Disputes, Appeals and Grievances

Provider appeal for adverse medical discrimination – gatekeeper products

Geisinger Health Plan

Right to speak with GHP Medical Director

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

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

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

Medical necessity adverse determination appeals for GHP Gatekeeper Products

Contingent upon the regulatory mandates of the insurance product, a provider may appeal a medical necessity adverse determination.

Insurance products regulated by Pennsylvania Department of Health (HMO and PPO with referral products) allow for provider appeals of medical necessity denials for which the provider cannot balance bill the member for denied services. An option for external review is included.

Provider appeal to adverse determinations must:

- Be submitted to the GHP Medical Management (MM) department in writing (submission by fax is recommended for Urgent Appeal), and;
- Be received by GHP MM within 60 days from the date of the discharge, and;
- Indicate urgency of appeal (Standard or Urgent timeframes), and;
- Include applicable medical documentation to support the appeal (it is not necessary to forward a complete medical record.), and;
- Indicate whether an internal or external review is requested:
    - **Internal review**: Performed by a GHP Medical Director who has not been involved in the original determination with input of the same or similar specialist as indicated; or
    - **External review**: Performed by an External Review Group (ERG). GHP will retain a contract with a recognized review body (ERG) for the purpose of offering the provider the option of review by a practitioner not otherwise associated with the plan. The cost associated with this review requires partial payment of the fee by the requesting provider prior to initiation of the appeal. Should the ERG decision reverse the original determination, this payment will be reimbursed to the requesting provider. Should the ERG decision uphold the original determination, the requesting provider shall be liable for full payment of the ERG fee. The cost for an external review will vary dependent on the details of the

requested service, amount of records to be reviewed, and the timeline for processing.

In the event of multiple providers requesting an appeal on the same adverse determination, the first request received will initiate the provider appeal process. GHP will ensure that all applicable information is gathered from other pertinent providers and included in review of the provider appeal.

The decision from either internal or external review, based upon information available at the time will be final.

Appeal submission

The appeal should be mailed or faxed to:

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

Urgent provider appeal

GHP defines urgent appeals as requests concerning initial or continued services for a member that, in the opinion of a GHP Medical Director, application of the standard timeframe for a provider appeal could seriously jeopardize life, health, or the ability of the member to regain maximum function.

Determination timeframe

Provider appeal determination and notification will be made within 30 days of receipt of the appeal and ERG fee payment if applicable. Urgent provider appeal determination and oral notification will be completed within seventy-two (72) hours from confirmed receipt of clinical information, and

confirmation of ERG fee payment if applicable. All decisions will be final.