

Authorization Guidelines 2011

Group Health Cooperative requires that you get a prior authorization from our Health Management team to see out-of-network providers. As well as for inpatient admissions and other specified services.

Authorization for service does not guarantee payment for services. Payment for services is dependent on other non-medical criteria such as the benefits associated with a member's specific plan and eligibility issues.

Retroactive event authorizations for services will not be granted unless there is a compelling reason for consideration. At no time will a retroactive event authorization be approved for a time span greater than two weeks prior to the receipt date.

Your provider should handle your authorization for you; however, **you should always check with Member Services before you receive the treatment if you are unsure about the status of an authorization request.**

Prior authorization is required for the following services:

Admissions

- Admissions to a hospital for non-emergent issues
- Admissions to rehabilitation facilities
- Admissions to skilled nursing facilities
- Admissions for sub-acute care
- Admissions for behavioral health, including admissions to residential treatment facilities
- Admissions for emergencies: authorization must be received within 24 hours following admission

Ambulance Transportation

An authorization is required for transportation by ambulance that is not due to an emergency. This includes both air and ground services.

Outpatient Laboratory

- Any genetic testing, such as DNA testing, except:
 - when billed in conjunction with amniocentesis
 - or prenatal triple test or alpha-fetoprotein (AFP), human chorionic gonadotropin (hCG), and estriol
- when provided in conjunction with Bone Marrow Biopsy

Outpatient Care

- Home care, except for one maternity follow-up visit within 48 hours after being discharged from the hospital for a vaginal delivery or 96 hours after being discharged from the hospital for a C-section
- Hospice services

Outpatient Therapies

Medically necessary short-term outpatient therapy (when a covered benefit) must be prescribed and monitored by a Primary or Specialty MD prior to any services being rendered.

Prior authorization from the Health Plan is not required for the first six visits, including the initial evaluation, for Physical Therapy, Occupational Therapy, Pulmonary Therapy and Cardiac Therapy. If additional visits beyond the first six are needed, prior authorization is required before the seventh visit.

Prior authorization is required for speech therapy, excluding the initial visit. Many commercial benefit plans do not cover Speech Therapy. If speech therapy is a covered benefit prior authorization is required for any subsequent visits after the initial evaluation.

Outpatient Radiology

(not performed at the time of an emergency department evaluation)

- PET Scans

Non-Emergent Surgeries and Procedures

- All plastic or reconstructive surgery
- Cancer clinical trials
- Circumcision not performed within one week of birth
- Gastric surgery for obesity (including consults, testing, and assessments prior to surgery)
- Sclerotherapy/Endovenous Ablation
- Pain management services in an outpatient setting
- Intradiscal electrothermal annuloplasty (IDET)
- Uvulopalatopharyngoplasty (UVPP, UPPP)
- Dental anesthesia procedures or oral surgery not performed in an office setting
- Temporomandibular joint (TMJ) treatment
- Organ transplant — including bone marrow transplant/stem cell transplant
- Non-cardiac radiofrequency ablation for treatment of chronic pain
- Abortion
- Podiatric surgery not performed in the doctor's office or Skilled Nursing Facility
- Any service billed with an unlisted CPT or Category III procedure code
- Essure sterilization not performed in a doctor's office.
- Hyperbaric Oxygen Chamber Treatment

Prosthetics and Durable Medical Equipment (DME)

- All DME rental beyond 30 days or with accumulated \$500 rental charges, per item
- New or used DME purchases over \$500 in billed charges, per item
- External and implantable infusion pumps and supplies, including insulin infusion pumps

Behavioral Health and Chemical Dependency Services

Authorization is not required for the initial six outpatient visits when services are received from a GHC contracted provider. Ongoing care, inpatient admission, psychological testing, day treatment and transitional care require prior authorization.

Specialized Pharmacy Services

- all outpatient injections or infusions of medications with billed charges of \$500 and above, excluding cancer chemotherapy, and drugs administered in conjunction with diagnostic or radiographic testing if the testing itself does not require prior authorization
- any drugs or therapies used in the diagnosis or the treatment of infertility
- off-label drug use

Out-of-Network Providers

If your health care provider believes you need to obtain professional services from a provider that is outside the GHC network of contracted providers, you must obtain a Referral Event Authorization. Contact a Member Service Advocate at (715) 552-4300 or (888) 203-7770 if you need additional information on this process.