Quick Reference Guide

Medical Prior Approval & Notification Requirements

2018

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Community HEALTH OPTIONS®

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: 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 medically necessary 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. ‣ 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	Prior Approval, to include plan of care, is required after the initial evaluation. Note: If additional services (e.g., treatment) are performed the same day as the initial evaluation, Prior Approval will be required for those services. The provider has ten business days from the initial date of service to initiate the Prior Approval request in this scenario.
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 50 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.

Medical Prior Approval and Notification Requirements

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
	Obesity related surgeries: All surgeries related to obesity, including but not limited to bariatric surgeries, lipectomy, or excision of skin due to weight loss
	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 require Prior Approval through Community Health Options to include PT/OT/ST services. Notification is required within 48 hours of the first home visit at which time concurrent review is initiated for ongoing care. All Out-of-Network Home Health Services require Prior Approval.
Home Infusion Therapy	Submit plan of care along with dose and frequency. Approval is based on number of doses and not the milligrams within the dose.
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. Quick Reference Guide Medications (Medication Benefit) Prior Approval Requirements 2018 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
In-home Biometric Monitoring	In-home biometric monitoring

Medical Prior Approval and Notification Requirements

Category	Service
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.
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
Outpatient Services (all procedures, surgeries and services performed in an outpatient setting or Ambulatory Surgical Unit) included but not limited to:	Advanced Imaging and outpatient therapies (PT, OT, ST) require 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
	Ocular photoscreening (e.g., PhotoScreener), except 12 months through 36 months of age
	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.

Category	Service
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
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 (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. Submit clinical documentation to commence concurrent review if observation stay is beyond 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)	Prior Approval, to include plan of care, is required after the initial evaluation. Note: If additional services (e.g., treatment) are performed the same day as the initial evaluation, Prior Approval will be required for those services. The provider has ten business days from the initial date of service to initiate the Prior Approval request in this scenario.
Transplant related services, including initial consult and evaluations	All transplant services, beginning with initial provider consultation, transplant evaluation, including testing, and transplant procedures (except corneal transplants). **Artificial heart transplants are not a covered benefit**
Transportation	Please see the above ambulance/air transportation overview.
Wound Care Clinic	Services provided in a Wound Care Clinic

Category	Service
Wound Care Products and Procedure	Bioengineered Skin Products, including but not limited to: ‣ Alloderm ‣ Apligraf ‣ Artiss ‣ BioBrane Biosynthetic Dressing ‣ Dermagraft ‣ Epicel ‣ GRAFTJACKET, GRAFTJACKET Regenerative Tissue Matrix ‣ Integra Bilayer Matrix Wound Dressing ‣ Integra Meshed Bilayer Wound Matrix ‣ Integra Dermal Regeneration Template (collagenglycosaminoglycan copolymer ‣ Oasis Wound Matrix ‣ Oasis tri-layer wound matrix ‣ Orcel (bilayered cellular matrix) ‣ Primatrix ‣ Regranex ‣ TransCyte (allogeneic human dermal fibroblasts) ‣ Allowrap ds or dry, per square centimeter ‣ Amnioband or guardian, per square centimeter ‣ Dermapure, per square centimeter ‣ Dermavest, per square centimeter ‣ Biovance, per square centimeter ‣ Neoxflo or clarixflo, 1 mg ‣ Neox 100, per square centimeter ‣ Revitalon, per square centimeter ‣ Marigen, per square centimeter ‣ Affinity, per square centimeter ‣ Nushield, per square centimeter