

2020 PRIOR AUTHORIZATION

This document outlines important information about the Common Ground Healthcare Cooperative (CGHC) prior authorization policy. Additional information is available in your certificate of coverage which can be found at www.commongroundhealthcare.org/certificate. If you would like a copy of the Certificate of Coverage, you may request that one be mailed to you by calling 877.514.2442.

Providers that participate in CGHC's network will generally obtain Prior Authorization before they provide the services listed on the second page of this document that require Prior Authorization. However, it is ultimately your responsibility to ensure Prior Authorization was obtained. If you have not received a Prior Authorization determination notice from us, please contact us BEFORE receiving health care services at 877.514.2442 to verify that your hospital, physician or medical providers are in-network and that Prior Authorization has been obtained. Our Member Services Representatives can tell you whether the Prior Authorization is approved, denied or is still pending as of 48 hours prior to the time you call.

Once you have obtained the Prior Authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the Prior Authorization. Important facts:

- A Prior Authorization request must be received by us at least 15 business days prior to the anticipated date of your service/procedure. In urgent or emergency admissions, Prior Authorization must be obtained within 24 hours of the admission or the next business day.
- Out-of-network care is generally not covered under our individual health plans except for emergency care, urgent care outside of our 20 counties or with an approved referral. If you get CGHC insurance through your employer, out-of-network care may be covered. In any case, it is your responsibility to contact us for Prior Authorization if you seek care out-of-network. An EPO Referral approved by CGHC is not the same as a prior authorization and in some cases, you need both.
- Please note that a verbal request for Prior Authorization does not guarantee approval. We will notify you in writing of the decision regarding a determination for outpatient services. If your Provider determines that additional care beyond the services specified or the length of time originally authorized is medically indicated, your doctor must request an extension of the original authorization. You and your Provider will be notified whether the request for an extension is approved or denied.
- If you fail to obtain written Prior Authorization for designated services, eligible expenses will be reduced by 50% up to a maximum penalty of \$1500 per service. The 50% reduction or penalty amount will apply first, before a deductible, coinsurance, or any other plan payment or action, and does not apply toward your deductible, coinsurance or maximum out-of-pocket.
- Prior Authorization must be obtained regardless of whether Common Ground Healthcare Cooperative is your primary or secondary health insurance carrier. Prior Authorization does not guarantee coverage and/or payment if a benefit maximum has been reached or coverage has been terminated.

A Prior Authorization is not a guarantee benefits will be paid. It is a determination that the services meet the definition of Medical Necessity. We authorize services or supplies based on the information that is available at the time of the authorization. If the bill that is submitted does not match the service authorized, the service may not be paid. The authorization does not guarantee a Covered Person's eligibility or Benefits under this Certificate. We make Benefit determinations in accordance with all the terms, conditions, limitations and exclusions of this Certificate. Your Policy must be in effect at the time services are rendered.

SERVICES THAT REQUIRE PRIOR AUTHORIZATION 2020 CGHC PLANS

- Certain Prescription Medications that are designated with “PA” in the “notes” column of our [formulary](#). You may also need a Prior Authorization if the drug is designated with a PV* (for a preventive medication available at no cost to you if a prior authorization is approved), or an ST (for step therapy) or QL (for quantity limit) if your doctor is prescribing medication that is beyond the limits we set in our medical policies. You may contact OptumRx for more information at 855-577-6545.
- Botox injections or any procedure that could be considered cosmetic
- Routine care associated with Clinical trials
- Cochlear Implants
- Diagnostic testing including, MRI, MRA, PET, CT Scans, Echocardiogram, psychological testing and neuropsychological testing
- Durable Medical Equipment that is generally anticipated to be \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). Some examples include but are not limited to:
 - Continuous glucose monitoring device
 - Insulin pump (not for supplies only)
 - Feeding pump
 - Implantable devices, including but not limited to infusion pumps and neurostimulators
 - Hospital bed(s)
 - Wheelchair(s)
 - Ventilator(s)
- Inpatient Confinement (not including observation stay which is less than two (2) midnights)
- Care or confinement levels other than Inpatient: Residential, Partial Hospitalization, Skilled Nursing Facility, and Inpatient Rehabilitation Facility.
- Prosthetics
- Reconstructive or plastic surgery procedures, including breast reconstruction surgery following mastectomy
- Specialty Medications administered in an office or outpatient setting
- Surgery - Outpatient hospital, free standing surgical center and ambulatory surgery centers (does not include physician office procedures)
- Temporomandibular joint (TMJ) disorder services and procedures, including but not limited to orthognathic procedures
- Transplant evaluations, services, and procedures

Please see Section 6 of your [Certificate of Coverage](#) for additional information about Prior Authorization.