Guideline Name: Medical Management

- Prenotification
- Certification/Prior Authorization
- Predetermination of Benefits

Pre-Notification: Pre-note is a non-penalty request made of enrollees/providers to advise of any upcoming hospital admissions. This provides our clinical staff with possible case management/disease management opportunities based on our criteria.

The general categories frequently requiring pre-notification:

- In Care System or in the Care System "Family" for In Patient Hospitalization and Rehabilitation.
- In Care System or in the Care System "family" for In Patient Mental Health/Chemical Dependency.

No letters are sent.

Certification/Prior Authorization: A determination as to whether a service, treatment, supply or facility is approved as Medically Necessary by the Claims Administrator, on behalf of the Plan , before payment can be made.

The general categories frequently required by the Employer's Summary Plan Description (SPD) for certification include the following:

- All out of area (not participating in any Care System) for the following:
  In Patient Hospitalization and Rehabilitation
  In Patient Mental Health/Chemical Dependency
  Skilled Nursing and Extended Care Admissions- NOTE: BHCAG requires pre-authorization for In Care Systems and certification for out of area
  Home Health Care
  Transplant Care- Note: this applies to both In/Out of Care Systems
  Durable Medical Equipment over $750 In/ $1500 out of area

Letters are generated and sent to Employee, Provider and Facility per URAC requirements.

Pre-Determination: A determination of benefits by the Claims Administrator, on behalf of the Plan, prior to services being provided when individuals want to know if the procedure/service is Medically Necessary and/or Covered under the Plan.

When requesting a pre-determination of benefits please include the patient's name, covered employee's name and the covered employee's social security number so the request can easily be identified and get to the appropriate area.

Once pre-determination has been made, letters are sent to the Employee, Provider of Service and Primary Care Provider.

The general categories or specific procedures frequently desired by providers or plan members to receive pre-determination of benefits may include the following:

- Surgeries that are often questionable as cosmetic, such as:

  Blepharoplasty / Levator Resection / Eyelid Surgery / Brow Lift
  Breast Reduction / Reduction Mammoplasty / Gynecomastia
  Prophylactic Mastectomy
  Panniculectomy / Abdominoplasty / Tummy Tuck
  Rhinoplasty / External Nasal Surgery / Combination Rhinoplasty Surgery
  Cleft Lip / Cleft Palate for individuals over 18 years of age
  Scar Revisions
  Chemical Peels / Dermabrasion
  Genioplasty
  Otoplasty
  Port Wine Stain / Birthmarks / Keloid Scars
  Rhytidectomy
  Any Reconstructive Procedures performed to improve the appearance

- Treatment of Obesity / Morbid Obesity
- Gastric Bypass / Roux-en-Y Jejuniostomy / Stomach Staple
- Procedures with potential to be investigational or experimental or not standard of care, such as:

  Clinical Trials
  EBCT (Electron-Beam Computer Tomography)
  IDET (Intradiscal Electrothermal Treatment-OP)
  IVIG (Intravenous immunoglobulin)

- Lung Volume Reduction Surgery
- UPPP / UP3 / Uvulopalatopharyngoplasty
- LAUP (Laser Assisted Uvulopalatoplasty)
- Somnoplasty / Tongue Reduction (Often done for snoring)
- Speech Therapy
- Implanted devices (such as morphine pump, nerve stimulator, etc.)
- Injections (such as Botulinium Toxin (Botox),,Depo Lupron, Synagis). Does not include in-patient services.
- Orthoptic Training / Vision Therapy
- Prolotherapy
- Biofeeback
- Acupunture