

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.

<u>REFERRALS</u>	<u>CPT CODES</u>	<u>COMMENTS</u>
Any referral to a non participating provider/facility for non emergent services		A signed written referral from the Health Plan is required prior to receiving services from a non participating provider/facility
<u>EXPERIMENTAL</u>		
Experimental/Investigational		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.
<u>MEDICAL SERVICES</u>		<u>COMMENTS</u>
Autism Spectrum Disorders		Submit supporting medical documentation.
Continuous Passive Motion (CPM)	E0935-E0936	Prior authorization required for CPM usage beyond 21 days post op. Submit supporting medical documentation

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Durable Medical Equipment (DME) including but not limited to prosthesis and hospital beds.		Rentals require prior authorization. Purchases and repairs require prior authorization based on cost and vary by group. Call Customer Service to verify all DME 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.
Enteral Therapy	B4034-B9999	Submit supporting medical documentation.
Genetic Testing		Submit supporting medical documentation.
Home Health		Member must be homebound and meet criteria for home health.
Home Sleep Studies (under C-PAP policy)		Prior authorization required from a sleep disorder physician specialist or provider practicing under the supervision of a sleep disorder specialist. Submit supporting medical documentation
Hyperbaric Oxygen Therapy (HBOT)		Prior authorization is required. Submit supporting medical documentation.
Skilled Nursing Facility		Prior authorization required from facility.
Swing Bed		Prior authorization required prior to admission.
Insulin pumps /Continuous glucose monitors	E0784/S1030, S1031, A9274-A9278, E0607, E2100, E2101	Submit supporting medical documentation.
IV Drugs and Biologicals (except EPO)		Submit supporting medical documentation.
IV Infusions		Home IV Therapy requires prior authorization. Request to be received from supplier.
Mental Health, Alcohol and other drug addictions (M.H./A.O.D.A) Transitional Treatment, Day Treatment		Submit supporting medical documentation.
Part B Therapies		Submit supporting medical documentation.
Power Operated Vehicle- POV		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

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		documentation with the provider signing prescription.
Wheelchairs		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.
<u>PROCEDURES\SURGICAL TREATMENTS</u>	<u>CPT CODES</u>	<u>COMMENTS</u>
Abortions	59840-59870	Only if medically necessary as determined by the Health Plan.
Artificial Intervertebral Disc Replacement for Cervical and Lumbar Degenerative Disc Disease	0092T, 0095T, 0098T, 0163T, 0164T, 0165T, 22856-22865 22558,22585,22851	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 one artificial intervertebral disc.
Bariatric surgical treatment for severe obesity	43770-43774 43842-43848 43644-43645 43659, S2083 43886,43888	Submit supporting medical documentation.
Blepharoplasty	15820-15823 67900-65908 Typo above- S/b 67908. 67909	Upper and lower lid blepharoplasty will be subject to prior authorization. Photos and visual fields will be required.
Chorionic Villus Sampling (CVS)	59015	Submit supporting medical documentation.
Cochlear Implants	69930, 69714-69718	Required for members age 18 and over.
<u>PROCEDURES/SURGICAL TREATMENTS CONTINUED</u>	<u>CPT CODES</u>	<u>COMMENTS</u>

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Deep Brain Stimulation	61850-61888 95961-95962 95970-95979 L8680-L8689	Submit supporting medical documentation.
Hyperhidrosis, Surgical Treatment	32664	Submit supporting medical documentation.
Reduction Mammoplasty	19318	Submit supporting medical documentation.
Refractive Surgery	65765, S0800, S0810, S0812	Submit supporting medical documentation.
Rhinoplasty or Rhino portion of Septorhinoplasty	30400-30450	Submit supporting medical documentation.
Surgical Removal of Redundant Skin	15824-15839, 15847	Submit supporting medical documentation.
Obstructive Sleep Apnea(OSA), Surgical Treatment		Submit supporting medical documentation. Pillar Implants are not covered for Commercial members.
Surgical Treatment of Pectus Excavatum and Carinatum Syndrome	21740-21743	Submit supporting medical documentation.
Transmyocardial Revascularization (TMR)	33140-33141	Submit supporting medical documentation.
Transplants (excluding corneal transplants)		A referral request is required for all members.
Treatment of Scars		Submit supporting medical documentation.
Vagus Nerve Stimulation	64573, 61885,64553 95974	Submit supporting medical documentation.
Varicose Vein Treatment (excludes vein stripping)	36468, 36469, 36470-36479 37765, 37766	Submit supporting medical documentation.

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