Prior Authorization List

Effective 1/1/17

Prior authorization is required for specialized services including those listed below. At times, prior authorization is referred to as pre-service authorization, pre-authorization, or pre-certification.

Disclaimer: These references are for informational purposes only and do not constitute medical advice, plan authorization, explanation of benefits, or a guarantee of payment. Benefit plans vary in coverage and some plans may not provide coverage for all services included on the list below. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and federal law. Some benefit plans administered by the organization may not utilize Medical Affairs medical policy in all of their coverage determinations. Call the number located on the member card for specific plan, benefit, and network status information.

Medical policies are based on constantly changing medical science. Our Medical policies are reviewed annually and are subject to change. The organization uses tools developed by third parties, such as the evidence-based clinical guidelines developed by MCG Health and Hayes publications to assist in administering health benefits. Medical policies and MCG Health guidelines are intended to be used in conjunction with the independent professional medical judgment of a qualified health care provider. To obtain a referenced MCG guideline specific to your patient's review, please call the number located on the back of the member's ID card. For general medical policy or MCG requests, please email medical.policies@wpsic.com.

Service/Procedure	Notes
Alternative Communications Device/Speech Generating Device or Digitized Speech	Verify member health plan coverage
Bone Anchored Hearing Aids (BAHA)	Verify member health plan coverage
Bariatric Surgical Services	Verify member health plan coverage
Biofeedback	This is often an exclusion of the member health plan
Behavioral Health Services: Inpatient and residential	Also includes: Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment
Bone Growth (Osteogenesis) Stimulators (BGS)	
Botulinum Toxin Injection	Approval through pharmacy PA
CPAP BiPAP Machines (see also DME)	
Clinical Trials	
Cochlear Implants	Verify member health coverage
Cosmetic and Plastic Surgery Procedures (and any procedure that may be considered cosmetic)	Examples of potential cosmetic procedures: • Blepharoplasty, canthoplasty, eyelid, or eyebrow surgery • Panniculectomy • Pectus excavatum/carinatum

	• Port Wine Stain Laser Treatment • Reduction/augmentation mammoplasty/mastopexy and related services (Services related to breast reconstruction following mastectomy do not require prior authorization) • Rhinoplasty • Temporomandibular Joint Disease (TMJ) • Orthognathic surgical services • Varicose vein treatment • Laser treatment for psoriasis
Cranial Orthotic	This is often an exclusion of the member health plan
Deep Brain Stimulation (DBS)	
Durable Medical Equipment (DME)	Examples of DME Benefit Prior authorization rental above $750 per month or purchase above $1,000 threshold (or lower if required per member health plan): • All CPAP/BiPAP rentals and purchases require authorization • Alternative Communications and Speech generating devices • Crutch substitutes • Hospital beds • Power wheelchairs, custom built wheelchairs, and scooters • Home UVB light treatment of skin conditions • Wearable cardiac defibrillator vest
Genetic Testing	Required documentation from the ordering provider or the genetic counselor associated with the ordering provider includes: • Diagnosis or symptoms being evaluated • Complete relevant family and personal history • Discussion of the calculated potential risks and benefits of the testing; role of heredity in the condition being confirmed diagnosed or treated • How the results of testing will change or influence the current treatment plan
High-tech Radiology –WPS **State ETF** Members	MRA, MRS, PET Scan, Coronary Computed Tomography Angiography (CCTA), and other high-tech imaging services are reviewed through National Imaging Association (NIA Magellan)
High-tech Radiology for all WPS **non-State ETF** Members	MRA, MRS, PET Scan: Member health plan requirements vary regarding imaging services that require prior authorization. Contact member services to verify requirements.
Home Infusion Services	Member health plans require prior authorization for the home infusion administration and the drug(s). Some drugs may require a separate review through specialty pharmacy if they are on the specialty drug prior authorization list. Documentation should include the diagnosis, name of the drug(s), dose infused, and duration of treatment.
Hyperbaric Oxygen Therapy	PA required for non-emergency use. (Example: diabetic wound care)
Intensity Modulated Radiation Therapy (IMRT)	

Immune Globulin (IVIG)	Approval through pharmacy prior approval review
Inpatient Admission: Planned (elective/scheduled) Includes Skilled Nursing Facility (SNF), Long-term Acute Care (LTAC) facility, and Inpatient Hospice Facility	• Notification to the health plan should be made a minimum of three days prior to date of planned admission • Notification to the health plan of urgent/emergent admissions should be made within two days of the admission
Intraoperative Neurophysiological Monitoring	When used with spinal surgery
Neuropsychological Testing	Initial visit to determine need for testing does not require PA
Neurostimulation	Including posterior tibial, hypoglossal, percutaneous, functional stimulation, and neurostimulators for pain management
New technology: medical, surgical, or biomedical services that might be considered experimental, investigational, or unproven	• Examples: Brachytherapy for breast cancer (includes SAVI Device); Second Generation Subcutaneous ICD; iStent Trabecular Micro-Bypass implant • Prior authorization required if not addressed in the Non-covered Services and Procedures Medical Policy • Category III coded procedures/services (T codes)
Pain Management Procedures (Certificate and Medical Policy Limitations may apply)	• Epidural steroid injections • Facet joint injections (Includes facet, MBB, zygapophysial joint, paravertebral facet joint, and dorsal/posterior ramus injections) • Intrathecal pump implantation • Lumbar discography • Radiofrequency ablation • Spinal cord/dorsal column Stimulation • Sacro-Iliac (SI) joint injections and treatment • Automated percutaneous lumbar diskectomy
Pediatric Vision, and Orthoptic/Pleoptic Training	
Physical, Occupational, and Speech Therapy	Prior Authorization must be submitted through Magellan-HSM **after the initial visit**. Include documentation from the initial evaluation.
Prosthetics	• PA required for prosthetics over $5,000 NOTE: Some member certificates may have a lower dollar threshold requirement for prior authorization. • Microprocessor-controlled prosthetic
Proton Beam Radiotherapy	
Skilled Nursing Facility	PA required for member admission
Sleep Study Evaluation and Treatment of Sleep Disorder	• Polysomnograms (sleep study: Home and in-lab) • CPAP/BiPAP machines • Oral appliances • Surgical Procedures (UPPP)

Spinal Surgery	Examples of spinal surgeries that require a PA: • Artificial Intervertebral Discs • Arthrodesis • Fusions (includes SI joint treatments) • Laminectomy and facetectomy NOTE: For percutaneous vertebroplasty, kyphoplasty, and sacroplasty (See Non-covered Services and Procedures Medical Policy)
Stereotactic Radiosurgery/Radiotherapy	
Therapeutic Contact Lens	
Total Ankle Arthroplasty	
Total Shoulder Arthroplasty	
Transplants	Solid organ, bone marrow, stem cell, and cartilage • For cartilage allografts, micro fracture, etc. (See Non-covered Services and Procedures Medical Policy)
Transport of Patients: Non-Emergency (MediVan, ground, or air ambulance)	Prior authorization is required for non-emergency transports

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