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 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 hips, knees, shoulders, ankles, digits
- Arthroscopy/Arthroscopic Surgery – ALL including but not limited to hip, knee, shoulder, wrist, TMJ, ankle
• 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
  o Roux-en-Y gastric bypass, open or laparoscopic
  o Sleeve Gastrectomy
  o Bilio-pancreatic diversion with duodenal switch (BPD/DS) gastric bypass, open or laparoscopic

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

• Behavioral Health Services
  o Acute Inpatient Hospitalization and/or Detoxification
  o Residential Treatment
  o Partial Hospitalization
  o Intensive Outpatient (Note some plans do not have benefits for Intensive Outpatient)
  o Applied Behavioral Analysis Therapy (ABA) or other therapies intended to Treat Autism Spectrum Disorder

• BIPAP Therapy

• Bone Anchored Hearing Aids/Osteointegrated Implants

• Bone Growth Stimulators, electrical and ultrasonic

• Chemoembolization

• Cosmetic Procedures, including but not limited to the following:
  o Abdominoplasty/Panniculectomy
  o Blepharoplasty and Ptosis Repair
  o Breast Reconstruction
  o Breast Reduction
  o Chemical Peels
  o Cleft Lip/Palate Repair
  o Liposuction
  o Removal or Excessive Skin
  o Rhinoplasty
  o Septoplasty

• Cardiovascular Procedures, both diagnostic and therapeutic
  Examples of Frequently Requested Services include but are not limited to
  o Ablations
  o Angioplasty of arteries or veins,
  o Coronary Stent
  o Coronary Artery Bypass
- Valve Replacement, Percutaneous and Traditional
- Electrophysiologic Studies
- Heart Transplant
- Pacemaker Implantation
- Defibrillator, Internal and External Wearable
- Vascular Bypass
- Carotid endarterectomy/Stenting
- Left Ventricular Assist Device (LVAD)
- Endovascular Shunting of Major Arteries

- Cochlear Implant
- 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 ≥$1500 or with monthly rental charges of ≥$200
  - For U of U Health Plans Members as follows:
    - Individual Exchange Plan Members ≥$750 total billed charges per claim
    - Commercial ≥$1,500 total billed charges per claim
    - ARUP ≥$5,000 total billed charges per claim
    - CTH ≥$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
- Orthotics*
- Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Conditions
- Oxygen therapy- PA required if needed beyond 90 days
- Manual & Power Wheelchair and related equipment
- Programmable Pneumatic Compression Pumps
- Prosthetics
- Speech Generating Devices
- Tumor Treatment Field Therapy – 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:
  - Preimplantation Testing
  - Prenatal genetic testing
  - Chromosomal Microarray (CMA)/Comparative Genomic Hybridization (CGH)
  - Hereditary Cancer Syndromes including BRCA
  - Pharmacogenomic Testing
  - Testing of suspected or confirmed cancerous blood and tissue
  - Testing for suspected genetic conditions
  - Testing of drug metabolism
  - Whole Exome Sequencing

• Hernia Repair – Ventral only

• Hip Surgery
  - Arthroscopic
  - Total Hip Arthroplasty
  - Hip Resurfacing

• Home Enteral/Parenteral Feeding

• Hyperhidrosis- Medical and Surgical Treatment

• Hyperbaric Oxygen Therapy (HBOT)

• Intrathecal Pump Therapy

• Infertility – Diagnostic or Therapeutic Procedures (if covered under the plan, please consult the summary of plan benefits document to determine if infertility related services are covered)

• Intrastromal Ring Implantation for Keratoconus (e.g. INTACS)

• Imaging
  - All MRI except Cancer Diagnosis
  - Computed Tomography to Detect Coronary Artery Calcification
  - Dopamine Transporter Imaging Single-Photon Emission Computed Tomography
  - PET scans
  - Nuclear Medicine Scans including cardiac stress testing
  - Functional MRI’s
  - Single Photon Emission Computed Tomography (SPECT) of the Brain

• 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)

- Out of Network Services
  - If your plan has this benefit, you may be held responsible (balance billed) by the provider for costs beyond plan’s Usual and Customary. These costs are not counted toward deductible or maximum out of pocket. Recommend prior authorization to see if services are available in-network.

- Orthognathic Surgery

- Ovarian/Gonadal/Pelvic Vein Embolization

- **Pharmaceuticals and Pharmacy Services** – for a list of drugs and pharmacy-related services please use the link on the prior authorization site - [Pharmacy Prior Authorization List](#)

- Peripheral Nerve Stimulators

- Physical/Occupational/Speech Therapies- PA required typically beyond plan benefit limit – please consult plan summary of benefits to determine as this may varying 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; this includes but is not limited to the following:
  - Brachytherapy
  - Stereotactic Body Radiation Therapy (SBRT)
  - Stereotactic Radiosurgery (SRS)
  - Proton Beam Therapy
  - Radioembolization, Transarterial Embolization (TAE), and Transarterial Chemoembolization (TACE)
  - Gamma knife /Cyber Knife Therapy
  - Selective Internal Radiation Therapy (SIRT)

- Radiofrequency Ablation, including but not limited to the following:
  - Oncology Applications
  - Pain Management
  - Fibroid Treatment

- 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
  - Common Examples include but are not limited to:
    - Spinal Fusion Surgery
    - Artificial Disc Replacement

- Stem Cell Therapy

- Temporomandibular Joint (TMJ) procedures

- Transcranial Magnetic Stimulation (TMS)

- Transcutaneous Treatments for Migraine Headache
  - Gamma-Core-S
  - eNeuro Stimulator
  - Cephaly Stimulator

- Transplants- All autologous and allogenic transplants including but not limited to bone marrow, cornea, heart, lung, liver, kidney, islet cell, pancreas, small bowel.

- Varicose Vein procedures

- Video/Ambulatory EEG – both inpatient and outpatient