THE OHIO STATE UNIVERSITY
HEALTH PLAN

SERVICES REQUIRING MEDICAL NECESSITY REVIEW AND/OR PRIOR AUTHORIZATION

Medical Necessity: To be medically necessary, covered services must:

- Be rendered in connection with an injury or sickness;
- Be consistent with the diagnosis and treatment of your condition;
- Be in accordance with the standards of good medical practice;
- Not be for your convenience or your physician's convenience and
- Not be considered experimental or investigative;

Prior Authorization: Notification requesting coverage is required before receipt of certain designated services, elective admission to a hospital or facility, or specific medications prescribed for certain uses. Participating facilities need to notify the Medical Management Department at OSU Health Plan within 48 hours of an urgent/emergent admission. Providers need to provide clinical documentation to OSU Health Plan at least five business days prior to a specified outpatient or elective inpatient procedure. Failure to obtain prior authorization for these designated services can result in penalty or denial of benefits.[1]

Please refer to the Specific Plan Details Document found at http://hr.osu.edu/hrpubs/ben/medicalspd.pdf for specific benefit information and plan limitations.

Utilization Review is required for all inpatient admissions.

Providers must contact OSU Health Plan Medical Management department prior to services being provided at (614) 292-4700 or (800) 678-6269, within 48 hours for urgent/emergent and 5 business days prior to elective admissions[2]. Clinical documentation can be faxed to 614-292-2667 and should include all the following information:

- **Procedure requested**
- **Diagnosis**
- **Physician and Facility**
- **Date of Service**
- **Medical record documentation to support medical necessity (such as patient history, progress notes, conservative treatment(s) failed, etc.)**

Claims submitted with unlisted procedure and unlisted medication codes will require documentation to identify what procedure/medication is being billed and require medical necessity review.

Please note that this list is not all-inclusive. We receive requests for coverage for new technologies, equipment, supplies, tests and procedures daily.

All facility based behavioral health services:

- Inpatient
- Outpatient – includes partial hospitalization and intensive outpatient treatment
- Substance Abuse treatment

All inpatient Admissions include:

- Elective admissions[2]
- Extended care facilities
- Hospice care
- Medical
- Rehabilitation
- Surgical
- Urgent/emergent admissions

Outpatient Services/procedures/treatment which require medical necessity review FIVE (5) business days prior to receipt of treatment include but are not limited to:**

- Abdominoplasty/panniculectomy
- Abortion
- Autologous Chondrocyte Implantation
- Back Pain – Invasive Procedures
- Blepharoplasty/ptosis repair
- Bone Growth Stimulators
- Breast reconstruction/repair[2]
- Breast reduction surgery
- Chemical peels/dermabrasion
- Coronary CT
- Durable Medical Equipment over $2,000
- Frenectomy
- Genetic testing
- Gynecomastia Surgery
- Hernia Repair
- Home health care/services
- Hospice services
- Infertility treatment
- Medical Supplies over $2,000
- Orthognathic surgery
- Orthotics over $2,000
- Outpatient radiology: MRIs, CTs, PETs
- Procedures for Obstructive Sleep Apnea (e.g., UPPP)
- Prolotherapy
- Prosthetics over $2,000
- Rhinoplasty
- Skin phototherapy/laser procedures
- Temporary Codes
- Unlisted Codes
- Varicose Vein procedures
- Weight loss surgery/procedures
- Weight management programs
- Wound Vac

**This list is not all inclusive. All experimental and investigational services and cosmetic services are specifically excluded under the OSU Medical Plans.

Medications

The following medications require medical necessity authorization for coverage under the MEDICAL benefit.

- Botulinum Toxins
- Hemophilia outpatient medications/infusions
- Remicade / Orencia / Actemra / Entyvio

The following medications require medical necessity authorization for coverage under the PHARMACY benefit.

http://hr.osu.edu/public/documents/hrpubs/ben/medpriorauth.pdf

[1] Prior authorization (see osuhealthplan.com/providers, Prior Authorization) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to $1,000 per admission of service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket limit.

[2] Scheduled c-sections and certain breast reconstruction procedures do not require clinical documentation prior to admission. C-sections will require clinical information if the stay exceeds 4 days. Breast reconstruction procedures will require clinical information prior to admission unless billed with ICD-10 C50.011 - C50.929, C79.81, D05.00 - D05.92, Z85.3, Z80.3, and/or Z90.10 - Z90.13.