

Effective March 12, 2012

**UTILIZATION MANAGEMENT STANDARD
CLINICAL REVIEW PREAUTHORIZATION LIST**

The following services require clinical review 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 regardless of place of service.

IMPORTANT

This list represents those services that require preauthorization with a clinical medical necessity review and is NOT inclusive of all insurance products and procedures requiring preauthorization. There may be services which require preauthorization/ notification that do not require clinical review. Please verify specific coverage requirements before rendering service.

These services require preauthorization regardless of place of service.

Clinical Review Preauthorization Requirements	Commercial Managed Care and POS, Medicare Products, Healthy New York HMO, Value Care and Active Univera PPO	Univera Community Health Products Child Health Plus, Family Health Plus, PlusMed
Abdominoplasty	Required	Required
Acoustic Cardiography	Required	Required
Air Ambulance (Non-Emergent)	Required	Required
Anesthesia for Dental Surgery	Required	Required
Autologous Chondrocyte Implantation	Required	Required
Bariatric Procedures including Gastric Bypass and Lap Banding	Required	Required
Biofeedback	Required	Required
BRCA Testing	Required	Required
Blepharoplasty	Required	Required
Breast Reconstruction, including but not limited to Implant Insertion, Removal, Reinsertion (except for breast cancer diagnosis)	Required	Required
Breast Reduction Surgery; including surgery for Gynecomastia	Required	Required
Cardiac Catheterization; Left Heart; (Non-Emergent)	Required	Required
Cardiovascular Telemetry Devices, Wearable; Mobile	Required	Required
Chelation Therapy	Required	Required

Clinical Review Preauthorization Requirements	Commercial Managed Care and POS, Medicare Products, Healthy New York HMO, Value Care and Active Univera PPO	Univera Community Health Products Child Health Plus, Family Health Plus, PlusMed
Clinical Trials	Required * For Medicare Advantage members, Medicare Approved clinical trials are covered by original Medicare or FFS Medicare and should be billed directly to your Fiscal Intermediary. Crossover claims will be sent directly to the plan by the Fiscal Intermediary. Be sure to use the correct clinical trial codes.	Required
Cochlear Device implants	Required	Required
Collagenase. Clostridium histolyticum; Xiaflex	Required	Required
Comfort; Convenience, Cosmetic or Custodial Services or Procedures	Required	Required
Computer Assisted Navigation for Knee and Hip Arthroscopy	Required	Required
Contact Lenses	Not Required	Required
Cranial Orthotics	Required	Required
Day Treatment (Behavioral Health)	Required	Required
Deep Brain Stimulation	Required	Required
Dermabrasion	Required	Required
Developmental Testing	Not Required	Required
Durable Medical Equipment	<p>Required for all equipment listed below or when member contract requirements dictate:</p> <ul style="list-style-type: none"> • Airway Clearance Devices • Ambulatory Traction Devices • BiPAP Machines • Bone Growth Stimulators • Continuous Glucose Monitoring Systems • Functional Neuromuscular Stimulators • Gait Trainers • Hospital Beds (including Air Fluidized Beds) • Insulin Pumps • Intrapulmonary Percussive Devices • Pneumatic Cervical Traction Devices • Pneumatic Compressors (Lymphedema Pumps) • Speech Generating Devices • Stander / Standing Devices • T.E.N.S. units • Wheel Chairs and Power Operated Vehicles • Wound Vacuum 	<p>Required for all equipment listed below or when member contract requirements dictate:</p> <ul style="list-style-type: none"> • Airway Clearance Devices • Ambulatory Traction Devices • BiPAP Machines • Bone Growth Stimulators • Continuous Glucose Monitoring Systems • Functional Neuromuscular Stimulators • Gait Trainers • Hospital Beds (including Air Fluidized Beds) • Insulin Pumps • Intrapulmonary Percussive Devices • Pneumatic Cervical Traction Devices • 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 Neurostimulation	Required	Required
Genetic Testing	Required	Required

Clinical Review Preauthorization Requirements	Commercial Managed Care and POS, Medicare Products, Healthy New York HMO, Value Care and Active Univera PPO	Univera Community Health Products Child Health Plus, Family Health Plus, PlusMed
Hearing Aids	Not Required	Required
Hip Replacement (including total and resurfacing)	Required	Required
Home Care and Home Infusion Nursing Visits	Required	Required
Home Tele-Monitoring (this is not Cardiac Surveillance)	Not Covered	Required (excludes Child Health Plus and Family Health Plus)
Home Uterine Monitoring	Required	Required
Hospital to Hospital Transfers	Required	Required
Hyperbaric Oxygen Therapy	Required	Required
Hyperhidrosis Surgery	Required	Required
Inpatient Admissions (except routine Maternity) to any facility including hospital, elective and direct admit, acute rehab, SNF, mental health, chemical dependency and hospital to hospital transfers. * Emergency Admissions require notification to the Health Plan.	Required	Required
Intensity – Modulated Radiation Therapy (IMRT)	Required	Required
Intensive Outpatient Behavioral Health Treatment	Required	Required
Keloid Scar Revision	Required	Required
Knee Replacement; includes Unicodylar	Required	Required
Left Ventricular Assist Devices (LVAD)	Required	Required
Medical Specialty Drugs reference: Univerahealthcare/provider.com Univeracommunityhealth/provider.org for frequently updated list	Required Follow the link to the left to view our Medical Specialty Drug Preauthorization Requirements	Required Follow the link to the left to view our Medical Specialty Drug Preauthorization Requirements
Miscellaneous and Unlisted Codes	Required	Required
Neuromuscular Stimulation for Scoliosis and electrical shock units	Required	Required
Neuropsychological Testing	Required	Required
Non-Participating Providers	Required (PPO products excluded)	Required
Orthopedic / Orthotic Devices	Required for Custom Knee Braces and Cranial Orthotics only or unless member contract limitations apply	Required for Custom Knee Braces and Cranial Orthotics only or unless member contract limitations apply
Osteochondral Bone Graft	Required	Required
Otoplasty	Required	Required

Clinical Review Preauthorization Requirements	Commercial Managed Care and POS, Medicare Products, Healthy New York HMO, Value Care and Active Univera PPO	Univera Community Health Products Child Health Plus, Family Health Plus, PlusMed
Partial Hospitalization (Behavioral Health)	Required	Required
Palatopharyngoplasty/ Uvulopalatopharyngoplasty	Required	Required
Personal Care Services (SAFETY NET ONLY)	NOT COVERED	Required
Platelet rich plasma for wound healing, each unit	Required	Required
Prolotherapy	Required	Required
Prosthetic Devices	Required for: <ul style="list-style-type: none"> • Computerized Prosthetic legs; “C” legs Miscellaneous and Unlisted “L” Codes, or unless member contract limitations apply	Required for: <ul style="list-style-type: none"> • Computerized Prosthetic legs; “C” legs • Prosthetic Eyes; device and service Miscellaneous and Unlisted “L” Codes, or unless member contract limitations apply
Psychological Testing	Required	Required
Radiofrequency Tumor Ablation	Required	Required
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"> • CTs and CTAs • MRAs • MRIs • Nuclear cardiology • All PET scans (Positron Emission Tomography) Miscellaneous or unlisted radiology procedure codes	Refer to Radiology CPT code list: <ul style="list-style-type: none"> • CTs and CTAs • MRAs • MRIs • Nuclear cardiology • All PET scans (Positron Emission Tomography) Miscellaneous or unlisted radiology procedure codes
Rhinoplasty/Septoplasty	Required	Required
Sacral Nerve Stimulation for Pelvic Floor Dysfunction	Required	Required
Sexual Reassignment Surgery	Required	Required
Skin Substitutes	Required	Required
Sleep Studies	Required for Medicare Advantage	Required
Spine Surgery Program	Required for all procedures listed below regardless of place of service: <ul style="list-style-type: none"> • Allograft for Spine Surgery • Arthrodesis / Fusion 	Required for all procedures listed below regardless of place of service: <ul style="list-style-type: none"> • Allograft for Spine Surgery • Arthrodesis / Fusion

Clinical Review Preauthorization Requirements	Commercial Managed Care and POS, Medicare Products, Healthy New York HMO, Value Care and Active Univera PPO	Univera Community Health Products Child Health Plus, Family Health Plus, PlusMed
Spine Surgery Program (con'td)	Required for all procedures listed below regardless of place of service: <ul style="list-style-type: none"> • Arthroplasty; Artificial Disc • Autograft for Spine Surgery • Decompression Procedure(s); Spine • Discectomy including Osteophyctomy • Kyphoplasty • Laminectomy • Laminotomy/Laminectomy; percutaneous • Vertebral Corpectomy • Vertebroplasty; Percutaneous 	Required for all procedures listed below regardless of place of service: <ul style="list-style-type: none"> • Arthroplasty; Artificial Disc • Autograft for Spine Surgery • Decompression Procedure(s); Spine • Discectomy including Osteophyctomy • Kyphoplasty • Laminectomy • Laminotomy/Laminectomy; percutaneous • Vertebral Corpectomy • Vertebroplasty; Percutaneous
Spinal Cord Stimulation	Required	Required
Stereotactic Radiosurgery (SRS)	Required	Required
Therapy; Physical and Occupational	Required	Required
Therapy; Speech	Required	Required
Transplants	Required	Required
Vagus Nerve Stimulation	Required	Required
Varicose Vein Treatment Procedures (including, but not limited to: Vein Ligation, Sclerosing Injection, VNUS and Laser procedures)	Required	Required
Vision Services Eyewear	Not Required	Required
Vision Therapy	Required	Required
Wireless Capsule Endoscopy for Examination of GI Tract	Required	Required
Yttrium-90 ; Selective Internal Radiation Therapy (SIRT)	Required	Required

This list is not inclusive of all insurance products and procedures requiring preauthorization. Please verify specific coverage requirements before rendering service. Some services, including mental health and chemical dependency, 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.