Quick Reference Guide

Medical Notification & Prior Approval Requirements

2019

MedicalPA-00-122718

Clarification update: 12.29.2018

Prior Approval Needed:

Category	Service
Out-of-Network Providers/Services	‣ Second Opinions ‣ Skilled Nursing Facilities, Long Term Acute Care, Acute Inpatient Rehab, Home Health Agencies Some Behavioral Health Services (see Quick Reference Guide: Behavioral Health Services Prior Approval & Notification Requirements for details)
Advanced Diagnostic Imaging	For other advanced diagnostic imaging: Health Options reviews Observation Stays. Any advanced imaging performed during an Observation Stay must be medically necessary for the 'admitting' diagnosis. See Quick Reference Guide: eviCore Medical Prior Approval Requirements.
Allergy Testing	Including IgG, IgE testing, Leukocyte Histamine Release (LHRT), Conjunctival Challenge Test (ophthalmic mucous membrane test), Direct nasal mucous membrane testing.
Ambulance/Air Transportation	Emergency ambulance transports (911 emergency transports from the scene to the nearest acute care facility) do not require Prior Approval. Non-emergent ambulance transports require Prior Approval. ‣ In-network inter-facility ground ambulance transports to the nearest facility for higher level of care (that is not available at the sending facility) requires notification by the sending facility within one business day of the transfer to initiate medical necessity review. ‣ The Plan does not provide coverage for wheelchair vans, limousines, taxicabs, etc. All fixed wing ambulance transports require Prior Approval. The Plan only covers medically necessary ambulance transport to the nearest medical facility licensed and capable of providing the medically necessary level of care.
Anesthesia	Anesthesia does not require separate Prior Approval, but an approved procedure must be on file for the date of service for the submitted anesthesia claim or the anesthesia claim will be denied.
Applied Behavioral Analysis (ABA)	Submit Prior Approval through Medical Benefit.
Behavioral Health Services	Prior Approval for Applied Behavioral Analysis (ABA) and Neuropsychological testing for clinical presentations with suspected medical origin go through Health Options Medical Management team. All other Behavioral Health Prior Approval requests are processed through our Behavioral Health partner (BHCP). Please refer to the Quick Reference Guide: Behavioral Health Services Prior Approval & Notification Requirements for further details.
Cardiac & Pulmonary Rehabilitation (Outpatient)	Outpatient Phase 2-4 Cardiac Rehabilitation (limited to 36 visits/year); Pulmonary Rehabilitation
Cardiac Surgery/ Cardiovascular	Percutaneous Transluminal Septal Myocardial Ablation
	Therapeutic apheresis, with extracorporeal selective adsorption or selective filtration and plasma reinfusion
	Transcatheter Aortic Valve Replacement
Cardiac Testing	Generally diagnostic cardiac testing requires Prior Approval through eviCore. Please see Quick Reference Guide: eviCore Medical Prior Approval Requirements for further details. However the following procedures do not require Prior Approval (PA): ‣ Electrocardiogram (ECG/EKG) ‣ Holter Monitor

Category	Service
Central Venous Catheters	No Prior Approval for placement, replacement or removal of central venous catheters.
Chemotherapy	Outpatient Chemotherapy
Chiropractic Care/ Manipulative Therapy	Notification is required for visits 1-24.* * Does not include excluded services (e.g., TMJ). Prior Approval is required for visits 25-40. As of 1/1/19 benefits will be capped at 40 combined Chiro/OMT visits per calendar year.
Colonoscopy	Includes screening and diagnostic exams and laboratory studies. Cologuard also requires Prior Approval.
Cosmetic	Cosmetic surgery/procedures done for cosmetic reasons only are not covered. Includes screening, diagnostic exams, and laboratory tests. Reconstructive surgery and potentially cosmetic procedures require Prior Approval to include but not limited to: ‣ Eye procedures (blepharoplasty, blepharoptosis repair, ptosis repair) ‣ Breast reconstruction/reduction ‣ Panniculectomy and/or removal of excess skin/tissue ‣ Congenital chest deformity repair (pectus carinatum, pectus excavatum, Poland syndrome) ‣ Nasal procedures (rhinoplasty, septoplasty, rhinophyma treatment) ‣ Removal of breast implants ‣ Skin proceduress (scar revisions, treatment of hemangiomas and port wine stains)
Dental and Orthognathic Related Services	All dental and orthognathic services, including associated services such as anesthesia, facility, or appliances. Please refer to the Member's Benefit Agreement for coverage details.
Dermatology	All potentially cosmetic procedures regardless of place of service.
Dialysis	End stage renal disease (ESRD) outpatient dialysis services.
Durable Medical Equipment	See Separate Quick Reference Guide: Durable Medical Equipment Prior Approval Requirements.
Early Intervention Services	Early Intervention Services. Limited to 30 visits per calendar year.
Elective inpatient procedures/admissions	Prior Approval is required for Elective inpatient Procedures and Admissions. Notification is required within 48 hours of admissions.
Emerging Technology	Category III codes- emerging technologies, services, and procedures are generally non-covered.
Experimental or Investigational Services, including potentially Experimental or Investigational and all Unlisted Procedure Codes	Experimental, investigational, new procedures without proven effectiveness, miscellaneous codes, and Category III codes are generally non-covered. Although Clinical Trials and/or Studies are not covered, notification is required to determine if any associated services require Prior Approval and/or care coordination.

Category	Service
Gastroenterology and General Surgery	Abdominoplasty, Lipectomy, Panniculectomy
	Breast related procedures: Reconstruction, Reduction, Augmentation, Breast Implant or Removal, Removal or Replacement of tissue expander
	Gastric electrical stimulation ‣ Implantation, replacement, or removal of gastric neurostimulator electrodes, antrum, laparscopic or open ‣ Insertion, replacement, or removal of peripheral or gastric neurostimulator pulse generator or receiver ‣ Electronic analysis of gastric neurostimulator pulse generator/transmitter system
	All Obesity-related (e.g., bariatric) surgeries
	Treatment of varicose veins, including but not limited to, radiofrequency ablation, sclerotherapy, stripping and ligation, endolaser therapy
	Motility and other gastroenterology studies
Genetic Testing	Genetic Testing, Molecular Diagnostics, Pharmacogenetic Testing. Some exclusions apply.
Genitourinary	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance
	Insertion or replacement of penile prosthesis. Excluded, not a covered service
	Implant of neurostimulator electrodes, sacral nerve, Insertion, replacement, or revision of peripheral neurostimulator pulse generator or receiver
	Penile revascularization for impotence Excluded, not a covered service.
	Percutaneous posterior tibial nerve stimulation
Hearing Aids or Repairs	Please refer to Member Benefit Agreement for coverage details. Cochlear implants are Excluded/not a covered service.
Home Health Services	All Home Health services including PT/OT/ST services. NOTE: HMO plans have a benefit limit of 90 total visits (nursing, therapies, social work, etc.) per calendar year.
Home Infusion Therapy	Prior Approval required. Please submit the Medication Prior Approval form Health Options encourages home infusions when medically appropriate. Quick Reference Guide Medications (Medical Benefit) Prior Approval Requirements 2019.
Hospice/Hospice Respite Care	Please refer to Members Benefit Agreement for coverage detail
Hyperthermia Treatment	Hyperthermia used as an adjunct to radiation therapy or chemotherapy
Infusion/Injectable	Select Medical Benefit drugs and biologicals. Please submit the Medication Prior Approval form If the medication is dispensed by a pharmacy please submit applicable authorization requests to Express Scripts. Express Scripts Fax: (877) 329-3760, Phone (800) 753-2851, Portal: https://client.medco.com/CWSCommonService/Login
In-home Biometric Monitoring	In-home biometric monitoring

Category	Service
Laboratory Tests/ Procedures	Below is a list of lab categories that generally require Prior Approval (not all inclusive). Please use online authorization tool for specific code requirements. Allergen Specific IGE/IGG please Urine Drug Testing (see Urine Drug Testing for details) Genetic Testing Molecular Pathology Procedure Necropsy (Autopsy) Unlisted Lab Codes
Long Term Acute Care Hospital (LTACH)	LTACH Admission
Mammograms	Mammograms (including 3-D mammograms/tomosynthesis) do not require Prior Approval, but they are subject to benefit edits.
Nuclear Studies	Nuclear studies generally require prior approval and they are processed by eviCore. Please see Quick Reference Guide: eviCore Medical Prior Approval Requirements for further details.
Neuropsychological Testing	Submit Prior Approval for neuropsychological testing for suspected medical origin through the Medical Benefit.
Neurosurgery (all surgical procedures require Prior Approval)	Neurosurgery procedures are processed by eviCore. Please see Quick Reference Guide: eviCore Medical Prior Approval Requirements for further details.
Nutritional Therapy	Prior Approval is needed for the 7th visit and beyond except for Nutrition therapy reassessment and subsequent interventions based on a second referral in plan year- these services require Prior Approval before 1st visit.
Observation Stays	Health Options will perform Medical Necessity review for the entire stay. Notification is required within 24 hours (or by noon on the first business day after the weekend) even if the patient is already discharged. Delayed notification may result in an administrative denial for observation days prior to notification. An approved day of Observation Stay is based on the clinical presentation and is not necessarily for all services rendered during the stay. Submit all supporting clinical documentation as soon as feasible and within 10 BD of the 1st Observation day. Health Options will review the Observation claim submission. If Health Options determines additional clinical information is needed to support medical necessity of any services/procedures rendered during an Observation Stay, a request will be made to the facility. Examples include but not limited to: Genetic Testing Surgical Procedures Unlisted Procedures Diagnostic Imaging If medical necessity is not met, line item may be denied. Facility/provider has appeal rights.

Category	Service
Ophthalmology	Electro-oculography with interpretation and report
	Implantation of intrastromal corneal ring segments
	Insertion of anterior segment aqueous drainage device, without extraocular reservoir
	Keratoprosthesis for refractive error
	Oculoplastic Surgery: Blepharoplasty, Eyebrow Ptosis Repair
	Transpupillary thermoplasty
Orthopedics	Generally orthopedic procedures require Prior Approval. Spine and joint (e.g., shoulder, hip, and knee) procedures generally require Prior Approval through eviCore. Please see Quick Reference Guide: eviCore Medical Prior Approval Requirements for further details.
	Arthroplasty, ankle, with implant (total ankle)
	Core hip decompression
Osteopathic Manipulation (As of 1/1/19) This requirement applies to DOs credentialed as specialists.	Requires submission of completed Therapies Notification & Prior Approval form Notification is required for visits 1-24.* *Does not include excluded services (e.g., TMJ). Prior Approval is required for visits 25-40. As of 1/1/19 benefits will be capped at 40 combined OMT/Chiro visits per calendar year.
Outpatient Services (all procedures, surgeries and services performed in an outpatient setting or Ambulatory Surgical Unit) included but not limited to:	Advanced Imaging requires Prior Approval through eviCore. See Quick Reference Guide: eviCore Medical Prior Approval Requirements.
	Bone Growth Stimulation for spine- related bone healing: Electrical or Low intensity US stimulation goes through eviCore; all other Bone Growth Stimulation authorization requests go through Health Options.
	Brachytherapy to reduce risk of a de novo restenosis in conjunction with a PTCA, with or without stent placement
	Chelation Therapy for Non-Overload Conditions, Chemical Endarterectomy, except with diagnoses specific to heavy metal poisoning or toxicity.
	Functional Capacity Evaluations
	Hyperbaric Oxygen Therapy, including topical oxygen for wound care
	Home Sleep Studies, Polysomnography, Acoustic Pharyngometer (SNAP) testing
Pain Management Services	Interventional Pain Management service authorization requests are processed by eviCore. See Quick Reference Guide: eviCore Medical Prior Approval Requirements.
Parenteral and Enteral Therapy	Outpatient Parenteral and Enteral Therapy
Plastic, Reconstructive, and/or Potentially Cosmetic Procedures including but not limited to: (any procedure done soley for cosmetic purpose is non-covered)	Oculoplastic Surgery: Blepharoplasty/Eyebrow Ptosis Repair
	Breast related procedures: Reconstruction, Reduction, Augmentation, Breast Implant or Removal, Removal or Replacement of tissue expander
	Abdominoplasty, Lipectomy, Panniculectomy
	Laser treatment for inflammatory skin disease, except for diagnosis of psoriasis
	Rhinoplasty with/without septal repair - except for nasal deformity secondary to congenital cleft lip and/or palate
	Treatment of varicose veins, including but not limited to, radiofrequency ablation, sclerotherapy, stripping and ligation, endolaser therapy

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all inclusive and is subject to change without notice. Providers will receive a 60 day notice of any substantive changes.
All benefits listed are subject to Member Benefit Agreement, contract terms and medical review. Effective 1/1/2019.

Category	Service
Radiation Treatment	Radiation Treatment (non-surgical oncology) to incude but not limited to: ‣ Compensator-based beam modulation treatment delivery ‣ Proton Beam Therapy for uveal melanomas ‣ Stereotactic body radiation therapy ‣ Thoracic target(s) delineation for stereotactic body radiation therapy
Radiology	Advanced imaging (see Advanced Imaging section) requires Prior Approval through eviCore. However, no Prior Approval is required for plain x-ray films except for dental x-ray films which require Prior Approval when covered under the medical benefit).
Respiratory	Bronchoscopies require Prior Approval.
Second Opinions	Second Opinions for non-plan providers
Sleep Studies	Polysomnography, Acoustic Pharyngometer (SNAP) testing. This includes home sleep studies as well as in-lab sleep studies.
Surgical procedures done inpatient or outpatient	All inpatient admissions (elective and unscheduled) require notification within 48 hours of the admission. Observation stays require notification within 24 hours. Must admit or discharge at 48 hours. Elective and unscheduled inpatient admissions requires notification within 48 hours. Inpatient stay requires passing at least one midnight. Notification responsibility: In-Network: Plan provider Responsibility Out-Of-Network: Member Responsibility
Therapies (PT, OT, ST)	Submit completed Therapies Notification & Prior Approval form Notification is required for visits 1-12.* * Does not include excluded services (e.g., TMJ). Prior Approval is required for visits 13-60. As of 1/1/19 benefits will be capped at 60 combined outpatient PT/ST/OT visits per calendar year.
Transplant related services, including initial consult and evaluations	All transplant services to include initial provider consultation, transplant evaluation, testing, and transplant procedures require Prior Approval. **Artificial heart transplants are not a covered benefit**
Transportation	Please see the above ambulance/air transportation overview.

Category	Service
Ultrasounds	Non-OB Ultrasounds are processed by eviCore. OB Ultrasounds are processed by Health Options as of 1/1/19. All OB US requests require Notification to Health Options within 10 BD of the procedure. Up to a maximum of four (4) OB ultrasound procedure codes from the below CPT code description list will be approved upon Notification to Health Options in normal low risk pregnancies, provided the services are rendered by a Plan provider, the Member is eligible for services, and the submitted codes are appropriate for the diagnosis and the woman's current gestational age. Prior Authorization is required for any OB US after the first four (4) or if additional tests from the screening list are requested. Notification for repeat screening is not allowed at the same facility, but repeat screenings are allowed at a different facility or group when referred to another provider. Note: Medical necessity review is required when an OB US visit/procedure includes two or more CPT codes. OB Ultrasound CPT Code Description List (eligible for notification when a single CPT code/procedure is performed): ‣ Ultrasound: OB U/S Ultrasound Obstetrical Pelvis, Pregnant Uterus, First Trimester less than 14 Weeks Single Or First Gestation ‣ Ultrasound: OB U/S Ultrasound Obstetrical Pelvis, Pregnant Uterus, First Trimester less than 14 Weeks Each Additional Gestation ‣ Ultrasound: OB U/S Ultrasound Obstetrical Pelvis, Pregnant Uterus, B-Scan ‣ Ultrasound: OB U/S Ultrasound Obstetrical Pelvis Complete, Multiple Gestation After 1st Trimester ‣ Ultrasound: OB U/S Ultrasound Pregnant Uterus Fetal & Maternal Evaluation Plus Fetal Anatomic Evaluation Transabdominal Single Or First Gestation ‣ Ultrasound: OB U/S Ultrasound Pregnant Uterus Fetal & Maternal Evaluation Plus Fetal Anatomic Evaluation Transabdominal Each Additional Gestation ‣ Ultrasound: OB U/S Ultrasound, pregnant uterus, real time with image documentation; First Trimester less than 14 weeks Single or First Gestation ‣ Ultrasound: OB U/S Ultrasound, pregnant uterus, real time with image documentation; First Trimester less than 14 weeks Each Additional Gestation ‣ Ultrasound: OB U/S Ultrasound Obstetrical Pelvis Limited (Gestational Age, Heart Beat, Emergency) Ultrasound: OB U/S Ultrasound Obstetrical Pelvis Follow Up Or Repeat ‣ Ultrasound: OB U/S Ultrasound Pregnant Uterus Transvaginal
Urine Drug Testing	UDS Requirements: ‣ All UDS tests performed by Out-of- Network labs require Prior Approval. ‣ UDS tests performed by In-network labs do not require Prior Approval with the exception of alcohol biomarkers. ‣ Alcohol biomarker tests require Prior Approval when performed by In-network and Out-of-Network labs. UDS Benefit Limit (per rolling 12 month period): ‣ 20 Qualitative UDS ‣ 20 Quantitative UDS Please consult Health Options Provider Directory for a current listing of In-network labs.
Wound Care Clinic	Services provided in a Wound Care Clinic
Wound Care Products and Procedure	All Bio-engineered Skin Products