

VBHP PPO – Services Requiring Pre-Authorization

PRE-AUTHORIZATION REQUIREMENTS

We require that certain medical services, care, or treatments be Pre-Authorized before We will pay for all related Covered Health Services. Pre-Authorization means that We review and confirm that proposed services, care, or treatments are Medically Necessary. You or Your Physician are responsible to Pre-Authorize any proposed services at least five days before You receive them. The services requiring preauthorization include, but are not limited to, those services listed below. This listing is subject to change. Please contact Customer Service at **(800) 829-6440 (Commercial)** or **(800) 249-7366 (Self-Funded)**, for information on the most up-to-date listing. We will reduce payment for covered services if You do not Pre-Authorize the services listed below. Refer back to Your Plan Document for the applicable pre-authorization penalty.

- Adenoidectomy, primary (age 12 or over);
- Adenoidectomy, secondary (age 12 or over);
- Ambulance transfers: Air & Non-emergent;
- Assistant Surgeon requests for procedures not designated as allowing for an assist per the approved Assistant Surgeon List;
- Blepharoplasty;
- Birthing Center Admissions;
- Bone Growth Stimulators & Implantation;
- Breast Reduction/Reconstruction;
- Capsule Endoscopy;
- Cardiac Spiral CT
- Spinal Manipulation Services;
- Cognitive Therapy;
- Cosmetic Surgery/Reconstructive Surgery/Plastic Surgery Procedures - Cosmetic surgery may be covered if a result of trauma, cancer, or a congenital anomaly;
- Dental Procedures;
- DME/Orthotics;
- Dietary education/counseling - for any diagnosis other than diabetes and hypoglycemia;
- Elective/Outpatient surgical procedures performed in a hospital or free standing Surgi-Center. Procedures performed in a provider's office do not require pre-authorizations.
- Excision of Turbinate;
- Genetic Testing – Excludes prenatal genetic testing;
- Growth Hormone Therapy;
- Home Health Care;
- Hospice Services;
- Hyperbaric Oxygen Treatment;
- Implantation of pumps for pain control;
- Infertility Services - Evaluation & Treatment;
- Inpatient Hospital Admissions;
- Inpatient Rehabilitation Admissions;
- Intensity Modulated Radiation Therapy (IMRT) - *Excluding prostate, head and neck cancers*;
- Intermediate Care Facility;
- Laser Vision Corrective Surgery-Only covered for diagnosis of Keratoconus;
- LEAP (Lifestyle Eating and Performance);
- Mental Health Services & Chemical Dependency Treatment;
- Military Treatment Center;
- Mobile Cardiac Output Telemetry (MCOT);

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- MRI and MRA (*all inclusive*);
- Procedures related to treatment for Morbid Obesity, including, but not limited to gastric bypass surgery; These procedures are only covered under certain plans. Please see *Section 4 - What is Covered*;
- Neuropsychological testing;
- Non-Emergent Transportation;
- Observation Stays;
- Obstetrical Ultrasounds – Greater than 1 standard ultrasound without the presence of known or suspected fetal anomalies;
- Occupational Therapy;
- Oral Surgery Procedures;
- Orthognathic Surgery;
- Orthotripsy;
- Oxygen: Distribution of Oxygen Equipment for use in the home;
- Pain Management Procedures
- Peripheral Nerve Stimulators -Trial and Permanent Placement;
- PET Scans;
- Pharmacy (Administered in office): Greater than \$250/dose requires pre-authorization (*oncology drugs not included*);
- Physical Therapy, including Cardiac and Pulmonary Rehab;
- Orthotics;
- Psychological/Psychiatric services for the treatment of Acquired Brain Injury;
- Rhizotomy;
- Septoplasty or Submucosal Resection of Turbinate;
- Skilled Nursing Facility Admissions;
- Sleep Studies;
- Speech Therapy;
- Spinal Cord Stimulators and Implantation;
- Strabismus Surgery - No authorization is required through age 21 and performed in-plan;
- Submucosal Resection of Turbinate;
- Tonsillectomy & Adenoidectomy (age 12 and over);
- Tonsillectomy, Primary or Secondary (age 12 and over);
- Transplants;
- Uvulectomy, Excision of Uvula;
- Uvulopalatopharyngoplasty (UPPP);
- Varicose Vein procedures; and
- Wound Care.

If You fail to get proper authorization, You may be charged additional amounts, which will not count toward Your Deductibles or out-of-pocket maximums. These amounts are shown on the Schedule of Benefits.