

**Gundersen Lutheran Health Plan**  
**Procedures & Services Requiring Prior Authorization**

**Benefits and eligibility must be verified with the Health Plan Customer service.**  
**Self-funded and Fully Insured Employer Group Plans: 608-775-8007 or 800-897-1923**  
**Senior Preferred: 608-775-8077 or 800-370-9718**  
**BadgerCare Plus: 608-775-0150 or 866-537-1477**

- ❖ **This grid applies to all GLHP members; it is intended to be a guide and does not guarantee coverage.**
- ❖ **Medical benefit plan language supersedes the general information provided on this grid.**
- ❖ **The presence or absence of an item on this list does not define whether or not coverage or benefits exist for the service or procedure and/or CPT code.**
- ❖ **Failure to prior authorize procedures or services on this grid may result in denial of coverage; as a result financial responsibility may be yours.**

<b><u>REFERRALS</u></b>		<b><u>COMMENTS</u></b>
<b>Any referral to a non participating provider/facility for non emergent services</b>		A signed written referral from the Health Plan is required prior to receiving services from a non participating provider/facility
<b><u>EXPERIMENTAL</u></b>		
<b>Experimental/Investigational</b>		Considered provider responsibility when the member would not be reasonably expected to know that the service is experimental. The Health Plan utilizes Hayes Medical Technology Directory to determine if services are experimental/ investigational. In addition to Hayes, other sources may be reviewed which include but are not limited to the evidence based medical literature, specialty Medical Advisory Panel, and other technology review resources.
<b><u>MEDICAL SERVICES</u></b>		<b><u>COMMENTS</u></b>
<b>Autism Spectrum Disorders</b>		-Submit supporting medical documentation.
<b>Continuous Passive Motion (CPM)</b>		Prior authorization required for CPM usage beyond 21 days post op. Submit supporting medical documentation
<b>Durable Medical Equipment (DME) including but not limited to prosthesis, hospital beds, and tens units.</b>		All rentals require prior authorization. Purchases and repairs require prior authorization based on cost and vary by group; call Customer Service to verify prior authorization requirements. Coverage for DME will be provided in accordance with internal policy or Medicare guidelines. Prior authorization request should be from DME vendor.

<b>Enteral Therapy</b>		Submit supporting medical documentation.
<b>Genetic Testing</b>		Submit supporting medical documentation.
<b>Home Health</b>		Member must be homebound and meet criteria for home health.
<b>Home Sleep Studies (under C-PAP policy)</b>		Prior authorization required from sleep order physician specialist or provider practicing under the supervision of a sleep disorder specialist. Submit supporting medical documentation
<b>Skilled Nursing Facility</b>		Prior authorization required from facility.
<b>Swing Bed</b>		Prior authorization required prior to admission.
<b>Insulin pumps /Continuous glucose monitors</b>		Submit supporting medical documentation.
<b>IV Drugs and Biologicals (except EPO)</b>		Submit supporting medical documentation.
<b>IV Infusions</b>		Home IV Therapy requires prior authorization. Request to be received from supplier.
<b>Mental Health, Alcohol and other drug addictions (M.H./A.O.D.A) Transitional Treatment</b>		Submit supporting medical documentation.
<b>Part B Therapies (Provided in a Skilled Nursing Facility)</b>		Submit supporting medical documentation.
<b>Power Operated Vehicle- POV</b>		Prior authorization requests must be submitted by participating vendor with the appropriate HCPCS codes. All power operated vehicles must have supporting medical documentation to include but not limited to Functional Mobility Assessment and Face-to-Face meeting documentation with the provider signing prescription.
<b>Surgical Treatment of Obstructive Sleep Apnea</b>		Submit supporting medical documentation.
<b>Wheelchairs</b>		Prior authorization requests must be submitted by participating vendor with the appropriate HCPCS codes. All wheelchairs must have supporting medical documentation to include but not limited to Functional Mobility Assessment and Face-to-Face meeting documentation with the provider signing prescription.
<b><u>PROCEDURES\SURGICAL TREATMENTS</u></b>	<b><u>CPT CODES</u></b>	<b><u>COMMENTS</u></b>
<b>Abortions</b>	<b>59840-59870</b>	Only if medically necessary as determined by the Health Plan.
<b>Artificial Intervertebral Disc Replacement for Cervical and Lumbar Degenerative Disc Disease</b>	<b>0092T, 0095T, 0098T, 0163T, 0164T, 0165T, 22856-22865</b>	Member must be 18 or over. Medicare does not provide coverage for patients over age 60. Coverage will be limited to the cost of the procedure and the cost of <b>one</b> artificial intervertebral disc.
<b>Bariatric surgical treatment for severe obesity</b>	<b>43770-43774 43842-43848</b>	Submit supporting medical documentation.

	<b>43644-43645 43659, S2083</b>	
<b>Blepharoplasty</b>	<b>15820-15823 67910-67909</b>	Upper and lower lid blepharoplasty will be subject to prior authorization. Photos and visual fields will be required.
<b>Chorionic Villus Sampling (CVS)</b>	<b>59015</b>	Submit supporting medical documentation.
<b>Cochlear Implants</b>	<b>69930</b>	Required for members age 18 and over.
<b><u>PROCEDURES/SURGICAL TREATMENTS CONTINUED</u></b>	<b><u>CPT CODES</u></b>	<b><u>COMMENTS</u></b>
<b>Deep Brain Stimulation</b>	<b>61850-61888 95961-95962 95970-95979 L8680-L8689</b>	Submit supporting medical documentation.
<b>Hyperhidrosis, Surgical Treatment</b>	<b>32664</b>	Submit supporting medical documentation.
<b>Reduction Mammoplasty</b>	<b>19318</b>	Submit supporting medical documentation.
<b>Refractive Surgery</b>	<b>65765</b>	Submit supporting medical documentation.
<b>Rhinoplasty or Rhino portion of Septorhinoplasty</b>	<b>30400-30450 30520</b>	Submit supporting medical documentation.
<b>Surgical Removal of Redundant Skin</b>	<b>15824-15839</b>	Submit supporting medical documentation.
<b>Surgical Treatment of Pectus Excavatum and Carinatum Syndrome</b>	<b>21740-21743</b>	Submit supporting medical documentation.
<b>Transmyocardial Ablation (TMR)</b>		Submit supporting medical documentation.
<b>Transplants (excluding corneal transplants)</b>		A referral request is required for all members.
<b>Treatment of Scars</b>		Submit supporting medical documentation.
<b>Vagus Nerve Stimulation</b>	<b>64573, 61885,64553 95974</b>	Submit supporting medical documentation.
<b>Varicose Vein Treatment</b>	<b>37735 37760-37785 36470-36479</b>	Submit supporting medical documentation.