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Date: November 01, 2019

To: All Participating Providers

From: Arlene Matanguihan
Utilization Review Manager

Re: Pre-Certification Policy

Pre-Certification procedures are required for all services below. Providers shall ensure that a completed Pre-Certification Form for all applicable services along with any required documentation be provided in order for the Plan to review 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 must be accompanied by the following:

- Appropriate ICD-10 and CPT codes
- Medical information (History and Physical Examination) to justify the request
- Laboratory, Imaging and other Diagnostic results relevant to the present illness

Pre-Certification requests must 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. We require 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 will result in a denial of claim payment.
- Services exceeding the authorized scope or duration shall not be paid by the Plan.
- Members cannot be billed for services that are denied due to a lack of approved Pre-Certification.
- Pre-Certification is only a determination of medical necessity, not an assurance of coverage, or guarantee of payment.

List of Procedures 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
1	All diagnostic procedures performed or ordered by the same provider on a single patient two or more times
2	All inpatient services (surgical/ non-surgical, skilled nursing, rehabilitation)
3	All outpatient surgical procedures requiring the use of surgical facilities (except for female sterilization)
4	All Diagnostic Procedures (including laboratory/ pathology) in excess of $500.00
5	Applied Behavioral Analysis services
6	BRCA Gene Testing (in accordance with the USPSTF Grade B Recommendation)
7	Cardiac Catheterization and Procedures
8	Carpal Tunnel Release, Monofilament Testing
9	Chemotherapy and Radiation Therapy
10	Durable Medical Equipment: Std. hospital bed, Std. wheelchairs, walkers, crutches, oxygen, suction machine
11	EMG / NCT (upper extremities)/ Autonomic Testing
12	Home Health, Hospice and Palliative Care Services
13	Hyperbaric Oxygen Therapy & Wound Care Services
14	Imaging (CT Scans, Dexa Scans, MRIs, MRAs, Angiographies, PET Scans, Ultrasounds – except first obstetric ultrasound)
15	Mammograms (except for routine screenings according to the guidelines of the American Cancer Society)
16	MIBI Scan, Thallium Stress Test, Exercise Stress Test
17	Nuclear Medicine Studies
18	Ophthalmology Diagnostic Procedures
19	Pain Management Studies & Treatment
20	Physical Therapy, Occupational Therapy, and Speech Therapy
21	Organ Transplant Services
22	Orthotics/ Prosthetics and Implantable Devices
23	Plastic/ Reconstructive procedures
24	Sleep Studies
25	Specialty Injections (Ophthalmic, Orthopedic)
26	Specialty Medications (See Drug Formulary)