatient dialysis services provided in an outpatient Hospital Provider setting or a dialysis facility Participating Provider do not require the issuance of a Referral to the Hospital Provider or outpatient dialysis facility Participating Provider. However, an SCP ordering the outpatient dialysis services must have a valid Referral from the Member’s PCP for “Evaluate and Treat.”

To ensure that the Health Plan receives accurate reimbursement for Gold Members with a primary diagnosis of end-stage renal disease (ESRD) or has had a kidney transplant, the Health Plan requests a copy of the completed CMS-2728-U3 form. This form should be completed by the treating nephrologist and the Facility Participating Provider rendering the outpatient dialysis services. Forms can be submitted via fax to the Gold Customer Service Team at (570) 271-5970.

Experimental/Investigational or Unproven Services

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

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

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

- The service has a measurable, reproducible positive effect on health outcomes as evidenced by well designed investigations, and has been endorsed by national medical bodies, societies or panels with regard to the efficacy and rationale for use; and
- The proposed service is at least as effective in improving health outcomes as are established treatments or technologies or is applicable in clinical circumstances in which established treatments or technologies are unavailable or cannot be applied; and
- The improvement in health outcome is attainable outside of the clinical investigation setting; and

- The majority of Health Care Providers practicing in the appropriate medical specialty recognize the service or treatment to be safe and effective in treating the particular medical condition for which it is intended; and
- The beneficial effect on health outcomes outweighs any potential risk or harmful effects.

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

Prenatal/Postpartum Member Care

PCPs and/or SCPs who provide obstetrical services to Members are required to complete the “Pregnancy Assessment Form (see Section 10 entitled “Health Plan Forms”). This ensures that each expectant Member is enrolled in the Health Plan’s Right From the Start Prenatal/Postpartum Care Management Program. This program assists expectant Members by providing educational materials and professional support from Health Plan nursing staff. A completed Pregnancy Assessment Form must be forwarded to the Health Plan within five (5) days after the date of an expectant Member’s initial (1-14 weeks gestation) and second prenatal screening. It is preferred that the Member’s second prenatal screening occur around the 28th week of gestation.

If an expectant Member changes to a different provider for obstetrical care during the course of pregnancy, a new Pregnancy Assessment Form is required to be completed by that provider.

Participating Providers are reminded that expectant Member’s coverage includes one (1) routine ultrasonography when the pregnancy is reported as V22.0 (normal first pregnancy), V22.1 (second or other normal pregnancy) and/or V22.2 (pregnancy state, incidental). Repeat ultrasounds in excess of one (1) when reported with the above diagnosis codes are not considered Medically Necessary and the ordering Participating Provider may be held financially liable for the incurred charges. Member elected repeat routine ultrasounds in excess of one (1) are the financial responsibility of the Member, who should be notified in advance of such.

Participating Providers with questions related to the Right From the Start Prenatal/ Postpartum Care Program can contact the Health Plan Care Coordination Department at (800) 883-6355 or (570) 271-8763.

Transplant Services

Members are required to utilize designated transplant centers. Precertification is required for transplant evaluations; testing and related services for organ, bone marrow and/or stem cell transplants. Participating Providers should contact the Medical Management Department at (800) 544-3907 option 2 or (570) 271-6497 option 2.

Vision Services

Members may be entitled to directly access, without PCP authorization or Referral, a Participating Provider to obtain a once per calendar year refraction service, which determines the general health and/or refractive error of the eye.

Members also have the option of purchasing a prescription eyewear rider with their Geisinger Health Plan medical coverage. The prescription eyewear rider allows Members to receive prescription eyewear (lenses, frames and/or contact lenses) from a prescription eyewear vendor. The benefit includes coverage for lens coating and/or treatment such as tinting, anti-reflective, scratch resistant coating, progressive lenses and polycarbonate lenses. Participating Providers are required to submit initial claims to the Health Plan for reimbursement. Please note: Members are not required to have the Refraction Rider to have the eyewear coverage rider.

Gold Members are entitled to receive routine eyewear (eyeglasses or contact lenses obtained from a Participating Provider). Gold Members are also entitled to one pair of eyeglasses or contact lenses after each cataract surgery (with the insertion of an IOL (intraocular lens) when provided by a Participating Provider) per year. Please note: The benefit for eyeglasses or contact lenses after cataract surgery is separate from the benefit allowance for prescription glasses (and frames) or contact lenses every two (2) years. When both eyes receive cataract surgery separately during the calendar year, the Gold Member is entitled to receive a pair of eyeglasses or contact lenses after each surgery.

Participating Providers are reminded to verify benefits in order to ensure coverage and benefit limits have not be exhausted prior to rendering services. All appropriate Referrals or authorizations should also be in place prior to rendering services. This information is available online at www.thehealthplan.com/providers_us/servicecenter.cfm. Providers are also able to view cost sharing and benefits, such as Refraction Rider or eyewear coverage by visiting the Provider Service Center. Please note: the Member's identification card does not identify these benefits.