

SERVICES REQUIRING PREAUTHORIZATION

The following medical care services and procedures require *preauthorization*:

- All non-emergency *inpatient* admissions including acute care, long-term acute care, *skilled nursing facilities*, and *rehabilitation hospitals*. Emergency admissions require notification within 48 hours;
- Observational Care greater than 48 hours;
- Diagnostic assessment and treatment for autism spectrum disorder;
- Non-emergency air and ground ambulance transports;
- Enhanced external counterpulsation (EECP);
- All testing for genetic disorders except: standard chromosomal tests, such as Down Syndrome, Trisomy, and Fragile X, and state mandated newborn genetic testing;
- Home health care;
- Home infusion therapy;
- Specialty medical injectable medications;
- Any reconstructive or cosmetic surgery, therapy or procedure for the treatment of a medical disease, injury, accident or congenital anomaly, except for reconstructive surgery incident to a mastectomy in a manner determined in consultation with the attending physician and the patient;
- Laser treatment of skin lesions;
- Outpatient Manipulation therapy (chiropractic and osteopathic) – Preauthorization is required for rehabilitation therapies after the initial fifteen (15) visits. The completion of a treatment plan is required for outpatient rehabilitation therapies to be covered beyond the initial fifteen (15) visits;
- Outpatient rehabilitation therapies including physical medicine, occupational and speech therapy. The completion of a treatment plan is required for review and preauthorization of outpatient rehabilitation therapies to be covered beyond the initial six (6) visits;
- Office surgical procedures that are performed in a facility, including but not limited to:
 - Arthrocentesis;
 - Aspiration of a joint;
 - Colposcopy;
 - Electrodesiccation condylomata (complex);
 - Excision of a chalazion;
 - Excision of a nail (partial or complete);
 - Enucleation or excision of external thrombosed hemorrhoids;
 - Injection of a ligament or tendon;
 - Interocular injection for retinal pathology
 - Oral Surgery;
 - Pain management (including facet joint injections, trigger point injections, stellate ganglion blocks, peripheral nerve blocks, SI joint injections, and intercostals nerve blocks);
 - Proctosigmoidoscopy/flexible Sigmoidoscopy;
 - Removal of partial or complete bony impacted teeth (if a benefit);
 - Repair of lacerations, including suturing (2.5 cm or less);
 - Vasectomy;
 - Wound care and dressings (including outpatient burn care)
- Outpatient surgeries - All potentially reconstructive/cosmetic and investigational surgeries/procedures;
- Pulmonary rehabilitation programs;
- Transplant evaluation and services. *Preauthorization* will include referral assistance to the Blue Quality Centers for Transplant network if appropriate;
- Bio-engineered or biological wound care products;
- Category IDE Trials;
- Clinical trials (including cancer related trials);
- Hyperbaric oxygen therapy (non-emergency);
- Sleep studies for diagnosis and medical management of obstructive sleep apnea syndrome;
- Radiofrequency ablation for pain management;

Preauthorization requirements do not apply to services provided by a *hospital* emergency room *provider*. If an *inpatient* admission results from an emergency room visit, notification must occur within two (2) business days of the admission. If the *hospital* is a *participating provider*, the hospital is responsible for performing the notification. If the *hospital* is a *non-participating provider*, the *member* or the *member's* responsible party acting on the *member's* behalf is responsible for the notification.

The following services require coordination through an outside entity other than *Capital*. Members should call the appropriate vendor with any questions regarding the coordination of these services.

- ***Mental Health and Substance Abuse Treatment services must be coordinated through Optum at 1-800-924-0105.***
- ***Durable Medical Equipment must be coordinated through DMEnsion Benefit Management at 1-888-732-6161.***

HOW TO OBTAIN REQUIRED PREAUTHORIZATION

The *member's identification card* will show if *preauthorization* is required before receiving the listed services or supplies.

Members should present their *identification card* to their health care *provider* when medical services or supplies are requested. The *member's participating provider* will be asked to provide medical information on the proposed treatment to *Capital's* Clinical Management Department by calling **1-800-471-2242**.

If *members* use a *non-participating provider* or a *BlueCard participating provider*, it is their responsibility to obtain *preauthorization*. *Members* should call *Capital's* Clinical Management Department toll-free at **1-800-471-2242** to obtain the necessary *preauthorization*. A *non-participating provider* may call on the *member's* behalf. However, it is ultimately the *member's* responsibility to obtain *preauthorization*.

Capital's Clinical Management Department will notify the *member's* health care *provider* and the *member* of the authorization or denial of the requested procedures, services, and/or supplies within fifteen (15) days after *Capital* receives the request for *preauthorization*. *Capital* may extend the fifteen (15)-day time period one (1) time for up to fifteen (15) days for circumstances beyond *Capital's* control. *Capital* will notify the *member* prior to the expiration of the original time period if an extension is needed. The *member* and *Capital* may also agree to an extension if the *member* or *Capital* requires additional time to obtain information needed to process the *member's preauthorization*.

Preauthorization of elective admissions and selected services should be obtained at least seven (7) days prior to the date of service. Maternity admissions require notification within two (2) business days of the date of admission.

PREAUTHORIZATION OF MEDICAL SERVICES INVOLVING URGENT CARE

Special rules apply to *preauthorization* of *urgent care* medical services.

If the *member's* request for *preauthorization* involves *urgent care*, the *member* or the *member's provider* should advise *Capital* of the urgent medical circumstances when the *member* or the *member's provider* submit the request to *Capital's* Clinical Management Department. *Capital* will respond to the *member* and the *member's provider* no later than seventy-two (72) hours after *Capital's* Clinical Management Department receives the *preauthorization* request.

Members who are dissatisfied with an adverse *preauthorization* determination regarding an *urgent care* claim may submit an appeal. *Urgent care* appeals may be submitted orally by contacting *Capital's* Customer Service Department, toll-free, at **1-800-889-3863**. *Capital* will notify the *member's* health care *provider* and the *member* of the outcome of the appeal via telephone or facsimile no later than seventy-two (72) hours after *Capital* receives the appeal.

PREAUTHORIZATION PENALTY

When a procedure is not *preauthorized* when required, there may be a *preauthorization penalty*.

If the *member* presents his/her *ID card* to a *participating provider* in the 21-county area and the *participating provider* fails to obtain or follow *preauthorization* requirements, the *allowable amount* will not be subject to reduction.

When *members* undergo a procedure requiring *preauthorization* and fail to obtain *preauthorization* (when responsible to do so), *benefits* will be provided for *medically necessary* covered services. However, in this instance, the allowable amount may be reduced by the dollar amount or the percentage established in the *Certificate of Coverage*.

PLEASE NOTE: This listing identifies those services that require *preauthorization* only as of the date it was printed. This listing is subject to change. *Members* should call *Capital* at **1-800-889-3863** (TDD number at **1-800-242-4816**) with questions regarding the *preauthorization* of a particular service.

This information highlights the standard Preauthorization Program. *Members* should refer to their *Certificate of Coverage* for the specific terms, conditions, exclusions and limitations relating to their *coverage*.