

- Prior authorization applies to all Group Health Cooperative plans including Commercial, BadgerCare Plus, Medicaid SSI and Medicare Advantage plans.
- Authorization for services 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.
- If a member receives services that require an approved prior authorization by the Cooperative and such authorization was not obtained, or the prior authorization was denied because services were not deemed medically necessary, all related services and/or follow-up care related to the services will be denied. This includes any ancillary, facility, and professional charges.
- The following list is not all-inclusive.

## **SERVICES REQUIRING PRIOR AUTHORIZATION**

- Abdominoplasty
- Abortion
- Allografts
- Ambulance if not due to an emergency; both air and ground services
- Autologous cultured chondrocytes
- Bariatric surgery
- Blepharoplasty and brow repair
- Blood pressure monitors
- Bone anchored hearing aid (BAHA) and cochlear implants
- Botox
- Breast reconstruction
- Cancer supportive care such as colony stimulating factors, IV antiemetics, IV steroids
- Cardiac and pulmonary rehabilitation services
- Cardiovascular monitoring services except EKG monitoring codes 93224-93227 and 93241-93248
- Chemotherapy
- Circumcision not performed at time of birth
- Commode chairs
- Cosmetic services including removal or destruction of benign skin lesions and masses such as but not limited to skin tags, cysts, and lipomas in the office or other places of service. The following codes do not require prior authorization: 17110 with symptoms or treatment of warts, 11600-11646
- Day treatment
- Dental anesthesia for children age > 5 years old
- Durable medical equipment: All DME items require a prior authorization except:
  - DME purchases less than or equal to \$300 unless specifically listed (such as orthotics, see below)
  - DME rentals less than or equal to 30 days
  - Nebulizers
- Enteral nutrition and supplies
- Genetic testing
- High end imaging (CT, PET, MRI, CTA, MRA)
- Home health services
- Hospital inpatient admissions - elective (planned)

- Hyaluronic acid
- Hyperbaric oxygen therapy
- Infertility services
- Injections or infusions with billed charges of \$500 or more including but not limited to iron, all monoclonal antibody drugs, immunoglobins, gene therapies, and treatments for multiple sclerosis, inflammatory bowel disease, rheumatoid arthritis, psoriasis, HIV/AIDS, cystic fibrosis, and hemophilia
- Intensity Modulated Radiation Therapy (IMRT)
- Lipectomy
- Long-term acute care hospital admission (LTACH)
- Occupational therapy
- Office based procedures performed in a non-office setting
- Oral appliances
- Oral surgery
- Orthotics
- Out of network services
- Panniculectomy
- Peripheral nerve blocks
- Phototherapy
- Physical Therapy: Prior authorization is required for ETF members once a combined 50 visit limit for physical, occupational, and speech therapies is reached. PT visits will require prior authorization once that combined limit is reached. Occupational and speech therapy services will continue to require prior authorization for all services.
- Plastic and reconstructive surgery
- Podiatric surgeries
- Prosthetics
- Proton beam therapy
- Psychological and Neuropsychologic testing
- Radiofrequency ablation
- Reduction mammoplasty
- Residential treatment services
- Rhinoplasty
- Sclerotherapy/Endovenous ablation
- Septoplasty
- Services with unlisted CPT code or category III procedure code
- Skilled nursing facility admission
- Skin substitutes
- Specialty medications
- Speech therapy
- Surgical consult regarding low back pain (for ETF members)
- Swing bed admission
- Synagis
- Temporomandibular joint (TMJ) treatment
- Transplants and stem cell harvesting
- Uvulopalatopharyngoplasty (UPPP)
- Viscosupplementation

## HOSPITAL ADMISSION NOTIFICATION

1. Emergent (unplanned) hospital inpatient admissions require notification and submission of clinical documentation for medical necessity review within one business day of admission.
2. Notification of hospital admissions associated with labor and delivery is only required if discharge is greater than two (2) days following vaginal delivery or is greater than four (4) days following cesarean delivery. Notification requires submission of clinical documentation for medical necessity review within one business day.

## HOSPITAL CONCURRENT REVIEW

Concurrent review is the process of reviewing extensions of previously approved ongoing care in the hospital and is required for all admissions outlined in the Hospital Admission Notification section above. Concurrent review is a collaborative process with hospital staff and includes reviewing medical records, determining coverage based on this information, and informing all parties about the coverage determination. Nationally recognized, evidence based clinical practice guidelines are used to evaluate hospital stays for medical necessity and appropriateness of care. The concurrent review process is important in providing discharge planning assistance and facilitating post-discharge services to ensure the member's needs are met. During this process Cooperative utilization management staff identify potential quality of care concerns or patient safety issues and refer to Cooperative QI staff for review.

## BEHAVIORAL HEALTH AND ALCOHOL AND OTHER DRUG ABUSE (AODA) SERVICES

### No prior authorization required:

- Outpatient Behavioral Health Counseling
- Outpatient AODA Counseling

### Services requiring prior authorization include but are not limited to:

- Day Treatment/Partial/Hospitalization Programs
- Family Stabilization Services
- Intensive In-Home Therapy
- Intensive Outpatient Therapy (9+Hours)
- Inpatient Admissions
- Neuropsychological and Psychological Testing
- Electroconvulsive Therapy
- Psychophysiological Therapy incorporating Biofeedback
- Procedures including Transcranial Magnetic Stimulation (TMS)
- Residential Treatment

\*Marriage counseling is NOT a covered benefit for commercial plans. Marriage counseling or domestic partnership counseling includes, but is not limited to, the presentation of an individual or couple for services primarily intended for: pre-marital/partnership counseling; the strengthening of a marital or partnership bond; improving or sustaining the relationship; skill building or communication improvement; conflict resolution; sexual difficulties or infidelity; and/or divorce or separation. Family counseling includes but is not limited to the strengthening of the familial bond; relationship improvement; skill building or communication improvement; and conflict resolution.