Prior Authorization List

Effective 1/1/19

WPS HEALTH INSURANCE
Local. Honest. Independent.

Prior authorization is required for specialized services including those listed below. At times, prior authorization is referred to as pre-service authorization, pre-authorization, or pre-certification.

Disclaimer: These references are for informational purposes only and do not constitute medical advice, plan authorization, explanation of benefits, or a guarantee of payment. Benefit plans vary in coverage and some plans may not provide coverage for all services included on the list below. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and federal law. Some benefit plans administered by the organization may not utilize Medical Affairs medical policy in all of their coverage determinations. Call the number located on the customer ID card for specific plan, benefit, and network status information.

Medical policies are based on constantly changing medical science. Our medical policies are reviewed annually and are subject to change. The organization uses tools developed by third parties, such as the evidence-based clinical guidelines developed by MCG Health and Hayes publications to assist in administering health benefits. Medical policies and MCG Health guidelines are intended to be used in conjunction with the independent professional medical judgment of a qualified health care provider. To obtain a referenced MCG guideline specific to your patient's review, please call the number located on the back of the customer's ID card. For general medical policy or MCG requests, please email medical.policies@wpsic.com.

Service/Procedure	Notes
Alternative Communications Device/Speech Generating Device or Digitized Speech	Verify customer health plan coverage
Bone Anchored Hearing Aids (BAHA)	Verify customer health plan coverage
Bariatric Surgical Services	Verify customer health plan coverage
Biofeedback	This is often an exclusion of the customer health plan
Behavioral Health Services: Inpatient and residential	Verify customer health plan coverage; also includes: Therapeutic repetitive transcranial
Bone Growth (Osteogenesis) Stimulators (BGS)	
Botulinum Toxin Injection	Approval through pharmacy prior authorization
CPAP/BiPAP Machines (see also DME)	
Clinical Trials	
Cochlear Implants	Verify customer health plan coverage

Service/Procedure	Notes
Cosmetic and Plastic Surgery Procedures (and any procedure that may be considered cosmetic)	Examples of potential cosmetic procedures: • Blepharoplasty, canthoplasty, eyelid, or eyebrow surgery • Panniculectomy • Pectus excavatum/carinatum • Port Wine Stain Laser Treatment • Reduction/augmentation mammoplasty/mastopexy and related services (Services related to breast reconstruction following mastectomy do not require prior authorization) • Rhinoplasty • Temporomandibular Joint Disease (TMJ) • Orthognathic surgical services • Varicose vein treatment • Laser treatment for psoriasis
Cranial Orthotic	This is often an exclusion of the customer health plan
Deep Brain Stimulation (DBS)	
Durable Medical Equipment (DME)	• Any DME or orthotic with rental price above $750 per month or purchase price above $1,000. Contact Customer Service to verify price threshold.
Genetic Testing	Verify customer health plan coverage; required documentation from the ordering provider or the genetic counselor associated with the ordering provider includes: • Diagnosis or symptoms being evaluated • Complete relevant family and personal history • Discussion of the calculated potential risks and benefits of the testing; role of heredity in the condition being confirmed diagnosed or treated • How the results of testing will change or influence the current treatment plan
High-Tech Radiology	MRA, MRS, PET Scan: Customer health plan requirements vary regarding imaging services that require prior authorization. Contact Customer Service to verify requirements.
High-Tech Radiology for Specific Groups: 10011021, 10011649, 10004436, 10003841, 10003900, 10004004, 10011764, 10011219, P100000032, 10004001, 10011297, 10003899, P100000044, 10004068	CT, MRI, MRA, MRS, PET Scan: Customer health plan requirements vary regarding imaging services that require prior authorization. Contact Customer Service to verify requirements.
Home Infusion Services	Customer health plans require prior authorization for the home infusion administration and the drug(s). Some drugs may require a separate review through specialty pharmacy if they are on the specialty drug prior authorization list. Documentation should include the diagnosis, name of the drug(s), dose infused, and duration of treatment.
Hyperbaric Oxygen Therapy	Required for non-emergency use (Example: diabetic wound care)

Service/Procedure	Notes
Intensity Modulated Radiation Therapy (IMRT)	
Immune Globulin (IVIG)	Approval through pharmacy prior approval review
Inpatient Admission: Planned (elective/scheduled) Includes Skilled Nursing Facility (SNF), Long-term	• Notification to the health plan should be made a minimum of three days prior to date of planned admission
Neuropsychological Testing	Verify customer health plan coverage; initial visit to determine need for testing does not require prior authorization
Neurostimulation	Including deep brain, posterior tibial, hypoglossal, percutaneous, functional stimulation; neurostimulators for pain management, central sleep apnea, and obstructive sleep apnea
New Technology: Medical, Surgical, or Biomedical Services That Might Be Considered Experimental, Investigational, or Unproven	• Examples: Brachytherapy for breast cancer (includes SAVI Device); Second Generation Subcutaneous ICD; iStent Trabecular Micro-Bypass implant; corneal treatments and specialty contact lenses; multianalyte laboratory assays and analyses (MAAA); and proprietary laboratory analyses (PLA) tests • Prior authorization required if not addressed in the Non-covered Services and Procedures Medical Policy • Category III coded procedures/services, also known as “T” codes
Pain Management Procedures (Certificate and Medical Policy Limitations May Apply)	• Epidural steroid injections • Facet joint injections (Includes facet, MBB, zygapophysial joint, paravertebral facet joint, and dorsal/posterior ramus injections) • Intrathecal pump implantation • Lumbar discography • Radiofrequency ablation • Spinal cord/dorsal column Stimulation • Sacro-Iliac (SI) joint injections and treatment • Automated percutaneous lumbar diskectomy
Pediatric Vision and Orthoptic/Pleoptic Training	Verify customer health plan coverage
Physical, Occupational, and Speech Therapy Referrals for Out-of-Network Providers	
Prosthetics	• Required for prosthetics over $5,000 ○ NOTE: Some customer certificates may have a lower dollar threshold requirement for prior authorization • Microprocessor and myoelectric-controlled prosthetics
Proton Beam Radiotherapy	
Skilled Nursing Facility	Prior authorization required for customer admission

Service/Procedure	Notes
Sleep Study Evaluation and Treatment of Sleep Disorder	• Polysomnograms (Sleep study: home and in-lab) • CPAP/BiPAP machines • Oral appliances • Surgical procedures (UPPP, Inspire system, remedē® System)
Spine Surgery	Examples of spinal surgeries that require a prior authorization: • Artificial Intervertebral Discs • Arthrodesis • Fusions (includes SI joint treatments) • Laminectomy and facetectomy NOTE: For percutaneous vertebroplasty, kyphoplasty, and sacroplasty, see Non-covered Services and Procedures Medical Policy
Stereotactic Radiosurgery/Radiotherapy	
Therapeutic Contact Lens	
Total Ankle Arthroplasty	Verify customer health plan coverage
Total Shoulder Arthroplasty	Verify customer health plan coverage
Transplants	Solid organ, bone marrow, stem cell, and cartilage See also Non-covered Services and Procedures Medical Policy
Transport of Patients: Non-emergency (MediVan, Ground, or Air Ambulance)	Required for non-emergency transports

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