

# 2011 Prior Authorization List and Utilization Guidelines Effective 01/01/2011



There are no changes applicable January 2011. Please visit [www.CHPW.org](http://www.CHPW.org) regularly for updates to this list. All procedures in an inpatient setting require prior authorization.

Outpatient procedures listed below require prior authorization.

Other services not listed may not be a benefit; please call to verify benefits and coverage or verify online at: <https://hip.chpw.org>

**Utilization Management requests may be made through the Care Management Provider Portal at <https://jiva.chpw.org>**

**BH=Basic Health; MA=Medicare Advantage**

## DRUGS/INJECTABLES

- 17 Alpha-hydroxyprogesterone
- Adalimumab (Humira)
- Abatacept (Orencia)
- Amifostine (Ethyol)
- Bevacizumab (Avastin)
- Botulinum toxin (Botox/Myobloc)
- Certolizumab (Cimzia)
- Cetuximab (Erbix)
- Corticotropin (Acthar)
- Docetaxel (Taxotere)
- Erythropoiesis-stimulating agents (Darbepoetin & Epoetin)
- Epoprostenol (Flolan)
- Etanercept (Enbrel)
- Gemcitabine (Gemzar)
- Golimumab (Simponi)
- GnRH agonists (e.g., Lupron)
- Granulocyte-colony stimulating factor (G-CSF) (e.g., Pegfilgrastim)
- Growth hormone (Somatropin)
- Hyaluronic acid derivatives (e.g., Synvisc/Hyalgan)
- Iloprost (Ventavis)
- Infliximab (Remicade)
- Intravenous immunoglobulin
- Natalizumab (Tysabri)
- Octreotide (Sandostatin)
- Omalizumab (Xolair)
- Oxaliplatin (Eloxatin)
- Palivizumab (e.g., Synagis)
- Pamidronate (Aredia)/Zoledronic Acid (Zometa)
- Rituximab (Rituxan)
- Trastuzumab (Herceptin)
- Treprostinil (Remodulin)

## INPATIENT FACILITIES

- Inpatient hospitalization & rehabilitation
- Skilled nursing facility

## RADIOLOGY

- CT- Head (non-emergent)
- CT Angiography
- PET scan
- MRI/MRA

## SURGICAL PROCEDURES

- Urethral suspensions
- Blepharoplasty
- Breast prostheses/implants
- Breast reduction/Mammoplasty
- Bunionectomy
- Capsule endoscopy
- Thoracic spinal fusion
- Thoracic spinal laminectomy
- Cochlear implant
- Cataract removal
- Endovenous laser/Radiofrequency ablation
- Essure hysteroscopic sterilization
- Hip/knee/shoulder replacement
- Hysterectomy
- Knee arthroscopy
- Reconstructive plastic surgery & supplies
- Rhinoplasty & septoplasty
- Sclerotherapy, leg veins
- Uvulopalatopharyngoplasty

## ALTERNATIVE CARE

- Acupuncture > 6 Visits (BH/WHP)
- Biofeedback > 6 Visits
- Chiropractic > 12 visits (except BH/WHP)
- Chiropractic (BH/WHP)
- Hypnotherapy > 6 visits (BH/WHP)

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- Massage > 6 visits (BH/WHP)
- Naturopathy > 6 visits (BH/WHP)
- Wound vac

## HOME HEALTH SERVICES AND HOME INFUSION (including enteral therapy and home-based therapy)

### BEHAVIORAL HEALTH

- Behavioral health care > 8 visits

### DENTAL

- Accidental dental
- Dental anesthesia

### DURABLE MEDICAL EQUIPMENT (DME) / PROSTHETICS

Please note: It is Community Health Plan's policy to require prior authorization for all DME with a purchase price that exceeds \$1000 per the DSHS fee schedule. (DME benefits are not covered for GA-U and Basic Health.)

Other specific services:

- Bone growth stimulators
- Chest compression devices
- Cough stimulating devices
- Communication devices (e.g., speech generators)
- C-PAP/Bi-PAP rental & purchase
- Insulin pumps
- Hospital beds & accessories
- Oxygen
- Patient lifts
- Prosthetic limbs
- TENS unit
- Ventilators
- Wheelchairs/scooters (rental & purchase)

### HOSPICE CARE

### THERAPIES & SPECIALTY SERVICES

- Cardiac rehabilitation
- CORF (MA Only)
- Dialysis
- PT/OT (BH/WHP)
- Extended therapy > 12 visits (PT/OT/ST/Wound Care)
- Extended specialty services (>12 visits per individual specialist)

### TRANSPLANTS

- Work-ups
- Transplants (excluding corneal)
- Donation

### OTHER

- Experimental/investigational services
- Hyperbaric oxygen treatment
- TMJ treatment
- Unlisted codes

### DOCUMENTATION

Please provide documentation with the request to support medical necessity. This should include the pre-procedure evaluation and your trial of nonsurgical conservative methods. The intent is to limit the administrative burden at the point of service and to ensure quality of care and attenuation of risk for our entire patient population.

### OUT-OF-NETWORK REFERRALS

On prior authorizations for all out-of-network requests, the first 2 visits will be approved. Any initial request for more than 2 visits will be returned for correction and resubmission. All subsequent visits require supporting clinical information and the initial consult document with the request. Ongoing services need to be out of primary care scope of services, per the Milliman Guidelines.

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## Information Required to Support Decision-Making

- PCP or specialist progress or consultation notes
- History and/or physical examination that addresses the problem
- Current notes that show requested service will be ordered or include a prescription for services
- Any other pertinent clinical information to support the request

Please note: To be reimbursed, all services must be a covered benefit under the member's plan. However, not all services require prior authorization.

For eligibility and benefits, please call our Customer Service team at 1-800-440-1561, M-F, 8 am - 5 pm. For Medicare Advantage, please call 1-800-942-0247, 7 days a week, 8 am - 8 pm.

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## Referral Policy (In-Network Participating Specialists)

Community Health Plan is a managed care health plan and requires written or verbal orders from the member's assigned Primary Care Physician (PCP) prior to all services being rendered or items being dispensed. PCP orders should be the result of a face-to-face encounter with the patient. All PCP orders should include both visit and length of authorization parameters. If verbal orders are given, a note must be written in the patient's medical chart, demonstrating PCP intent to refer.

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## Referral Policy (Out-of-Network Specialists)

Community Health Plan requires use of in-network providers whenever possible. When circumstances arise that require a referral to an out-of-network specialist, the Plan requires a referral to be generated. There must be a referral in the system for the claim to be paid. Referrals to nonparticipating providers may be submitted using the Care Management Provider Portal at <https://iiva.chpw.org> or by FAX to (206) 652-7076. They may be phoned in by calling our Customer Service team at 1-800-440-1561, M-F, 8 am - 5 pm. For Medicare Advantage, please call 1-800-942-0247, 7 days a week, 8 am - 8 pm.

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## Inpatient Hospitalizations

Community Health Plan requires hospitals to notify the Plan of all inpatient admissions within the next business day. You may submit the notification using the Care Management Provider Portal at <https://iiva.chpw.org> or fax the notification to 206-652-7078. You may also call Customer Service at 1-800-440-1561, M-F, 8 am – 5 pm. For Medicare Advantage, call 1-800-942-0247, 7 days a week, 8 am - 8 pm.

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## Pregnancy Notifications

Although Community Health Plan does not require prior authorization for maternity-related services, notification of pregnancy is needed. Early notification of pregnancy enables the Plan to identify high-risk members and assess for high-risk case management services. Please see the Pregnancy Notification Form or contact Nicole Kline, RN, BSN at 206-613-5053 for additional information.

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## Case Management Services

Case management is a process that promotes a client's access to care, the containment of costs, the enhancement of quality services and products, the identification of alternative care plans, the increase of a client's awareness of his disease, and the facilitation of the member's empowerment over his disease. A case manager's role is advocacy, assessment, and coordination of care between multiple providers and the member.

Some Prior Authorization requests after processing will be referred automatically to Case Management.

If you feel your patient would benefit from Case Management services, please complete a referral form, which may be found at: <http://chpw.org/for-providers/care-and-case-management/for-providers-case-management/?id=for-providers/care-and-case-management/case-management/>

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