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Date: November 03, 2014

To: All Participating Providers

From: Arlene Matanguihan
Utilization Review Manager

**Re: Pre-Certification Policy**

Pre-Certification procedures are required for all services below. Participating Providers shall ensure that a completed Pre-Certification Form for all applicable services along with any required documentation be provided to and approved by the Plan prior to such services being rendered. Upon approval, Providers shall only provide services within the scope and duration as specifically contained and outlined in the Authorized Pre-Certification.

Pre-Certification requests can be faxed to (671) 477-7304.

To facilitate prompt processing of Pre-Certification requests, they should be accompanied by the following:

- Appropriate ICD and CPT codes
- Medical information (History and Physical Examination) to justify the request
- Laboratory, Imaging and other Diagnostic results relevant to the present illness

For routine non-emergency procedures, Pre-Certification requests should be submitted at least 3 to 5 business days prior to the intended date of service.

Approved Pre-Certifications are valid for 30 days from the date of approval.

STAT procedures should be performed without delay. The Pre-Certification process, however, is still required for these procedures. We require notification via phone within 48 hours, and the submission of a completed Pre-Certification Form and all required documentation within 10 days of the STAT procedure.

**Please be aware that:**

- Failure to obtain Pre-Certification approval for those services or benefits requiring Pre-Certification from SelectCare may result in a disallowance of up to 50% of allowable charges or denial of claim.
- Services exceeding the authorized scope or duration shall not be paid by the Plan.
- Pre-Certification is only a determination of medical necessity, not an assurance of coverage, or guarantee of payment.

**List of Procedures & CPT Codes Requiring Pre-Certification:**

Procedures which are not specifically listed will be evaluated based on Medical Necessity and the member's plan benefits. Medicare CCI rules apply.

| | Procedures | CPT Range |
|---|---|---|
| 1 | All outpatient surgical procedures requiring use of surgical facilities (except for female sterilization) | |
| 2 | Any and all Diagnostic & Surgical Procedures in excess of $300.00 | |
| 3 | Arthroscopy (knee) | 29870 |
| 4 | Cardiac Catheterization | 93501, 93510-11, 93514, 93524, 93526-93533, 93536, 93539-45 |
| 5 | Carpal Tunnel Release, Monofilament Testing | |
| 6 | Chemotherapy and Radiation Therapy | |
| 7 | Diagnostic Colonoscopy / Proctosigmoidoscopy | 45380, 45355, 45382-83, 45379, 45384-85, 44388-44392, 44394 |
| 8 | CT Scan (All) | |
| 9 | Dexa Scans | 76075-76076 |
| 10 | Diagnostic Laparoscopy (pelvic) | 49320 |
| 11 | Durable Medical Equipment: Std. hospital bed, Std. wheelchairs, walkers, crutches, oxygen, suction machine | |
| 12 | EMG / NCT (upper extremities)/ Autonomic Testing | 95860-95864, 95872 |
| 13 | Home Health Referrals | |
| 14 | Laparoscopic Vaginal Hysterectomy | 47562-47564 |
| 15 | Mammograms (with the exception of those for routine screening according to the guidelines of the American Cancer Society) | |
| 16 | MIBI Scan, Thallium Stress Test, Exercise Stress Test | |
| 17 | MRI (all) | |
| 18 | Nuclear Medicine Studies | |
| 19 | Ophthalmology Diagnostic Procedures | 92225-92287, 92018-92140 |
| 20 | Pain Management Studies & Treatment | |
| 21 | Percutaneous Coronary Angioplasty | 92982, 92984, 92986, 92986, 92987, 92990 |
| 22 | Percutaneous Diskectomy | 62287 |
| 23 | Physical Therapy requiring more than five (5) out-patient visits | |
| 24 | Wellness Center Referrals | |
| 25 | Sleep Apnea Studies | 95810 |
| 26 | Ultrasounds (Except the first OB ultrasound) | 76506-76999 |
| 27 | Upper GI Endoscopy | 43234-35, 43239, 43241, 43243, 43233-51, 43255, 43258-59 |
| 28 | Dx procedures performed or ordered by the same provider on any one patient two or more times | |
| 29 | Specialty Medications | See Drug Formulary |