

# 2024 Prior Authorization List and Utilization Guidelines - Medical & Surgical

Effective: January 1, 2024

Services for a specific program may not be a covered benefit; please call Customer Service to verify benefits and coverage or verify online at

## CLINICAL TRIALS

## DURABLE MEDICAL EQUIPMENT, PROSTHETICS & MEDICAL SUPPLIES

- All DME > \$500 allowed amount or DME with rental >\$200 a month
- Automatic External Defibrillator
- Bone growth stimulators
- C-Pap/Bi-Pap
- Chest compression devices
- Enteral Nutrition (21 and over)
- Enteral Pumps
- Hospital beds & accessories
- Ventilators
- Wheelchair/Scooters
- Wound Vac

## UNLISTED/UNSPECIFIED CODES WITH CHARGES GREATER THAN \$250

Medical necessity documentation and pricing must be submitted with the request

## EXPERIMENTAL/ INVESTIGATIONAL SERVICES AND DRUGS

## GENETIC TESTING

## HLA TESTING

## PRIVATE DUTY NURSING AND HOME HEALTH

Any service provided in the home (RN, OT, PT, ST) requires prior authorization

## OUTPATIENT AND SPECIALTY SERVICES

- Chiropractic (> 12 visits **MA** and qualifying **WAH** 20 and under; (see Benefits for further info)
- Hyperbaric oxygen treatment
- Orthoptic/Pleoptic Training
- Spinal Injections
- Therapies for Speech (21 and over), Physical and Occupational: initial 12 visits in a calendar year do not require Prior Authorization. Prior Authorization is required for any subsequent visits.

## TRANSPLANTS

- Evaluation/Work-Up
- Organ donation (living)
- Transplants (excluding corneal)

## IMAGING/RADIOLOGY RADIOLOGY

- CT Heart with Quantitative Evaluation of Coronary Artery Calcium
- Intensity Modulated Radiation Therapy **WAH**
- MRI/MRA
- Proton Beam Radiation Therapy **WAH**

## SURGICAL PROCEDURES

- All planned Inpatient procedures
- Arthroplasty
- Arthroplasty, Hip **WAH**
- Arthroscopy, Hip
- Arthroscopy, Knee
- Arthroscopy, Shoulder
- Bariatric surgery
- Cardiac Stents **WAH**
- Cochlear implant
- Cranial Neurostimulator
- Endovenous laser/Radiofrequency ablation
- Extracorporeal Membrane Oxygenation **WAH**
- Facet Neurotomy
- Hysterectomy
- Mammoplasty (Augmentation/Reduction)
- Neurostimulator peripheral nerves
- Reconstructive plastic surgery & supplies
- Rhinoplasty and septoplasty
- Sclerotherapy, leg veins
- Spinal Cord Stimulator
- Spinal surgeries

## INPATIENT SERVICES

*All admissions, planned and urgent, require notification of admission within 24 hours or next business day*

- Administrative Days following denial of inpatient days require prior authorization **WAH**
- Inpatient rehabilitation
- Planned inpatient services, including surgery
- Skilled nursing facility

## Line of Business (LOB) Legend:

**WAH**

Washington Apple Health IMC

**CS**

Cascade Select

**MA**

Medicare Advantage

\*If no LOB is highlighted next to the service, then Notification or Authorization applies across all LOBs for that service.

## DOCUMENTATION REQUIRED TO SUPPORT DECISION-MAKING

Please provide documentation with the request to support medical necessity. Examples of appropriate documents include:

- Current (within 6 months, or more recent depending on condition) history and/or physician examination notes that address the problem and need for services requested
- Relevant lab and/or radiology results
- Relevant specialty consultation notes
- Other pertinent information

## REFERRAL POLICY

### PCP to PCP Referrals:

For All Plans - If you are the member's assigned PCP or group, an authorization to provide primary care is required from the Plan if your member needs to see a PCP outside of your group.

CHPW-Cascade Select: Any service provided by a non-networked provider for a Cascade Select member requires prior authorization. Cascade Select members will be redirected to networked providers whenever possible. Any request for authorization to a non-network provider should include rationale why the member cannot receive those services with a networked provider.

## INPATIENT HOSPITALIZATION

CHPW requires notification of all inpatient admissions, planned and urgent, within 24 hours or next business day.

All planned admissions also require prior authorization.

## BENEFIT and COVERAGE

This PA list is not all-inclusive. Please refer to the coverage guidelines for each unique line of business.

Washington Apple Health IMC = HCA Provider Billing Guidelines Manual and/or Fee Schedule

Medicare Advantage = National Coverage Guidelines and/or Local Coverage Guidelines

Cascade Care – Cascade Select = CHPW - Cascade Select Explanation of Coverage (EOC)

Failure to obtain the required prior authorization may result in a denied claim. Services are subject to benefit coverage, limitations and exclusions as described in plan coverage guidelines.

**Please refer to the PA Code Lookup Tool for additional details on services listed.**

<https://forms.chpw.org/pclt>