

# Services Requiring Prior Authorization Effective 1/1/2020

## *General Services Requiring Prior Authorization*

The following services require prior authorization for elective circumstances; notification is required for urgent/emergent circumstances within 24 hours of admission or provision of the service. These include:

- Inpatient Acute Care Hospitals
- Long-Term Acute Care Hospitals
- Inpatient Behavioral Health and Substance Use
- Inpatient Hospice
- Acute Rehabilitation
- Skilled Nursing Facility
- Home Health/Outpatient Hospice Services
- Air Medical Transport

## *Specific Services Requiring Prior Authorization*

The following list of Services require prior authorization for coverage. This list reflects those services which may be covered if prior authorization is obtained. This list does not reflect those services which are excluded from coverage due to benefit exclusion or not covered as they are considered investigational. If you have a question as to whether a Service listed on this list is not covered, please contact the plan at the following numbers:

For Medicaid members: 801-213-4104; Toll Free 833-981-0212

For Commercial Group members: 801-213-4008; Toll Free 833-981-0213

For Individual Exchange members: 801-213-4111; Toll Free 833-981-0214

For Mountain Health Cooperative members: 844-262-1560

For Carson Tahoe members: 801-213-0150; Toll Free 833-661-3915

- Ambulance – both ground and air ambulance for non-emergent situations
- Arthroplasty/Joint Replacements - ALL (including but not limited to):
  - Ankles
  - Digits
  - Hips
  - Knees

- Shoulders
- Arthroscopy/Arthroscopic Surgery - ALL (including but not limited to):
  - Ankles
  - Hips
  - Knees
  - Shoulders
  - TMJ
  - Wrists
- Autologous Chondrocyte Implantation for Focal Articular Cartilage Lesions
- Balloon Ostial Dilation for Treatment of Sinusitis
- Bariatric Surgery - *for those plans with coverage of this Service* (including but not limited to):
  - Bilio-pancreatic diversion with duodenal switch (BPD/DS) gastric bypass, open or laparoscopic
  - Roux-en-Y gastric bypass, open or laparoscopic
  - Sleeve Gastrectomy

*Note: Gastric banding and multiple other bariatric procedures are not covered*

- Behavioral Health Services
  - Acute Inpatient Hospitalization and/or Detoxification
  - Applied Behavioral Analysis Therapy (ABA) or other therapies intended to Treat Autism Spectrum Disorder
  - Intensive Outpatient (Note some plans do not have benefits for Intensive Outpatient)
  - Partial Hospitalization
  - Residential Treatment
- BIPAP Therapy
- Bone Anchored Hearing Aids/Osteointegrated Implants
- Bone Growth Stimulators, electrical and ultrasonic
- Cardiovascular Procedures, both diagnostic and therapeutic (including but not limited to):
  - Ablations
  - Angioplasty of arteries or veins,
  - Carotid endarterectomy/Stenting
  - Coronary Artery Bypass
  - Coronary Stent
  - Defibrillator, Internal and External Wearable

- Electrophysiologic Studies
- Endovascular Shunting of Major Arteries
- Heart Transplant
- Left Ventricular Assist Device (LVAD)
- Pacemaker Implantation
- Valve Replacement, Percutaneous and Traditional
- Vascular Bypass
  
- Chemoembolization
  
- Cochlear Implant
  
- Cosmetic Procedures (including but not limited to the following):
  - Abdominoplasty/Panniculectomy
  - Blepharoplasty and Ptosis Repair
  - Breast Reconstruction
  - Breast Reduction
  - Chemical Peels
  - Cleft Lip/Palate Repair
  - Liposuction
  - Removal or Excessive Skin
  - Rhinoplasty
  - Septoplasty
  
- Cryoablation Therapy
  
- Dialysis – Prior authorization required if requested services are with an out of network provider
  
- Durable Medical Equipment
  - For Mountain Health Cooperative Members – all items with billed charges  $\geq$  \$1500 or with monthly rental charges of  $\geq$  \$200
  - For U of U Health Plans Members as follows:
    - Individual Exchange Plan Members  $\geq$  \$750 total billed charges per claim
    - Commercial  $\geq$  \$1,500 total billed charges per claim
    - ARUP  $\geq$  \$5,000 total billed charges per claim
    - CTH  $\geq$  \$5,000 total billed charges per claim

*Examples of Frequently Requested DME items requiring Prior Authorization (not intended to be a complete list):*

- Continuous Glucose Monitors
- Home Dialysis Equipment
- Insulin Pumps, artificial pancreas

- Manual & Power Wheelchair and related equipment
  - Orthotics
  - Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Conditions
  - Oxygen therapy- PA required if needed beyond 90 days
  - Programmable Pneumatic Compression Pumps
  - Prosthetics
  - Speech Generating Devices
  - Tumor Treatment Field Therapy – (e.g., Novocure®)
  - Ventilators, both invasive and noninvasive
- Endometrial Ablation
  - Gastric Electrical Stimulation
  - Gastroesophageal Reflux- Surgical or Endoscopic therapy
  - Gender Dysphoria Treatment
  - Gender Reassignment Surgery
  - Genetic Testing - ALL (including but not limited to):
    - Chromosomal Microarray (CMA)/Comparative Genomic Hybridization(CGH)
    - Hereditary Cancer Syndromes including BRCA
    - Pharmacogenomic Testing
    - Preimplantation Testing
    - Prenatal genetic testing
    - Testing for suspected genetic conditions
    - Testing of drug metabolism
    - Testing of suspected or confirmed cancerous blood and tissue
    - Whole Exome Sequencing
  - Hernia Repair – Ventral only
  - Hip Surgery
    - Arthroscopic
    - Hip Resurfacing
    - Total Hip Arthroplasty
  - Home Enteral/Parenteral Feeding
  - Hyperbaric Oxygen Therapy (HBOT)
  - Hyperhidrosis- Medical and Surgical Treatment

- Imaging
  - All MRIs except for Cancer Diagnoses
  - Computed Tomography to Detect Coronary Artery Calcification
  - Dopamine Transporter Imaging Single-Photon Emission Computed Tomography
  - Functional MRI's
  - Nuclear Medicine Scans including Cardiac Stress Testing
  - PET Scans
  - Single Photon Emission Computed Tomography (SPECT) of the Brain
  
- Infertility – Diagnostic or Therapeutic Procedures (please consult the summary of plan benefits document to determine if infertility related services are covered)
  
- Intrastromal Ring Implantation for Keratoconus (e.g., INTACS)
  
- Intrathecal Pump Therapy
  
- Laser Therapy
  
- Neurostimulator Implantation for any condition (including but not Limited to):
  - Hypoglossal Nerve Stimulation
  - Phrenic Nerve Stimulation
  - Sacral Nerve Stimulation
  - Spinal Cord Stimulation (both trial and definitive implantation)
  
- Orthognathic Surgery
  
- Out of Network Services
  - If your plan has this benefit, you may be held responsible (balance billed) by the provider for costs beyond the plan's Usual and Customary charges. These costs are not counted toward deductible or maximum out of pocket. Prior authorization is Required for Out of Network services to see if services are available in-network.
  
- Ovarian/Gonadal/Pelvic Vein Embolization
  
- Peripheral Nerve Stimulators
  
- *Pharmaceuticals and Pharmacy Services – for a list of drugs and pharmacy-related services please use the link on the prior authorization site or click on either of the following links below:*
  - Commercial/Individual Pharmacy Prior Authorization List
  - Healthy U/Medicaid Pharmacy Prior Authorization List
  
- Physical/Occupational/Speech Therapies- PA required typically beyond plan benefit limit. Please consult plan summary of benefits to determine as this may vary from plan to plan, often limited to 20 visits per plan year

- Platelet Rich Plasma Treatment
- Posterior Tibial Nerve Stimulation for Treatment of Incontinence
- Radiation Therapy – ALL (including but not limited to):
  - Brachytherapy
  - Gamma knife /Cyber Knife Therapy
  - Proton Beam Therapy
  - Radioembolization, Transarterial Embolization (TAE), and Transarterial Chemoembolization (TACE)
  - Selective Internal Radiation Therapy (SIRT)
  - Stereotactic Body Radiation Therapy (SBRT)
  - Stereotactic Radiosurgery (SRS)
- Radiofrequency Ablation (including but not limited to):
  - Fibroid Treatment
  - Oncology Applications
  - Pain Management
- Sacroiliac Fusion
- Sinus Surgery including Stereotactic Guidance
- Sleep Apnea
  - BIPAP
  - CPAP – prior authorization required after initial 90 day rental to assure effectiveness and compliance with therapy
  - Oral Appliances
  - Surgical Intervention
- Spinal Surgery – ALL (including but not limited to):
  - Artificial Disc Replacement
  - Spinal Fusion Surgery
- Stem Cell Therapy
- Temporomandibular Joint (TMJ) procedures
- Transcranial Magnetic Stimulation (TMS)
- Transcutaneous Treatments for Migraine Headache (including but not limited to):
  - Cephalic Stimulator
  - eNeuro Stimulator

- Gamma-Core-S
- Transplants- ALL Autologous and Allogenic transplants (including but not limited to):
  - Bone marrow/Hematopoietic Stem Cell Transplant (HSCT)
  - Cornea
  - Heart
  - Islet cell
  - Kidney
  - Liver
  - Lung
  - Pancreas
  - Small bowel
- Varicose Vein procedures
- Video/Ambulatory EEG – both inpatient and outpatient