

~ **Prior Authorization Guidelines** ~

Services marked by a bullet in the columns to the left require prior authorization for the designated line of business.

HMO PPO

<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Cosmetic Procedures (or those potentially cosmetic), such as but not limited to:
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	▶ Abdominoplasty
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	▶ Blepharoplasty
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	▶ Breast Reduction
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Dental Services
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Diagnostic Testing
<input checked="" type="checkbox"/>	<input type="checkbox"/>	▶ Neuropsychological Testing
<input checked="" type="checkbox"/>	<input type="checkbox"/>	▶ Psychological Evaluations for medical reasons
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Durable Medical Equipment (See Prosthetics listed separately below)
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	▶ All Rental Items
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	▶ Items > \$600.00 (Purchase)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	▶ Penile Implants
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Home Health Agency Services
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Inpatient Admissions
<input type="checkbox"/>	<input type="checkbox"/>	▶ Scheduled admissions, including acute hospital admissions, acute to acute hospital transfers, rehabilitation facility, hospice and skilled nursing facility admissions.
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	▶ NOTE: For urgent/emergency admits (including obstetric admits), prior authorization is NOT required. However, notification of urgent/emergency admits (including obstetric admits) within 24 hour or the first business day after the admission is required.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Investigational Procedures (or those potentially investigational)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Nonparticipating Providers and Services
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Pharmaceuticals (See formulary)
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Prosthetics
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Rehabilitation/Therapy
<input checked="" type="checkbox"/>	<input type="checkbox"/>	▶ Cardiac Rehabilitation Initial 36 visits during a 16 week period are covered without PA. Additional rehab. requires PA
<input checked="" type="checkbox"/>	<input type="checkbox"/>	▶ Pulmonary Rehabilitation Initial 31 visits during a 16 week period are covered without PA. Additional rehab. requires PA
<input checked="" type="checkbox"/>	<input type="checkbox"/>	▶ Speech Therapy
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Surgery
<input checked="" type="checkbox"/>	<input type="checkbox"/>	▶ Extracapsular cataract extraction with intraocular lens
<input checked="" type="checkbox"/>	<input type="checkbox"/>	▶ MOHS Surgery
<input checked="" type="checkbox"/>	<input type="checkbox"/>	▶ Refractive Surgical Procedures
<input checked="" type="checkbox"/>	<input type="checkbox"/>	▶ Sacral Neurostimulators
<input checked="" type="checkbox"/>	<input type="checkbox"/>	▶ Spinal Neurostimulators
<input checked="" type="checkbox"/>	<input type="checkbox"/>	▶ Deep Brain Stimulators
<input checked="" type="checkbox"/>	<input type="checkbox"/>	▶ Neuromuscular Stimulators
<input checked="" type="checkbox"/>	<input type="checkbox"/>	▶ Vagal Nerve Stimulators for Epilepsy
<input checked="" type="checkbox"/>	<input type="checkbox"/>	▶ Surgical Treatment of Morbid Obesity
<input checked="" type="checkbox"/>	<input type="checkbox"/>	▶ Surgical Treatment of Sleep Apnea
<input checked="" type="checkbox"/>	<input type="checkbox"/>	▶ Temporomandibular Joint Surgery
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	▶ Transplants, Bone Marrow and Organ
<input checked="" type="checkbox"/>	<input type="checkbox"/>	▶ Varicose Vein Treatment
<input checked="" type="checkbox"/>	<input type="checkbox"/>	▶ Vertebroplasty and Kyphoplasty, Percutaneous
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Transportation (non-emergency)

Effective: 1/1/2010