Clinical Documentation Requirements for Health Care Services that Require Authorization

This listing provides the clinical documentation required to be submitted with requests for medical necessity review and approval through Superior's contracted Utilization Review Agents (URA). The required clinical documentation must be included with all authorization requests submitted by fax transmission and the secure provider portal. Regardless of how the authorization request is submitted, each request must include the clinical documentation required for the applicable health-care service, for prospective, concurrent and retrospective authorization requests. Additional details related to specific clinical documentation required for applicable services can be accessed through the Clinical Policies posted online at: SuperiorHealthPlan.com/Policies. All faxed authorization requests must be submitted with the appropriate authorization form. Authorization requests that do not include the required clinical documentation may be delayed for processing, and/or reviewed based upon the clinical information available. All authorization forms (including the TDI Standardized Form) can be accessed at the following location on Superior's website: SuperiorHealthPlan.com/ProviderForms

HEALTH CARE SERVICE CATEGORY	HEALTH CARE SERVICE(S) REQUIRING AUTHORIZATION	CLINICAL DOCUMENTATION REQUIRED
Autism Services	Applied Behavioral Analysis (ABA)	**Initial Assessment:** •Name •DOB •Medicaid ID •Member phone number •Member address •Members primary language •ABA provider treatment address •ABA provider NPI and Tax ID •Treating LBA •ABA provider contact, phone or email •Prescribing Clinician i.e., PCP •Date of diagnosis, severity level and validated assessment tool use for diagnosis •Co-morbid diagnosis •Additional levels of care i.e., ST, OT, PT •Trauma History **Initial 90-Day Treatment Request:** •Name •DOB •Medicaid ID •Member phone number •Member address •Members primary language •ABA provider treatment address •ABA provider NPI and Tax ID •Treating LBA •ABA provider contact, phone or email •Prescribing Clinician i.e., PCP •Date of diagnosis, severity level and validated assessment tool use for diagnosis •Co-morbid diagnosis •Additional levels of care i.e., ST, OT, PT •History of ABA services •Trauma History •Signed and dated referral from PCP with frequency and duration of treatment •Documentation of interview with caregiver •Validated assessment of cognitive abilities, i.e., Vineland •Behavior Support Plan •Identification of specific targeted behaviors/skills related to the symptoms of ASD •Baseline data for all behavior and skills •The planned frequency and duration of treatment •Measurable parent training goals pertaining to ABA principles •Plan to ensure maintenance and generalizations of skills •Clearly defined, measurable, realistic discharge criteria •Plan to coordinate care with other providers **180-Day Recertification:** •Name •DOB •Medicaid ID •Member phone number •Member address •Members primary language •ABA provider treatment address •ABA provider NPI and Tax ID •Treating LBA •ABA provider contact, phone or email •Prescribing Clinician i.e., PCP •Date of diagnosis, severity level and validated assessment tool use for diagnosis •Co-morbid diagnosis •Additional levels of care i.e., ST, OT, PT •History of ABA services. •Trauma History •Signed and dated referral from PCP with frequency and duration of treatment •Documentation of interview with caregiver •Validated assessment of cognitive abilities, i.e., Vineland •Behavior Support Plan •Identification of specific targeted behaviors/skills related to the symptoms of ASD •Baseline data for all behavior and skills •The planned frequency and duration of treatment •Measurable parent training goals pertaining to ABA principles •Plan to ensure maintenance and generalizations of skills •Clearly defined, measurable, realistic discharge criteria •Plan to coordinate care with other providers
Abortion	Elective termination of a live pregnancy	Information and documents should relate to current request for services. • Admission Notification and/or Face Sheet • Diagnosis • History and Physical • Progress Notes • Consult Notes and/or Reports from Specialists • Physician Orders • Radiology/Imaging Results • Laboratory Results • Vital Sign Reports • Medication Administration Record (MAR) • Plan of Care
Allergy Testing and Immunotherapy	Allergy Testing and Immunotherapy Services *NOTE: Authorization not required for Allergists, Immunologists, Pulmonologists or ENTs.*	• Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation
Anesthesia Services: Pain Management	Interventional Pain Management *NOTE: For members 18 years of age and older. Contact Texas National Imaging Associates (TNIA) at 1-800-642-7554, or visit www.RadMD.com.*	• Clinical notes • Reports of previous procedures • Specialist reports/evaluation
Authorization Requests	All Inpatient, Outpatient, and Therapy Requests for Services (in addition to items listed below)	Prior Authorization requests submitted by requesting/services providers must contain *all* the following essential information: • Member name; and • Member number or Medicaid number; and • Member date of birth; and • Requesting and rendering/servicing provider's name; and • Requesting and rendering/servicing provider's National Provider Identifier (NPI); and • Rendering/servicing provider's Tax Identification number; and • Service requested - Current Procedural Terminology (CPT), Healthcare Common Procedure and Coding System (HCPCS); and • Service requested start and end date(s); and • Quantity of service units requested based on the CPT or HCPCS requested

HEALTH CARE SERVICE CATEGORY	HEALTH CARE SERVICE(S) REQUIRING AUTHORIZATION	CLINICAL DOCUMENTATION REQUIRED
Behavioral Health Services	Intensive Outpatient Program (IOP) Services (Mental Health/Substance Use Disorder)	**Initial Admission Request:** • Authorization Request Form (Includes: Diagnosis (Psychiatric and Medical, Attending physician/provider, Dates of service, Service code, and Facility contact information • Initial intake assessment (Reason for admission, symptoms and functional impairment) • Program details (Number of hours/days per week), Planned interventions (individualized goal directed treatment plan, medication reconciliation, programming 6 or more contact hours per week, psychosocial assessment) • Psychosocial information (support system, stable living environment, transportation) • Substance Use history • Treatment history (SUD) • UDS (SUD) • Discharge plan **Concurrent review request:** • Updated diagnosis • Confirmation of program attendance includes dates/hours per week (SUD – include types of groups attended) • Clinical progress notes • UDS (SUD) • Individualized treatment plan • Relapse Prevention plan (SUD) • Safety plan (BH only) • Medication list • Discharge plan
	Partial Hospitalization Program (PHP) Services (Mental Health/Substance Use Disorder)	**Initial Admission Request:** • Initial intake assessment (Reason for admission, symptoms and functional impairments – include coping skills, relapse prevention, daily structure, attempts to stop using for SUD requests) • Program details (Number of hours/days per week), Planned interventions (daily clinical assessment, individualized goal directed treatment plan, medication reconciliation, psychiatric medication evaluation by licensed clinical practitioner, psychosocial assessment, structured therapeutic program at least 3 hours per day) • Psychosocial information (support system, living environment, transportation) • Substance Use history (include longest sobriety, treatment history and treatment plan for SUD) • UDS (SUD) • Discharge plan **Concurrent review request:** • Updated diagnosis • Confirmation of program attendance includes dates/hours per week (SUD – include types of groups attended) • Clinical progress notes • UDS (SUD) • Individualized treatment plan • Relapse Prevention plan (SUD) • Confirm staff monitoring during program hours (SUD) • Safety plan (BH only) • Medication list • Discharge plan
	Residential Treatment Center (RTC) Services (Substance Use Disorder)	**Initial Admission Request:** • Initial intake assessment (Reason for admission, symptoms and functional impairments – include coping skills, relapse prevention risk, daily structure, attempts to stop using) • Program details (days per week), Planned interventions [individual, group, or family therapy at least 3 times per week, individualized goal directed treatment plan, medication reconciliation, psychiatric medication evaluation by licensed clinical practitioner, psychosocial assessment, toxicology screen, quantitative drug analysis, self-help, 12-step or education group as needed (IQ specific)] • Psychosocial information (support system, living environment) • Substance use history (include longest sobriety, treatment history and treatment plan • UDS • Lab results • Vitals • Discharge plan **Concurrent reviews:** • Updated diagnosis • Confirmation of program therapy attendance of at least 3 times per week • Clinical progress notes • UDS • Individualized treatment plan • Relapse Prevention plan • Confirm staff monitoring during 24 hours per day • Medication list • Discharge plan
	Outpatient Services	**Behavioral Health Outpatient Services: Prior Authorization Requirements can be found on the Superior HealthPlan website. https://www.superiorhealthplan.com/providers/training-manuals.html** • Current DSM diagnosis(es) • Current psychotropic medications • Current symptoms requiring the service(s) requested • Treatment plan, including measurable short term goals, specific therapeutic interventions utilized and measurable expected outcomes of therapy • Number and type of services requested, and anticipated dates that the services will be provided • Documentation of court-ordered or Texas Department of Family and Protective Services (DFPS)-directed services
	Psychological and Neuropsychological Testing	• Current DSM diagnosis/diagnoses • Documentation of court-ordered or DFPS-directed services • Number of units per service code requested • Start date, end date and duration of treatment for this request • Referral source information • Previous clinical interview or psychiatric diagnostic evaluation information, including any standardized screening and assessment tools used • Psychiatric and medical history of the member and member's family • Treatment history and outcomes, including dates and durations of the following: o Medication – include type and class o Psychotherapy – include specific modalities used • Rationale for requested testing, to include current client symptoms and the case-specific question(s) to be answered by testing • Testing plan information, including specific tests requested • Treatment plan information, including how the test(s) will impact the plan • Additional information regarding: o Member's cognitive and language skills. If impaired, include etiology and presentation o Any medical, psychiatric or substance use condition which impacts testing o Previous testing results, if applicable
	Transcranial Magnetic Stimulation Services	• Credentials of servicing provider • Number of units per service code requested • Start date, end date, and duration of treatment for this request • Current DSM diagnosis/es • Physician's Health Questionnaire-9 (PHQ-9) score and date assessed • Treatment history and outcomes, including dates and duration of the following: o Medication - include type and class o Psychotherapy - include specific modalities used o Electroconvulsive therapy *Note: If member is unable to take medication and/or electroconvulsive therapy is not recommended, please indicate the reason(s) • Current treatment and outcomes, including the specific types of treatment above • Medical conditions, if applicable • Substance use, if applicable • Suicidal ideation, homicidal ideation, or any risk behaviors • If requesting additional sessions after initial course of transcranial magnetic stimulation treatment with no progress or response, please include rationale for additional treatment
Clinician Administered Drugs	Biologicals and certain biosimilars Botulinum toxins Chemotherapy and supportive care drugs Gene therapy Injectable medications with miscellaneous billing codes Intravenous immunoglobulins Intravitreal injectable medications for ophthalmology use Viscosupplementation	• For specific criteria by drug, please visit: https://www.superiorhealthplan.com/providers/resources/clinical-payment-policies.html • Provider must submit documentation that supports member has met all approval criteria; including, but not limited to: o Office chart notes o Lab results o Other clinical information specified in the drug specific criteria support o Previous drug therapies tried (if applicable) o Drug allergies o Response to therapy if requesting continuation of services
Dental Services: Dental Anesthesia	Sedation or general anesthesia for dental procedures for children six years of age or younger	• Criteria for Dental Therapy Under General Anesthesia Form • Dental Maintenance Organization approval letter for the dental procedure requiring anesthesia (not required for CHIP members). • Pertinent diagnosis/conditions that relate to the need for the service • Clinical documentation supporting the need for the requested service

HEALTH CARE SERVICE CATEGORY	HEALTH CARE SERVICE(S) REQUIRING AUTHORIZATION	CLINICAL DOCUMENTATION REQUIRED
Dental Services (STAR Health): Orthodontia	Orthodontic Services (STAR Health) *NOTE: Contact DentaQuest at 1-888-308-9345, or visit https://govservices.dentaquest.com.*	• Credentials for servicing provider • ADA 2018, 2019, or newer claim form with service codes noted • Duplicate diagnostic models or a complete set of diagnostic photographs • Radiographs (x-rays) • Cephalometric x-ray with tracings • Photographs (if plaster models are submitted) • Treatment plan
DME/Medical Supplies/Orthotics-Prosthetics/Enteral and Parenteral Nutrition	Custom Manual Wheelchairs (CPWC) and Powered Mobility Devices	• Completed DME order signed and dated by physician within 90 days of authorization start date • Requested HCPCS with modifiers if applicable on physician order • Date last seen by physician • All relevant diagnosis • History and physical with all clinical notes, must be current within last 6 months • Completed and signed Wheelchair and Seating Assessment completed by ATP/QRP and PT or OT • Completed in home accessibility assessment • Copy of the manufacturer's specifications of the requested seating system, including all components and accessories required for use • Medical necessity and justification for all accessories and components
	Durable Medical Equipment (DME) greater than $500/ item	• Completed DME order signed and dated by physician within 90 days of authorization start date • Requested HCPCS with modifiers if applicable on physician order • Date last seen by physician • All relevant diagnosis/es • History and physical with all clinical notes, must be current within last 6 months • Consult Notes and/or Reports from Specialists • Documentation of medical justification for requested device • Relevant diagnostic testing results, operative and/or pathological reports • Pertinent treatment plan • The provider's intended fee for any miscellaneous codes including the manufacturer suggested retail price (MSRP), average wholesale price (AWP) or other payment documentation
	Incontinence supplies	• Completed DME order signed and dated by physician within 90 days of authorization start date • Requested HCPCS with modifiers if applicable on physician order • Date last seen by physician • All relevant diagnosis/es • History and physical with all clinical notes, must be current within last 6 months • Progress Notes • Consult Notes and/or Reports from Specialists • Documentation of medical justification for requested supplies • Laboratory results • Alternate therapies trialed • Documentation on surgical interventions considered or reasons not applicable
	Medical Supplies	• Completed DME order signed and dated by physician within 90 days of authorization start date • Requested HCPCS with modifiers if applicable on physician order • Date last seen by physician • All relevant diagnosis/es • History and physical with all clinical notes, must be current within last 6 months • Consult Notes and/or Reports from Specialists • Documentation of medical justification for requested supplies • Pertinent laboratory results
	Nurtition - Enteral	• Completed DME order signed and dated by physician within 90 days of authorization start date • Requested HCPCS with modifiers if applicable on physician order • Date last seen by physician • All relevant diagnosis/es • History and physical with all clinical notes (including growth charts when applicable) must be current within last 6 months • Pertinent surgical history • Consult Notes and/or Reports from Specialists • Documentation of medical justification for requested device/supplies • Laboratory results • Alternate therapies trialed
	Nutrition - Total Parenteral (TPN)	• Completed DME order signed and dated by physician within 90 days of authorization start date • Requested HCPCS with modifiers if applicable on physician order • Date last seen by physician • All relevant diagnosis/es • History and physical with all clinical notes, must be current within last 6 months • Progress Notes • Consult Notes and/or Reports from Specialists • Documentation of medical justification for requested supplies • Laboratory results • Alternate therapies attempted
	Orthotics/Prosthetics	• Completed DME order signed and dated by physician within 90 days of authorization start date • Requested HCPCS on physician order, modifiers if applicable • Date last seen by physician • All relevant diagnosis • History and physical with all clinical notes, must be current within last 6 months • Progress Notes • Consult Notes and/or Reports from Specialists • Current functional level (K level 0-4) • Orthotist/Prosthetist evaluation and exam • Clinical documentation supporting the need for the requested device
Hearing and Audiology Devices and Services	Hearing Aids	**Hearing aids** • Completed physician order signed and dated within 90 days of authorization start date • Medical exam documented with Otologist or Otolaryngologist within past 6 months; include if hearing loss is surgically or medically correctable without the use of a hearing aid/device • Documentation of presence of Auditory Neuropathy Spectrum Disorder (ANSD) • All relevant diagnosis • Complete audiologist testing and report with type of hearing loss identified • Confirmation 30-day trial period will be completed with the selected hearing aid • Hearing aid will be fitted and dispensed by an audiologist • For members ages 0-20 documentation that a parent or caretaker will assist with child adapting to the hearing aid **Audiological tests that must be documented** • Air and Bone conduction • Click-Evoked auditory brainstorm response testing • Conditioned play audiometry or word recognition testing • Tympanometry with 1000 Hz (infant) or 226 Hz (> 6months) probe tone • Speech audiometry • Otoacoustic emissions
	Bone Anchor Hearing Aid (BAHA) *NOTE: Contact TurningPoint Healthcare Solutions at 1-855-336-4391 (phone) 1-833-409-5393 (fax)*	• Completed physician order signed and dated within 90 days of authorization start date • Medical exam documented with Otologist or Otolaryngologist within past 6 months; include if hearing loss is surgically or medically correctable without the use of a hearing aid/device • All relevant diagnosis/es • History and physical with all clinical notes, must be current within last 6 months • Treatment plan • Consult Notes and/or Reports from Specialists • Indications for BAHA device verses standard hearing aid • Complete audiologist testing and report with type of hearing loss identified • Audiological testing of Pure Tone Average (measured at 0.5, 1, 2, and 3kHz) • Specify if Implantable or Head Band Device requested
Imaging Services	Cardiac Imaging Modalities STAR+PLUS ONLY (Stress Echo, Echocardiography and Nuclear Cardiology	• Clinical notes • Reports of previous procedures • Specialist reports/evaluation
	Diagnostic Imaging (CT, CTA, MRI, MRA, PET) *NOTE: Contact Texas National Imaging Associates at 1-800-642-7554, or visit www.RadMD.com.*	• Clinical notes • Reports of previous procedures • Specialist reports/evaluation
Implantable Devices	Access catheter	• Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation
	Auditory osseo integrated device	
	Cardiac event recorder	• Physician order if service is requested for in-home • Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation

HEALTH CARE SERVICE CATEGORY	HEALTH CARE SERVICE(S) REQUIRING AUTHORIZATION	CLINICAL DOCUMENTATION REQUIRED
Implantable Devices	Cochlear device/implant	• Member name • Member ID number • Member Date of Birth • Requesting and rendering name, address, and contact information • NPI/TIN for all rendering and requesting PR actioners and facilities • CPT code(s)/HCPCS code(s) • Diagnosis codes to the highest level of specificity • Place of service • Date of service (start and end date) • Number of requested units per procedure code • Clinical documentation to support the request
	Infusion pump Injectable bulking agent Intraocular lens	• Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation
	Joint implant	• Member name • Member ID number • Member Date of Birth • Requesting and rendering name, address, and contact information • NPI/TIN for all rendering and requesting PR actioners and facilities • CPT code(s)/HCPCS code(s) • Diagnosis codes to the highest level of specificity • Place of service • Date of service (start and end date) • Number of requested units per procedure code • Clinical documentation to support the request
	Lacrimal duct implant	• Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation
	Neurostimulator	• Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation • Consult Notes and/or Reports from Specialists • Complete Radiology Reports
	Ocular implant	• Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation
	Osteogenesis stimulator	• Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation • Consult Notes and/or Reports from Specialists • Complete Radiology Reports
	Prosthetic implant	• Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation
Inpatient Admissions - Elective	Medical and Surgical Inpatient Admissions	Information and documents should relate to current admission. In addition to applicable documents listed above: • Admission Notification and/or Face Sheet • Diagnosis • History and Physical • Progress Notes • Consult Notes and/or Reports from Specialists • Behavioral Health Inpatient Extended Stay Form • Physician Orders • Radiology/Imaging Results • Laboratory Results • Blood Glucose Testing • Vital Sign Reports • Medication Administration Record (MAR) • Plan of Care • Level of Care (Med/Surg, ICU, IMC) • Discharge Summary
	Behavioral Health Inpatient Admissions	**Facilities must submit:** • All relevant and updated information and medical records related to the inpatient admission, necessary to complete the review including: o An enrollee/member's mental health medical record summary; or o Medical records or process or progress notes that relate to treatment of conditions or disorders other than a mental or emotional condition or disorder • The medical record documentation may include the following, and be obtained from the appropriate source: o Clinical and diagnostic testing information regarding the diagnoses of the enrollee and the medical history of the enrollee relevant to the diagnoses; o The enrollee's prognosis; o And the plan of treatment prescribed by the provider of record, along with the provider of record's justification for the plan of treatment
Inpatient Admissions - Non-Elective	Medical and Surgical Inpatient Admissions	Information and documents should relate to current physical or behavioral health admission • Admission Notification and/or Face Sheet • Diagnosis • History and Physical • Progress Notes • Consult Notes and/or Reports from Specialists • Physician Orders • Radiology/Imaging Results • Laboratory Results • Blood Glucose Testing • Vital Sign Reports • Medication Administration Record (MAR) • Plan of Care • Level of Care (Med/Surg, ICU, IMC) • Delivery info: Baby DOB, gender, weight & APGAR • Discharge Summary
Interventional Pain Management	Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis) Paravertebral Facet Joint Injections or Blocks Sacroiliac Joint Injections Spinal Epidural Injections *NOTES:* *Contact Texas National Imaging Associates at 1-800-642-7554, or visit www.RadMD.com. For members 21 years of age and older.*	• Clinical notes • Reports of previous procedures • Specialist reports/evaluation
Non-emergent Ambulance Transportation	Non-emergent air ambulance transportation	• Prior authorization form, physician signed or physician-extender signed order for non-emergent ambulance transport • Medical condition that necessitates the transportation • Reason the member cannot be transported by any other mode • Transportation dates scheduled/anticipated • Medical appointment dates and provider with whom appointments are scheduled
Medicine Services: Sleep Studies	Sleep Studies. *NOTE: Contact TurningPoint Healthcare Solutions at 1-855-336-4391 (phone) 1-833-409-5393 (fax).*	• Member name • Member ID number • Member Date of Birth • Requesting and rendering name, address, and contact information • NPI/TIN for all rendering and requesting PR actioners and facilities • CPT code(s)/HCPCS code(s) • Diagnosis codes to the highest level of specificity • Place of service • Date of service (start and end date) • Number of requested units per procedure code • Clinical documentation to support the request
Medicine Services: Therapy Treatment	Cognitive Rehabilitative Services	• Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation • Neurobehavioral Assessment • Plan of Care
	Outpatient and Home Health: Physical Therapy (PT), Speech Therapy (ST) and Occupational Therapy OT) NOTE: Prior authorization not required for ECI therapy, identified through ECI IFSP.	• Plan of Care (including the assessment findings, the treatment goals, and the frequency/duration) signed by physician no less than 60 days from date of submission - **Initial Treatment Requests** to include: • Clinical assessment documentation supporting the medical necessity for therapy services as related to the member's diagnosis, prognosis and ability to participate in therapy • A description of the functional impairments or deficits as they relate to the member's day-to-day needs (e.g., ADLs, mobility, communication, etc.). • Treatment goals that are in the SMART format (specific, measurable, attainable, relevant and time-based) as well as tied to a specific functional outcome for that member - **Continuation of Treatment Requests** to include all initial treatment requirements and: • Clinical documentation of those previous goals that were met and unmet. • Documentation of the baseline and current status for all unmet goals as well as any barriers to treatment which impacted progress and/or modifications made to the treatment plan

HEALTH CARE SERVICE CATEGORY	HEALTH CARE SERVICE(S) REQUIRING AUTHORIZATION	CLINICAL DOCUMENTATION REQUIRED
Pathology and Laboratory Services	Quantitative Testing for Drugs of Abuse	• Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation • Prior authorization request should be submitted within 10 Business days from specimen collection
	Genetic Testing and Molecular Diagnostics	• Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation • Pretesting counseling • Prior authorization request should be submitted within 10 Business days from specimen collection
Prescribed Pediatric Extended Care Centers (PPECC)	Prescribed Pediatric Extended Care Services (PPECC)	• Completed PPECC Plan of Care (signed by physician within 30 Days from start of care); • Completed CCP Prior Authorization Request Form; • Completed Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form which includes: o The identification of the client and the responsible adult, and the requested start/end dates, and number of PPECC hours and/or days requested per week o A Nursing Care Plan Summary, which includes a problem list with specific measurable outcomes and current progrss towards goal o The Summary of Recent Health History or an updated 90-Day summary for subsequent PPECC services o The Rationale for PDN and/or PPECC hours and for subsequent PPECC requests the rationale for the PPECC hours to either increase, decrease, or stay the same. The rationale should include the medical necessity documentation to substantiate the request for PPECC hours and/or days. o Completed Schedule of Services 24-hour daily flow sheet o Signed acknowledgement
Services in the Home	Physical Therapy, Occupational Therapy, Speech Therapy	See Medicine Services: Therapy Treatment section
	Skilled Nursing Visits	• A signed provider order or acceptable alternative order less than 90 days old which requests SN visits or home health aide services at a given frequency and duration • Up-to-date Plan of Care (POC) completed by a registered nurse • Date the member was last seen by the provider • Supporting clinical documentation for service type requested
	Private Duty Nursing	• Documentation by the primary provider includes all of the following: • Signed and dated physician's order (physician-designated advanced practice registered nurse (APRN) or physician assistant (PA) is acceptable) or signed Plan of Care for PDN that is less than 30 days old prior to the start of care, indicating the number of hours per day or week and the duration of the request • The plan of care must be up to date and include the member's current diagnosis, functional status, and medical conditions that are relevant to the intended skilled nursing services • Supporting clinical documentation for service type requested • A completed THSteps-CCP Prior Authorization Request form signed and dated by the primary physician within 30 calendar days prior to the SOC date • A completed POC form, signed and dated by the primary physician within 30 calendar days prior to the SOC date • A completed Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form signed and dated by the primary physician, the RN completing the assessment and parent or guardian within 30 calendar days prior to the SOC date • A completed THS-Steps CCP Prior Authorization Private Duty Nursing 6-Month Authorization form when requesting prior authorization for six months when applicable
Surgical Services and Procedures	Abdominal Hysterectomy	• Pertinent diagnosis/conditions that relate to the need for the service • Appropriate CPT codes • Alternative methods considered
	Bariatric Surgery	• Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation • Co-morbidity 35-40% BMI and >40% no co-morbidity
	Circumcision (One year and older)	• Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation
	Cardiac Surgeries ENT Services: Nasal/Sinus Endoscopy, Tonsillectomy & Adenoidectomy, Typanostomy, Myringotomy Musculoskeletal Surgical Procedures *NOTE: Contact TurningPoint Healthcare Solutions at 1-855-336-4391 (phone) 1-833-409-5393 (fax).*	• Member name • Member ID number • Member Date of Birth • Requesting and rendering name, address, and contact information • NPI/TIN for all rendering and requesting PR actioners and facilities • CPT code(s)/HCPCS code(s) • Diagnosis codes to the highest level of specificity • Place of service • Date of service (start and end date) • Number of requested units per procedure code • Clinical documentation to support the request
	Excision of lesions	• Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation • Consult Notes and/or Reports from Specialists
	Musculoskeletal Surgical Procedures (Outpatient) *NOTE: Contact TurningPoint Healthcare Solutions at 1-855-336-4391 (phone) 1-833-409-5393 (fax).*	• Member name • Member ID number • Member Date of Birth • Requesting and rendering name, address, and contact information • NPI/TIN for all rendering and requesting PR actioners and facilities • CPT code(s)/HCPCS code(s) • Diagnosis codes to the highest level of specificity • Place of service • Date of service (start and end date) • Number of requested units per procedure code • Clinical documentation to support the request
	Opthalmology - Specialized Services	• Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation • Consult Notes and/or Reports from Specialists
	Oral Surgery	• Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation • General Anesthesia Form
	Outpatient Surgery	• Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation • Consult Notes and/or Reports from Specialists
	Podiatry	• Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation
	Reconstructive and Cosmetic Procedures	• Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation • Consult Notes and/or Reports from Specialists
	Treatment of Varicose Veins Vagus Nerve Stimulation	• Pertinent diagnosis/conditions that relate to the need for the service • Supporting clinical documentation
	Organ Transplant Evaluation	1. Appropriate Prior Authorization form. 2. Routine complete history and physical within 1 year including: a. History of present illness, including a list of all current medications b. Past medical history, pertinent family history and social history c. Complete review of systems, physical examination, including height, weight and BMI

HEALTH CARE SERVICE CATEGORY	HEALTH CARE SERVICE(S) REQUIRING AUTHORIZATION	CLINICAL DOCUMENTATION REQUIRED
Surgical Services and Procedures: Transplants	Transplant Listing and Authorization Extension	1. Appropriate Prior Authorization Form 2. Letter of medical necessity from a transplant service physician with signature 3. Complete history and physical performed by a transplant service physician within 6 months of the request, including: a. History of present illness, including a list of all current medications b. Past medical history, pertinent family history and social history c. Complete review of systems, physical examination, including height, weight and BMI 4. Basic labs (complete chemistry panel/LFTs and CBC) within 6 months: 5. Appropriate testing and imaging for the requested transplant o Liver – INR, MELD or PELD score, hepatitis serologies, imaging studies (MRI, CT, ultrasound), and liver biopsy as indicated o Kidney – GFR or creatinine clearance if not on dialysis o Heart – echocardiogram, cardiac catheterization results.NYHA Class and peak VO2 results o Lung – PFTs, imaging (Chest x-rays and/or CT scans), and 6-minute walk test o Pancreas – BMI, C-peptide, and history of insulin treatment o Intestine/Multivisceral – no specific additional testing o Stem cell – most recent bone marrow biopsy as indicated, most recent ECOG score or Karnofsky score and documentation of donor identification for allogeneic transplants 6. Annual dental evaluation and clearance (Transplant clearance from DDS or a panoramic dental x-ray with clearance from MD) 7. Routine health screening exams as per standards of care (mammogram, Pap, and/or colonoscopy) 8. Appropriate comorbidity testing/clearance, including cardiology 9. Serum or Urine Drug screen results (within 90 days of request) 10. Infectious disease screening: a. Hepatitis B testing within one year, unless baseline surface antibody positive b. Hepatitis C within one year, unless baseline positive (viral load required within three months if positive) c. RPR within one year d. HIV within one year, unless baseline positive (CD4 count and viral load required within three months if positive) e. CMV and VZV within one year unless baseline IgG antibody positive f. EBV within one year for all transplants except autologous stem cell transplants, unless baseline IgG antibody positive g. Toxoplasma titer for heart transplant recipients h. Results of annual PPD, T-Spot, or QuantiFERON for all solid organ transplants, unless previously positive 11. Detailed psychosocial evaluation and clearance within 6 months
	Transplant Authorization: Relisting	Requests require validation of UNOS listing status in addition to the above information
	Transplant Continuity of Care	Submit documentation validating previous insurer coverage, evaluation or listing approval plus a copy of the current UNOS listing
	Post Transplant Visits Authorization	1. Appropriate PA form 2. Discharge summary from transplant inpatient hospital stay