

Referrals and Precertifications/Prior Authorizations

Precertification / prior authorization overview



Precertification – A process utilized by the medical management department to obtain and document appropriate clinical information and the rationale used in determining coverage for certain designated services on the basis of medical necessity.

Prior Authorization – A determination made by GHP to approve or deny payment for a provider's request to deliver a service or course of treatment of a specific duration and scope to a member, prior to the provider's initiation or continuation of the requested service.

Precertification/prior authorization

- Precertification/prior authorization does not guarantee member's coverage or Geisinger Health Plan payment.
- Member's coverage is determined by the terms and conditions of the member's benefit document.
- Precertification requirements may vary based on product line.
- Member is not financially responsible for a participating provider's failure to precertify or provide accurate required information to the Geisinger Health Plan.
- Copayments, coinsurance and/or deductibles are the financial responsibility of the member, when applicable.
- Determination may be made by Geisinger Health Plan medical management staff or by delegated vendors.
- Precertification/prior authorization is not a guarantee of payment.
- A [complete list of services requiring Prior Authorization](#) is available online.

Precertification/prior authorization process

Precertification/prior authorization of services may be required and will be performed by GHP Medical Management staff, or through delegated vendor relationships. Delegated vendors may review services such as, but not be limited to, radiology and dental services. Precertification staff, which includes appropriate practitioner reviewers, utilizes nationally recognized medical guidelines as well as internally developed medical benefit policies, individual assessment of the Member, and other resources to guide precertification, Concurrent Review, and Retrospective Review processes in accordance with the Member's eligibility and benefits.

Requesting precertification/prior authorization

- Verify member's eligibility and benefits.
- Have information available as identified in each specific type of authorization
- Submit using the appropriate vendor platform or form

Authorization notification process

- Upon receipt of the required information, the medical management department or delegated vendor will provide written and/or verbal notification of the determination.
- Notification will occur within applicable regulatory or National Committee for Quality Assurance (NCQA) time frames, whichever is more rigorous.
- Any information regarding provider appeal will be communicated (please see appeals section of provider guide).
- If a denial is issued, the participating provider is verbally notified of the option to speak with a medical director regarding the denial.

Medical management criteria

GHP medical management criteria is available under the [For Providers](#) section of the website under clinical policies and clinical guidelines. upon request. Contact the medical management department at 800-544-3907, Monday through Friday, 8:00 a.m. — 4:30 p.m.

Medical management decision making

Decision making is based only on appropriateness of care, service and existence of coverage. GHP does not specifically reward practitioners or other individuals conducting utilization review for issuing approvals or denials of coverage or services. GHP does not offer incentives for medical management decision makers that encourage decisions that might result in under-utilization.

Medical benefit policies

- A medical policy is the written description of Geisinger Health Plan's position concerning the use or application of a biologic, device, pharmaceutical, or procedure, based on any or all the following: Medicare guidelines, clinical practice guidelines, nationally accepted standards, and the findings and conclusions drawn from a complete technology assessment (TA).
- Medical policies, which include services deemed to require precertification, establish medical necessity criteria and describe any special requirements for claims processing.
- The current list of medical benefit policies can be found on the GHP web site. You must log in to the web site as a provider or provider office to view the policies.
- A minimum of 30 days advance notice is provided when a service is added to Geisinger Health Plan's precertification list. Participating providers with questions about the above medical policies can contact the medical management department at 800-544-3907, Monday through Friday, 8:00 a.m. — 4:30 p.m.

Verification of eligibility and benefit limit

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

- [NaviNet](#), or
- GHP Family Customer Care Team at (855) 227-1302

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

Geisinger Health Plan, Geisinger Indemnity Insurance Company and Geisinger Quality Options, Inc. are collectively referred to as "GHP" in this summary.

All rights, duties and responsibilities of participating providers will be applied according to the following document order: 1) member's benefit document; 2) the participating provider's contract agreement, 3) the GHP Family Provider Guide; and 4) the Geisinger Health Plan Provider Guide.

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