

Operations Bulletin⁰¹⁻¹³



Date: January 31, 2013

To: Participating Physicians and Hospitals

Re: **Inpatient Hospitalization Precertification Process & Forms**

As a leading Managed Care Organization, Geisinger Health Plan¹ believes in the value and quality an efficient precertification process can provide for Members. Timely notifications of admissions and planned procedures help Medical Management staff ensure Members are receiving care in harmony with their benefits and in the appropriate setting; while inpatient review allows for early focus on discharge planning and identification of Members that may benefit from case management.

In an effort to expedite the precertification process for both patients and providers, Geisinger Health Plan is shifting emphasis to a form-based precertification request and notification process for inpatient procedures, admissions, and concurrent review. This new suite of inpatient forms are intended and expected to decrease the turn-around time for authorizations.

Beginning March 1, 2013, Geisinger Health Plan will consider the forms described herein as the sole acceptable mode for inpatient precertification requests and notifications. These forms will be made available online at www.thehealthplan.com.

Inpatient Planned Precertification Form

The *Inpatient Planned Precertification Form* should be used by admitting providers when requesting authorization for planned inpatient hospital admissions. This one page form must be legible, completed in its entirety, and faxed to Medical Management at (570) 271-5534 no less than two (2) Business Days prior to the planned date of admission. Failure to submit the form may result in denial of payment for the planned procedure. No other form of precertification request will be accepted.

Inpatient Admission Notification Form

The *Inpatient Admission Notification Form* should be used by hospital providers for all planned and unplanned admissions, including observation admissions that exceed 23 hours. This two page form must be legible, completed in entirety, and faxed to Medical Management at (570) 271-5534 within one (1) Business Day of a Member's admission to the facility. No other form of notification will be accepted.

Update for Inpatient Review

The *Update for Inpatient Review Form* should be used by hospital providers to conduct concurrent review. This one page form must be legible, completed in entirety, and faxed to Medical Management at (570) 271-5534 within one (1) Business Day of an admission. Authorizations will be pended if this form is not returned. No other form of notification will be accepted.

Newborn Information Form

The *Newborn Information Form* should be used by hospital providers to give notice of new births. This one page form must be legible, completed in entirety, and faxed to Medical Management at (570) 271-5534 upon discharge of the mother from the facility. No other form of notification will be accepted.

Please contact Medical Management at (800) 544-3907 if you have questions regarding these forms. Information contained in this Operations Bulletin is effective March 1, 2013 for all Geisinger Health Plan product lines and amends the Participating Provider Guide.

¹ *Geisinger Health Plan, Geisinger Indemnity Insurance Company, and Geisinger Quality Options, Inc. shall be collectively referred to herein as "Geisinger Health Plan."*



Inpatient Planned Precertification Form

WE ONLY PRECERT WITHIN 30 DAYS OF THE PLANNED PROCEDURE

Please fax completed form to 570-271-5534.
You will receive a call back within 24 business hours.

PLEASE PRINT:

Requestor's Name:	
Requestor's Number:	
Requestor's Fax #:	
Member Name:	
Member ID#:	
Member Date of Birth:	
Date of Admission:	
Physician's Name:	
Name of facility completing procedure:	
Diagnosis:	
Diagnosis Code(s):	
Procedure:	
Procedure code(s):	

Discharge plan received (pre-op joints)	YES	NO	N/A
If YES:	INPT REHAB / OTPT REHAB / SKILLED NURSING / HOME WITH HOME HEALTH		
Proven Care:	YES	NO	N/A
Clinical Trial:	YES	NO	N/A
Other Insurance:			
Additional information:			



Inpatient Admission Review
Please Fax to 570-271-5534

Date/Time:		Auth #:	
Member Name:		ID #:	
DOB:		COB: Yes or No	
Admitting Facility:		Admitting Diagnosis:	
Date of Admission:		Admitting Physician:	
Reviewer's Name:		Reviewer's Phone #:	
Admitted from.... (Ex: ER, PCP, SPU, Clinic)		Admitted to... (Ex: ICU, CCU, Tele, Med- Surg, Peds)	
Request being made for....(Ex: Admission, Observation or Extended Observation)			

Past Medical History: Check all that apply.							
Heart Failure	<input type="checkbox"/>	COPD	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	CVA	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	HTN	<input type="checkbox"/>	MI	<input type="checkbox"/>
CAD	<input type="checkbox"/>	PVD	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>
Lung Cancer	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	Breast Cancer	<input type="checkbox"/>	Colon Cancer	<input type="checkbox"/>
UTI's	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	Syncope	<input type="checkbox"/>	GERD	<input type="checkbox"/>
Hyperlipidemia	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Falls	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>	Alcohol Use	<input type="checkbox"/>	Drug Use	<input type="checkbox"/>
Additional Past Medical History and Surgical History:							

Story of Event/Admission:
Vitals, EKG:

Inpatient Admission Review
Please Fax to 570-271-5534

Abnormal Labs including Cultures:					
WBC		Glucose		Trop	
H/H		K		CK	
PT/INR		Na		MB	
PTT		BUN		Cultures	
Plates		CR		ABG's	
BNP		GFR			
Amylase		Ca			
Lipase		Mag			
Imaging including CXR, CT, MRI/MRA:					
Orders/Plans/Management:					
Comments/What is reason for admission?					
Anticipated Length of Stay:					
Discharge Plans/Needs:					



Update for Inpatient Review

Please Fax to 570-271-5534

Date of Review:		Auth #:	
Member Name:		ID #:	
Date of Birth:		Admitting Diagnosis:	
Admitting Facility:		Admitting Physician:	
Reviewer's Name:		Reviewer's Phone #:	

Vitals:					
Abnormal Labs Including Cultures:					
WBC		Glucose		Trop	
H/H		K		CK/MB	
PT/INR		Na		BNP	
PTT		BUN/CR		Amylase	
Plates		Ca		Lipase	
Mag		GFR		Cultures	
Imaging including CXR, CT, MRI/MRA:					
Orders/Plans/Management:					
Anticipated Length of Stay:					
Discharge Plans/Needs:					
Needed Outpatient Referrals:					

Newborn Information Form

Fax completed form to 570-271-5534 upon discharge of the Mother

Mother Information	
Mother's Name:	
ID #:	
Mother's Phone #:	
Is the Mother a dependent on her parent's policy?	Yes No
Facility:	
Reviewer's Name & Phone #:	
Date of Admission:	
Date of Discharge:	
Diagnosis:	Vaginal C-section
Attending Physician:	

Baby Information	
Newborn:	Male Female
Name of Newborn: [REQUIRED]	
Date of Birth:	
Discharge/ NICU/ Detained:	
Attending Physician:	
Newborn Weight:	
Apgars:	
Newborn's Primary Care Physician: [REQUIRED]	
Comments:	

GHP USE ONLY	
Auth #:	