Pre-authorization Requirements
The following two pages include a complete listing of services and procedures that require pre-authorization under our ConnectiCare, Inc. products.

Note: The listing of services and procedures that require pre-authorization is subject to change. ConnectiCare will notify you, in advance, of such changes.

Services & Procedures Requiring Pre-authorization

Admissions:
• Behavioral health admissions, please call 1-800-349-5365 (for some self-funded plans this may vary)
• Hospital admissions (elective/non-emergency)
• Rehabilitation admissions
• Skilled nursing facility admissions
• Sub-acute admissions

Ambulance:
• Land or air ambulance/medical transport that is not due to an emergency

Behavioral Health Services:
• Behavioral health services must be authorized through the Behavioral Health Program at 1-800-349-5365 (for some self-funded plans this may vary)

These services include but are not limited to:
Admissions that are elective or not the result of an emergency, including:
  • Acute hospital admissions
  • Partial Hospitalization Programs (PHP)
  • Rehabilitation facility admissions
  • Residential treatment facility admissions

Elective Services & Procedures:
  • Applied Behavioral Analysis (ABA) for the treatment of Autism Spectrum Disorder (ASD), if a covered benefit
  • Extended outpatient behavioral health treatment visits beyond 45-50 minutes in duration with or without medication management
  • Intensive Outpatient Treatment Programs (IOP)
  • Neuropsychological testing
  • Outpatient Electro-Convulsive Treatment (ECT)
  • Outpatient behavioral health treatment provided in a member’s home
  • Outpatient treatment of opioid dependence
  • Psychological testing over 4 hours
  • All out-of-plan services (non-emergency), excluding Point-of-Service plans

Durable Medical Equipment & Prosthetics:
• Customized wheelchairs, power mobility devices, scooters, if a covered benefit
• Continuous glucose monitors – Type II diabetes only
• Electronic or Myoelectric prosthetics or artificial limbs, including the purchase, replacement and repair – lower limb only – if a covered benefit
• Mechanical stretching devices
• Oral appliance for the treatment of sleep apnea
• Osteogenic stimulators (spinal, non-spinal and ultrasound), if a covered benefit

Elective Services or Procedures:
• Artificial intervertebral disc, if a covered benefit
• Clinical trials, patient consent form required
• Cardiac monitoring with Mobile Cardiac Outpatient Telemetry or Continuous Computerized Daily Monitoring with Auto-Detection (no pre-authorization is required for standard Holter monitors or loop event recording devices)
• Craniofacial treatment
• Dental anesthesia and facility charges, if a covered benefit
• Gastric bypass surgery/bariatric surgery, if a covered benefit
• Genetic testing, pre-authorization is required except for the following tests:
  o Cystic Fibrosis, screening only
  o Factor V Leiden
  o Fragile X
  o Hereditary hemochromatosis
  o Prothrombin
  o FISH testing for diagnosis of lymphoma or leukemia
  o Chromosomal microarray for children and adults (Note: Chromosomal microarray for prenatal/fetal diagnosis does require pre-authorization.)

• Infertility Services, if a covered benefit
• Mammoplasty, including surgery to treat gynecomastia, if a covered benefit
• Mandibular-maxillary osteotomy to treat obstructive sleep apnea
• Oncotype DX breast cancer test
• Orthognathic surgery, if a covered benefit
• Radiopharmaceuticals
• Reconstructive surgery
• Transplant services, except corneal (10 days prior to services being rendered)
• Varicose vein surgery, if a covered benefit
• Ventricular Assist Devices

Home Health Care:
• Home-based health care services—to request a continuation of authorization for home health care or IV therapy complete the appropriate online form

Injectable Drugs & Nutritional Supplements:
• Injections of Botulinum Toxin, Enbrel, Herceptin, IVIG, Prolastin, Remicade, Hyaluronic Acid, and Synagis
• Nutritional supplements and food products, including modified food products for inherited metabolic diseases and specialized formulas

Out-of-Plan Services:
• All out-of-plan services (non-emergency), excluding Point-of-Service plans, unless procedure or service being provided requires pre-authorization
• Out-of-network or out-of-plan hospital clinics, not due to an emergency

Outpatient Rehabilitative Services – Pediatric Only (except for the treatment of autism):
• Occupational therapy
• Physical therapy
• Speech therapy (including specialty hospitals, acute care hospitals and providers of rehabilitation services)

Radiological Services (except for inpatient or emergency services, or when such radiological services are done in conjunction with a biopsy or other surgical procedure):
• Bone mineral density exams ordered more frequently than every 23 months
• CT scans (all diagnostic exams)
• MRI/MRA (all examinations)
• Nuclear cardiology
• PET scans
• Radiation therapy for the following cancer diagnoses: Breast, Prostate, Lung, Colon, Rectal
• Stress echocardiograms
• Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) (e.g., gamma knife, cyberknife) for all diagnoses

Note: Services, supplies or drugs that are considered to be experimental or investigational will not be considered a covered benefit.