

PRIOR AUTHORIZATION DOCUMENT REQUIREMENTS - Effective 01/2021

Admissions to facilities (including transfers between separate facilities, even if within the same hospital system) Ambulance/Transportation Bariatric Surgery (may not be a covered benefit on all programs) Behavioral Health Services Behavioral Health Services Behavioral Health Services Cardiac Imaging (Nuclear studies, ECG, ECHOs, MRI, MRA, CT, CTA, PET, PET/CT, Electron beam CT Dental Procedures (may not be a covered benefit on all programs) Durable Medical Equipment (DME) and Prostheses Durable Medical Equipment (DME) and Prostheses Genetic/Molecular Testing Genetic/Molecular Testing Durable Drugs Coutpatient Procedures (SN, HHA, PT/OT/ST) Injectable Drugs Outpatient Procedures/Surgeries Outpatient Procedures/Surgeries Outpatient Procedures (Surgeries Outpatient Procedures Durable Management Procedures Ambulance/Transportian rational clinical documentation on medical necessity and physical or demission within 24 hours of notification. Progress notes from the last 24 hours por to transport. Progress notes from the last 24 hours por to transport. Progress notes from the last 24 hours por to transport. Progress notes from the last 24 hours por to transport. History and physical, documentation of medical necessity, nutritional evaluation, psychological necessity, nutritional evaluation, psychological peace with psychological intervention(s) and goal(s). History and physical, documentation of medical necessity for the test. Documentation of treatment plan, all related dental imaging and procedures, signed parent or guardian consent, completed Criteria for Dental Therapy Under General Anesthesia form. History and physical or clinical notes, including anticipated length of use, Title XIX form, plan of care, and documentation of medical necessity. Past experience if any using similar equipment, evaluation of upper extremity strength, if applicable and commentation of medical necessity. Recent history and physical, plan of care, therapy evaluation, progress notes for continuation of servic	Covered Service	Document Requirements
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Covered Service	Document Requirements
Pregnancy Services	
 Terminations/Abortions For OBs who are not MFM specialists, authorization required for: Use of 17-P More than two (2) NSTs or BPPs (with or without NST) More than two (2) ultrasounds (except nuchal translucency, CPT 76813) 	Documentation of medical necessity, history and physical, completion of appropriate request form.
Proton Beam Radiation Therapy	Recent history and physical, plan of care, and documentation of medical necessity.
Radiology/Imaging Services (members 21 years and over)	History and physical, documentation of medical necessity, anatomical location, results of previous diagnostics procedure report.
Reconstructive/Plastic Surgery/Possible Cosmetic Procedures	Pre-operative evaluation, documentation of medical necessity, history and physical including functional impairment, and operative report.
Rehabilitative/Habilitative Services	Recent history and physical, plan of care, documentation of medical necessity, therapy evaluation with prior and current level of function and progress notes for continuation of services.
Transplantation	If transplant approval on record: Date of transplant If no transplant approval: history and physical, documentation of medical necessity, transplant evaluation, and date of transplant.
Wound Care Services	History and physical, documentation of medical necessity, wound description and measurements, prior wound treatments.