

Effective April 1, 2009

PREAUTHORIZATION REQUIREMENTS

The following services require preauthorization for commercial managed products, Medicare, Medicaid, Family Health Plus and Child Health Plus and certain PPO products. Please review the column that applies to the member's specific health benefit program. **This list is not inclusive of all insurance products and procedures requiring preauthorization. Please verify specific coverage requirements before rendering service.** These services require preauthorization regardless of place of service. Revisions are shaded in gray.

| Preauthorization Requirements | Commercial Managed Care and Medicare Products, including but not limited to: Medicare PPO, Healthy New York HMO and ActiveUnivera | Univera Community Health Products: Child Health Plus, Family Health Plus, and PlusMed |
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| Abdominoplasty | Required | Required |
| Air Ambulance (Non-Emergent) | Required | Required |
| Anesthesia for Dental Surgery | Required | Required |
| Autologous Chondrocyte Implantation | Required | Required |
| BRCA Testing | Required | Required |
| Blepharoplasty | Required | Required |
| Breast Implant Insertion, Removal, Reinsertion (except for breast cancer diagnosis) | Required | Required |
| Breast Reduction Surgery | Required | Required |
| Clinical Trials | Required | Required |
| Cochlear Device implants | Required | Required |
| Comfort; Convenience, Cosmetic or Custodial Services or Procedures | Required | Required |
| Congenital Chest Wall Deformity | Required | Required |
| Contact Lenses | Not Required | Required |
| Day Treatment (Behavioral Health) | Required | Required |
| Deep Brain Stimulation | Required | Required |
| Dermabrasion | Required | Required |
| Developmental Testing | Not Required | Required |

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| Durable Medical Equipment | Required for all equipment listed below or when member contract requirements dictate: <ul style="list-style-type: none"> Ⓢ Airway Clearance Devices Ⓢ BiPAP Machines Ⓢ Bone Growth Stimulators Ⓢ Continuous Glucose Monitoring Systems Ⓢ Hospital Beds Ⓢ Insulin Pumps Ⓢ Pneumatic Compressors (Lymphedema Pumps) Ⓢ Speech Generating Devices Ⓢ Stander / Standing Devices Ⓢ T.E.N.S. units Ⓢ Wheel Chairs and Power Operated Vehicles Ⓢ Wound Vacuum | Required for all equipment listed below or when member contract requirements dictate: <ul style="list-style-type: none"> Ⓢ Airway Clearance Devices Ⓢ BiPAP Machines Ⓢ Bone Growth Stimulators Ⓢ Continuous Glucose Monitoring Systems Ⓢ Hospital Beds Ⓢ Insulin Pumps Ⓢ Pneumatic Compressors (Lymphedema Pumps) Ⓢ Speech Generating Devices Ⓢ Stander / Standing Devices Ⓢ T.E.N.S. units Ⓢ Wheel Chairs and Power Operated Vehicles Ⓢ Wound Vacuum |
| Experimental and Investigational Procedures and /or Services | Required | Required |
| Gastric Bypass (Bariatric procedures) | Required | Required |
| Genetic Testing | Required | Required |
| Hemilaminectomy – Cervical or Lumbar, with or without Discectomy or Foraminotomy | Required | Required |
| Hip Replacement (included total and resurfacing) | Required | Required |
| Home Care and Home Infusion Nursing Visits | Required Up to 16 visits over 9 weeks w/o Clinical Review. Clinical Review required for Visits 17 and beyond OR beyond 9 Weeks of therapy | Required |
| Hospital to Hospital Transfers | Required | Required |
| Hyperhidrosis Surgery | Required | Required |

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| Inpatient Admissions (except routine Maternity) to any facility including hospital, elective and direct admit, acute rehab, SNF, behavioral health substance abuse and hospital to hospital transfers. * Emergency Admissions require notification to the Health Plan | Required | Required |
| Intensive Outpatient Behavioral Health Treatment | Required | Required |
| Keloid Scar Revision | Required | Required |
| Knee Replacement | Required | Required |
| Laminectomy Fusion (Cervical, Thoracic or Lumbar) | Required | Required |
| Medical Specialty Drugs https://www.univerahealthcare.com/wps/myportal/xl/prv/drg/specialty | Required. Follow the link to the left view our Medical Specialty Drug Preauthorization Requirements | Required. Follow the link to the left view our Medical Specialty Drug Preauthorization Requirements |
| Miscellaneous and Unlisted Codes | Required | Required |
| Neuropsychological Testing | Required | Required |
| Non-Participating Providers | Required (PPO Products excluded) | Required |
| Orthopedic / Orthotic Devices | Required for Custom Knee Braces Only or unless member contract limitations apply | Required for Custom Knee Braces Only or unless member contract limitations apply |
| Osteochondral Bone Graft | Required | Required |
| Otoplasty | Required | Required |
| Partial Hospitalization (Behavioral Health) | Required | Required |
| Palatopharyngoplasty / Uvulopalatopharyngoplasty | Required | Required |
| Prosthetic Devices | Required for Miscellaneous and Unlisted "L" Codes or unless member contract limitations apply | Required for Miscellaneous and Unlisted "L" Codes or unless member contract limitations apply |
| Psychological Testing | Required | Required |
| Radiofrequency Tumor Ablation | Required | Required |

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| Radiology (Imaging) Services (Excludes imaging performed in the Inpatient, Observation and Emergency Room settings) | Refer to Radiology CPT code list : <ul style="list-style-type: none"> ② CTs and CTAs ② MRAs ② MRIs ② Nuclear Cardiology ② All PET Scans (Positron Emission Tomography) ② Miscellaneous or Unlisted Radiology Procedure Codes | Refer to Radiology CPT code list : <ul style="list-style-type: none"> ② CTs and CTAs ② MRAs ② MRIs ② Nuclear Cardiology ② All PET Scans (Positron Emission Tomography) ② Miscellaneous or Unlisted Radiology Procedure Codes |
| Rhinoplasty | Required | Required |
| Sacral Nerve Stimulation for Pelvic Floor Dysfunction | Required | Required |
| Sleep Apnea Studies | Not Required | Required |
| Spinal Cord Stimulation | Required | Required |
| Therapy; Physical Up to 16 visits within 16 weeks approved without Clinical Review. Clinical Review required for subsequent treatment visits | Required | Required |
| Therapy; Speech and Occupational One evaluation visit w/o clinical review. Clinical review required for subsequent treatment visits | Required | Required |
| Transplants | Required | Required |
| Vagus Nerve Stimulation | Required | Required |
| Varicose Vein Surgery: (e.g., Vein Ligation, Sclerosing Injection, VNUS) | Required | Required |
| Vision Therapy | Required | Required |
| Wireless Capsule Endoscopy for Examination of GI Tract | Required | Required |

This list is not inclusive of all insurance products and procedures requiring preauthorization. Please verify specific coverage requirements before providing service. Some services, including behavioral health and substance abuse, are not covered benefits under Healthy New York HMO.

Some member contracts may have other restrictions. Not all contracts include all benefits. Payment is based on member contract benefits, eligibility and medical necessity at the time of service. The provider delivering the service is responsible for ensuring that the required Pre-authorization has been obtained and contract is active at time of service. Claims will process according to the member's benefit plan on the date of service. Failure to obtain the necessary preauthorization may result in the denial of the claim or reduced payment allowance.