



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.¹

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

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- 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

¹ 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