



# Prior Authorization Guidelines for Commercial, BadgerCare Plus and Medicaid SSI Plans

Authorization for services does not guarantee payment for services. Payment for services is dependent on other non-medical criteria such as the benefits associated with a member's specific plan and eligibility issues.

**Retroactive event authorizations for services will not be granted unless there is a compelling reason for consideration. At no time will a retroactive event authorization be approved for a time span greater than two weeks prior to the receipt date.**

Please note: If a member receives services that require an approved authorization by the Cooperative and such authorization is not obtained, or the prior authorization was denied because services were not deemed medically necessary, all services (including out-of-network and future related services and/or follow-up care related to the services) will be denied. This includes any ancillary, facility, and/or professional charges.

## All Facility Admissions

- Non-emergent hospital admissions
- Rehabilitation facility admissions
- Skilled nursing facility admissions
- Sub-acute care admissions
- Swing bed admissions
- Behavioral health admissions including residential treatment facility admissions (See Behavioral Health and Chemical Dependency Services for benefit information and phone numbers)

Additional clinical information may be needed to assess length of stays that are prolonged after the initial length of stay authorization approval. (Concurrent Review)

- Emergency admissions require next business day notification and notification of discharge date at time of discharge. Additional clinical information may be needed to assess length of stays that are prolonged after the initial length of stay authorization approval (Concurrent Review).

Use the Notification for Admission Event Authorization Request form.

\*Medical appropriateness for hospital admission associated with labor and delivery charges is only required if discharge is greater than two (2) days following vaginal delivery or is greater than four (4) days following cesarean delivery. No notification of inpatient admission by hospital is needed if admission is less than or equal to these timeframes.

## Alternative Medicine Services

Alternative medicine specialists include massage therapists, acupuncturists and/or herbal therapists are non-covered benefits for all plans. *No services will be authorized or paid for.*

## Ambulance Transportation

- Ambulance transportation that is not due to an emergency; both air and ground services. *Prior to the scheduling of the transfer and as soon as possible.*

Use the Service Event Authorization Request form.

## Behavioral Health & Alcohol and Other Drug Abuse (AODA)

The behavioral health and AODA service areas of the Cooperative are referred to as Region 1 and Region 2. When a primary care provider or a member themselves, determines that behavioral health or AODA services (either inpatient or outpatient) are needed, they must adhere to the following:

**Region 1** services are for BadgerCare Plus members who reside in the counties of Barron, Chippewa and Eau Claire. These services are provided directly by Vantage Point Clinic & Assessment Center who can be reached at (715) 836-3171 to schedule services.

**Region 2** services are for BadgerCare Plus members who reside outside of Barron, Chippewa and Eau Claire counties and all Cooperative commercial and Medicaid SSI members. These services **are not** provided directly by Vantage Point Clinic & Assessment Center. Members and the providers who serve them should contact Group Health Cooperative's Health Management Department at (800) 218-1745 for all authorization and referral needs.

- No authorization is required for the 1st six visits (including eval) for outpatient mental health/AODA counseling.
- Authorization is required prior to any:
  - Day treatment
  - In-home therapy (including autism)
  - Partial and/or in-patient hospitalization

Use the appropriate Behavioral Health Authorization forms.

## Eyeglasses (BadgerCare Plus and/or Medicaid SSI only)

Prior authorization is required if a prescription change occurs resulting in the need for replacement of eyeglasses above and beyond the benefit of 2 pair within the member's annual membership year.

Use the Service Event Authorization Request form.

## Non-Emergent Surgeries and Procedures

- Abortion
- Bone conduction hearing implants
- Cancer clinical trials
- Circumcision not performed within one week of birth
- Corneal transplants/Keratoplasty
- Dental anesthesia procedures or oral surgery not performed in an office setting (dental anesthesia not performed in an office setting for children 5 years old and under does not require prior authorization)
- Gastric surgery for obesity (including consults, testing, and assessments prior to surgery)
- Hyperbaric Oxygen Chamber Treatment
- Intra-discal electrothermal annuloplasty (IDET)
- Radiofrequency ablation for the treatment of chronic pain
- Office based procedures not performed in an office based setting
- Organ transplant including bone marrow transplant/stem cell transplant
- Pain management services in an outpatient clinic and outpatient hospital setting (see May 2017 update)
- Plastic or reconstructive surgery including but not limited to: blepharoplasty, ptosis repair, panniculectomy, reduction mammoplasty, breast implant removal, scar revision
- Podiatric surgery not performed in the doctor's office or Skilled Nursing Facility
- Rhinoplasty/septoplasty

- Sclerotherapy/Endovenous Ablation
- Temporomandibular joint (TMJ) treatment
- Uvulopalatopharyngoplasty (UVPP, UPPP)
- Viscosupplementation
- Any service billed with an unlisted CPT or category III procedure code, or previously unlisted CPT or category III procedure code that now has a permanent code

Use the Service Event Authorization Request form.

## Out-of-Network Referral Requests

Any request for a member to obtain professional services from an out-of-network provider must be authorized by the Cooperative Health Management Department.

Use the Out-of-Network Referral Event Authorization Request form.

## Out-of-Practice-Group Referral Requests

*(as applicable)*

Out-of-Practice-Group referrals for BadgerCare Plus members to other Cooperative network providers must be authorized by the Cooperative Health Management Department.

Use the Out-of-Practice Group Referral Event Authorization Request form.

## Home Health

- Home Health Services require prior authorization
- Prior authorization is no longer required for Palliative Care and Hospice Services

## Outpatient Laboratory

- Any genetic testing such as DNA testing **except**:
- When billed in conjunction with amniocentesis or
- Prenatal triple test or **AFP**: *alpha-fetoprotein*, **hCG**: *human chorionic gonadotropin*, and **Estriol**
- When provided in conjunction with Bone Marrow Biopsy

Use the Service Event Authorization Request form.

## Outpatient Psychological Testing

Authorization for outpatient psychological testing must be obtained by contacting the Cooperative's Health Management department at (800) 218-1745.

## Outpatient Radiology not Performed at the Time of an Emergency Department Service or Visit, or an Inpatient or Observation Stay

- MRI/MR Arthrogram
- PET Scans/SPECT Scans
- CT Scans/CTA Scans/CT Arthrogram
- Cardiac CT Scans for calcium scoring

Use the Service Event Authorization Request form.

## Outpatient Therapies

Medically necessary outpatient therapy (when a covered benefit) must be prescribed by a physician.

### Physical Therapy & Occupational Therapy

Prior authorization from the Cooperative is not required for the first six outpatient visits, including the initial evaluation, for physical therapy and occupational therapy. All therapies must be medically necessary. If upon review medical necessity criteria are not met, the Cooperative may recoup payment for non-medically necessary services. If additional visits beyond the first six are needed, prior authorization is required before the seventh visit.

Use the PT/OT Request form.

### Speech Therapy

Prior authorization is required for speech therapy.

Many commercial benefit plans do not cover Speech Therapy. If speech therapy is a covered benefit, prior authorization is required for any subsequent visits after the initial evaluation.

Use the Speech Therapy Request form.

### Cardiac Rehabilitation & Pulmonary Rehabilitation

Prior authorization is required for Pulmonary and Cardiac Rehabilitation prior to any services being rendered.

Use the Cardiac & Pulmonary Rehabilitation Request form.

## Prosthetics and Durable Medical Equipment (DME)

- Continuous Passive Motion Device (CPM)
- All other DME rental beyond 30 days or accumulated \$300 rental charges, per item excluding nebulizers.
- New or used DME purchases over \$300 billed charges, per item excluding nebulizers.
- External and implantable infusion pumps and supplies,

including insulin infusion pump, short and long term continuous glucose monitors

- CPAP, BIPAP, NIV machines
- Wheelchairs and scooters

Use the DME Authorization Request form.

## Specialized Pharmacy Services

- All outpatient injections or infusions of medications with billed charges of \$500 and above, excluding cancer chemotherapy, and drugs administered in conjunction with diagnostic or radiographic testing if the testing itself does not require prior authorization
- Any drugs or therapies used in the diagnosis or the treatment of infertility
- Enteral nutrition and related supplies
- Off-label drug use

Use the Service Event Authorization Request form.

## Surgical Consult for Low Back Pain (State of WI/ETF members only)

Effective January 1, 2014, prior authorization will be required for State of Wisconsin (ETF) members prior to receiving a surgical consult for low back pain. These members must complete conservative measures before receiving authorization to be surgically evaluated for low back pain. Use the Surgical Consult for Low Back Pain Request form.