



# Health Plan

## SERVICES REQUIRING MEDICAL NECESSITY REVIEW AND/OR PRIOR AUTHORIZATION

**Medical Necessity:** To be medically necessary, covered services must:

- Be rendered in connection with an injury or sickness;
- Be consistent with the diagnosis and treatment of your condition;
- Be in accordance with the standards of good medical practice;
- Not be for your convenience or your physician's convenience and
- Not be considered experimental or investigative;

**Prior Authorization:** Notification requesting coverage is required before receipt of certain designated services, elective admission to a hospital or facility, or specific medications prescribed for certain uses. Participating facilities need to notify the Medical Management Department at OSU Health Plan within 48 hours of an urgent/emergent admission. **Providers need to notify OSU Health Plan five business days prior to a specified outpatient or elective inpatient procedure.** Failure to obtain prior authorization for these designated services can result in penalty or denial of benefits.<sup>1</sup>

Please refer to the 2009 Specific Plan Details Document found at <http://hr.osu.edu/hrpubs/ben/medicalsdpd.pdf> for specific information.

Providers must contact OSU Health Plan Medical Management department prior to services being provided at (614) 292-4700 or (800) 678-6269, within 48 hours for urgent/emergent and 5 business days for elective admissions.

Claims submitted with unlisted procedure and unlisted medication codes will require documentation to identify what procedure/medication is being billed and *MAY* require medical necessity review.

Please note that this list is not all-inclusive. We receive requests for coverage for new technologies, equipment, supplies, tests and procedures daily.

**All facility-based behavioral health services:**

- Inpatient
- Outpatient – includes partial hospitalization and intensive outpatient treatment
- Substance Abuse treatment

**All inpatient admissions include:**

- Elective admissions (see \* list of inpatient/outpatient procedures below)
- Extended care facilities
- Hospice care
- Medical
- Rehabilitation
- Surgical
- Urgent/emergent admissions

**Utilization Review is required for all inpatient admissions following notification.**

**Inpatient and Outpatient Services/procedures/treatment that require medical necessity review FIVE (5) business days prior to receipt of treatment include but are not limited to:**

- Abdominoplasty/panniculectomy
- Blepharoplasty/ptosis repair
- Chemical peels/dermabrasion
- Gastric Bypass surgery

*(continued on next page)*

- Gastric Lap Band adjustment/repair
- Gastric Lap Band procedure
- Genetic testing
- Home health care/services
- Hospice services
- Infertility treatment
- Injections – spinal, epidural, and facet for chronic pain after 3 injections per plan year
- Mastectomy for Gynecomastia
- Nutritional services (visits 4-6)
- Orthognathic surgery
- Radiofrequency ablation/percutaneous facet denervation
- Reduction mammoplasty
- Repair/or Reconstruction surgery that may be considered cosmetic (Including, but not limited to: scar revision and breast reconstruction)
- Rhinoplasty
- Skin Laser procedures, including Excimer laser
- TMJ injections
- UVB Light
- Uvulopalatoplasty
- Varicose Vein surgery/sclerotherapy
- Ventral/Incisional hernia surgery
- Weight management programs

**All Durable Medical Equipment and Medical Supplies >\$2,000**

**All Orthotic devices >\$2,000**

**All Prosthetic devices >\$2,000**

## **Medications**

The following medications require medical necessity authorization through OSU Health Plan for coverage under the **MEDICAL** benefit.

- Botox
- Hemophilia outpatient medications/infusions

The following medications require medical necessity authorization through OSU Health Plan for coverage under the **PHARMACY** benefit.

- Anabolic Steroids
- Botox
- Infertility Products
- Myobloc
- Testosterone Products

<sup>1</sup> Prior authorization (see [osuhealthplan.com/providers, Prior Authorization](http://osuhealthplan.com/providers/Prior_Authorization)) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission of service. When non-network providers are utilized, a benefit reduction (penalty) will occur. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket limit.

## **Services No Longer Requiring Prior Authorization**

As of July 20, 2009, these services, procedures or treatments no longer require prior authorization. However, reimbursement is still subject to OSU Health Plan guidelines for medical necessity.

- Maternity inpatient admissions
- Cardiac rehabilitation
- Orthoptic therapy
- Diabetic education classes
- Medical Massage therapy
- Occupational therapy – after first 15 visits
- Physical therapy – after first 15 visits
- Pulmonary rehabilitation