

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
0001A	PR IMM ADMN SARSCOV2 30MCG/0.3ML DIL RECON 1ST DOSE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
0002A	PR IMM ADMN SARSCOV2 30MCG/0.3ML DIL RECON 2ND DOSE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
0003A	COVID-19 PFIZER VACCINE ADMINISTRATION	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
0004A	IMMUNIZATION ADMINISTRATION BY INTRAMUSCULAR INJECTION OF SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARSCOV-2) (CORONAVIRUS DISEASE COVID-19) VACCINE, MRNALNP, SPIKE PROTEIN, PRESENTATION	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024

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00103	PR ANESTH,BLEPH AROPLASTY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
0011A	PR IMM ADMN SARSCOV2 100 MCG/0.5 ML 1ST DOSE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		8/12/2021
0012A	PR IMM ADMN SARSCOV2 100 MCG/0.5 ML 2ND DOSE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		8/12/2021
0013A	COVID-19 MODERNA VACCINE ADMINISTRATION	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		8/12/2021
00170	PR ANESTH,PROCEDURE ON MOUTH	NO AUTHORIZATION REQUIRED	TMPPM DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: K02.3, K02.51, K02.53, K02.61, K02.63, K02.7, K02.9-K03.9, K04.0 AGE: NO AUTH REQUIRED IF OLDER THAN 6 YEARS. EXCLUSIONS: AUTH REQUIRED FOR CHIP LINE OF BUSINESS	HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	12/1/2023

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00170	PR ANESTH,PROCEDURE ON MOUTH	<p>AUTHORIZATION REQUIRED</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: K02.3, K02.51, K02.53, K02.61, K02.63, K02.7, K02.9-K03.9, K04.0</p> <p>AGE: PRIOR AUTH IS REQUIRED IF 6 YEARS OF AGE OR YOUNGER.</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	12/1/2023
0031A	PR IMM ADMIN SARSCOV2 AD26 5X1010VP/0.5 ML DOSAGE;SINGLE DOSE	<p>NO AUTHORIZATION REQUIRED</p> <p>AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.</p> <p>EXCLUSIONS: FQHC, RHC</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK, CP		8/12/2021
0034A	PR IMMUNIZATION ADMINISTRATION BY INTRAMUSCULAR INJECTION OF SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2) (CORONAVIRUS DISEASE COVID-19) VACCINE, DNA, SPIKE PROTEIN, AD26	<p>NO AUTHORIZATION REQUIRED</p> <p>AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.</p> <p>EXCLUSIONS: FQHC, RHC</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK, CP		1/1/2024

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0041A	PR IMM ADMN SARSCOV2 5 MCG/0.5 ML 1ST DOSE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		12/1/2022
0042A	PR IMM ADMN SARSCOV2 5 MCG/0.5 ML 2ND DOSE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		12/1/2022
0044A	ADM SARSCOV2 5MCG/0.5ML BST	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		12/1/2022
0051A	PR IMMUNIZATION ADMINISTRATI ON BY INTRAMUSCUL AR INJECTION OF SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARSCOV-2) (CORONAVIRU S DISEASE) VACCINE, MRNALNP, SPIKE PROTEIN, PRESE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024

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0052A	IMMUNIZATION ADMINISTRATI ON BY INTRAMUSCUL AR INJECTION OF SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARSCOV-2) (CORONAVIRU S DISEASE COVID-19) VACCINE, MRNALNP, SPIKE PROTEIN, PRESE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
0053A	IMMUNIZATION ADMINISTRATI ON BY INTRAMUSCUL AR INJECTION OF SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARSCOV-2) (CORONAVIRU S DISEASE COVID-19) VACCINE, MRNALNP, SPIKE PROTEIN, PRESE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024

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0054A	PR IMMUNIZATION ADMINISTRATI ON BY INTRAMUSCUL AR INJECTION OF SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARSCOV-2) (CORONAVIRU S COVID-19) VACCINE, MRNALNP, SPIKE PROTEIN, PRESE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
0064A	PR IMMUNIZATION ADMINISTRATI ON BY INTRAMUSCUL AR INJECTION OF SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARSCOV-2) (CORONAVIRU S DISEASE COVID-19) VACCINE, MRNALNP, SPIKE PROT	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
0071A	PR FIRST DOSE: AGE 5-11 IMMUNIZATION ADMIN BY INTRAMUSCULAR INJECTION OF SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2)	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
0072A	PR SECOND DOSE; AGE 5-11 IMMUNIZATION ADMIN BY INTRAMUSCULAR INJECTION OF SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2)	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
00731	PR ANESTHESIA UPPER GI ENDOSCOPIC PX NOS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
00732	PR ANESTHESIA UPPER GI ENDOSCOPIC PX ERCP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

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0073A	IMMUNIZATION ADMINISTRATI ON BY INTRAMUSCUL AR INJECTION OF SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARSCOV-2) (CORONAVIRU S DISEASE (COVID-19) VACCINE, MRNA-LNP, SPIKE PROTEIN, PRES	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
0074A	IMMUNIZATION ADMINISTRATI ON BY INTRAMUSCUL AR INJECTION OF SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2) (CORONAVIRU S DISEASE COVID-19) VACCINE, MRNA-LNP, SPIKE PROTEIN, PRE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
00811	PR ANESTHESIA LOWER INTST ENDOSCOPIC PX NOS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

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00812	PR ANESTHESIA LOWER INTST ENDOSCOPIC PX SCR COLSC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
00813	PR ANESTHESIA COMBINED UPPER&LOWE R GI ENDOSCOPIC PX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
0081A	PR IMM ADMIN 2SARS-COV-2 MRNA-LNP PFIZER 1ST DOSE 6MOS-4YRS	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		1/1/2024
0082A	PR IMM ADMN 2 SARS-COV-2, MRNA-LNP PFIZER 2ND DOSE 6MOS-4YRS	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		1/1/2024
0083A	PR IMM ADMN 2 SARS-COV-2, MRNA-LNP PFIZER 3RD DOSE 6MOS-4YRS	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		1/1/2024

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0091A	MODERNA COVID-19 PEDIATRIC VACCINE (AGED 6 YEARS THROUGH 11 YEARS) (BLUE CAP WITH PURPLE BORDER) ADMINISTRATI ON - FIRST DOSE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		1/1/2024
0092A	MODERNA COVID-19 PEDIATRIC VACCINE (AGED 6 YEARS THROUGH 11 YEARS) (BLUE CAP WITH PURPLE BORDER) ADMINISTRATI ON - SECOND DOSE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		1/1/2024
0093A	MODERNA COVID-19 PEDIATRIC VACCINE (AGED 6 YEARS THROUGH 11 YEARS) (BLUE CAP WITH PURPLE BORDER) ADMINISTRATI ON - THIRD DOSE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		1/1/2024

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0094A	ADM SARS-COV-2 50MCG/0.5 MLBST	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
0111A	PR IMM ADMIN 2 SARS-COV-2 VACCINE, MRNA-LNP MODERNA 1ST DOSE 6MOS-5YRS	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		3/1/2023
0112A	PR IMM ADMIN 2 SARS-COV-2 VACCINE, MRNA-LNP, MODERNA SUBSEQUENT DOSE 6MOS-5YRS	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		3/1/2023
0113A	MODERNA COVID-19 PEDIATRIC VACCINE (AGED 6 MONTHS THROUGH 5 YEARS) (BLUE CAP WITH MAGENTA BORDER) ADMINISTRATION - THIRD DOSE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		3/1/2023

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0121A	ADM SARSCV2 BVL 30MCG/.3ML 1	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
0124A	ADM SARSCV2 BVL 30MCG/.3ML ADDL DOSE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
0134A	ADM SARSCV2 BVL 50MCG/.5ML ADDL DOSE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
0141A	ADM SRSCV2 BVL 25MCG/.25ML 1	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		1/1/2024
0142A	ADM SRSCV2 BVL 25MCG/.25ML 2	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		1/1/2024

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0144A	ADM SARSCV2 BVL 25MCG/.25ML ADDL DOSE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		1/1/2024
0151A	ADM SARSCV2 BVL 10MCG/.2ML 1	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
0154A	IMMUNIZATION ADMINISTRATI ON BY INTRAMUSCUL AR INJECTION OF SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2) (CORONAVIRU S DISEASE COVID-19) VACCINE, MRNA-LNP, BIVALENT SPIKE PRO	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
0164A	MODERNA COVID-19 BIVALENT BOOSTER VACCINE TO INDIVIDUALS 6 MONTHS THROUGH 5 YEARS OF AGE ADDL DOSE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		3/1/2023

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0171A	ADM SARSCV2 BVL 3MCG/0.2ML 1	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		1/1/2024
0172A	ADM SARSCV2 BVL 3MCG/0.2ML 2	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		1/1/2024
0173A	PFIZER-BIONTECH COVID-19 BIVALENT BOOSTER VACCINE TO INDIVIDUALS 6 MONTHS THROUGH 4 YEARS OF AGE ADD; DOSE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		1/1/2024
0174A	IMM ADMN SARSCOV2 BIVALENT 3 MCG/0.2 ML ADDL	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		1/1/2024
01916	PR ANESTH,DX ARTERIOGRAP HY/VENOGRAP HY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

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01920	PR ANESTH,CARDI AC CATH W/CORON ART & VENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
01922	PR ANESTH,CAT/M RI SCAN,RADIATN THERAPY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
01924	PR ANESTH,INTER RAD,ARTERIAL SYS,NOS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
01925	ANESTH,INTER RAD, ARTERIAL, CAROTID/COR ONARY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
01926	ANESTH,INTER RAD,ARTERIAL, INTRACRA/INTR ACAR/AORT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
01930	PR ANESTH,INTER RAD,VENOUS/L YMPH SYS,NOS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
01931	ANESTH,INTER RAD,VENOUS/L YMPH,INTRAHE PAT/PORTAL CIRC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
01932	ANESTH,INTER RAD,VENOUS/L YMPH,INTRATH ORACIC/JUGUL AR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
01933	ANESTH,INTER RAD,VENOUS/L YMPH,INTRACR ANIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

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01937	PR ANES PERQ IMG NJX DRG/ASPIR PX SPI/SP CRV/THRC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
01938	PR ANES PERQ IMG NJX DRG/ASPIR PX SPI/SP LMBR/SAC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
01939	PR ANES PERQ IMG DSTRJ PX NULYT AGT SPI/SP CRV/THRC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
01940	PR ANES PERQ IMG DSTRJ PX NULYT AGT SPI/SP LMBR/SAC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
01941	PR ANES PERQ IMG NEUROMD/NTR VRT PX SPI/SP CRV/THRC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
01942	PR ANES PERQ IMG NEUROMD/NTR VRT PX SPI/SP LMBR/SAC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
0537T	PR CAR-T THERAPY HRVG BLD DRV T LMPHCYT PR DAY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
0538T	PR CAR-T THERAPY PREPJ BLD DRV T LMPHCYT F/TRNS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
0539T	PR CAR-T THERAPY RECEIPT & PREP CAR-T CELLS F/ADMN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
0540T	PR CAR-T THERAPY AUTOLOGOUS CELL ADMINISTRATI ON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
0604T	PR REMOTE OCT RETINA 1ST DEV SET-UP & PT EDUCAJ	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
0605T	PR REM OCT RETINA TECHL SUPRT MIN 8 DLY REC EA 30D	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
0606T	PR REMOTE OCT RETINA REVIEW I&R PHYS/QHP EA 30 D	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
0616T	PR INSJ IRIS PROSTH W/SUTURE FIXATION&RPR/ RMVL IRIS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
0617T	PR INSJ IRIS PROSTH RMVL CRYSTLN LENS &INSJ IO LENS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
0618T	PR INSJ IRIS PROSTH SECONDARY IO LENS PLMT/EXCHANGE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
0621T	PR TRABECULOSTOMY AB INTERNO BY LASER	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
0622T	PR TRABECULOSTOMY AB INTERNO LASER W/OPH ENDOSCOPE	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
10004	PR FINE NEEDLE ASPIRATION BX W/O IMG GDN EA ADDL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
10005	PR FINE NEEDLE ASPIRATION BX W/US GDN 1ST LESION	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
10006	PR FINE NEEDLE ASPIRATION BX W/US GDN EA ADDL	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
10007	PR FINE NEEDLE ASPIRATION BX W/FLUOR GDN 1ST LESION	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
10008	PR FINE NEEDLE ASPIRATION BX W/FLUOR GDN EA ADDL	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
10009	PR FINE NEEDLE ASPIRATION BX W/CT GDN 1ST LESION	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
10010	PR FINE NEEDLE ASPIRATION BX W/CT GDN EA ADDL	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
10011	PR FINE NEEDLE ASPIRATION BX W/MR GDN 1ST LESION	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
10012	PR FINE NEEDLE ASPIRATION BX W/MR GDN EA ADDL	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
10021	PR FINE NEEDLE ASPIRATION BX W/O IMG GDN 1ST LESION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
10040	PR ACNE SURGERY OF SKIN ABSCESS	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
10040	PR ACNE SURGERY OF SKIN ABSCESS	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
10060	PR DRAIN SKIN ABSCESS SIMPLE	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
10060	PR DRAIN SKIN ABSCESS SIMPLE	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
10061	PR DRAIN SKIN ABSCESS COMPLIC	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
10061	PR DRAIN SKIN ABSCESS COMPLIC	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
10080	PR DRAIN PILONIDAL CYST SIMPL	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
10080	PR DRAIN PILONIDAL CYST SIMPL	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
10081	PR DRAIN PILONIDAL CYST COMPLIC	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
10081	PR DRAIN PILONIDAL CYST COMPLIC	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
10120	PR REMOVE FOREIGN BODY SIMPLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
10121	PR REMOVE FOREIGN BODY COMPLIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
10140	PR DRAINAGE OF HEMATOMA/FL UID	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
10140	PR DRAINAGE OF HEMATOMA/FLUID	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
10160	PR PUNCTURE DRAINAGE OF LESION	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
10160	PR PUNCTURE DRAINAGE OF LESION	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
10180	PR COMPLEX DRAINAGE, WOUND	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
10180	PR COMPLEX DRAINAGE, WOUND	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11042	PR DEBRIDEMENT, SKIN, SUB-Q TISSUE,=<20 SQ CM	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11042	PR DEBRIDEMENT, SKIN, SUB-Q TISSUE,=<20 SQ CM	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11043	PR DEBRIDEMENT, SKIN, SUB-Q TISSUE,MUSCLE,=<20 SQ CM	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
11043	PR DEBRIDEMENT, SKIN, SUB-Q TISSUE, MUSCLE, =<20 SQ CM	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11044	PR DEBRIDEMENT, SKIN, SUB-Q TISSUE, MUSCLE, BONE, =<20 SQ CM	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11044	PR DEBRIDEMENT, SKIN, SUB-Q TISSUE, MUSCLE, BONE, =<20 SQ CM	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11045	PR DEBRIDEMENT, SKIN, SUB-Q TISSUE, EACH ADD 20 SQ CM	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11045	PR DEBRIDEMENT, SKIN, SUB-Q TISSUE, EACH ADD 20 SQ CM	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
11046	PR DEBRIDEMENT, SKIN, SUB-Q TISSUE, MUSCLE, EACH ADD 20 SQ CM	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11046	PR DEBRIDEMENT, SKIN, SUB-Q TISSUE, MUSCLE, EACH ADD 20 SQ CM	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11047	PR DEBRIDEMENT, SKIN, SUB-Q TISSUE, MUSCLE, BONE, EACH ADD 20 SQ CM	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11047	PR DEBRIDEMENT, SKIN, SUB-Q TISSUE, MUSCLE, BONE, EACH ADD 20 SQ CM	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11055	PR TRIM HYPERKERATOTIC SKIN LESION, ONE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
11055	PR TRIM HYPERKERATOTIC SKIN LESION, ONE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11056	TRIM BENIGN HYPERKERATOTIC SKIN LESION,2-4	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11056	TRIM BENIGN HYPERKERATOTIC SKIN LESION,2-4	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11057	TRIM BENIGN HYPERKERATOTIC SKIN LESION,>4	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
11057	TRIM BENIGN HYPERKERATOTIC SKIN LESION,>4	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11102	PR TANGENTIAL BIOPSY SKIN SINGLE LESION	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
11103	PR TANGENTIAL BIOPSY SKIN EA SEP/ADDITIONAL LESION	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
11104	PR PUNCH BIOPSY SKIN SINGLE LESION	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
11105	PR PUNCH BIOPSY SKIN EA SEP/ADDITIONAL LESION	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
11106	PR INCISIONAL BIOPSY SKIN SINGLE LESION	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
11107	PR INCISIONAL BIOPSY SKIN EA SEP/ADDITIONAL LESION	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
11400	PR EXC SKIN BENIG <5MM TRUNK,ARM,LEG	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
11401	PR EXC SKIN BENIG 0.6-1CM TRUNK,ARM,LEG	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
11402	PR EXC SKIN BENIG 1.1-2CM TRUNK,ARM,LEG	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
11403	PR EXC SKIN BENIG 2.1-3CM TRUNK,ARM,LEG	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
11404	PR EXC SKIN BENIG 3.1-4CM TRUNK,ARM,LE G	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
11420	PR EXC SKIN BENIG <5MM REMAINDR BODY	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
11421	PR EXC SKIN BENIG 0.6-1CM REMAINDR BODY	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
11422	PR EXC SKIN BENIG 1.1-2CM REMAINDR BODY	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
11423	PR EXC SKIN BENIG 2.1-3CM REMAINDR BODY	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
11426	PR EXC SKIN BENIG >4CM REMAINDR BODY	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
11440	PR EXC SKIN BENIG <5MM FACE,FACIAL	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
11440	PR EXC SKIN BENIG <5MM FACE,FACIAL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
11441	PR EXC SKIN BENIG 0.6-1CM FACE,FACIAL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
11441	PR EXC SKIN BENIG 0.6-1CM FACE,FACIAL	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
11442	PR EXC SKIN BENIG 1.1-2CM FACE,FACIAL	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
11442	PR EXC SKIN BENIG 1.1-2CM FACE,FACIAL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
11443	PR EXC SKIN BENIG 2.1-3CM FACE,FACIAL	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
11444	PR EXC SKIN BENIG 3.1-4CM FACE,FACIAL	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
11719	PR TRIM NAIL (S)	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11719	PR TRIM NAIL (S)	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11720	PR DEBRIDEMENT OF NAIL(S), 1-5	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
11720	PR DEBRIDEMENT OF NAIL(S), 1-5	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11721	PR DEBRIDEMENT OF NAILS, 6 OR MORE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11721	PR DEBRIDEMENT OF NAILS, 6 OR MORE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11730	PR REMOVAL OF NAIL PLATE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
11730	PR REMOVAL OF NAIL PLATE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11732	PR REMOVE ADDITIONAL NAIL PLATE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11732	PR REMOVE ADDITIONAL NAIL PLATE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11750	PR REMOVAL OF NAIL BED	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
11752	PR REMOVE NAIL BED/FINGER TIP	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
11755	PR BIOPSY, NAIL UNIT (SEP PROC)	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
11765	PR EXCISION OF NAIL FOLD, TOE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11765	PR EXCISION OF NAIL FOLD, TOE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11770	PR REMV PILONIDAL LESION SIMPLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11771	PR REMV PILONIDAL LESION EXTENS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11772	PR REMV PILONIDAL LESION COMPLIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
11900	INJECTION INTO SKIN LESIONS, UP TO 7	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
11900	INJECTION INTO SKIN LESIONS, UP TO 7	<p>NO AUTHORIZATION REQUIRED</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
11901	INJECTION INTO SKIN LESIONS, 8 OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
11920	PR CORRECT SKIN COLR DEFCT <6SQ CM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
11921	PR CORRECT SKIN COLR DEFCT 6.1-20SQ CM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
11922	PR CORRECT SKIN COLR DEFCT ADDN 20SQ CM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
11950	PR FILL CONTOUR DEFCT <1CC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
11951	PR FILL CONTOUR DEFCT 1.1-5CC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
11952	PR FILL CONTOUR DEFCT 5.1-10CC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
11954	PR FILL CONTOUR DEFCT >10CC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
11976	PR REMOVAL OF CONTRACEPTIVE CAPSUL	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
11980	PR IMPLANT,HORMONE,SUBCUTANEOUS	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	5/10/2021
11981	PR INSERTION DRUG DELIVERY IMPLANT	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	5/10/2021
11982	PR REMOVAL DRUG IMPLANT DEVICE	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	5/10/2021
11983	PR REMOVAL W/ REINSERT DRUG IMPLANT DEVICE	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	5/10/2021
12031	PR LAYR CLOS WND TRUNK,ARM,LEG <2.5CM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
12032	PR LAYR CLOS WND TRUNK,ARM,LEG 2.6-7.5	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
14000	PR ADJ TISS XFER TRUNK <10SQCM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
14001	PR ADJ TISS XFER TRUNK 10.1-30	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
14020	PR ADJ TISS XFER SCALP,EXTREM <10SQCM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
14021	PR ADJ TISS XFER SCALP,EXTREM 10.1-30	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
14040	PR ADJ TISS XFER HEAD,FAC,HAN D <10SQCM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
14041	PR ADJ TISS XFER HEAD,FAC,HAN D 10.1-30	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
14060	PR ADJ TISS XFER LID,NOS,EAR <10SQCM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
14061	PR ADJ TISS XFER LID,NOS,EAR 10.1-30	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
14301	PR ADJ TISS XFER/REARRANGE 30.1-60.0SQCM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
14302	PR ADJT TIS TRNSFR/REAR GMT DEFEC EA ADDL 30 SQCM/<	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
15002	PR WOUND PREP, PED, TRK/ARM/LG 1ST 100 CM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
15003	PR WOUND PREP, PED, TRK/ARM/LG ADDL 100 CM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
15004	PR WND PREP PED, FACE/NCK/HND /FT/GEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
15005	PR WND PREP,PED, FACE/NCK/HND /FT/GEN ADD 100CM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
15040	PR SKIN GRAFT, HARVEST CULTURED TISSUE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
15050	PR SKIN PINCH GRAFT PROCEDURE <2CM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
15271	ACELL GRAFT TRUNK ARAMS LEG TO 100 SQ CM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
15272	PR APP SKN SUB GRFT T/A/L AREA/<100SCM EA ADL 25SCM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
15273	PR APP SKN SUB GRFT T/A/L AREA/>100SCM 1ST 100SCM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
15274	PR APP SKN SUB GRFT T/A/L AREA/>100SCM ADL 100SCM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
15275	PR SUB GRFT F/S/N/H/F/G/M/D /<100SCM /<1ST 25 SCM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
15276	PR SUB GRFT F/S/N/H/F/G/M/D /<100SCM EA ADL 25SCM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
15277	PR SUB GRFT F/S/N/H/F/G/M/D />100SCM 1ST 100SCM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
15278	PR SUB GRFT F/S/N/H/F/G/M/D />100SCM ADL 100SCM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
15570	PR FORM SKIN PEDICLE FLAP TRUNK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15572	PR FORM SKIN PEDICLE FLAP SCALP,ARM,LE G	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15574	PR FORM SKIN PEDICLE FLAP FACE,GEN,HAN D	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15576	PR FORM SKIN PEDICLE FLAP LID,EAR,NOSE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15630	PR DELAY/SECTN FLAP LID,NOS,EAR,LI P	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
15730	PR MIDFACE FLAP W/PRESERVATION OF VASCULAR PEDICLES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15731	PR FOREHEAD FLAP W/VASC PEDICLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15733	PR MUSC MYOQ/FSCQ FLAP HEAD&NECK W/NAMED VASC PEDCL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15734	PR MUSCLE-SKIN FLAP,TRUNK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15736	PR MUSCLE-SKIN FLAP,ARM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15738	PR MUSCLE-SKIN FLAP,LEG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15740	PR FLAP ISLAND PEDICLE ANATOMIC NAMED AXIAL ARTERY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15750	PR NEUROVASCULAR PEDICLE GRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
15756	PR FREE MUSC-SKIN FLAP W/MICROVASC ANAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15757	PR FREE SKIN FLAP W MICROVASC ANAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15758	PR FREE FASCIAL FLAP W MICROVASC ANAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15760	PR COMPOSITE SKIN GRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15769	PR GRAFTING OF AUTOLOGOUS SOFT TISS BY DIRECT EXC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15770	PR DERMA-FAT-FASCIA GRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15771	PR GRAFTING OF AUTOLOGOUS FAT BY LIPO 50 CC OR LESS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15772	PR GRAFTING OF AUTOLOGOUS FAT BY LIPO EA ADDL 50 CC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15773	PR GRAFTING OF AUTOLOGOUS FAT BY LIPO 25 CC OR LESS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
15774	PR GRAFTING OF AUTOLOGOUS FAT BY LIPO EA ADDL 25 CC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15775	PR HAIR XPLANT PUNCH GRFT 1-15	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15776	PR HAIR XPLANT PUNCH GRFT >15	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15777	PR IMPLNT BIO IMPLNT FOR SOFT TISSUE REINFORCEMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15778	PR IMPLANTATION OF ABSORBABLE MESH OR OTHER PROSTHESIS FOR DELAYED CLOSURE OF DEFECT(S) (IE, EXTERNAL GENITALIA, PERINEUM, ABDOMINAL WALL) DUE TO SOFT TISSUE INFECTION OR TRAUMA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15780	PR DERMABRAS RX SKIN TOTAL FACE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
15781	PR DERMABRAS RX SKIN SGMENT FACE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15782	PR DERMABRAS RX SKIN REGIONAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15783	PR DERMABRAS RX SKIN SUPERFICIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15786	PR ABRASION SINGLE LESION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15787	PR ABRASION, EACH ADDN 4 OR LESS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15788	PR CHEM PEEL, FACE, EPIDERM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15789	PR CHEM PEEL, FACE, DERMAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15792	PR CHEM PEEL, NONFACIAL EPIDERM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15793	PR CHEM PEEL, NONFACIAL DERMAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15819	PR PLASTIC SURGERY, NECK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
15820	PR REVISION OF LOWER EYELID	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15821	PR REV LOWER EYELID EXTEN FAT PAD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15822	PR REVISION OF UPPER EYELID	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
15822	PR REVISION OF UPPER EYELID	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
15823	PR REV UPPER EYELID W EXCESS SKIN	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
15823	PR REV UPPER EYELID W EXCESS SKIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
15824	PR REMOVAL OF FOREHEAD WRINKLES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15825	PR REMOV NECK WRINKLES W PLTSY TIGHT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15826	PR REMOVAL OF BROW WRINKLES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15828	PR REML OF CHEEK,CHIN,NECK WRINKLES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15829	PR REMOVAL OF SKIN WRINKLES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15830	PR EXCISE EXCESS SKIN TISSUE,ABDOMEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15831	PR EXCISE EXCESS SKIN TISSUE,ABDOMEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
15832	PR EXCISE EXCESS SKIN TISSUE, THIGH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
15833	PR EXCISE EXCESS SKIN TISSUE, LEG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
15834	PR EXCISE EXCESS SKIN TISSUE, HIP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
15835	PR EXCISE EXCESS SKIN TISSUE,BUTTOCK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
15836	PR EXCISE EXCESS SKIN TISSUE,ARM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
15837	PR EXCISE EXCESS SKIN TISSUE,FOREARM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
15838	PR EXCISE EXCESS SKIN TISSUE,SUBMENTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
15839	PR EXCISE EXCESS SKIN TISSUE, OTHER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
15840	PR GRAFT FACE N PALSY, FREE FASCIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15841	PR GRAFT FACE N PALSY, FREE MUSCLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15842	PR GRAFT FACE FREE MUSCLE GRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15845	PR GRAFT FACE N PALSY, REGN MUSC XFER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
15851	PR REMOVAL OF SUTURES OR STAPLES REQUIRING ANESTHESIA (IE, GENERAL ANESTHESIA, MODERATE SEDATION)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
15876	PR SUCT ASSIS LIPECTOMY, HEAD/NECK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
15877	PR SUCT ASSIS LIPECTOMY,TR UNK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
15878	PR SUCT ASSIS LIPECTOMY,UP EXTREM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
15879	PR SUCT ASSIS LIPECTOMY,LOW EXTREM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
16000	PR INITIAL RX BURN(S) 1ST DEGREE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
16020	PR DRESS/DEBRID SMALL BURN NO ANES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
16025	PR DRESS/DEBRID MED BURN NO ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
16030	PR DRESS/DEBRID LARGE BURN NO ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
16035	PR ESCHAROTOM Y	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
16036	PR INCISION OF BURN SCAB, EACH ADDNTL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
17106	PR DESTRUC CUT/VASC <10SQ CM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
17107	PR DESTRUC CUT/VASC 10-50 SQ CM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
17108	PR DESTRUC CUT/VASC >50 SQ CM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
17110	PR DESTRUCTION BENIGN LESIONS UP TO 14	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
17110	PR DESTRUCTION BENIGN LESIONS UP TO 14	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
17111	DESTRUCTION BENIGN LESIONS 15 OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
17340	PR CRYOTHERAPY ACNE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
17360	PR SKIN PEEL THERAPY ACNE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
17380	PR HAIR REMOV ELECTROLYSIS EA 30 MIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
17999	PR SKIN TISSUE PROCEDURE UNLISTED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
19081	PR BX BREAST W DEVICE 1ST LESION STEREOTACTIC GUIDE	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
19082	PR BX BREAST W DEVICE ADDL LESION STEREOTACTIC GUIDE	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
19083	PR BX BREAST W DEVICE 1ST LESION ULTRASOUND GUIDE	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
19084	PR BX BREAST W DEVICE ADDL LESION ULTRASOUND GUIDE	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
19085	PR BX BREAST W DEVICE 1ST LESION MAGNETIC RES GUIDE	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
19086	PR BX BREAST W DEVICE ADDL LESION MAGNET RES GUIDE	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
19100	PR BIOPSY OF BREAST, NEEDLE CORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
19101	PR BIOPSY OF BREAST, INCISIONAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
19300	PR MASTECTOMY FOR GYNECOMASTIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
19316	PR SUSPENSION OF BREAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
19318	PR BREAST REDUCTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
19324	PR ENLARGE BREAST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
19325	PR BREAST AUGMENTATION WITH IMPLANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
19328	PR REMOVAL INTACT BREAST IMPLANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
19330	PR RMVL RUPTURED BREAST IMPLANT W/IMPLANT CONTENTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
19364	PR BREAST RECONSTRUCT ION W/FREE FLAP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
19367	PR BREAST RECONSTRUCT ION SINGLE PEDICLED TRAM FLAP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
19368	PR BREAST RECONSTRUCT ION 1PEDICLED TRAM FLAP ANAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
19369	PR BREAST RECONSTRUCT ION BIPEDICLED TRAM FLAP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
19370	PR REVISION PERI-IMPLANT CAPSULE BREAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
19371	PR PERI-IMPLANT CAPSULECTOM Y BREAST COMPLETE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
19380	PR REVISION OF RECONSTRUCT ED BREAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
19396	PR DESIGN CUSTOM BREAST IMPLANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
20200	PR MUSCLE BIOPSY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
20205	PR DEEP MUSCLE BIOPSY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
20206	PR NEEDLE BIOPSY, MUSCLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
20220	PR BONE BIOPSY, TROCAR/NEEDLE SUPERF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
20225	PR BONE BIOPSY, TROCAR/NEEDLE DEEP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
2022F	PR DILATED RETINAL EXAM W/EVIDENCE OF RETINOPATHY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
2023F	PR DILATED RETINAL EXAM W/O EVIDENCE OF RETINOPATHY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
20240	PR BIOPSY BONE OPEN SUPERFICIAL	<p>NO AUTHORIZATION REQUIRED</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
20245	PR BIOPSY BONE OPEN DEEP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
20250	PR OPEN BONE BIOP VERT DORSAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
20251	PR OPEN BONE BIOP VERT LUMB/CERV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
20520	PR REMOVAL OF FOREIGN BODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
20525	PR REMOVAL OF FOREIGN BODY DEEP/COMPLIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
20550	PR INJECT TENDON SHEATH/LIGAMENT	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
20550	PR INJECT TENDON SHEATH/LIGAMENT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
20600	PR ARTHROCENTESIS ASPIR&INJ SMALL JT/BURSA W/O US	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
20604	PR ARTHROCENT ASPIR&INJ SMALL JT/BURSAW/US REC RPRT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
20605	PR ARTHROCENTESIS ASPIR&INJ INTERM JT/BURS W/O US	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
20606	PR ARTHROCENTESIS ASPIR&INJ INTERM JT/BURS W/US	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
20610	PR ARTHROCENTESIS ASPIR&INJ MAJOR JT/BURSA W/O US	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
20611	PR ARTHROCENTESIS ASPIR&/INJ MAJOR JT/BURSA W/US	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
20612	PR ASPIRAT/INJECTION GANGLION CYST(S)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
20615	PR ASPIR/INJECTION BONE CYST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
20665	PR REMOVAL TONG/HALO APPLIED BY ANOTHER INDIVIDUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
20670	PR REMOVAL SUPERFICIAL IMPLANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
20680	PR REMOVAL DEEP IMPLANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
20693	PR ADJUST EXTERN BONE FIX DEV W ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
20694	PR REMOVE EXTERN BONE FIX DEV W ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
20696	PR COMP ASSIST MULTIPLANE EXT FIXATION, INITIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
20697	PR COMP ASSIST MULTIPLANE EXT FIXATION, CHANGE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
21025	PR EXCISION OF BONE, LOWER JAW	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
21026	PR EXCISION OF FACIAL BONE(S)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
21029	PR CONTOUR OF FACE BONE LESION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
21030	PR EXCISION,BENIGN TUMOR,MAXILLARY/ZYGOMA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
21031	PR EXCISION,TORUS MANDIBULARIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
21032	PR EXCISION,MAXILLARY TORUS PALATINUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21034	PR EXCISION,MALIG TUMOR, MAXILLA/ZYGO MA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
21040	PR EXCISION,BENI GN TUMOR,MANDI BLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
21044	PR REMV MALIG JAW BONE LESION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
21083	PR PREP FACE/ORAL PROST PALATAL LIFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21086	PR PREP FACE/ORAL PROST AURICULAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
21087	PR PREP FACE/ORAL PROST NASAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21120	PR RECONST CHIN AUGMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21121	PR RECONST CHIN SLIDE SINGL OSTEOTOMY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21122	PR RECONST CHIN SLIDE MULTIP OSTEOTMY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21123	PR RECONST CHIN SLIDE INTERPOS GRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21125	PR AUGMENT LOWER JAW BONE,PROSTH ETIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21127	PR AUGMENT LOWER JAW BONE,BONE GRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21137	PR REDUC FOREHEAD,CO NTOURING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21138	PR REDUC FOREHEAD,CO NTOUR+GRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21139	PR REDUC FOREHEAD,CO NTOUR +SETBACK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21141	PR RECONST FACE,LEFORT I,1 PIECE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21142	PR RECONST FACE,LEFORT I,2 PIECES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21143	PR RECONST FACE,LEFORT I,3+ PIECES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21145	PR RECONST FACE,LEFORT I,1 PIECE+GRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21146	PR RECONST FACE,LEFORT I,2 PIECES +GRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21147	PR RECONST FACE,LEFORT I,3+PIECES +GRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21150	PR RECONST FACE,LEFORT II	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21151	PR RECONST FACE,LEFORT II +GRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21154	PR RECONST FACE,LEFORT III	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21155	PR RECONST FACE,LEFORT III+LEFORT I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21159	PR RECONST FACE,LEFORT III COMPLEX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21160	PR RECONST FACE,LEFORT III+I COMPLX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21172	PR RECONST ORBIT/FOREHE AD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21175	PR RECONST ORBIT/FOREHE AD BIFRONTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21179	PR RECONST ENTIRE FOREHEAD +GRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21180	PR RECONST ENTIRE FOREHEAD +AUTOGRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21181	PR CONTOUR CRANIAL BONE LESION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21181	PR CONTOUR CRANIAL BONE LESION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
21182	PR RECONST ORB/FORHD/NA SOETH,GRAFT< 40 SQ CM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21183	PR RECON ORB/FORHD/NA SOETH,GRFT 40-80 SQ CM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21188	PR RECONST MIDFACE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21208	PR AUGMENT FACIAL BONES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21209	PR REDUCTION OF FACIAL BONES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21210	PR NASAL,MAXILLA,MALAR BONE GRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21215	PR MANDIBLE GRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21230	PR RIB CARTILAGE GRAFT TO FACE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21235	PR EAR CARTILAGE GRAFT TO FACE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21235	PR EAR CARTILAGE GRAFT TO FACE	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
21240	PR ARTHROPLASTY TMJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21242	PR ARTHROPLASTY TMJ +ALLOGRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21243	PR ARTHROPLASTY TMJ +PROSTHESIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21244	PR RECONSTR MANDIBLE, BONE PLATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21245	PR RECONSTR JAW, PART-SUB IMPLNT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21246	PR RECONSTR JAW, FULL-SUB IMPLNT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21247	PR RECONSTR MANDIB CONDYLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21248	PR RECONSTR JAW, PART-ENDO IMPLNT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21249	PR RECONSTR JAW,FULL,END O IMPLNT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
21255	PR RECONSTR ZYGOMA/GLEN OID FOSSA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21256	PR RECONSTR OF ORBIT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21260	PR REVISE ORBITS,EXTRA CRANIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21261	PR REVISE ORBITS,INTRA/ EXTRA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21263	PR REVISE ORBITS,FOREH D ADVANC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21267	PR REPOSITN ORBITS,EXTRA CRAN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21268	PR REPOSITN ORBITS,INTRA/ EXTRA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21270	PR AUGMENTATION CHEEK BONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21275	PR REVISION ORBITOFACIAL BONES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21280	PR REVISION OF EYELID, MEDIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21282	PR REVISION OF EYELID, LATERAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21295	PR REVISION JAW MUSCLE/BONE, EXTRAORAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21296	PR REVISION JAW MUSCLE/BONE, INTRAORAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21315	PR CLOSED TX NASAL BONE FX W/MNPJ W/O STABILIZATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21320	PR CLOSED TX NASAL BONE FX W/MNPJ W/STABILIZATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21325	PR OPEN RX NOSE FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21325	PR OPEN RX NOSE FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21330	PR OPEN RX NOSE FX COMPLICATED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21330	PR OPEN RX NOSE FX COMPLICATED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21335	PR OPEN RX NOSE FX +OPEN FIX SEPTUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21335	PR OPEN RX NOSE FX +OPEN FIX SEPTUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21336	PR OPEN RX NASAL SEPTAL FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21336	PR OPEN RX NASAL SEPTAL FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21337	PR CLOSED RX NASAL SEPTAL FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21337	PR CLOSED RX NASAL SEPTAL FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21338	PR REPAIR NASOETHMOID FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21338	PR REPAIR NASOETHMOID FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21339	PR REPAIR NASOETHMOID FX+EXTERN FIXATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21339	PR REPAIR NASOETHMOID FX+EXTERN FIXATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21340	PR REPAIR NASOETHMOID COMPLEX FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21340	PR REPAIR NASOETHMOID COMPLEX FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21343	PR OPEN RX DEPRES FRONTAL SINUS FRAC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21343	PR OPEN RX DEPRES FRONTAL SINUS FRAC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21344	PR OPEN RX COMPLIC FRONT SINUS FRACT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21344	PR OPEN RX COMPLIC FRONT SINUS FRACT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21345	PR CLOSED RX NOSE/JAW FRAC+WIRES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21345	PR CLOSED RX NOSE/JAW FRAC+WIRES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21346	PR OPEN RX NOSE/JAW FRACT+WIRES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21346	PR OPEN RX NOSE/JAW FRACT+WIRES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21347	PR OPEN RX NOSE/JAW FRACT/COMPL X	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21347	PR OPEN RX NOSE/JAW FRACT/COMPL X	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21348	PR OPEN RX NOSE/JAW FRACT+GRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21348	PR OPEN RX NOSE/JAW FRACT+GRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21355	PR CLOSED REPAIR CHEEK BONE FRAC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21355	PR CLOSED REPAIR CHEEK BONE FRAC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21356	PR OPEN RX DEPRESS ZYGOMA FRAC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21356	PR OPEN RX DEPRESS ZYGOMA FRAC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21360	PR OPEN RX DEPRESS MALAR FRAC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21360	PR OPEN RX DEPRESS MALAR FRAC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21365	PR OPEN RX COMPLX CHEEK BONE FRAC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21365	PR OPEN RX COMPLX CHEEK BONE FRAC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21366	PR OPEN RX COMPLX CHEEK FX +GRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21366	PR OPEN RX COMPLX CHEEK FX +GRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21385	PR REPAIR EYE BLOWOUT,TRA NSANTRAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21385	PR REPAIR EYE BLOWOUT,TRA NSANTRAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21386	PR REPAIR EYE BLOWOUT,PERI ORBITAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21386	PR REPAIR EYE BLOWOUT,PERI ORBITAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21387	PR REPAIR EYE BLOWOUT,COM BINED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21387	PR REPAIR EYE BLOWOUT,COM BINED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21390	PR REPAIR EYE BLOWOUT,PERI ORB+IMPLNT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21395	PR REPAIR EYE BLOWOUT,PERI ORB+GRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21400	PR CLOSED RX FX ORBIT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21401	PR CLOSED RX FX ORBIT W MANIPULATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21406	PR OPEN RX FX ORBIT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21406	PR OPEN RX FX ORBIT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21407	PR OPEN RX FX ORBIT W IMPLANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21407	PR OPEN RX FX ORBIT W IMPLANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21408	PR OPEN RX FX ORBIT W GRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21408	PR OPEN RX FX ORBIT W GRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21421	PR CLOSED RX LEFORTE I +WIRES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21421	PR CLOSED RX LEFORTE I +WIRES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21422	PR OPEN RX LEFORTE I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21422	PR OPEN RX LEFORTE I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21423	PR OPEN RX LEFORTE I,COMPLICATE D	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21423	PR OPEN RX LEFORTE I,COMPLICATE D	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21431	PR CLOSED RX LEFORTE III +WIRES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21431	PR CLOSED RX LEFORTE III +WIRES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21432	PR OPEN RX LEFORTE III +FIXATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21432	PR OPEN RX LEFORTE III +FIXATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21433	PR OPEN RX LEFORTE III,COMPLICATE D	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21433	PR OPEN RX LEFORTE III,COMPLICATE D	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21435	PR OPEN RX LEFORTE III,COMPL +FIXATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21435	PR OPEN RX LEFORTE III,COMPL +FIXATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21436	PR OPEN RX LEFORTE III,COMPL+++	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21436	PR OPEN RX LEFORTE III,COMPL+++	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21440	PR CLOSED RX DENTAL RIDGE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21440	PR CLOSED RX DENTAL RIDGE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21445	PR OPEN RX DENTAL RIDGE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21445	PR OPEN RX DENTAL RIDGE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21450	PR CLOSED RX MANDIBLE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21450	PR CLOSED RX MANDIBLE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21451	PR CLOSED RX MANDIBLE FX +MANIPULATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21451	PR CLOSED RX MANDIBLE FX +MANIPULATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21452	PR PERCUT RX MANDIBLE FX EXT FIXATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21452	PR PERCUT RX MANDIBLE FX EXT FIXATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21453	PR CLOSED RX MANDIBLE FX +DENTAL FIX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21453	PR CLOSED RX MANDIBLE FX +DENTAL FIX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21454	PR OPEN RX MANDIBLE FX +EXTERN FIX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21454	PR OPEN RX MANDIBLE FX +EXTERN FIX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21461	PR OPEN RX MANDIBLE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21461	PR OPEN RX MANDIBLE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21462	PR OPEN RX MANDIBLE FX +DENTAL FIX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21462	PR OPEN RX MANDIBLE FX +DENTAL FIX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21465	PR OPEN RX MANDIBLE CONDYLE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21465	PR OPEN RX MANDIBLE CONDYLE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21470	PR OPEN RX MANDIBLE CONDYLE FX,COMPL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21470	PR OPEN RX MANDIBLE CONDYLE FX,COMPL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21480	PR REDUCE TEMPOROMAN DIBL DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21480	PR REDUCE TEMPOROMAN DIBL DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
21480	PR REDUCE TEMPOROMAN DIBL DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21485	PR REDUCE TEMPOROMAN DIBL DISLOC,COMP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21485	PR REDUCE TEMPOROMAN DIBL DISLOC,COMP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
21485	PR REDUCE TEMPOROMAN DIBL DISLOC,COMP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21490	PR OPEN REDUCTN TEM-MANDIBLE DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
21490	PR OPEN REDUCTN TEM-MANDIBLE DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21493	PR CLOSED RX HYOID BONE FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21494	PR CLOSED RX HYOID FX +MANIPULATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21495	PR OPEN RX HYOID BONE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21510	PR INCIS BONE CORTEX THORAX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
21550	PR BIOPSY SOFT TISSUE NECK/CHEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
21740	PR RECONST PECTUS EXCAV/CARIN, OPEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21742	PR RECONST PECTUS EXCAV/CARIN W/0 THORACOS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21743	PR RECONST PECTUS EXCAV/CARIN W/ THORACOS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
21800	PR CLOSED RX RIB FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21805	PR OPEN RX RIB FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21805	PR OPEN RX RIB FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21810	PR RX RIB FRACTURE W EXTERN FIXATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21810	PR RX RIB FRACTURE W EXTERN FIXATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21811	PR OPEN TX RIB FX W/FIXJ THORACOSCO PIC VIS 1-3 RIBS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21811	PR OPEN TX RIB FX W/FIXJ THORACOSCO PIC VIS 1-3 RIBS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21812	PR OPEN TX RIB FX W/FIXJ THORACOSCO PIC VIS 4-6 RIBS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21812	PR OPEN TX RIB FX W/FIXJ THORACOSCO PIC VIS 4-6 RIBS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21813	PR OPEN TX RIB FX W/FIXJ THORACOSCO PIC VIS 7+ RIBS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21813	PR OPEN TX RIB FX W/FIXJ THORACOSCO PIC VIS 7+ RIBS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21820	PR CLOSED RX STERNUM FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21820	PR CLOSED RX STERNUM FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
21825	PR OPEN RX STERNUM FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
21920	PR BIOPSY SOFT TISSUE BACK,SUPERF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
21925	PR BIOPSY SOFT TISSUE BACK,DEEP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
22305	PR CLOSED TREAT SPINE PROCESS FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
22856	PR TOT DISC ARTHRP ART DISC ANT APPRO 1 NTRSPC CRV	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2022
22858	PR TOT DISC ARTHRP ANT APPR DISC 2ND LEVEL CERVICAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2022
22861	PR REVISION TOTAL DISC ARTHROPLAST Y, CERVICAL, SINGLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
22864	PR REMOVE TOTAL DISC ARTHROPLASTY, CERVICAL, SINGLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2022
23000	PR REMOVAL SUBDELTOID CALCAREOUS DEP, OPEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23020	PR RELEASE SHLDR JOINT CONTRACTURE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23030	PR INCIS/DRAIN SHLDR ABSC/HEMA, DE EP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23031	PR DRAIN INFECT SHOULDER BURSA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23035	PR DRAIN SHOULDER BONE LESION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23040	PR DEEP INCIS SHLDR BONE CORTEX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23044	PR EXPLOR/REMV INFECT GLENO-HUM JT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23065	PR EXPLOR INFECT A-C/S-C JT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
23066	PR BIOPSY SHLDR SOFT TISSUES,SUPERFIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
23071	PR EXCISION TUMOR SOFT TISSUE SHOULDER SUBQ 3 CM/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23073	PR EXC TUMOR SOFT TISSUE SHOULDER SUBFASCIAL 5 CM/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23075	PR BIOPSY SHLDR SOFT TISSUES,DEEP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23076	PR EXCIS SUBCUT SHLDR TUMOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23077	PR RAD RESECTION TUMOR SOFT TISSUE SHOULDER <5CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23078	PR RAD RESECTION TUMOR SOFT TISSUE SHOULDER 5 CM/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23100	PR OPEN BIOPSY SHOULDER JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23101	PR OPEN BX/EXCIS CART A-C/S-C JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23105	PR REMOVE SHOULDER JOINT SYNOVIUM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23106	PR REMOVE STERNOCLAV JT SYNOVIUM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23107	PR EXPLORE SHOULDER JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23120	PR PARTIAL REMOVAL, CLAVICLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23125	PR TOTAL REMOVAL OF CLAVICLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23130	PR PARTIAL REMOVAL/REP AIR,ACROMION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23140	PR EXCIS/CURET BENIGN TUMR CLAV/SCAPULA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23145	PR EXCIS BENIGN TUMR CLAV/SCAP,AU TOGRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23146	PR EXCIS BENIGN TUMR CLAV/SCAP,ALL OGRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23150	PR EXCIS/CURET BENIGN TUMR PROX HUMERUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23155	PR EXCIS BENIG TUMR PROX HUMER,AUTOG RFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23156	PR EXCIS BENIG TUMR PROX HUMER,AUTOG RFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23170	PR SEQUESTRECT OMY, CLAVICLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23172	PR SEQUESTRECT OMY, SCAPULA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23174	PR SEQUESTRECT OMY,HUMER HEAD-SURG NECK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23180	PR PART EXCIS CLAVICLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23182	PR PART EXCIS SCAPULA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23184	PR PART EXCIS PROX HUMERUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23190	PR PART REMV SCAPULA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23195	PR REMOVAL OF HEAD OF HUMERUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23200	PR RAD RESECT CLAVICLE FOR TUMOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23210	PR RAD RESECT SCAPULA FOR TUMOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23220	PR RAD RESECT PROX HUMERUS FOR TUMOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23221	PR RAD RESECT PROX HUMERUS,W AUTOGRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23222	PR RAD RESECT PROX HUMERUS,W ALLOGRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23330	PR REMOVE SUBCUT SHOULDER FOREIGN BODY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23330	PR REMOVE SUBCUT SHOULDER FOREIGN BODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23331	PR REMOVE DEEP SHOULDER FOREIGN BODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23331	PR REMOVE DEEP SHOULDER FOREIGN BODY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23332	PR REMOVE COMPLIC SHOULDER FOREIGN BODY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23332	PR REMOVE COMPLIC SHOULDER FOREIGN BODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23333	PR REMOVAL SHOULDER FOREIGN BODY DEEP SUBFASCIAL/IM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23333	PR REMOVAL SHOULDER FOREIGN BODY DEEP SUBFASCIAL/IM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23334	PR PROSTHESIS REMOVAL HUMERAL/GLENOID COMPONENT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23335	PR PROSTHESIS REMOVAL HUMERAL AND GLENOID COMPONENT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23350	PR INJ PROC SHOULDER ARTHROGRAPHY/CT/MRI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23395	PR MUSCLE TRANSFER, SHOULDER/ARM, SINGLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23397	PR MUSCLE TRANSFER, SHOULDER/ARM, MULTIPLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23400	PR FIXATION OF SHOULDER BLADE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23405	PR INCISE TENDON/MUSCLE, SHOULDER, SINGLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23406	PR INCISE TENDON/MUSCLE,SHLDR,MULTIPLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23410	PR REPAIR ROTATOR CUFF,ACUTE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23412	PR REPAIR ROTATOR CUFF,CHRONIC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23415	PR CORACO-ACROMIAL LIG RELEASE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23420	PR REPAIR COMPL ROTATOR CUFF AVULSN,CHR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23430	PR REPAIR BICEPS LONG TENDON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23440	PR REMV/TRANSP LANT LONG BICEPS TENDON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23450	PR REPAIR SHOULDER CAPSULE, ANTE RIOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23455	PR REPAIR SHOULDER CAPSULE, BANK ART	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23460	PR REPAIR SHLDR CAPSUL, ANT, B ONE BLOCK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23462	PR REPAIR SHLDR CAPSU,ANT,CO RACOID XFER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23465	PR REPAIR SHLDR CAPSU,POST,R ECUR DISLOC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23466	PR REPAIR SHLDR CAPSU FOR INSTABILITY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23470	PR RECONSTRUCT PROX HUMERAL IMPLANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23472	PR RECONSTR TOTAL SHOULDER IMPLANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23473	PR REVIS SHOULDER ARTHRPLSTY HUMERAL/GLE NOID COMPNT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23474	PR REVIS SHOULDER ARTHRPLSTY HUMERAL&GLE NOID COMPNT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23480	PR OSTEOTOMY CLAVICLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23485	PR OSTEOTOMY CLAVICLE W BONE GRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23490	PR REINFORCE CLAVICLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23491	PR REINFORCE PROX HUMERUS/HEAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23500	PR CLOSED RX CLAVICLE FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23505	PR CLOSED RX CLAVICLE FX,MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23515	OPEN TREATMENT CLAVICULAR FRACTURE INTERNAL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23515	OPEN TREATMENT CLAVICULAR FRACTURE INTERNAL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23520	PR CLOSED RX STERNO-CLAV DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23520	PR CLOSED RX STERNO-CLAV DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23520	PR CLOSED RX STERNO-CLAV DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23525	PR CLOSED RX STERN-CLAV DISLOC,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23525	PR CLOSED RX STERN-CLAV DISLOC,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23525	PR CLOSED RX STERN-CLAV DISLOC,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23525	PR CLOSED RX STERN-CLAV DISLOC,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23530	PR OPEN RX STERN-CLAV DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23530	PR OPEN RX STERN-CLAV DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23530	PR OPEN RX STERN-CLAV DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23532	PR OPEN RX STERN-CLAV DISLOC,FASC GRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23532	PR OPEN RX STERN-CLAV DISLOC,FASC GRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23532	PR OPEN RX STERN-CLAV DISLOC,FASC GRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23540	PR CLOSED RX A-C JT DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23540	PR CLOSED RX A-C JT DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23540	PR CLOSED RX A-C JT DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23545	PR CLOSED RX A-C JT DISLOC,MANIP ULATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23545	PR CLOSED RX A-C JT DISLOC,MANIP ULATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23545	PR CLOSED RX A-C JT DISLOC,MANIP ULATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23550	PR OPEN RX A-C JT DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23550	PR OPEN RX A-C JT DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23550	PR OPEN RX A-C JT DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23552	PR OPEN RX A-C JT DISLOC,FASCIAL GRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23552	PR OPEN RX A-C JT DISLOC,FASCIAL GRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23552	PR OPEN RX A-C JT DISLOC,FASCIAL GRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23570	PR CLOSED RX SCAPULA FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23570	PR CLOSED RX SCAPULA FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23570	PR CLOSED RX SCAPULA FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23575	PR CLOSED RX SCAPULA FX,MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23575	PR CLOSED RX SCAPULA FX,MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23585	PR OPEN RX SCAPULA FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23585	PR OPEN RX SCAPULA FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23600	PR CLOSED RX PROX HUMERUS FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23605	PR CLOSED RX PROX HUMERUS FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23615	OPEN TREATMENT PROX HUMERAL FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23615	OPEN TREATMENT PROX HUMERAL FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23616	OPEN PROX HUMERAL FRACTURE PROSHETIC REPLACEMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23616	OPEN PROX HUMERAL FRACTURE PROSHETIC REPLACEMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23620	PR CLOSED RX GR TUBEROSITY HUM FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23620	PR CLOSED RX GR TUBEROSITY HUM FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23625	PR CLOSED RX GR TUBER HUM FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23625	PR CLOSED RX GR TUBER HUM FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23630	PR OPEN RX GR TUBEROSITY FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23630	PR OPEN RX GR TUBEROSITY FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23650	PR CLOSED RX SHLDR DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23650	PR CLOSED RX SHLDR DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23655	PR CLOSED RX SHLDR DISLOC,ANEST HESIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23655	PR CLOSED RX SHLDR DISLOC,ANEST HESIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23660	PR OPEN RX ACUTE SHLDR DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23660	PR OPEN RX ACUTE SHLDR DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23665	PR CLOSED RX SHLDR DISLOC,GR TUB FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23665	PR CLOSED RX SHLDR DISLOC,GR TUB FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23670	PR OPEN RX SHLDR DISLOC,GR TUB FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23670	PR OPEN RX SHLDR DISLOC,GR TUB FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23675	PR CLOSED RX SHLDR DISLOC,PROX HUM FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23675	PR CLOSED RX SHLDR DISLOC,PROX HUM FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23680	PR OPEN RX SHLDR DISLOC,PROX HUM FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
23680	PR OPEN RX SHLDR DISLOC,PROX HUM FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23700	PR MANIPULATN SHLDR JT W ANESTHESIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
23800	PR FUSION SHOULDER JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23802	PR FUSION SHOULDER JOINT W GRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23900	PR AMPUTATION OF ARM & GIRDLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23920	PR AMPUTATION AT SHOULDER JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23921	PR AMPUTATION SHLDR JT,2ND CLOSURE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23929	PR SHOULDER SURG PROC UNLISTED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23930	PR INCIS/DRAIN ARM,DEEP ABSC/HEMATO MA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
23931	PR INCIS/DRAIN ARM/ELBOW INFECT BURSA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
23935	PR INCIS DEEP ARM/ELBOW BONE LESION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24000	PR EXPLORE/DRAIN ELBOW FOR INFECT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24006	PR ARTHROTOMY/CAPULE RELEASE ELBOW JT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24065	PR BX ARM/ELBOW SOFT TISSUE,SUPERFICIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
24066	PR BX ARM/ELBOW SOFT TISSUE,DEEP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24071	PR EXC TUMOR SOFT TISSUE UPPER ARM/ELBOW SUBQ 3CM/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24073	PR EXC TUMOR SOFT TISS UPPER ARM/ELBW SUBFASC 5CM/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24075	PR EXCIS TUMOR,SOFT TISS UP ARM/ELBOW,S UBQ	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24076	PR EXCIS TUMOR,SOFT TISS UP ARM/ELBOW,D EEP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24077	PR RAD RESECT TUMOR SOFT TISS UPPER ARM/ELBOW <5CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24079	PR RAD RESECT TUMOR SOFT TISS UPPER ARM/ELBOW 5CM/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24100	PR BIOPSY SYNOVIUM ELBOW JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24101	PR EXPLORE ELBOW JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24102	PR EXPLOR ELBOW JT/REMOV SYNOVIUM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24105	PR REMOVAL OF ELBOW BURSA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24110	PR EXCIS/CURET BENIGN HUMERUS LESN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24115	PR EXCIS BENIGN HUMERUS LESN,AUTOGR FT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24116	PR EXCIS BENIGN HUMERUS LESN,ALLOGRF T	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24120	PR EXCIS/CURET BENIGN ELBOW LESN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24125	PR EXCIS BENIGN ELBOW LESN,AUTOGR FT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24126	PR EXCIS BENIGN ELBOW LESN,ALLOGRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24130	PR REMOVAL OF HEAD OF RADIUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24134	PR SEQUESTRECT OMY,MID/DIST HUMERUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24136	PR SEQUESTRECT OMY,RAD HEAD/NECK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24138	PR SEQUESTRECT OMY,OLECRAN NON PROCESS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24140	PR PARTIAL REMOVAL HUMERUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24145	PR PARTIAL REMOVAL RADIAL HEAD/NECK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24147	PR PARTIAL REMOVAL OLECRANON PROCESS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24149	PR RADICAL RESECT ELBOW, CONTRAC RELEAS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24150	PR RADICAL RESEC MID/DIST HUMERUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24151	PR RAD RESEC MID/DIST HUMERUS,AUT OGRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24152	PR RADICAL RESEC RADIAL HEAD/NECK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24153	PR RAD RESEC RADIAL HEAD/NECK,AU TOGRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24155	PR RESECTION OF ELBOW JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24160	PR PROSTHESIS REMOVAL HUMERAL AND ULNAR COMPONENTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24164	PR PROSTHESIS REMOVAL RADIAL HEAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24200	PR REMOVAL ARM/ELBOW F.B.,SUPERFICIAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24200	PR REMOVAL ARM/ELBOW F.B.,SUPERFICIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24201	PR REMOVAL ARM/ELBOW F.B.,DEEP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24201	PR REMOVAL ARM/ELBOW F.B.,DEEP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24220	PR INJECTION FOR ELBOW ARTHROGRAM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24300	PR MANIPULATE ELBOW W/ANESTH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24301	PR MUSC/TENDON XFER,ARM/ELB OW,SINGLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24305	PR ARM/ELBOW TENDON LENGTHEN,SIN GLE,EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24310	PR TENOTOMY,EL BOW- SHLDR,SINGL,E ACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24320	PR TENOPLASTY,E LB- SHLDR,MUSC XFER,SINGL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24330	PR FLEXORPLAST Y,ELBOW	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24331	PR FLEXORPLAST Y,ELBOW,EXTENSOR ADVANCMT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24332	PR TENOLYSIS, TRICEPS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24340	PR REPAIR OF BICEPS TENDON AT ELBOW	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24341	PR MUSC/TENDON REPAIR EACH; ARM/ELBOW	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24342	PR REINSERT BI/TRICEPS TENDON,DISTAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24343	PR REPR ELBOW LAT LIGMNT W/TISS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24344	PR RECONSTRUCT ELBOW LAT LIGMNT W/GRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24345	PR REPR ELBW MED LIGMNT W/TISS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24346	PR RECONSTRUCT ELBOW MED LIGMNT W/GRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24350	PR FASCIOTOMY,E LBOW,MED OR LAT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24351	PR FASCIOTOMY,E LBOW,EXTEN ORIGIN DETACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24352	PR FASCIOTOMY,E LBOW,ANNULA R LIG RESEC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24354	PR FASCIOTOMY,E LBOW,W STRIPPING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24356	PR FASCIOTOMY,E LBOW,PARTIAL OSTECTOMY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24357	PR TENOTOMY ELBOW LATERAL/MEDIAL PERCUTANEOUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24358	PR TENOTOMY ELBOW LATERAL/MEDIAL DEBRIDE OPEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24359	PR TENOTOMY ELBOW LATERAL/MEDIAL DEBRIDE REPAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24360	PR ARTHROPLASTY, ELBOW, WITH MEMBRANE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24361	PR ARTHROPLASTY, ELBOW, DISTAL HUMERUS PROSTHESIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24362	PR ARTHROPLASTY, ELBOW, IMPLANT/RECONSTRUCT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24363	PR ARTHROPLASTY, ELBOW, TOTAL PROSTHETIC REPLACEMENT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24365	PR RECONSTRUCT RADIAL HEAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24366	PR RECONSTRUCT RADIAL HEAD WITH IMPLANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24370	PR REVISION ELBOW ARTHROPLASTY HUMERAL/ULNAR COMPONENT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24371	PR REVIS ELBOW ARTHRPLSTY HUMERAL&ULN A COMPNT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24400	PR OSTEOTOMY HUMERUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24410	PR OSTEOTOMY,H UMERUS,MULTI ,REALIGN ROD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24420	PR OSTEOPLASTY HUMERUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24430	PR REPAIR NON/MALUNION HUMERUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24435	PR REPAIR NON/MALUNIO N HUMERUS,GRA FT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24470	PR HEMIEPIPHYSE AL ARREST DIST HUMERUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24495	PR DECOMPRESS FOREARM,BRA CH ART EXPLOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24498	PR REINFORCE HUMERUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24500	PR CLOSED RX MID HUMERUS FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24505	PR CLOSED RX MID HUMERUS FX,MANIPULAT N	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24515	PR OPEN FIXATN MID HUMERUS FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24516	PR OPEN ROD FIXATN HUMERAL SHAFT FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24530	PR CLOSED RX HUMERAL SUPRACONDYL AR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24535	PR CLOSED RX HUM SUPRACONDYL R FX,MANIPU	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24538	PR PERCUT FIX HUM SUPRACONDYL AR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24545	OPEN TX HUMERAL SUPRACONDYL AR FRACTURE W/O XTN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24545	OPEN TX HUMERAL SUPRACONDYL AR FRACTURE W/O XTN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24546	OPEN TX HUMERAL SUPRACONDYL AR FRACTURE W XTN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24546	OPEN TX HUMERAL SUPRACONDYL AR FRACTURE W XTN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24560	PR CLOSED RX HUMER EPICONDYLR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24560	PR CLOSED RX HUMER EPICONDYLR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24565	PR CLOSED RX HUMER EPICONDYLR FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24565	PR CLOSED RX HUMER EPICONDYLR FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24566	PR PERCUT FIXATN HUMERAL EPICONDYLAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24566	PR PERCUT FIXATN HUMERAL EPICONDYLAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24575	OPEN TX HUMERAL EPICONDYLAR FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24575	OPEN TX HUMERAL EPICONDYLAR FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24576	PR CLOSED RX HUMER CONDYLR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24576	PR CLOSED RX HUMER CONDYLR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24577	PR CLOSED RX HUMER CONDYLR FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24577	PR CLOSED RX HUMER CONDYLR FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24579	OPEN TX HUMERAL CONDYLAR FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24579	OPEN TX HUMERAL CONDYLAR FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24582	PR PERCUT FIXATN HUMERAL CONDYLAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24586	PR OPEN RX PERIARTIC FX/DISLOC ELBOW	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24587	PR OPEN RX PERIARTIC FX ELBOW,IMPLNT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24600	PR CLOSED RX ELBOW DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24605	PR CLOSED RX ELBOW DISLOCATN,AN ESTHESIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24615	PR OPEN RX ELBOW DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24615	PR OPEN RX ELBOW DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24620	PR CLOSED RX MONTEGGIA FX/DISLOC ELBOW	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24620	PR CLOSED RX MONTEGGIA FX/DISLOC ELBOW	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24620	PR CLOSED RX MONTEGGIA FX/DISLOC ELBOW	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24635	OPEN TX MONTEGGIA FRACTURE DISLOCATION ELBOW	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24635	OPEN TX MONTEGGIA FRACTURE DISLOCATION ELBOW	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24635	OPEN TX MONTEGGIA FRACTURE DISLOCATION ELBOW	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24640	PR CLOSED RX RADIAL HEAD DISLOC,CHILD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24640	PR CLOSED RX RADIAL HEAD DISLOC,CHILD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24640	PR CLOSED RX RADIAL HEAD DISLOC,CHILD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24650	PR CLOSED RX RADIAL HEAD/NECK FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24650	PR CLOSED RX RADIAL HEAD/NECK FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24650	PR CLOSED RX RADIAL HEAD/NECK FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24655	PR CLOSED RX RADIAL HEAD/NECK FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24655	PR CLOSED RX RADIAL HEAD/NECK FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24655	PR CLOSED RX RADIAL HEAD/NECK FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24665	OPEN TX RADIAL HEAD/NECK FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24665	OPEN TX RADIAL HEAD/NECK FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24665	OPEN TX RADIAL HEAD/NECK FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24666	OPEN TX RADIAL HEAD/NECK FRACTURE PROSTHETIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24666	OPEN TX RADIAL HEAD/NECK FRACTURE PROSTHETIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24666	OPEN TX RADIAL HEAD/NECK FRACTURE PROSTHETIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24670	CLOSED TX ULNAR FRACTURE PROX END W/O MANIPULATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24670	CLOSED TX ULNAR FRACTURE PROX END W/O MANIPULATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24670	CLOSED TX ULNAR FRACTURE PROX END W/O MANIPULATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24675	CLOSED TX ULNAR FRACTURE PROX END W MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24675	CLOSED TX ULNAR FRACTURE PROX END W MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24675	CLOSED TX ULNAR FRACTURE PROX END W MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24685	OPEN TX ULNAR FRACTURE PROX END	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
24685	OPEN TX ULNAR FRACTURE PROX END	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
24800	PR FUSION OF ELBOW JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24802	PR FUSION/GRAFT OF ELBOW JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24900	PR AMPUTATN ARM,THRU HUMERUS,PRI M CLOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24920	PR AMPUTATN ARM,THRU HUMERUS,CIRCULAR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24925	PR AMPUTATN ARM,THRU HUMER,SECOND CLOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24930	PR RE-AMPUTATN ARM,THRU HUMERUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24931	PR AMPUTATE UPPER ARM & IMPLANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24935	PR STUMP ELONGATN,UPPER EXTREM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
24940	PR REVISION OF UPPER ARM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
24999	PR UPPER ARM/ELBOW SURGERY UNLISTED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25000	PR INCIS TENDON SHEATH,RADIAL STYLOID	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25000	PR INCIS TENDON SHEATH,RADIAL STYLOID	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25001	PR INCIS FLEXOR TENDON SHEATH,WRIST	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25001	PR INCIS FLEXOR TENDON SHEATH,WRIST	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25020	PR DECOMP FOREARM,1 COMPART,W/O DEBRIDE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25023	PR DECOMPRESS FOREARM,EXCIS MUSC/NERV	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25024	PR DECOMP FOREARM,2 COMPART,W/O DEBRIDE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25025	PR DECOMP FOREARM,2 COMPART,W/ DEBRIDE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25028	PR INCIS/DRAIN FOREARM DEEP ABSCESS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25031	PR INCIS/DRAIN FOREARM INFECTED BURSA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25035	PR INCIS FOREARM BONE LESION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25040	PR EXPLORE/TREAT WRIST JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25065	PR BIOPSY FOREARM SOFT TISSUES,SUPERFICIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
25066	PR BIOPSY FOREARM SOFT TISSUES,DEEP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
25071	PR EXC TUMOR SOFT TISS FOREARM AND/WRIST SUBQ 3CM/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25073	EXC FOREARM TUMOR DEEP = 3 CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25075	PR EXCIS TUMOR,SOFT TISS FOREARM/WRIST,SUBQ	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25076	PR EXCIS TUMOR,SOFT TISS FOREARM/WRI ST,DEEP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25077	PR RAD RESECT TUMOR SOFT TISS FOREARM&/WR IST <3 CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25078	PR RAD RESCJ TUM SOFT TISSUE FOREARM&/WR IST 3 CM/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25085	PR INCISION OF WRIST CAPSULE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25100	PR BIOPSY OF WRIST JOINT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25101	PR EXPLORE/TREAT WRIST JOINT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25105	PR EXPLOR WRIST JT/REMOV SYNOVIUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25107	PR REPAIR TRIANGULAR CART,WRIST JT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25109	PR EXCISE TENDON FOREARM/ WRIST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25110	PR EXCIS TENDON SHEATH LESN,WRIST/F ORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25110	PR EXCIS TENDON SHEATH LESN,WRIST/F ORE	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25110	PR EXCIS TENDON SHEATH LESN,WRIST/F ORE	AUTHORIZATION REQUIRED	TMPPM RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25111	PR EXCIS PRIMARY GANGLION WRIST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25112	PR EXCIS RECURRENT GANGLION WRIST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25115	PR RAD EXCIS WRIST SYNOV/TENDON,FLEXOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25116	PR RAD EXCIS WRIST SYNOV/TENDON,EXTEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25118	PR EXCIS SYNOV WRIST,EXTENS TENDON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25119	PR EXCIS SYNOV WRIST,PART REMV ULNA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25120	PR EXCIS/CURET BENIG BONE LES RAD/ULNA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25125	PR EXCIS BENIGN LESN RAD/ULNA,AUT OGRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25126	PR EXCIS BENIGN LESN RAD/ULNA,ALO GRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25130	PR EXCIS BENIGN LESN CARPALS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25135	PR EXCIS BENIGN LESN CARPALS,AUTO GRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25136	PR EXCIS BENIGN LESN CARPALS,ALLO GRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25145	PR SEQUESTRECT OMY,FOREARM /WRIST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25150	PR PART REMOVAL BONE,ULNA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25151	PR PART REMOVAL BONE,RADIUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25170	PR RAD RESEC TUMOR, FOREARM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25210	PR REMOVAL OF CARPAL BONE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25215	PR REMOVAL OF PROX ROW CARPAL BONES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25230	PR REMOVAL OF RADIAL STYLOID	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25240	PR EXCIS DISTAL ULNA,PART/COMPLETE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25246	PR INJECTION FOR WRIST ARTHROGRAM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25248	PR REMOVE FOREARM/WRI ST FOREIGN BODY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25248	PR REMOVE FOREARM/WRI ST FOREIGN BODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25250	PR REMOVAL WRIST PROSTHESIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25251	PR REMOVAL WRIST PROSTHESIS,C OMPLIC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25259	PR MANIPULATE WRIST W/ANESTHES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25260	PR REPR FOREARM TEND/MUSC,FL EX,PRIM,EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25263	PR REPR FOREARM TEND/MUSC,FL EX,SECON,EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25265	PR REPR FOREARM TEND/FLEX,SE COND,GRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25270	PR REPR FOREARM TEND/MUSC,EX TEN,PRIM,EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25272	PR REPR FOREARM TEND/MUSC,EXTEN,SECOND	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25274	PR REPR FOREARM TEND/EXT,SECOND,GRAFT,EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25275	PR REPR FOREARM EXT TEND SHEATH,GRAFT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25275	PR REPR FOREARM EXT TEND SHEATH,GRAFT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25280	PR REVISE WRIST/FOREARM TENDON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25290	PR INCISE WRIST/FOREARM TENDON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25295	PR RELEASE WRIST/FOREARM TENDON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25300	PR FUSION TENDONS WRIST,FINGR FLEXORS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25301	PR FUSION TENDONS WRIST,FINGR EXTENSORS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25310	PR TRANSPLANT FOREARM/WRI ST TENDON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25312	PR XPLANT FOREARM TENDON,W TENDON GRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25315	PR REVISE PALSY HAND TENDON(S)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25316	PR REVISE PALSY HAND TENDON(S),W XFER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25320	PR REVISE WRIST JOINT,CARPAL INSTABIL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25332	PR ARTHROPLAST Y WRIST JT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25335	PR REALIGNMENT OF WRIST ON ULNA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25337	PR RECONSTRUCT ULNA/RADIOUL NAR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25350	PR OSTEOTOMY RADIUS,DISTAL THIRD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25355	PR OSTEOTOMY RADIUS,PROX/ MID THIRD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25360	PR OSTEOTOMY ULNA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25365	PR OSTEOTOMY RADIUS/ULNA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25370	PR OSTEOTOMY +ROD,RADIUS OR ULNA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25375	PR OSTEOTOMY +ROD,RADIUS AND ULNA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25390	PR OSTEOPLASTY, RADIUS OR ULNA,SHORTEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25391	PR OSTEOPLASTY, RADIUS OR ULNA,LENTH W/GRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25392	PR OSTEOPLASTY, RADIUS AND ULNA,SHORTEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25393	PR OSTEOPLASTY, RADIUS AND ULNA,LENTH W/GRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25394	PR OSTEOPLASTY, CARPAL BONE,SHORTEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25400	PR REPAIR NONUNION RADIUS OR ULNA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25405	PR REPAIR NONUNION RADIUS OR ULNAW/GRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25415	PR REPAIR NONUNION RADIUS AND ULNA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25420	PR REPAIR NONUNION RADIUS AND ULNA W/GRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25425	PR REPAIR DEFECT RAD OR ULNA W/ AUTOGRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25426	PR REPAIR DEFECT RAD AND ULNA W/ AUTOGRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25430	PR INSERT VASC PEDICLE,CARPAL BONE (HARII)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25431	PR REPAIR NONUNION CARPAL BONE,EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25440	PR REPAIR NONUNION SCAPHOID CARPAL BONE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25441	PR RECONSTRUCT DIST RADIUS W PROSTH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25442	PR RECONSTRUCT DIST ULNA W PROSTHESIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25443	PR RECONSTRUCT SCAPHOID CARPAL W PROSTHESIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25444	PR RECONSTRUCT LUNATE W PROSTHESIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25445	PR RECONSTRUCT TRAPEZIUM W PROSTHESIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25446	PR TOTAL WRIST REPLACEMENT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25447	PR REPAIR INTERCARP/CA RP-METACARP JT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25449	PR REMOVE WRIST JOINT IMPLANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25450	PR EPIPHYSEAL ARREST DIST RAD OR ULNA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25455	PR EPIPHYSEAL ARREST DIST RAD & ULNA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25490	PR REINFORCE RADIUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25491	PR REINFORCE ULNA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25492	PR REINFORCE RADIUS AND ULNA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25500	PR CLOSED RX RADIAL SHAFT FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25500	PR CLOSED RX RADIAL SHAFT FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25505	PR CLOSED RX RADIAL SHAFT FX,MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25505	PR CLOSED RX RADIAL SHAFT FX,MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25515	OPEN TREATMENT RADIAL SHAFT FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25515	OPEN TREATMENT RADIAL SHAFT FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25515	OPEN TREATMENT RADIAL SHAFT FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25520	PR CLOSED RX RADIAL SHAFT FX W/DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25520	PR CLOSED RX RADIAL SHAFT FX W/DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25520	PR CLOSED RX RADIAL SHAFT FX W/DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25525	OPEN RDL SHAFT FX CLOSED RAD/ULN JT DISLOCATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25525	OPEN RDL SHAFT FX CLOSED RAD/ULN JT DISLOCATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25525	OPEN RDL SHAFT FX CLOSED RAD/ULN JT DISLOCATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25526	OPEN RDL SHAFT FX OPEN RAD/ULN JT DISLOCATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25526	OPEN RDL SHAFT FX OPEN RAD/ULN JT DISLOCATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25526	OPEN RDL SHAFT FX OPEN RAD/ULN JT DISLOCATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25530	PR CLOSED RX ULNA SHAFT FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25530	PR CLOSED RX ULNA SHAFT FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25530	PR CLOSED RX ULNA SHAFT FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25535	PR CLOSED RX ULNA SHAFT FX,MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25535	PR CLOSED RX ULNA SHAFT FX,MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25535	PR CLOSED RX ULNA SHAFT FX,MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25545	OPEN TREATMENT OF ULNAR SHAFT FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25545	OPEN TREATMENT OF ULNAR SHAFT FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25545	OPEN TREATMENT OF ULNAR SHAFT FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25560	PR CLOSED RX RAD/ULNA SHAFT FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25560	PR CLOSED RX RAD/ULNA SHAFT FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25560	PR CLOSED RX RAD/ULNA SHAFT FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25565	PR CLOSED RX RAD/ULNA SHAFT FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25565	PR CLOSED RX RAD/ULNA SHAFT FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25565	PR CLOSED RX RAD/ULNA SHAFT FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25574	OPEN TX RADIAL & ULNAR SHAFT FX FIX RADIUS OR ULNA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25574	OPEN TX RADIAL & ULNAR SHAFT FX FIX RADIUS OR ULNA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25575	OPEN TX RADIAL & ULNAR SHAFT FX FIX RADIUS AND ULNA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25575	OPEN TX RADIAL & ULNAR SHAFT FX FIX RADIUS AND ULNA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25600	PR CLOSED RX DIST RAD/ULNA FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25605	PR CLOSED RX DIST RAD/ULNA FX,MANIPUL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25606	PR PERCUT SKELETAL FIX, DISTAL RADIUS FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25607	PR OPEN RX DISTAL RADIUS FX, EXTRA-ARTICULAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25608	PR OPEN RX DISTAL RADIUS FX, INTRA-ARTICULAR, 2 FRAG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25609	PR OPEN RX DISTAL RADIUS FX, INTRA-ARTICULAR, 3+ FRAG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25611	PR PERCUT FIX DIST RAD/ULNA FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25620	PR OPEN RX DIST RAD/ULNA FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25622	PR CLOSED RX NAVICULAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25622	PR CLOSED RX NAVICULAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25624	PR CLOSED RX NAVICULAR FX,MANIPULAT N	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25624	PR CLOSED RX NAVICULAR FX,MANIPULAT N	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25628	OPEN TX CARPAL SCAPHOID NAVICULAR FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25628	OPEN TX CARPAL SCAPHOID NAVICULAR FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25628	OPEN TX CARPAL SCAPHOID NAVICULAR FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25630	PR CLOSED RX CARPAL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25630	PR CLOSED RX CARPAL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25630	PR CLOSED RX CARPAL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25635	PR CLOSED RX CARPAL FX,MAIPULATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25635	PR CLOSED RX CARPAL FX,MAIPULATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25635	PR CLOSED RX CARPAL FX,MAIPULATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25645	PR OPEN RX CARPAL BONE FX,EACH BONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25645	PR OPEN RX CARPAL BONE FX,EACH BONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25645	PR OPEN RX CARPAL BONE FX,EACH BONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25650	PR CLOSED RX ULNA STYLOID FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25650	PR CLOSED RX ULNA STYLOID FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25650	PR CLOSED RX ULNA STYLOID FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25651	PR PERCUT SKELETAL FIX,ULNAR STYLOID FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25651	PR PERCUT SKELETAL FIX,ULNAR STYLOID FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25651	PR PERCUT SKELETAL FIX,ULNAR STYLOID FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25652	PR OPEN RX ULNAR STYLOID FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25652	PR OPEN RX ULNAR STYLOID FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25652	PR OPEN RX ULNAR STYLOID FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25660	PR CLOSED TREAT WRIST DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25660	PR CLOSED TREAT WRIST DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25660	PR CLOSED TREAT WRIST DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25670	PR OPEN REPAIR WRIST DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25670	PR OPEN REPAIR WRIST DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25670	PR OPEN REPAIR WRIST DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25671	PR PERCUT SKELETAL FIX,DIST RADIOULN DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25671	PR PERCUT SKELETAL FIX,DIST RADIOULN DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25671	PR PERCUT SKELETAL FIX,DIST RADIOULN DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25675	PR CLOSED RX RADIO-ULNA DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25675	PR CLOSED RX RADIO-ULNA DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25675	PR CLOSED RX RADIO-ULNA DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25676	PR OPEN RX RADIO-ULNA DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25676	PR OPEN RX RADIO-ULNA DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25676	PR OPEN RX RADIO-ULNA DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25680	PR CLOSED RX NAVIC/LUNATE FX/DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25680	PR CLOSED RX NAVIC/LUNATE FX/DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25680	PR CLOSED RX NAVIC/LUNATE FX/DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25685	PR OPEN RX NAVIC-PERILUNATE FX/DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25685	PR OPEN RX NAVIC-PERILUNATE FX/DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25685	PR OPEN RX NAVIC-PERILUNATE FX/DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25690	PR CLOSED RX LUNATE DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
25690	PR CLOSED RX LUNATE DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25690	PR CLOSED RX LUNATE DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25695	PR OPEN REPAIR LUNATE DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
25695	PR OPEN REPAIR LUNATE DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25800	PR FUSION OF WRIST JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25805	PR FUSION/SLIDING GRAFT WRIST JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25810	PR FUSION/GRAFT WRIST JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25820	PR FUSION INTERCARPAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25825	PR FUSION/GRAFT INTERCARPAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25830	PR FUSION RADIOULNAR JNT/ULNA RESEC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25900	PR AMPUTATION FOREARM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25905	PR AMPUTATION FOREARM,CIRCULAR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25907	PR AMPUTATION FOREARM,SECOND CLOSURE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25909	PR RE-AMPUTATION FOREARM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25915	PR KRUENBERG PROCEDURE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25920	PR AMPUTATE THRU WRIST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25922	PR AMPUTATE THRU WRIST,SECOND CLOSE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25924	PR RE-AMPUTATION THRU WRIST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25927	PR AMPUTATION TRANSMETACARPAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
25929	PR AMPUTATION TRANSMETACARP,SECOND CLOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25931	PR RE-AMPUTATION TRANSMETACARPAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
25999	PR FOREARM/WRI ST SURGERY UNLISTED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26010	PR DRAIN FINGER ABSCESS,SIMPLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26010	PR DRAIN FINGER ABSCESS,SIMPLE	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26010	PR DRAIN FINGER ABCESS,SIMPLE	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26011	PR DRAIN FINGER ABCESS,COMPLICATED	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26011	PR DRAIN FINGER ABCESS,COMPLICATED	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26011	PR DRAIN FINGER ABCESS,COMPLICATED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26020	PR DRAIN HAND TENDON SHEATH	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26020	PR DRAIN HAND TENDON SHEATH	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26020	PR DRAIN HAND TENDON SHEATH	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26020	PR DRAIN HAND TENDON SHEATH	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26025	PR DRAINAGE PALM BURSA,SINGLE	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26025	PR DRAINAGE PALM BURSA,SINGLE	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26025	PR DRAINAGE PALM BURSA,SINGLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26030	PR DRAINAGE PALM BURSA,MULTIP/ COMPLX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26030	PR DRAINAGE PALM BURSA,MULTIP/ COMPLX	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26030	PR DRAINAGE PALM BURSA,MULTIP/ COMPLX	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26034	PR INCIS DEEP FINGR/HAND BONE LESN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26035	PR DECOMPRESS FINGERS/HAND ,INJECT INJ	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26037	PR DECOMPRESS FASCIOTOMY FINGR/HAND	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26040	PR RELEASE PALM CONTRACT,PE RCUTANEOUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26045	PR RELEASE PALM CONTRACT,OPEN,PARTIAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26055	PR INCISE FINGER TENDON SHEATH	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26055	PR INCISE FINGER TENDON SHEATH	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26060	PR INCIS PERCUT FINGER TENDON,SINGLE,EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26070	PR EXPLORE & TREAT CARPOMETACARP JT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26075	PR EXPLORE & TREAT METACARPO-PHAL JT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26080	PR EXPLORE/TREAT INTERPHALAN GEAL JT,EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26100	PR BIOPSY SYNOVIUM CARPOMETACARP JT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26105	PR BIOPSY SYNOVIUM MCP JT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26110	PR BIOPSY SYNOVIUM I-P JT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26111	PR EX TUM/VASC MALF SFT TISS HAND/FNGR SUBQ 1.5CM/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26113	PR EX TUM/VASC MAL SFT TIS HAND/FNGR SUBFSC 1.5CM/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26115	PR EXCIS SOFT TISSUE LESION HAND SUBCUT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26116	PR EXCIS SOFT TISSUE LESION HAND DEEP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26117	PR RAD RESECT TUMOR SOFT TISSUE HAND/FINGER <3CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26118	PR RAD RESCJ TUM SOFT TISSUE HAND/FINGER 3 CM/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26121	PR PALMAR FASCIECTOMY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26123	PR PART PALMAR FASCIEC,OPEN 1 DIGIT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26125	PR PART PALMAR FASCIEC,OPEN ADDNL DIGIT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26130	PR EXCIS JT LINING,CARPO METACARPAL JT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26135	PR EXCIS JT LINING,MC-P JT,EACH DIGIT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26140	PR EXCIS JT LINING,PROX I-P JT,EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26145	PR RAD EXCIS JT LINING,FLEXOR ,EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26160	PR EXCIS TENDON SHEATH LESION, HAND/FINGER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26170	PR EXCIS PALM TENDON FLEXOR, EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26180	PR EXCIS FINGER TENDON FLEXOR, EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26185	PR SESAMOIDECT OMY, THUMB/FINGER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26200	PR EXCIS BENIGN BONE LESN,METACARPAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26205	PR EXCIS/GRFT BENIGN LESN,METACARPAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26210	PR EXCIS BENIGN BONE LESN,PHALANX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26215	PR EXCIS/GRFT BENIGN LESN,PHALANX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26230	PR PART REMV BONE,METACARPAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26235	PR PART REMV BONE,PROX/MID PHALANX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26236	PR PART REMV BONE,DISTAL PHALANX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26250	PR RAD RESEC METACARPAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26255	PR RAD RESEC METACARPAL,A UTOGRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26260	PR RAD RESEC PROX/MID PHALANX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26261	PR RAD RESEC PROX/MID PHALANX,AUTO GRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26262	PR RAD RESEC DISTAL PHALANX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26320	PR REMOVAL OF IMPLANT FROM HAND/FINGR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26340	PR MANIPULATE FINGER JT W/ ANESTH,EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26341	PR MANIPLATN PALAR FASCIAL CRD POST INJ SINGLE CORD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26350	PR REPAIR FLEXOR TENDON,HAND, W/O GRAFT,EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26352	PR REPAIR FLEXOR TENDON,HAND, W/ GRAFT,EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26356	PR REPAIR FLEX TENDON,ZONE 2,HAND	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26357	PR REPAIR FLEX TENDON,ZONE 2,SECON,HAND ,EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26358	PR REPAIR FLEX TEND,ZONE 2,SEC,HAND,W/ GRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26370	PR REPAIR PROFUNDUS TENDON,PRIMARY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26372	PR REPAIR PROFUNDUS TENDON,SECONDARY/GRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26373	PR REPAIR PROFUNDUS TENDON,SECONDARY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26390	PR EXCIS FLEX TEND HAND,IMPL ROD,DELAY GRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26392	PR REMOV ROD & INSERT FLEX TEND HAND GRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26410	PR REPAIR EXTEN TENDON,DORSUM HAND,EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26412	PR REPAIR EXTEN TENDON,DORSUM HAND,GRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26415	PR EXCIS EXT TEND HAND,IMPL ROD,DELAY GRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26416	PR REMOV ROD & INSERT EX TEND HAND GRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26418	PR REPAIR EXTEN TENDON,DORS UM FINGR,EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26420	PR REPAIR EXTEN TENDON,DORS UM FINGR,GRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26426	PR REPAIR EXT TEND,CENT SLIP,SEC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26428	PR REPAIR EXT TEND,CENT SLIP,SEC,W/ GRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26432	PR REPAIR EXTEN TENDON,DISTAL INSERT,CLOSE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26433	PR REPAIR EXTEN TENDON,DISTAL INSERT,OPEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26434	PR REPAIR EXTEN TENDON,DIST, OPEN,GRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26437	PR REALIGNMENT OF TENDONS,HAND	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26440	PR TENOLYSIS, FLEX TENDON,PALM/ FINGER,EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26442	PR TENOLYSIS FLEX TENDON,PALM & FINGER,EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26445	PR TENOLYSIS EXT TENDON,HAND/ FINGER,EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26449	PR RELEASE FOREARM/HAN D EXTEN TENDON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26450	PR TENOTOMY PALM FLEX,SINGLE,O PEN,EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26455	PR TENOTOMY FINGR FLEX,SINGLE,O PEN,EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26460	PR TENOTOMY HAND EXTEN,SINGLE, OPEN,EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26471	PR FUSION FINGER TENDONS,PIP JT STABIL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26474	PR FUSION FINGER TENDONS,DIP JT STABIL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26476	PR LENGTHEN,TEN DON,HAND/FIN GER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26477	PR TENDON SHORTENING, EXTEN, HAND/FINGER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26478	PR TENDON LENGTHENING, FLEX, HAND/FINGER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26479	PR TENDON SHORTENING, FLEX, HAND/FINGER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26480	PR TRANSPLANT HAND TENDON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26483	PR TRANSPLANT/GRAFT HAND TENDON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26485	PR TRANSPLANT PALM TENDON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26489	PR TRANSPLANT/G RAFT PALM TENDON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26490	PR REVISE THUMB TENDON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26492	PR THUMB TENDON TRANSFER,GR AFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26494	PR HYPOTHENAR MUSC TRANSFER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26496	PR REVISE THUMB TENDON,OTHR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26497	PR FINGER TENDON TRANSFER,4-5 FINGRS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26498	PR FINGER TENDON TRANSFER,2-5 FINGRS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26499	PR CORRECT CLAW FINGER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26500	PR HAND TENDON PULLEY RECONSTRUCT ION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26502	PR HAND TENDON PULLEY RECONST,GRA FT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26504	PR HAND TENDON PULLEY RECONST,PRO STH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26508	PR RELEASE THUMB CONTRACTURE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26510	PR CROSS INTRINSIC TRANSFER,EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26516	PR FUSION MC-P JOINT,SINGLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26517	PR FUSION MC-P JOINT,2 DIGITS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26518	PR FUSION MC-P JOINT,3-4 DIGITS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26520	PR RELEASE MC-P JT CONTRACTURE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26525	PR RELEASE I-P JT CONTRACTURE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26530	PR ARTHROPLAST Y MC-P JT,SINGLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26531	PR ARTHROPLAST Y MC-P JT,IMPLANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26535	PR ARTHROPLAST Y I-P JT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Bunionectomy): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/Bun ionectomy.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26536	PR ARTHROPLAST Y I-P JT,IMPLANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Bunionectomy): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/Bun ionectomy.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26540	PR FIX COLLAT LIG,MC-P JT,I-P JT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26541	PR FIX COLLAT LIG,MC-P JT,GRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26542	PR FIX COLLAT LIG,MC-P JT,LOCAL TISS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26545	PR FIX COLAT LIG,I-P JT,GRAFT,EAC H	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26546	PR FIX NONUNION METACARPAL/P HALANX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26548	PR FIX FINGER,VOLAR PLATE,I-P JT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26550	PR POLLICIZATION OF DIGIT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26551	PR GREAT TOE-HAND XFER,MICROVA SC ANAST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26553	PR SINGLE TOE-HAND XFER,MICROVA SC ANAST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26554	PR DOUBLE TOE-HAND XFER,MICROVA SC ANAST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26555	PR POSITIONAL CHANGE OF FINGER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26556	PR FREE TOE JT XFER W MICROVASC ANAST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26560	PR REPAIR OF WEB FINGER,EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26561	PR REPAIR OF WEB FINGER,GRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26562	PR REPAIR OF WEB FINGER,COMPL EX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26565	PR CORRECT METACARPAL DEFORM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26567	PR CORRECT FINGER DEFORMITY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26568	PR LENGTHEN METACARPAL/FINGER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26580	PR REPAIR CLEFT HAND DEFORMITY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26587	PR RECONST POLYDACT DIGIT,SOFT TIS & BONE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26590	PR REPAIR MACRODACTYL IA,EACH DIGIT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26591	PR REPAIR MUSCLES OF HAND	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26593	PR RELEASE MUSCLES OF HAND	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26596	PR EXCISION CONSTRICT FINGR TISSUE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26600	PR CLOSED RX METACARPAL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26605	PR CLOSED RX METACARPAL FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26607	PR CLOSED RX METACARP FX,W/MANIP,W/ EXT FIX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26608	PR CLOSED RX METACARPAL FX,PERCUT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26615	OPEN TX METACARPAL FRACTURE SINGLE EA BONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26615	OPEN TX METACARPAL FRACTURE SINGLE EA BONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26641	PR TREAT THUMB DISLOC,MANIP ULATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26641	PR TREAT THUMB DISLOC,MANIP ULATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26645	PR TREAT THUMB FX/DISLOC,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26645	PR TREAT THUMB FX/DISLOC,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26650	PRQ SKEL FIXATION CARP/MTCRPL FX DISLOCATE THUMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26650	PRQ SKEL FIXATION CARP/MTCRPL FX DISLOCATE THUMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26665	OPEN TX CARPOMETACARPAL FRACTURE DISLOCATE THUMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26665	OPEN TX CARPOMETACAR PAL FRACTURE DISLOCATE THUMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26670	PR CLOSED RX, CARPOMETACAR DISLOC, NON-THUMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26670	PR CLOSED RX, CARPOMETACAR DISLOC, NON-THUMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26675	PR CLOSED RX C-MC DISLOC, ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26675	PR CLOSED RX C-MC DISLOC, ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26676	PR PERCUT FIX CARPOMETACAR DISLOC, NON-THUMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26676	PR PERCUT FIX CARPOMETACAR DISLOC, NON-THUMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26685	OPEN TX CARPOMETACAR PAL DISLOCATE NOT THUMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26685	OPEN TX CARPOMETACAR PAL DISLOCATE NOT THUMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26686	PR OPEN RX C-MC DISLOC,COMPL EX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26700	PR CLOSED RX MC-P DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26705	PR CLOSED RX MC-P DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26706	PR PERCUT RX MC-P DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26715	OPEN TREATMENT METACARPOPH ALANGEAL DISLOCATION 1	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26715	OPEN TREATMENT METACARPOPH ALANGEAL DISLOCATION 1	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26720	PR CLOSE RX PROX/MID FING SHFT FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26720	PR CLOSE RX PROX/MID FING SHFT FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26725	PR CLOSE RX PROX/MID FING SHFT FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26725	PR CLOSE RX PROX/MID FING SHFT FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26727	PR PERCUT RX PROX/MID FING SHFT FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26727	PR PERCUT RX PROX/MID FING SHFT FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26735	OPEN TX PHALANGEAL SHAFT FRACTURE PROX/MIDDLE EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26735	OPEN TX PHALANGEAL SHAFT FRACTURE PROX/MIDDLE EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26740	PR CLOSE RX FINGR ARTICULAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26740	PR CLOSE RX FINGR ARTICULAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26742	PR CLOSE RX FINGR ARTICULAR FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26742	PR CLOSE RX FINGR ARTICULAR FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26746	OPEN TX ARTICULAR FRACTURE MCP/IP JOINT EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26746	OPEN TX ARTICULAR FRACTURE MCP/IP JOINT EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26750	PR CLOSE RX DIST FINGR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26750	PR CLOSE RX DIST FINGR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26755	PR CLOSE RX DIST FINGR FX,MANIPULAT N	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26755	PR CLOSE RX DIST FINGR FX,MANIPULAT N	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26756	PR PERCUT RX DIST FINGR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26756	PR PERCUT RX DIST FINGR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26765	OPEN TX DISTAL PHALANGEAL FRACTURE EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26765	OPEN TX DISTAL PHALANGEAL FRACTURE EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26770	PR CLOSED RX IP JT DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26770	PR CLOSED RX IP JT DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26775	PR CLOSED RX IP JT DISLOCATION,A NESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26775	PR CLOSED RX IP JT DISLOCATION,A NESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26776	PR PERCUT RX IP JT DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26776	PR PERCUT RX IP JT DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26785	OPEN TX INTERPHALAN GEAL JOINT DISLOCATION 1	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
26785	OPEN TX INTERPHALAN GEAL JOINT DISLOCATION 1	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
26820	PR THUMB FUSION WITH GRAFT,IN OPPOSITN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26841	PR FUSION 1ST CARPOMETACA RPAL JT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26842	PR FUSION 1ST CARPOMETACA RPAL JT,GRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26843	PR FUSION 2-5 CARPOMETACA RPAL JT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26844	PR FUSION 2-5 CARPOMETACA RPAL JT,GRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26850	PR FUSION MC-P JT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26852	PR FUSION MC-P JT,GRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26860	PR FUSION FINGER JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26861	PR FUSION FINGER JOINT,EACH ADDNL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26862	PR FUSION/GRAFT FINGER JT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26863	PR FUSION/GRAFT FINGER JT,EACH ADDNL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26910	PR AMPUTATE METACARPAL +FINGER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26951	PR AMPUTATION FINGER/THUMB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26952	PR AMPUTATION FINGER/THUMB +FLAPS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26989	PR HAND/FINGER SURGERY UNLISTED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26990	PR INCIS/DRAIN PELVIS/HIP, DE EP ABSCESS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
26991	PR INCIS/DRAIN PELVIS/HIP,INFECT BURSA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
26992	PR INCIS/DRAIN PELVIS/HIP,OPEN BONE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27000	PR INCIS HIP ADDUCTOR,SUBCUT,CLOSED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27001	PR INCIS HIP ADDUCTOR,SUBCUT,OPEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27003	PR INCIS HIP ADDUC,OPEN,OUTURE NEUREC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27005	PR INCIS ILIOPSOAS,OPEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27006	PR INCIS HIP ADDUCTORS,OPEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27025	PR INCIS OF HIP/THIGH FASCIA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27027	PR DECOMPRESSION FASCIOTOMY PELVIC COMPART, UNILAT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27030	PR DRAINAGE OF HIP JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27033	PR EXPLORATION OF HIP JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27035	PR DENERVATION OF HIP JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27036	PR RELEASE HIP FLEXION CONTRACTURE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27040	PR BX SOFT TISSUES, PELV/ HIP, SUPERFICL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
27041	PR BX SOFT TISSUES, PELV/ HIP, DEEP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
27043	PR EXCISION TUMOR SOFT TISSUE PELVIS&HIP SUBQ 3CM/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27045	PR EXC TUMOR SOFT TISSUE PELVIS & HIP SUBFASC 5CM/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27047	PR REMOVE HIP/PELVIS TUMOR,SUBCU T	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27048	PR REMOVE HIP/PELVIS TUMOR,DEEP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27049	PR RAD RESECT TUMOR SOFT TISSUE PELVIS & HIP <5 CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27050	PR OPEN BIOPSY SACROILIAC JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27052	PR OPEN BIOPSY OF HIP JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27054	PR REMOVAL OF HIP JOINT LINING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27057	PR DECOMPRESSI ON FASCIOTOMY PELVIC COMPART, UNILAT, W DEBRIDE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27059	PR RAD RESECTION TUMOR SOFT TISS PELVIS&HIP 5 CM/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27060	PR REMOVAL OF ISCHIAL BURSA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27062	PR REMOVE TROCH BURSA/CALCIFI CATN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27065	PR EXCISION BONE CYST BENIGN TUMOR, PELVIS/ HIP, SUPERFICIAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27066	PR EXCISION BONE CYST BENIGN TUMOR, PELVIS/ HIP, DEEP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27067	PR EXCISION BONE CYST BENIGN TUMOR, PELVIS/ HIP, AUTOGRAFT SEP INCISION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27070	PR PARTIAL EXCISION SUPERFICIAL PELVIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27071	PR PARTIAL EXCISION DEEP PELVIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27075	PR RAD RESEC UNILAT ILEUM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27076	PR RAD RESEC ILIUM +ACETABULUM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27077	PR RAD RESEC ENTIRE INNOMINATE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27078	PR RAD RESEC ISCHIAL TUBER +GR TROCH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27079	PR RAD RESEC ISCH TUBER +GR TROCH +FLAPS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27080	PR REMOVAL OF COCCYX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27086	PR REMOVE PELV/HIP F.B.,SUBCUTAN EOUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27086	PR REMOVE PELV/HIP F.B.,SUBCUTAN EOUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27087	PR REMOVE PELV/HIP F.B.,DEEP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27087	PR REMOVE PELV/HIP F.B.,DEEP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27090	PR REMOVAL OF HIP PROSTHESIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27091	PR REMOVAL OF HIP PROSTHESIS, COMPLEX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27093	PR INJECTION HIP ARTHROGRAM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27095	PR INJECTION HIP ARTHROGRAM, ANESTH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27096	PR INJECT SI JOINT ARTHROGRPHY & /ANES/STEROID W/IMAGE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27097	PR HAMSTRING RECESSON,PROX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27098	PR ADDUCTOR TRANSFER TO ISCHIUM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27100	PR XFER ABD MUSC TO GR TROCHANTER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27105	PR XFER PARASPINAL MUSC TO HIP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27110	PR XFER ILIOPSOAS MUSC TO GREAT TROCHANTER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27111	PR XFER ILIOPSOAS MUSC TO FEM NECK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27120	PR RECONSTRUC HIP SOCKET	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27122	PR RECONSTRUC HIP SOCKET, RESE C FEM HEAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27125	PR PARTIAL HIP REPLACEMENT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27130	PR TOTAL HIP ARTHROPLAST Y	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27132	PR CONV PREV HIP SURG TO TOT HIP ARTHROPLAS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27134	PR REVISE TOTAL HIP REPLACEMENT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27137	PR REVISE ACETABULAR PART OF TOTAL HIP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27138	PR REVISE FEM PART OF TOTAL HIP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27140	PR OSTEOTOMY & TRANSFER, GR EATER TROCHANTER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27146	PR OSTEOTOMY OF HIP BONE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27147	PR OSTEOTOMY HIP BONE, OPEN REDN HIP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27151	PR OSTEOTOMY HIP/FEMUR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27156	PR OSTEOTOMY HIP/FEMUR, OP EN REDN HIP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27158	PR OSTEOTOMY PELVIS BILAT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27161	PR OSTEOTOMY OF NECK OF FEMUR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27165	PR OSTEOTOMY/FIX INTER/SUBTROCH FEMUR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27170	PR BONE GRAFT FEMUR HEAD/NECK/RIDGE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27175	PR CLOSED RX SLIP FEM EPIPHYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27176	PR CLOSED RX SLIP FEM EPIPHYSIS,PINS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27177	PR OPEN RX SLIP EPIPHYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27178	PR OPEN RX SLIP EPIPHYSIS,CLO SED MANIP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27179	PR OPEN RX SLIP EPIPHY,REVIS FEM NECK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27181	PR OPEN RX SLIP EPIPHYSIS,OST EOTOMY/FIX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27185	PR EPIPHYSEAL ARREST,GREAT ER TROCANTER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27187	PR REINFORCE HIP BONES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27197	PR CLSD TX PELVIC RING FX W/O MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27198	PR CLSD TX PELVIC RING FX W/MANIPULATION W/ANES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27200	PR CLOSED RX COCCYGEAL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27200	PR CLOSED RX COCCYGEAL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27202	PR OPEN REPAIR COCCYGEAL FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27202	PR OPEN REPAIR COCCYGEAL FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27202	PR OPEN REPAIR COCCYGEAL FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27215	PR OPEN FIX ILIAC FX,INTERN FIXATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27215	PR OPEN FIX ILIAC FX,INTERN FIXATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27215	PR OPEN FIX ILIAC FX,INTERN FIXATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27216	PR PERCUT FIX POST PELV RING FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27216	PR PERCUT FIX POST PELV RING FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27216	PR PERCUT FIX POST PELV RING FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27217	PR OPEN INTERN FIX ANTER PELV RING FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27217	PR OPEN INTERN FIX ANTER PELV RING FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27217	PR OPEN INTERN FIX ANTER PELV RING FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27218	PR OPEN INTERN FIX POST PELV RING FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27218	PR OPEN INTERN FIX POST PELV RING FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27218	PR OPEN INTERN FIX POST PELV RING FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27220	PR CLOSED RX ACETABULAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27220	PR CLOSED RX ACETABULAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27220	PR CLOSED RX ACETABULAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27222	PR CLOSED RX ACETABULAR FX,MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27222	PR CLOSED RX ACETABULAR FX,MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27222	PR CLOSED RX ACETABULAR FX,MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27226	PR OPEN INTERN FIX ACETABULAR WALL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27226	PR OPEN INTERN FIX ACETABULAR WALL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27226	PR OPEN INTERN FIX ACETABULAR WALL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27227	PR OPEN INTERN FIX ACETABULAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27227	PR OPEN INTERN FIX ACETABULAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27227	PR OPEN INTERN FIX ACETABULAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27228	PR OPEN INTERN FIX COMPLEX ACETABUL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27228	PR OPEN INTERN FIX COMPLEX ACETABUL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27228	PR OPEN INTERN FIX COMPLEX ACETABUL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27230	PR CLOSED RX PROX/NECK FEMUR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27230	PR CLOSED RX PROX/NECK FEMUR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27230	PR CLOSED RX PROX/NECK FEMUR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27232	PR CLOSED RX PROX/NECK FEMUR FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27232	PR CLOSED RX PROX/NECK FEMUR FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27232	PR CLOSED RX PROX/NECK FEMUR FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27235	PR PERCUT FIX PROX/NECK FEMUR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27235	PR PERCUT FIX PROX/NECK FEMUR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27235	PR PERCUT FIX PROX/NECK FEMUR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27236	PR FEMORAL FX, OPEN TX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27236	PR FEMORAL FX, OPEN TX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27236	PR FEMORAL FX, OPEN TX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27238	PR CLOSED RX INTER/SUBTRO CH FEMUR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27238	PR CLOSED RX INTER/SUBTRO CH FEMUR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27238	PR CLOSED RX INTER/SUBTRO CH FEMUR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27240	PR CLOSED RX INTER/SUBTRO CH FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27240	PR CLOSED RX INTER/SUBTRO CH FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27240	PR CLOSED RX INTER/SUBTRO CH FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27244	PR TREAT INTER/SUBTRO CH FX,W/PLATE/SC REW	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27244	PR TREAT INTER/SUBTRO CH FX,W/PLATE/SC REW	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27244	PR TREAT INTER/SUBTRO CH FX,W/PLATE/SC REW	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27245	PR OPEN FIX INTER/SUBTRO CH FX,IMPLNT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27245	PR OPEN FIX INTER/SUBTRO CH FX,IMPLNT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27245	PR OPEN FIX INTER/SUBTROCH FX,IMPLNT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27246	PR CLOSED RX GR TROCHANTERIC FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27246	PR CLOSED RX GR TROCHANTERIC FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27246	PR CLOSED RX GR TROCHANTERIC FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27248	OPEN TREATMENT GREATER TROCHANTERIC FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27248	OPEN TREATMENT GREATER TROCHANTERIC FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27248	OPEN TREATMENT GREATER TROCHANTERIC FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27250	PR CLOSED RX TRAUMATIC HIP DISLOCATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27250	PR CLOSED RX TRAUMATIC HIP DISLOCATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27250	PR CLOSED RX TRAUMATIC HIP DISLOCATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27252	PR CLOSED RX TRAUMA HIP DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27252	PR CLOSED RX TRAUMA HIP DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27252	PR CLOSED RX TRAUMA HIP DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27253	PR OPEN RX TRAUMATIC HIP DISLOCATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27253	PR OPEN RX TRAUMATIC HIP DISLOCATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27253	PR OPEN RX TRAUMATIC HIP DISLOCATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27254	PR OPEN RX HIP DISLOC/ACETA BULAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27254	PR OPEN RX HIP DISLOC/ACETA BULAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27254	PR OPEN RX HIP DISLOC/ACETA BULAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27256	PR CLOSED RX SPONTANEOUS HIP DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27256	PR CLOSED RX SPONTANEOUS HIP DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27256	PR CLOSED RX SPONTANEOUS HIP DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27257	PR CLOSED RX SPONT HIP DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27257	PR CLOSED RX SPONT HIP DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27257	PR CLOSED RX SPONT HIP DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27258	PR OPEN RX SPONTANEOUS HIP DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27258	PR OPEN RX SPONTANEOUS HIP DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27258	PR OPEN RX SPONTANEOUS HIP DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27259	PR OPEN RX SPONT HIP DISLOC,FEM SHORT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27259	PR OPEN RX SPONT HIP DISLOC,FEM SHORT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27259	PR OPEN RX SPONT HIP DISLOC,FEM SHORT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27265	PR CLOSED RX POST HIP ARTHRPLAS DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27265	PR CLOSED RX POST HIP ARTHRPLAS DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27265	PR CLOSED RX POST HIP ARTHRPLAS DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27266	PR CLOSED RX POST HIP FIX DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27266	PR CLOSED RX POST HIP FIX DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27266	PR CLOSED RX POST HIP FIX DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27267	PR CLOSED TX FEMORAL FRACTURE PROX HEAD W/O MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27267	PR CLOSED TX FEMORAL FRACTURE PROX HEAD W/O MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27267	PR CLOSED TX FEMORAL FRACTURE PROX HEAD W/O MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27268	PR CLOSED TX FEMORAL FRACTURE PROX HEAD W MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27268	PR CLOSED TX FEMORAL FRACTURE PROX HEAD W MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27268	PR CLOSED TX FEMORAL FRACTURE PROX HEAD W MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27269	PR OPEN TX FEMORAL FRACTURE PROXIMAL END HEAD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27269	PR OPEN TX FEMORAL FRACTURE PROXIMAL END HEAD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27275	PR MANIPULATION HIP JOINT W ANESTHESIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27278	ARTHRD SI JT PRQ W/PLMT IARTIC IMPLT WO TFXJ DEV	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27279	ARTHRODESIS SI JOINT PERCUTANEOUS/MIN INVASIVE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27280	PR ARTHRODESIS SACROILIAC JOINT OPEN W/OBTAINING GRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27282	PR FUSION OF PUBIC BONES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27284	PR FUSION HIP JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27286	PR FUSION HIP JOINT +SUBTROCH OSTEOTOMY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27290	PR HINDQUARTER AMPUTATION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27295	PR DISARTICULATION OF HIP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27299	PR PELVIS/HIP JOINT SURGERY UNLISTED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27301	PR INCIS/DRAIN THIGH/KNEE ABSCESS,DEEP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27303	PR INCIS DEEP BONE LESN,FEMUR/KNEE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27305	PR FASCIOTOMY,IL IOTIBIAL,OPEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27306	PR INCIS THIGH TENDON,ADDU C/HAMST,SING L	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27307	PR INCIS THIGH TENDON,ADDU C/HAMST,MULT I	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27310	PR EXPLOR/DRAIN KNEE,INFECTN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27323	PR BX THIGH/KNEE SOFT TISSUES,SUPERF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
27324	PR BX THIGH/KNEE SOFT TISSUES,DEEP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
27325	PR NEURECTOMY, HAMSTRING MUSCLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27326	PR NEURECTOMY, POPLITEAL (GASTROCNEMIUS)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27327	PR REMV THIGH/KNEE TUMOR,SUBCUTANEOUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27328	PR REMV THIGH/KNEE TUMOR,DEEP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27329	PR RAD RESECT TUMOR SOFT TISSUE THIGH/KNEE <5CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27330	PR BIOPSY SYNOVIUM KNEE JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27331	PR ARTHROTOMY/ EXPLORE/TREAT KNEE JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27332	PR EXCIS KNEE CARTILAGE, MEDIAL OR LATERAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27333	PR EXCIS KNEE CARTILAGE, MEDIAL & LATERAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27334	PR RMV KNEE SYNOVIUM,ANT /POST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27335	PR REMV SYNOVIUM KNEE,ANTER & POST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27337	PR EXCISION TUMOR SOFT TISSUE THIGH/KNEE SUBQ 3 CM/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27339	PR EXC TUMOR SOFT TISSUE THIGH/KNEE SUBFASC 5 CM/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27340	PR REMOVAL PREPATELLA BURSA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27345	PR REMOVAL SYNOVIAL CYST,KNEE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27347	PR REMOVE KNEE CYST/GANGLION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27350	PR PART/FULL REMOVAL OF KNEECAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27355	PR REMV BENIGN FEMUR LESION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27356	PR REMV BENIGN FEMUR LESN/ALLOGRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27357	PR REMV BENIGN FEMUR LESN/AUTOGR AFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27358	PR REMV BENIGN FEMUR LESN/INTERN FIX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27360	PR PART REMV FEMUR/PROX TIB/FIB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27364	PR RAD RESECTION TUMOR SOFT TIS THIGH/KNEE 5 CM/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27365	PR RAD RESEC TUMOR,FEMUR OR KNEE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27369	PR NJX PX CNTRST KNE ARTHG CNTRST ENHNCD CT/MRI KNE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27370	PR INJECTION KNEE ARTHROGRAPH Y	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27372	PR REMV FOREIGN BODY,KNEE/THI GH,DEEP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27380	PR FIX INFRAPATELLA TENDON,PRIMA RY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27381	PR FIX PATELLA TENDN,SECON DARY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27385	PR FIX QUAD/HAMSTR MUSC RUPT,PRIMARY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27386	PR FIX QUAD/HAMSTR MUSC RUPT,SECOND	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27390	PR TENOTOMY,HA MSTR,KNEE-THIGH,SINGL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27391	PR TENOTOMY,UNI HAMSTR,KNEE-THIGH,MULTI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27392	PR TENOTOMY,BI HAMSTR,KNEE-THIGH,MULTI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27393	PR LENGTHEN HAMSTR TENDON,SINGLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27394	PR LENGTHEN HAMSTR TENDON,MULTI ,ONE LEG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27395	PR LENGTHEN HAMSTR TENDON,MULTI ,2 LEGS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27396	PR XPLANT HAMSTR TENDON-PATELLA,SINGLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27397	PR XPLANT HAMSTR TENDONS-PATELLA,MULTI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27400	PR TENDON/MUSC XFER,HAMSTR-FEMUR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27403	PR ARTHROTOMY, OPEN REPAIR MENISCUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27405	PR REPAIR COLLAT LIGAMT/CAPSU LE,KNEE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27407	PR REPAIR CRUCIATE LIGAMENT,KNEE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27409	PR REPAIR COLLAT & CRUCIATE LIG,KNEE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27412	PR AUTOCHONDRAL KNEE IMPLANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27415	PR OSTEOCHONDRAL KNEE ALLOGRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27416	PR OSTEOCHONDRAL KNEE AUTOGRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27418	PR REPAIR ANTERIOR TIBIAL TUBERCLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27420	PR REVISION OF UNSTABLE PATELLA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27422	PR FIX UNSTABLE PATELLA,EXTEN REALIGN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27424	PR REVISION/REMOVAL OF KNEECAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27425	PR LATERAL RETINACULAR RELEASE OPEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27427	PR LIGMT REVISION,KNEE,EXTRA-ARTIC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27428	PR LIGMT REVISION,KNEE,INTRA-ARTIC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27429	PR LIGMT REVISN,KNEE,I NTRA/EXTRA-ART	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27430	PR REVISION QUADRICEPS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27435	PR POST CAPSULAR RELEASE,KNEE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27437	PR ARTHROPLAST Y PATELLA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27438	PR ARTHROPLAST Y PATELLA WITH IMPLANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27440	PR ARTHROPLASTY TIBIAL PLATEAU	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27441	PR PLASTY TIBIAL PLATEAU +DEBRIDE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27442	PR PLASTY TIB PLAT OR FEM CONDYLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27443	PR PLASTY TIB PLAT/FEM CONDY +DEBRIDE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27445	PR PLASTY KNEE,CONSTRAINED PROSTHESIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27446	PR PLASTY KNEE,MED OR LAT COMPARTMT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27447	PR TOTAL KNEE ARTHROPLAST Y	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27448	PR OSTEOTOMY FEMUR SHAFT/SUPRAC ONDY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27450	PR OSTEOTOMY FEMUR SHAFT,W FIXATN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27454	PR OSTEOTOMIES FEMUR SHAFT +INTRA ROD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27455	PR OSTEOTOMY PROX TIB,<EPIPHY CLOSUR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27457	PR OSTEOTOMY PROX TIB,AFTR EPIPHY CLOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27465	PR SHORTENING OF FEMUR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27466	PR LENGTHENING OF FEMUR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27468	PR COMBINE SHORTEN/LEN GTHEN FEMUR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27470	PR FIX NON/MALUNION FEMUR BELOW NECK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27472	PR FIX NON/MALUNION FEMUR, W GRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27475	PR ARREST, EPIPHYSEAL, DISTAL FEMUR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27477	PR SURGERY TO STOP TIB/FIB GROWTH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27479	PR SURGERY STOP FEMUR/TIB/FIB GROWTH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27485	PR HEMIEPIPHYSE AL LEG ARREST SURGERY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27486	PR REVISE KNEE JOINT REPLACE,1 PART	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27487	PR REVISE KNEE JOINT REPLACE,ALL PARTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27488	PR REMOVAL OF KNEE PROSTHESIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27495	PR REINFORCE FEMUR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27496	PR DECOMPRESS THIGH/KNEE,1 COMPARTMT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27497	PR DECOMPRESS THIGH/KNEE,1+ DEBRIDE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27498	PR DECOMPRESS THIGH/KNEE,>1 COMPARTMT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27499	PR DECOMPRESS THIGH/KNEE,>1 +DEBRIDE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27500	PR CLOSED RX FEMUR SHAFT FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27500	PR CLOSED RX FEMUR SHAFT FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27501	PR CLOSED RX CONDYLAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27501	PR CLOSED RX CONDYLAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27502	PR CLOSED RX FEMUR SHAFT FX+MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27502	PR CLOSED RX FEMUR SHAFT FX+MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27503	PR CLOSED RX CONDYLAR FX +MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27503	PR CLOSED RX CONDYLAR FX +MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27506	PR OPEN RX FEMUR FX +INTRAMED ROD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27506	PR OPEN RX FEMUR FX +INTRAMED ROD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27507	PR OPEN RX FEMUR FX +PLATE/SCREW	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27507	PR OPEN RX FEMUR FX +PLATE/SCREW	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27508	PR CLOSED RX FEMUR,DISTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27508	PR CLOSED RX FEMUR,DISTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27509	PR PERCUT FIX DISTAL FEMUR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27509	PR PERCUT FIX DISTAL FEMUR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27510	PR CLOSED RX FEMUR,DISTAL +MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27510	PR CLOSED RX FEMUR,DISTAL +MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27511	OPEN TX FEMORAL SUPRACONDYL AR FRACTURE W/O EXTENSION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27511	OPEN TX FEMORAL SUPRACONDYL AR FRACTURE W/O EXTENSION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27511	OPEN TX FEMORAL SUPRACONDYL AR FRACTURE W/O EXTENSION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27513	OPEN TX FEMORAL SUPRACONDYL AR FRACTURE W EXTENSION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27513	OPEN TX FEMORAL SUPRACONDYL AR FRACTURE W EXTENSION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27513	OPEN TX FEMORAL SUPRACONDYL AR FRACTURE W EXTENSION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27514	OPEN TX FEMORAL FRACTURE DISTAL MED/LAT CONDYLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27514	OPEN TX FEMORAL FRACTURE DISTAL MED/LAT CONDYLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27514	OPEN TX FEMORAL FRACTURE DISTAL MED/LAT CONDYLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27516	PR CLOSED RX DIST FEM EPIPHYSIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27516	PR CLOSED RX DIST FEM EPIPHYSIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27516	PR CLOSED RX DIST FEM EPIPHYSIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27517	PR CLOSED RX DIST FEM EPIPHYSIS +MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27517	PR CLOSED RX DIST FEM EPIPHYSIS +MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27517	PR CLOSED RX DIST FEM EPIPHYSIS +MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27519	OPEN TX DISTAL FEMORAL EPIPHYSEAL SEPARATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27519	OPEN TX DISTAL FEMORAL EPIPHYSEAL SEPARATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27519	OPEN TX DISTAL FEMORAL EPIPHYSEAL SEPARATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27520	PR CLOSED RX PATELLA FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27520	PR CLOSED RX PATELLA FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27520	PR CLOSED RX PATELLA FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27524	PR OPEN RX PATELLA FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27524	PR OPEN RX PATELLA FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27524	PR OPEN RX PATELLA FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27530	PR CLOSED RX TIBIAL PLATEAU FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27530	PR CLOSED RX TIBIAL PLATEAU FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27530	PR CLOSED RX TIBIAL PLATEAU FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27532	PR CLOSED RX TIB PLAT FX +MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27532	PR CLOSED RX TIB PLAT FX +MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27532	PR CLOSED RX TIB PLAT FX +MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27535	OPEN TX TIBIAL FRACTURE PROXIMAL UNICONDYLAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27535	OPEN TX TIBIAL FRACTURE PROXIMAL UNICONDYLAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27535	OPEN TX TIBIAL FRACTURE PROXIMAL UNICONDYLAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27536	PR OPEN RX BILAT TIB PLAT FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27536	PR OPEN RX BILAT TIB PLAT FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27536	PR OPEN RX BILAT TIB PLAT FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27538	PR CLOSED RX TIB TUBER FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27538	PR CLOSED RX TIB TUBER FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27538	PR CLOSED RX TIB TUBER FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27540	OPEN TX INTERCONDYLAR SPINE/TUBRST FRACTURE KNEE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27540	OPEN TX INTERCONDYLAR SPINE/TUBRST FRACTURE KNEE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27540	OPEN TX INTERCONDYLAR SPINE/TUBRST FRACTURE KNEE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27550	PR CLOSED RX KNEE DISLOCATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27550	PR CLOSED RX KNEE DISLOCATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27550	PR CLOSED RX KNEE DISLOCATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27552	PR CLOSED RX KNEE DISLOC +ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27552	PR CLOSED RX KNEE DISLOC +ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27552	PR CLOSED RX KNEE DISLOC +ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27556	OPEN TX KNEE DISLOCATION W/O LIGAMENTOUS REPAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27556	OPEN TX KNEE DISLOCATION W/O LIGAMEN TOUS REPAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27556	OPEN TX KNEE DISLOCATION W/O LIGAMEN TOUS REPAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27557	OPEN TX KNEE DISLOCATION W LIGAMEN TOUS REPAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27557	OPEN TX KNEE DISLOCATION W LIGAMEN TOUS REPAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27557	OPEN TX KNEE DISLOCATION W LIGAMEN TOUS REPAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27558	OPEN TX KNEE DISLOCATION W REPAIR/RECON STRUCTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27558	OPEN TX KNEE DISLOCATION W REPAIR/RECON STRUCTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27558	OPEN TX KNEE DISLOCATION W REPAIR/RECON STRUCTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27560	PR CLOSED RX KNEECAP DISLOCATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27560	PR CLOSED RX KNEECAP DISLOCATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27562	PR CLOSED RX KNEECAP DISLOC +ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27562	PR CLOSED RX KNEECAP DISLOC +ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27566	PR OPEN RX KNEECAP DISLOCATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27570	PR MANIPULATN KNEE JT +ANESTHESIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27580	PR FUSION OF KNEE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27590	PR AMPUTATE THIGH,THRU FEMUR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27591	PR AMPUTATE THIGH+STAT FITTING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27592	PR AMPUTATE THIGH,OPEN CIRCULAR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27594	PR AMPUTATE THIGH,SECOND RY CLOSUR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27596	PR AMPUTATE THIGH,RE- AMPUTATN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27598	PR AMPUTATE LOWER LEG AT KNEE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27599	PR FEMUR/KNEE SURG UNLISTED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27600	PR DECOMPRESS ANT/LAT LEG CMPART	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27601	PR DECOMPRESS POST LEG COMPARTMT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27602	PR DECOMPRESS ANT/LAT+POST LEG CMPART	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27603	PR DRAIN LOWER LEG DEEP ABSC/HEMATO MA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27604	PR DRAIN LOWER LEG BURSA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27605	PR INCIS ACHILLES TENDON +LOCAL ANESTH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27606	PR INCIS ACHILLES TENDON+GEN ANESTH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27607	PR DRAIN LEG/ANKLE BONE FOR INFECT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27610	PR EXPLORE/TREAT ANKLE JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27612	PR EXPLORE/RELEASE POST CAP ANKLE JT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27613	PR BX LOW LEG SOFT TISSUE,SUPER FICIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
27614	PR BX LOW LEG SOFT TISSUE,DEEP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
27615	PR RAD RESECTION TUMOR SOFT TISSUE LEG/ANKLE <5CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27616	PR RAD RESECTION TUMOR SOFT TISSUE LEG/ANKLE 5 CM/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27618	PR RESEC TUMOR LOWER LEG,SUBCUT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27619	PR RESEC TUMOR LOWER LEG,DEEP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27620	PR EXPLOR ANKLE JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27625	PR EXPLOR ANKLE JT +SYNOVECTOM Y	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27626	PR EXPLOR ANKLE JT +TENOSYNOVE CTOMY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27630	PR EXCIS LESN TENDON SHEALTH LEG/ANKLE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27630	PR EXCIS LESN TENDON SHEALTH LEG/ANKLE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGES/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27632	PR EXCISION TUMOR SOFT TISSUE LEG/ANKLE SUBQ 3 CM/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGES/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27634	PR EXC TUMOR SOFT TISSUE LEG/ANKLE SUBFASC 5 CM/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGES/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27635	PR EXCIS BENIGN LESN,TIB/FIB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGES/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27637	PR EXCIS BENIGN LESN,TIB/FIB +AUTOGRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27638	PR EXCIS BENIGN LESN,TIB/FIB +ALLOGRFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27640	PR PARTIAL REMOVAL OF TIBIA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27641	PR PARTIAL REMOVAL OF FIBULA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27645	PR RAD RESEC TUMOR,TIBIA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27646	PR RAD RESEC TUMOR,FIBULA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27647	PR RAD RESEC TUMOR,TALUS/ CALCANEUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27648	PR INJECTION FOR ANKLE ARTHROGRAM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27650	PR REPAIR ACHILLES TENDON,PRIMARY	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27650	PR REPAIR ACHILLES TENDON, PRIMARY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27652	PR REPAIR/GRAFT ACHILLES TENDON	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27652	PR REPAIR/GRAFT ACHILLES TENDON	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27654	PR REPAIR ACHILLES TENDON,SECONDARY	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27654	PR REPAIR ACHILLES TENDON,SECONDARY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27656	PR REPAIR LEG FASCIA DEFECT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27658	PR REPAIR FLEX LEG TENDON,PRIMARY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27658	PR REPAIR FLEX LEG TENDON, PRIM, EA	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27659	PR REPAIR FLEX LEG TENDON, SECO ND, EA	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27659	PR REPAIR FLEX LEG TENDON, SECO ND, EA	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27664	PR REPAIR EXTEN LEG TENDN,PRIM,E ACH	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27664	PR REPAIR EXTEN LEG TENDN,PRIM,E ACH	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27665	PR REPAIR EXTEN LEG TENDN,SECON D,EA	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27665	PR REPAIR EXTEN LEG TENDN,SECON D,EA	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27675	PR REPAIR PERONEAL TENDONS	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27675	PR REPAIR PERONEAL TENDONS	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27676	PR REPAIR PERONEAL TENDONS,FIB OSTEOTMY	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27676	PR REPAIR PERONEAL TENDONS,FIB OSTEOTMY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27680	PR RELEASE TIB/FIB/ANKLE FLEX TENDON,EA	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27680	PR RELEASE TIB/FIB/ANKLE FLEX TENDON,EA	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27681	PR RELEASE TIB/FIB/ANKL FLEX TENDON,MUL	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27681	PR RELEASE TIB/FIB/ANKL FLEX TENDON,MUL	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27685	PR LENGTH/SHORT LEG/ANKLE TENDON,SINGLE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27685	PR LENGTH/SHORT LEG/ANKLE TENDON,SINGLE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27686	PR LENGTH/SHORT LEG/ANKLE TENDON,MULTI	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27686	PR LENGTH/SHORT LEG/ANKLE TENDON, MULTIPLE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27687	PR GASTROCNEMIUS RESECTION	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27687	PR GASTROCNEMIUS RESECTION	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27690	PR XFER SINGLE SUPERFICIAL LOW LEG TENDON	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27690	PR XFER SINGLE SUPERFICIAL LOW LEG TENDON	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27691	PR XFER SINGLE DEEP LOW LEG TENDON	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27691	PR XFER SINGLE DEEP LOW LEG TENDON	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27692	PR XFER ADDNL LOWER LEG TENDON	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27692	PR XFER ADDNL LOWER LEG TENDON	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27695	PR REPAIR 1 COLLAT ANKLE LIGMNT,PRIMARY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27696	PR REPAIR BOTH COLLAT ANKL LIGMT,PRIMRY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27698	PR REPAIR COLLAT ANKLE LIGMNT,SECONDARY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27700	PR ARTHROPLASTY ANKLE JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27702	PR TOTAL ANKLE REPLACEMENT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27703	PR SECONDARY RECONSTRUCT ION,ANKLE JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27704	PR REMOVAL OF ANKLE IMPLANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27705	PR OSTEOTOMY TIBIA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27707	PR OSTEOTOMY FIBULA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27709	PR OSTEOTOMY TIBIA & FIBULA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27712	PR OSTEOTOMIES TIB/FIB +INTRAMED ROD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27715	PR LENGTHENING TIBIA/FIBULA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27720	RPR NON/MALUNIO N TIBIA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27722	RPR NON/MALUNIO N TIBIA +SLIDING GRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27724	RPR NON/MALUNIO N TIBIA +AUTOGRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27725	RPR NON/MALUNION TIBIA,FUSE W FIBULA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27726	PR RPR FIBULA NONUNION/MALUNION W INT FIXATION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27727	RPR CONGEN PSEUDOARTHROSIS TIBIA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27730	PR ARREST,EPIPHYSEAL,OPEN,DISTAL TIBIA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27732	PR STOP GROWTH DISTAL FIBULA EPIPHYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27734	PR STOP GROWTH DISTAL TIB/FIB EPIPHYSES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27740	PR STOP GROWTH PROX/DIST TIBIA/FIBULA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27742	PR STOP GROWTH PROX/DIST TIB/FIB+FEMUR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27745	PR REINFORCE TIBIA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27750	PR CLOSED RX TIBIA SHAFT FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27752	PR CLOSED RX TIBIA SHAFT FX,MANIPULAT N	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27756	PR PERCUT RX TIBIA SHAFT FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27758	PR OPEN RX TIBIA SHAFT FX,SCREWS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27759	PR TREAT TIBIAL SHAFT FX, INTRAMED IMPLANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27760	PR CLOSED RX MED MALLEOLUS FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27762	PR CLOSED RX MED MALLEOLUS FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27766	OPEN TREATMENT MEDIAL MALLEOLUS FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27766	OPEN TREATMENT MEDIAL MALLEOLUS FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27767	PR CLOSED TREATMENT PST MALLEOLUS FRACTURE W/O MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27767	PR CLOSED TREATMENT PST MALLEOLUS FRACTURE W/O MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27767	PR CLOSED TREATMENT PST MALLEOLUS FRACTURE W/O MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27768	PR CLOSED TREATMENT PST MALLEOLUS FRACTURE W MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27768	PR CLOSED TREATMENT PST MALLEOLUS FRACTURE W MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27768	PR CLOSED TREATMENT PST MALLEOLUS FRACTURE W MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27769	PR OPEN TREATMENT POSTERIOR MALLEOLUS FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27769	PR OPEN TREATMENT POSTERIOR MALLEOLUS FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27780	PR CLOSED RX PROX/SHAFT FIBULA FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27780	PR CLOSED RX PROX/SHAFT FIBULA FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27781	PR CLOSED RX PROX/SHAFT FIB FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27781	PR CLOSED RX PROX/SHAFT FIB FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27784	OPEN TREATMENT PROXIMAL FIBULA/SHAFT FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27784	OPEN TREATMENT PROXIMAL FIBULA/SHAFT FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27786	PR CLOSED RX DIST FIBULA FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27786	PR CLOSED RX DIST FIBULA FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27788	PR CLOSED RX DIST FIBULA FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27788	PR CLOSED RX DIST FIBULA FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27792	OPEN TX DISTAL FIBULAR FRACTURE LAT MALLEOLUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27792	OPEN TX DISTAL FIBULAR FRACTURE LAT MALLEOLUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27808	CLOSED TX BIMALLEOLAR ANKLE FRACTURE W/O MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27808	CLOSED TX BIMALLEOLAR ANKLE FRACTURE W/O MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27810	CLOSED TX BIMALLEOLAR ANKLE FRACTURE W MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27810	CLOSED TX BIMALLEOLAR ANKLE FRACTURE W MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27814	OPEN TREATMENT BIMALLEOLAR ANKLE FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27814	OPEN TREATMENT BIMALLEOLAR ANKLE FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27814	OPEN TREATMENT BIMALLEOLAR ANKLE FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27816	PR CLOSED RX TRIMALLEOLAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27816	PR CLOSED RX TRIMALLEOLAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27816	PR CLOSED RX TRIMALLEOLAR FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27818	PR CLOSED RX TRIMALLEOLAR FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27818	PR CLOSED RX TRIMALLEOLAR FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27818	PR CLOSED RX TRIMALLEOLAR FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27822	OPEN TX TRIMALLEOLAR ANKLE FX W/O FIX PST LIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27822	OPEN TX TRIMALLEOLAR ANKLE FX W/O FIX PST LIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27822	OPEN TX TRIMALLEOLAR ANKLE FX W/O FIX PST LIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27823	OPEN TX TRIMALLEOLAR ANKLE FX W FIX PST LIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27823	OPEN TX TRIMALLEOLAR ANKLE FX W FIX PST LIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27823	OPEN TX TRIMALLEOLAR ANKLE FX W FIX PST LIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27824	PR CLOSED RX WEIGHT BEAR DIST TIBIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27824	PR CLOSED RX WEIGHT BEAR DIST TIBIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27824	PR CLOSED RX WEIGHT BEAR DIST TIBIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27825	PR CLOSED RX WEIGHT BEAR DIST TIB,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27825	PR CLOSED RX WEIGHT BEAR DIST TIB,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27825	PR CLOSED RX WEIGHT BEAR DIST TIB,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27826	OPEN TREATMENT FRACTURE DISTAL TIBIA FIBULA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27826	OPEN TREATMENT FRACTURE DISTAL TIBIA FIBULA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27826	OPEN TREATMENT FRACTURE DISTAL TIBIA FIBULA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27827	OPEN TREATMENT FRACTURE DISTAL TIBIA ONLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27827	OPEN TREATMENT FRACTURE DISTAL TIBIA ONLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27827	OPEN TREATMENT FRACTURE DISTAL TIBIA ONLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27828	OPEN TREATMENT FRACTURE DISTAL TIBIA & FIBULA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27828	OPEN TREATMENT FRACTURE DISTAL TIBIA & FIBULA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27828	OPEN TREATMENT FRACTURE DISTAL TIBIA & FIBULA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27829	OPEN TX DISTAL TIBIOFIBULAR JOINT DISRUPTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27829	OPEN TX DISTAL TIBIOFIBULAR JOINT DISRUPTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27829	OPEN TX DISTAL TIBIOFIBULAR JOINT DISRUPTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27830	PR CLOSED RX PROX TIB/FIB DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27830	PR CLOSED RX PROX TIB/FIB DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27830	PR CLOSED RX PROX TIB/FIB DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27831	PR CLOSED RX PROX TIB/FIB DISLOC +ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27831	PR CLOSED RX PROX TIB/FIB DISLOC +ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27831	PR CLOSED RX PROX TIB/FIB DISLOC +ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27832	OPEN TX PROX TIBFIB JOINT DISLOCATE EXC PROX FIB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27832	OPEN TX PROX TIBFIB JOINT DISLOCATE EXC PROX FIB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27832	OPEN TX PROX TIBFIB JOINT DISLOCATE EXC PROX FIB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27840	PR CLOSED RX ANKLE DISLOCATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27840	PR CLOSED RX ANKLE DISLOCATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
27842	PR CLOSED RX ANKLE DISLOCATN,AN ESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27846	PR OPEN RX ANKLE DISLOCATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27848	PR OPEN RX ANKLE DISLOCATN +FIXATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27860	PR MANIPULATION ANKLE JT W ANESTHESIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
27870	PR ARTHRODESIS, ANKLE,OPEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27871	PR FUSION OF TIBIOFIBULAR JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27880	PR AMPUTATION LOW LEG THRU TIB/FIB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27881	PR AMPUTATION LOW LEG+STAT FITTING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27882	PR AMPUTATION LOW LEG,CIRCULAR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27884	PR AMPUTATION LOW LEG,SECOND CLOSURE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27886	PR RE-AMPUTATION LOWER LEG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27888	PR AMPUTATION ANKLE-TIB/FIB MALLEOLI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27889	PR ANKLE DISARTICULATION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27892	PR DECOMPRESS FASCIOTOMY LEG,ANT/LAT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27893	PR DECOMPRESS FASCIOT LEG,POST ONLY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
27894	PR DECOMPRESS LEG,ANT/LAT & POST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
27899	PR LEG/ANKLE SURGERY PROC UNLISTED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
28001	PR INCIS/DRAINAGE BURSA OF FOOT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28001	PR INCIS/DRAINAGE BURSA OF FOOT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28002	PR DEEP DISSEC FOOT INFEC,1 BURSA	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28002	PR DEEP DISSEC FOOT INFEC,1 BURSA	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28003	PR DEEP DISSEC FOOT INFEC,MULTIPLE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28003	PR DEEP DISSEC FOOT INFEC,MULTIPLE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28005	PR DEEP INCIS FOOT BONE INFECTN	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28005	PR DEEP INCIS FOOT BONE INFECTN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28008	PR INCISION OF FOOT/TOE FASCIA	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28008	PR INCISION OF FOOT/TOE FASCIA	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28010	PR INCISION SUBCUT TOE TENDON	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28010	PR INCISION SUBCUT TOE TENDON	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28011	PR INCISION SUBCUT TOE TENDON,>1	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28011	PR INCISION SUBCUT TOE TENDON,>1	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28020	PR EXPLOR TARSAL/TARSO METATAR JT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28020	PR EXPLOR TARSAL/TARSO METATAR JT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28022	PR EXPLOR METATARSO-PHALANG JT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28022	PR EXPLOR METATARSO-PHALANG JT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28024	PR EXPLOR INTERPHALAN GEAL JT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28024	PR EXPLOR INTERPHALAN GEAL JT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28030	PR REMOVAL OF FOOT NERVE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28030	PR REMOVAL OF FOOT NERVE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28035	PR TARSAL TUNNEL RELEASE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28035	PR TARSAL TUNNEL RELEASE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28039	EXC FOOT/TOE TUM SC > 1.5 CM	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28039	EXC FOOT/TOE TUM SC > 1.5 CM	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28041	PR EXC TUMOR SOFT TISSUE FOOT/TOE SUBFASC 1.5 CM/>	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28041	PR EXC TUMOR SOFT TISSUE FOOT/TOE SUBFASC 1.5 CM/>	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28043	PR EXCIS FOOT TUMOR, SUBCU TANEOUS	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28043	PR EXCIS FOOT TUMOR, SUBCU TANEOUS	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28045	PR EXCIS FOOT TUMOR,DEEP	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28045	PR EXCIS FOOT TUMOR,DEEP	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28046	PR RAD RESECTION TUMOR SOFT TISSUE FOOT/TOE <3CM	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28046	PR RAD RESECTION TUMOR SOFT TISSUE FOOT/TOE <3CM	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28047	PR RAD RESECTION TUMOR SOFT TISSUE FOOT/TOE 3 CM/>	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28047	PR RAD RESECTION TUMOR SOFT TISSUE FOOT/TOE 3 CM/>	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28050	PR BX SYNOVIUM TARS/TARSOM ETA JT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28050	PR BX SYNOVIUM TARS/TARSOM ETA JT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28052	PR BX SYNOVIUM METATARSO-PHAL JT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28052	PR BX SYNOVIUM METATARSO- PHAL JT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28054	PR BX SYNOVIUM INTERPHALAN G JT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28054	PR BX SYNOVIUM INTERPHALAN G JT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28055	PR NEURECTOMY, INTRINSIC MUSCULATURE FOOT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28055	PR NEURECTOMY, INTRINSIC MUSCULATURE FOOT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28060	PR PART EXCIS PLANTAR FASCIA	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28060	PR PART EXCIS PLANTAR FASCIA	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28062	PR RAD EXCIS PLANTAR FASCIA	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28062	PR RAD EXCIS PLANTAR FASCIA	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28070	PR SYNOVECTOMY TARS/TARSOM ETA JT,EA	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28070	PR SYNOVECTOMY TARS/TARSOM ETA JT,EA	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28072	PR SYNOVECTOMY METATAR-PHAL JT,EA	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28072	PR SYNOVECTOMY METATAR-PHAL JT,EA	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28080	PR EXCIS INTERDIGITAL NEUROMA,EA	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28080	PR EXCIS INTERDIGITAL NEUROMA,EA	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28086	PR SYNOVECTOMY FLEX TENDN SHEATH,FOOT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY, PODIATRY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
28086	PR SYNOVECTOMY FLEX TENDN SHEATH,FOOT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY, PODIATRY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28088	PR SYNOVECTOMY EXTEN TENDN SHEATH,FOOT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY, PODIATRY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
28088	PR SYNOVECTOMY EXTEN TENDN SHEATH,FOOT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY, PODIATRY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
28090	PR EXCIS TENDN/CAPSUL E LESN,FOOT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY, PODIATRY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28090	PR EXCIS TENDN/CAPSUL E LESN,FOOT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY, PODIATRY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
28092	PR EXCIS TENDN/CAPSUL E LESN,TOES	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY, PODIATRY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
28092	PR EXCIS TENDN/CAPSUL E LESN,TOES	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT AN ORTHOPAEDICS, ORTHOPAEDIC SURGERY, PEDIATRIC ORTHOPAEDIC SURGERY, PODIATRY EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28100	PR REMV TALUS/HEEL BENIGN BONE LESN	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28100	PR REMV TALUS/HEEL BENIGN BONE LESN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28102	PR REMV TALUS/HEEL BENIGN LESN,AUTOGR FT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28102	PR REMV TALUS/HEEL BENIGN LESN,AUTOGR FT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28103	PR REMV TALUS/HEEL BENIGN LESN,ALLOGRF T	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28103	PR REMV TALUS/HEEL BENIGN LESN,ALLOGRF T	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28104	PR REMV TARSAL/METAT ARSAL BENIGN BONE LESN	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28104	PR REMV TARSAL/METAT ARSAL BENIGN BONE LESN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28106	PR REMV OTHR FOOT BENIGN LESN,AUTOGR FT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28106	PR REMV OTHR FOOT BENIGN LESN,AUTOGR FT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28107	PR REMV OTHR FOOT BENIGN LESN,ALLOGRF T	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28107	PR REMV OTHR FOOT BENIGN LESN,ALLOGRF T	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28108	PR REMV TOE BENIGN BONE LESN	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28108	PR REMV TOE BENIGN BONE LESN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28110	PR PART EXCIS 5TH METATARSAL HEAD	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Bunionectomy): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Bunionectomy.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28110	PR PART EXCIS 5TH METATARSAL HEAD	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST	MD GUIDELINE 1 (Bunionectomy): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Bunionectomy.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28111	PR FULL EXCIS 1ST METATARSAL HEAD	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28111	PR FULL EXCIS 1ST METATARSAL HEAD	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28112	PR FULL EXCIS 2,3 OR 4TH METATAR HEAD	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28112	PR FULL EXCIS 2,3 OR 4TH METATAR HEAD	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28113	PR FULL EXCIS 5TH METATARSAL HEAD	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28113	PR FULL EXCIS 5TH METATARSAL HEAD	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28114	PR FULL EXCIS 2 - 5 METATARSAL HEADS	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28114	PR FULL EXCIS 2 - 5 METATARSAL HEADS	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28116	PR EXCIS TARSAL COALITION	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28116	PR EXCIS TARSAL COALITION	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28118	PR REMOVAL OF HEEL BONE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28118	PR REMOVAL OF HEEL BONE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28119	PR REMOVAL OF HEEL SPUR	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28119	PR REMOVAL OF HEEL SPUR	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28120	PR PART REMV TALUS OR CALCANEUS	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28120	PR PART REMV TALUS OR CALCANEUS	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28122	PR PART REMV OTHR TARSAL/METAT ARSAL	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28122	PR PART REMV OTHR TARSAL/METAT ARSAL	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28124	PR PART REMV PHALANX OF TOE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28124	PR PART REMV PHALANX OF TOE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28126	PR RESEC ONE TOE PHALANGEAL BASE,EA	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28126	PR RESEC ONE TOE PHALANGEAL BASE,EA	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28130	PR REMOVAL OF TALUS	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28130	PR REMOVAL OF TALUS	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28140	PR REMOVAL OF METATARSAL	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28140	PR REMOVAL OF METATARSAL	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28150	PR REMOVAL OF SINGLE TOE,EACH	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28150	PR REMOVAL OF SINGLE TOE,EACH	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28153	PR RESEC HEAD OF PHALANX,TOE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28153	PR RESEC HEAD OF PHALANX,TOE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28160	PR RESEC TOE AT I-P JT,SINGLE,EA	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28160	PR RESEC TOE AT I-P JT,SINGLE,EA	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28171	PR RAD RESEC OTHR TARSAL BONE TUMOR	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28171	PR RAD RESEC OTHR TARSAL BONE TUMOR	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28173	PR RAD RESEC METATARSAL	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28173	PR RAD RESEC METATARSAL	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28175	PR RAD RESEC PHALANX,TOE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28175	PR RAD RESEC PHALANX,TOE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28190	PR REMV FOOT FOREIGN BODY,SUBCUT ANEOUS	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28190	PR REMV FOOT FOREIGN BODY,SUBCUT ANEOUS	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28192	PR REMV FOOT FOREIGN BODY,DEEP	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28192	PR REMV FOOT FOREIGN BODY,DEEP	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28193	PR REMV FOOT FOREIGN BODY,COMPLE X	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28193	PR REMV FOOT FOREIGN BODY,COMPLE X	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28200	PR REPAIR FLEX FOOT TENDON,EA	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28200	PR REPAIR FLEX FOOT TENDON,EA	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28202	PR REPAIR/GRAFT FLEX FOOT TENDON	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28202	PR REPAIR/GRAFT FLEX FOOT TENDON	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28208	PR REPAIR EXTEN LEG TENDON, PRIM, EA	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28208	PR REPAIR EXTEN LEG TENDON, PRIM, EA	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28210	PR REPAIR/GRAFT EXTEN FOOT TENDON	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28210	PR REPAIR/GRAFT EXTEN FOOT TENDON	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28220	PR RELEASE FLEX FOOT TENDON,SINGLE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28220	PR RELEASE FLEX FOOT TENDON,SINGLE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28222	PR RELEASE FLEX FOOT TENDON,MULTIPLE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28222	PR RELEASE FLEX FOOT TENDON,MULTIPLE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28225	PR RELEASE EXTEN FOOT TENDON,SINGLE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28225	PR RELEASE EXTEN FOOT TENDON,SINGLE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28226	PR RELEASE EXTEN FOOT TENDONS,MULTIPL	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28226	PR RELEASE EXTEN FOOT TENDONS,MULTIPL	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28230	PR INCISION FLEX FOOT TENDON(S)	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28230	PR INCISION FLEX FOOT TENDON(S)	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28232	PR INCISION FLEX TOE TENDON	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28232	PR INCISION FLEX TOE TENDON	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28234	PR INCISION EXTEN FOOT/TOE TENDON	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28234	PR INCISION EXTEN FOOT/TOE TENDON	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28238	PR RECONST POST TIB TEND,EXCIS ACC TAR NAV	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28238	PR RECONST POST TIB TEND,EXCIS ACC TAR NAV	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28240	PR RELEASE OF BIG TOE TENDN	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Bunionectomy): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Bunionectomy.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28240	PR RELEASE OF BIG TOE TENDN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST	MD GUIDELINE 1 (Bunionectomy): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Bunionectomy.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28250	PR DIVISN PLANTAR FASCIA/MUSCLE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28250	PR DIVISN PLANTAR FASCIA/MUSCLE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28260	PR CAPSULOTOMY MIDFOOT JT,MED RELEASE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28260	PR CAPSULOTOMY MIDFOOT JT,MED RELEASE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28261	PR CAPSULOTOMY MIDFOOT, TENDON LENGTH	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28261	PR CAPSULOTOMY MIDFOOT,TEND N LENGTH	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28262	PR CAPSULOTOMY MIDFOOT,EXTE NSIVE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28262	PR CAPSULOTOMY MIDFOOT,EXTE NSIVE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28264	PR CAPSULOTOMY MIDTARSAL	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28264	PR CAPSULOTOMY MIDTARSAL	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28270	PR CAPSULOTOMY MT-P JT,FOOT,EACH	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28270	PR CAPSULOTOMY MT-P JT,FOOT,EACH	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28272	PR CAPSULOTOMY I-P JT,FOOT,EA	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28272	PR CAPSULOTOMY I-P JT,FOOT,EA	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28280	PR FUSION OF TOES	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28280	PR FUSION OF TOES	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28285	PR REPAIR OF HAMMERTOE, ONE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28285	PR REPAIR OF HAMMERTOE, ONE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28286	PR REPAIR 5TH TOE,COCK-UP	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28286	PR REPAIR 5TH TOE,COCK-UP	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28288	PR PART REMV BONE METATARSAL HEAD,EA	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28288	PR PART REMV BONE METATARSAL HEAD,EA	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28289	PR HALLUX RIGIDUS W/CHEILECTO MY 1ST MP JT W/O IMPLT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST	MD GUIDELINE 1 (Bunionectomy): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Bunionectomy.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28289	PR HALLUX RIGIDUS W/CHEILECTOMY 1ST MP JT W/O IMPLT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (Bunionectomy): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Bunionectomy.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28290	PR CORRECT BUNION,SIMPLE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28290	PR CORRECT BUNION,SIMPLE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28291	PR HALLUX RIGIDUS W/CHEILECTOMY 1ST MP JT W/IMPLT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST	MD GUIDELINE 1 (Bunionectomy): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Bunionectomy.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28291	PR HALLUX RIGIDUS W/CHEILECTOMY 1ST MP JT W/IMPLT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Bunionectomy): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Bunionectomy.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28292	PR CORRECTION OF BUNION	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Bunionectomy): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Bunionectomy.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28292	PR CORRECTION OF BUNION	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST	MD GUIDELINE 1 (Bunionectomy): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Bunionectomy.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28293	PR CORRECT BUNION,RESEC JT+IMPLNT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28293	PR CORRECT BUNION, RESEC JT+IMPLNT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28294	PR CORRECT BUNION, TENDN XPLANTS	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28294	PR CORRECT BUNION, TENDN XPLANTS	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28295	PR CORRECTION OF BUNION WITH ALIGNMENT CORRECTION OF MIDFOOT BONE TOWARD ANKLE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST	MD GUIDELINE 1 (Bunionectomy): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Bunionectomy.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28295	PR CORRECTION OF BUNION WITH ALIGNMENT CORRECTION OF MIDFOOT BONE TOWARD ANKLE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Bunionectomy): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Bunionectomy.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28296	PR CORRECTION OF BUNION WITH FOREFOOT AND MIDFOOT BONE FUSION	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Bunionectomy): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Bunionectomy.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28296	PR CORRECTION OF BUNION WITH FOREFOOT AND MIDFOOT BONE FUSION	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST	MD GUIDELINE 1 (Bunionectomy): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Bunionectomy.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28297	PR CORRJ HALLUX VALGUS W/SESMD W/1METAR MEDIAL CNF	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28297	PR CORRJ HALLUX VALGUS W/SESMDC W/1METAR MEDIAL CNF	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28298	PR CORRECTION OF BUNION WITH ALIGNMENT CORRECTION OF BIG TOE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28298	PR CORRECTION OF BUNION WITH ALIGNMENT CORRECTION OF BIG TOE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28299	PR CORRECTION OF BUNION WITH 2 AREAS OF REALIGNMENT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28299	PR CORRECTION OF BUNION WITH 2 AREAS OF REALIGNMENT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28300	PR OSTEOTOMY HEEL BONE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28300	PR OSTEOTOMY HEEL BONE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28302	PR OSTEOTOMY TALUS	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28302	PR OSTEOTOMY TALUS	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28304	PR OSTEOTOMY MIDTARSAL BONES	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28304	PR OSTEOTOMY MIDTARSAL BONES	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28305	PR OSTEOTOMY MIDTARSAL,AU TOGRAFT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28305	PR OSTEOTOMY MIDTARSAL,AU TOGRAFT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28306	PR OSTEOTOMY 1ST METATARSAL,B ASE/SHAFT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28306	PR OSTEOTOMY 1ST METATARSAL,B ASE/SHAFT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28307	PR OSTEOTOMY 1ST METATARSAL,A UTOGRAFT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28307	PR OSTEOTOMY 1ST METATARSAL,A UTOGRAFT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28308	PR OSTEOTOMY METATARSAL (NOT 1ST)	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28308	PR OSTEOTOMY METATARSAL (NOT 1ST)	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28309	PR OSTEOTOMY METATARSALS, MULTIPLE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28309	PR OSTEOTOMY METATARSALS, MULTIPLE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28310	PR OSTEOTOMY PROX PHALANX,1ST TOE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28310	PR OSTEOTOMY PROX PHALANX,1ST TOE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28312	PR OSTEOTOMY,A NY PHALANX,ANY TOE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28312	PR OSTEOTOMY,A NY PHALANX,ANY TOE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28313	PR RECONSTRUC TOE DEFORM,SOFT TISSUE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28313	PR RECONSTRUC TOE DEFORM,SOFT TISSUE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28315	PR REMOV SESAMOID BONE,1ST TOE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28315	PR REMOV SESAMOID BONE,1ST TOE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28320	PR REPAIR NON/MALUNION TARSAL BONE(S)	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28320	PR REPAIR NON/MALUNION TARSAL BONE(S)	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28322	PR REPAIR NON/MALUNION METATARSAL	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28322	PR REPAIR NON/MALUNION METATARSAL	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28340	PR RESECT ENLARGED TOE TISSUE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28340	PR RESECT ENLARGED TOE TISSUE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28341	PR RESECT ENLARGED TOE TISSUE/BONE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28341	PR RESECT ENLARGED TOE TISSUE/BONE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28344	PR REPAIR EXTRA TOE(S)	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28344	PR REPAIR EXTRA TOE(S)	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28345	PR REPAIR WEBBED TOE (S)	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28345	PR REPAIR WEBBED TOE (S)	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28360	PR RECONSTRUCT CLEFT FOOT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28360	PR RECONSTRUCT CLEFT FOOT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28400	PR CLOSED RX HEEL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28400	PR CLOSED RX HEEL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28405	PR CLOSED RX HEEL FX,MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28405	PR CLOSED RX HEEL FX,MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28406	PR PERCUT RX HEEL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28406	PR PERCUT RX HEEL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28415	OPEN TREATMENT CALCANEAL FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28415	OPEN TREATMENT CALCANEAL FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28415	OPEN TREATMENT CALCANEAL FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28420	OPEN TREATMENT CALCANEAL FRACTURE W BONE GRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28420	OPEN TREATMENT CALCANEAL FRACTURE W BONE GRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28420	OPEN TREATMENT CALCANEAL FRACTURE W BONE GRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28430	PR CLOSED RX TALUS FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28430	PR CLOSED RX TALUS FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28430	PR CLOSED RX TALUS FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28435	PR CLOSED RX TALUS FX,MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28435	PR CLOSED RX TALUS FX,MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28435	PR CLOSED RX TALUS FX,MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28436	PR PERCUT RX TALUS FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28436	PR PERCUT RX TALUS FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28436	PR PERCUT RX TALUS FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28445	OPEN TREATMENT TALUS FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28445	OPEN TREATMENT TALUS FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28445	OPEN TREATMENT TALUS FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28446	PR OPEN OSTEOCHOND RAL AUTOGRAFT TALUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28446	PR OPEN OSTEOCHOND RAL AUTOGRAFT TALUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28446	PR OPEN OSTEOCHOND RAL AUTOGRAFT TALUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28450	PR CLOSED RX TARSAL FX,EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28450	PR CLOSED RX TARSAL FX,EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28450	PR CLOSED RX TARSAL FX,EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28455	PR CLOSED RX TARSAL FX,MANIP,EAC H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28455	PR CLOSED RX TARSAL FX,MANIP,EAC H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28455	PR CLOSED RX TARSAL FX,MANIP,EAC H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28456	PR PERCUT RX TARSAL FX,EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28456	PR PERCUT RX TARSAL FX,EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28456	PR PERCUT RX TARSAL FX,EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28465	OPEN TX TARSAL FRACTURE XCP TALUS &CALCANEUS EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28465	OPEN TX TARSAL FRACTURE XCP TALUS &CALCANEUS EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28465	OPEN TX TARSAL FRACTURE XCP TALUS &CALCANEUS EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28470	PR CLOSED RX METATARSAL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28470	PR CLOSED RX METATARSAL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28470	PR CLOSED RX METATARSAL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28475	PR CLOSED RX METATARSAL FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28475	PR CLOSED RX METATARSAL FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28475	PR CLOSED RX METATARSAL FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28476	PR PERCUT RX METATARSAL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28476	PR PERCUT RX METATARSAL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28476	PR PERCUT RX METATARSAL FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28485	OPEN TREATMENT METATARSAL FRACTURE EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28485	OPEN TREATMENT METATARSAL FRACTURE EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28485	OPEN TREATMENT METATARSAL FRACTURE EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28490	PR CLOSED RX BIG TOE FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28490	PR CLOSED RX BIG TOE FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28495	PR CLOSED RX BIG TOE FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28495	PR CLOSED RX BIG TOE FX,MANIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28496	PR PERCUT BIG TOE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28496	PR PERCUT BIG TOE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28505	OPEN TX FRACTURE GREAT TOE/PHALANX/ PHALANGES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28505	OPEN TX FRACTURE GREAT TOE/PHALANX/ PHALANGES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28505	OPEN TX FRACTURE GREAT TOE/PHALANX/ PHALANGES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28510	PR CLOSED RX TOE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28510	PR CLOSED RX TOE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28510	PR CLOSED RX TOE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28515	PR CLOSED RX TOE FX,MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28515	PR CLOSED RX TOE FX,MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28515	PR CLOSED RX TOE FX,MANIPULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28525	OPEN TX FRACTURE PHALANX/PHALANGES NOT GREAT TOE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28525	OPEN TX FRACTURE PHALANX/PHALANGES NOT GREAT TOE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28525	OPEN TX FRACTURE PHALANX/PHALANGES NOT GREAT TOE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28530	PR CLOSED RX SESAMOID BONE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28530	PR CLOSED RX SESAMOID BONE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28530	PR CLOSED RX SESAMOID BONE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28531	PR OPEN RX SESAMOID BONE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28531	PR OPEN RX SESAMOID BONE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28531	PR OPEN RX SESAMOID BONE FX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28540	PR CLOSED RX TARSAL DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28540	PR CLOSED RX TARSAL DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28540	PR CLOSED RX TARSAL DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28545	PR CLOSED RX TARSAL DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28545	PR CLOSED RX TARSAL DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28545	PR CLOSED RX TARSAL DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28546	PR PERCUT RX TARSAL DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28546	PR PERCUT RX TARSAL DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28546	PR PERCUT RX TARSAL DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28555	OPEN TREATMENT TARSAL BONE DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28555	OPEN TREATMENT TARSAL BONE DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28555	OPEN TREATMENT TARSAL BONE DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28570	PR CLOSED RX TALOTARSAL DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28570	PR CLOSED RX TALOTARSAL DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28570	PR CLOSED RX TALOTARSAL DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28575	PR CLOSED RX TALOTARSAL DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28575	PR CLOSED RX TALOTARSAL DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28575	PR CLOSED RX TALOTARSAL DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28576	PR PERCUT RX TALOTARSAL DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28576	PR PERCUT RX TALOTARSAL DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28585	OPEN TREATMENT TALOTARSAL JOINT DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28585	OPEN TREATMENT TALOTARSAL JOINT DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28600	PR CLOSED RX TAR-METATAR DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28605	PR CLOSED RX TAR-METATAR DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28606	PR PERCUT RX TAR-METATAR FOOT DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28615	OPEN TREATMENT TARSOMETATA RSAL JOINT DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28615	OPEN TREATMENT TARSOMETATA RSAL JOINT DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28630	PR CLOSED RX MT-PHAL TOE DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28630	PR CLOSED RX MT-PHAL TOE DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28635	PR CLOSED RX MT-PHAL TOE DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28635	PR CLOSED RX MT-PHAL TOE DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28636	PR PERCUT RX MT-PHAL TOE DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28636	PR PERCUT RX MT-PHAL TOE DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28645	OPEN TX METATARSOPH ALANGEAL JOINT DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28645	OPEN TX METATARSOPH ALANGEAL JOINT DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28660	PR CLOSED RX I-P JT,TOE DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28660	PR CLOSED RX I-P JT,TOE DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28665	PR CLOSED RX I-P JT,TOE DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28665	PR CLOSED RX I-P JT,TOE DISLOC,ANEST H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28666	PR PERCUT RX I-P JT,TOE DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28666	PR PERCUT RX I-P JT,TOE DISLOC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28675	OPEN TREATMENT INTERPHALAN GEAL JOINT DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28675	OPEN TREATMENT INTERPHALAN GEAL JOINT DISLOCATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
28705	PR FUSION FOOT BONES,PANTAL AR	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28705	PR FUSION FOOT BONES,PANTAL AR	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28715	PR FUSION FOOT BONES,TRIPLE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28715	PR FUSION FOOT BONES,TRIPLE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28725	PR FUSION FOOT BONES,SUBTAL AR	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28725	PR FUSION FOOT BONES,SUBTAL AR	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28730	PR FUSION FOOT BONES,MIDTAR SAL,MULTI	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28730	PR FUSION FOOT BONES,MIDTAR SAL,MULTI	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28735	PR FUSION FOOT BONES,MIDTAR SAL,OSTEOTM Y	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28735	PR FUSION FOOT BONES,MIDTAR SAL,OSTEOTM Y	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28737	PR FUSION W/TEND ADV,MIDTAR NAV-CUNEIFORM	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28737	PR FUSION W/TEND ADV,MIDTAR NAV-CUNEIFORM	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28740	PR FUSION FOOT BONE,MIDTARS AL,1 JT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28740	PR FUSION FOOT BONE,MIDTARS AL,1 JT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28750	PR FUSION BIG TOE,MT-P JT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28750	PR FUSION BIG TOE,MT-P JT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28755	PR FUSION BIG TOE,I-P JOINT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28755	PR FUSION BIG TOE,I-P JOINT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28760	PR FUSION BIG TOE,I-P JT +TENDN XFER	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28760	PR FUSION BIG TOE,I-P JT +TENDN XFER	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28800	PR AMPUTATION FOOT,MIDTARS AL-CHOPART	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28800	PR AMPUTATION FOOT,MIDTARS AL-CHOPART	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28805	PR AMPUTATION FOOT,TRANSM ETATARSAL	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28805	PR AMPUTATION FOOT, TRANSM ETATARSAL	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28810	PR AMPUTATION METATARSAL +TOE, SINGLE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28810	PR AMPUTATION METATARSAL +TOE, SINGLE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28820	PR AMPUTATION TOE, MT-P JT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28820	PR AMPUTATION TOE,MT-P JT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28825	PR AMPUTATION TOE,I-P JT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28825	PR AMPUTATION TOE,I-P JT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28890	PR ESWT HI NRG PHYS/QHP W/US GDN INVG PLNTAR FASCIA	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28890	PR ESWT HI NRG PHYS/QHP W/US GDN INVG PLNTAR FASCIA	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
28899	PR FOOT/TOES SURGERY PROC UNLISTED	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
28899	PR FOOT/TOES SURGERY PROC UNLISTED	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29000	PR APPLY BODY CAST,HALO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29010	PR APPLY BODY CAST,RISSER JACKET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29015	PR APPLY BODY CAST,RISSER +HEAD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29020	PR APPLY BODY CAST,TURNBU CKLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29025	PR APPLY BODY CAST,TURNBU C+HEAD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29035	PR APPLY BODY CAST,SHLDR- HIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
29040	PR APPLY BODY CAST,SHLDR-HIP+HEAD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29044	PR APPLY BODY CAST,SHLDR-HIP+1 THIGH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29046	PR APPLY BODY CAST,SHLDR-HIP+2 THIGHS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29049	PR APPLY CAST,FIGURE-OF-EIGHT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29055	PR APPLY SHOULDER CAST,SPICA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29058	PR APPLY SHOULDER CAST,PLASTR VELPEAU	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29065	PR APPLY LONG ARM CAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29075	PR APPLY FOREARM CAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29085	PR APPLY HAND/WRIST CAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29086	PR APPLY CAST,FINGER (CONTRACTUR E)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
29105	PR APPLY LONG ARM SPLINT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29125	PR APPLY FOREARM SPLINT,STATIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29126	PR APPLY FOREARM SPLINT,DYNAMI C	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29130	PR APPLY FINGER SPLINT,STATIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29131	PR APPLY FINGER SPLINT,DYNAMI C	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29200	PR STRAPPING OF CHEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29220	PR STRAPPING OF LOW BACK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29240	PR STRAPPING OF SHOULDER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29260	PR STRAPPING OF ELBOW OR WRIST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29280	PR STRAPPING OF HAND OR FINGER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
29305	PR APPLY OF HIP CAST,ONE LEG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29325	PR APPLY OF HIP CASTS,TWO LEGS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29345	PR APPLY LONG LEG CAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29355	PR APPLY LONG LEG CAST,WALKER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29358	PR APPLY LONG LEG CAST BRACE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29365	PR APPLY LONG LEG CAST,CYLINDER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29405	PR APPLY SHORT LEG CAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29425	PR APPLY SHORT LEG CAST,WALKER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29435	PR APPLY PATELLA TENDON BEARING CAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29440	PR ADDITION OF WALKER TO CAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
29445	PR APPLY RIGID LEG CAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29450	PR APPLY OF CLUBFOOT CAST	NO AUTHORIZATION REQUIRED	<p>DIAGNOSIS CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: M21.541, M21.542, M21.549, Q66.00, Q66.01, Q66.02, Q66.10, Q66.11, Q66.11, Q66.211, Q66.212, Q66.219, Q66.221, Q66.222, Q66.229, Q66.30, Q66.31, Q66.32, Q66.40, Q66.41, Q66.42, Q66.51, Q66.52, Q66.6, Q66.70, Q66.71, Q66.72 Q66.81, Q66.82, Q66.89, Q66.90, Q66.91, Q66.92</p> <p>PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
29450	PR APPLY OF CLUBFOOT CAST	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: M21.541, M21.542, M21.549, Q66.00, Q66.01, Q66.02, Q66.10, Q66.11, Q66.11, Q66.211, Q66.212, Q66.219, Q66.221, Q66.222, Q66.229, Q66.30, Q66.31, Q66.32, Q66.40, Q66.41, Q66.42, Q66.51, Q66.52, Q66.6, Q66.70, Q66.71, Q66.72, Q66.81, Q66.82, Q66.89, Q66.90, Q66.91, Q66.92 PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF NOT PERFORMED IN OFFICE SETTING (11). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29505	PR APPLY LONG LEG SPLINT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29515	PR APPLY LOWER LEG SPLINT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29520	PR STRAPPING OF HIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29530	PR STRAPPING OF KNEE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
29540	PR STRAPPING; ANKLE &/OR FOOT	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN AMBULATORY SURGICAL CENTER SETTING WHEN MEMBER IS 3 YEARS OF AGE AND YOUNGER (24). AGE: NO AUTH REQUIRED IF 3 YEARS OF AGE OR YOUNGER.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29540	PR STRAPPING; ANKLE &/OR FOOT	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED. IF INPATIENT HOSPITAL SETTING AND/OR MEMBER IS OLDER THAN 3 YEARS (21). AGE: PRIOR AUTH IS REQUIRED IF OLDER THAN 3 YEARS. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29550	PR STRAPPING OF TOES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29580	PR APPLY OF PASTE BOOT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29581	PR APPL MLTLAYR COMPRES LEG BELOW KNEE W/ANKLE FOOT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
29582	PR APPL MLTLAYR COMPRES THGH LEG ANKLE FT WHEN DONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29583	PR APPL MLTLAYR COMPRES SYSTEM UPPER & LOWER ARM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29584	PR APPL MLTLAYR COMPRES SYS UPARM LWARM HAND&FINGER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29700	PR REMV/REVISN BOOT/BODY CAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29705	PR REMV/REVISN FULL ARM/LEG CAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29710	PR REMV/REVISN SHLDR/HIP SPICA CAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29715	PR REMV/REVISN TURNBUCKLE JACKET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29720	PR REPAIR SPICA/BODY/JACKET CAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29730	PR WINDOWING OF CAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
29740	PR WEDGING OF CAST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29750	PR WEDGING OF CLUBFOOT CAST	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF INPATIENT HOSPITAL AND MEMBER IS 3 YEARS OF AGE AND YOUNGER (21). AGE: NO AUTH REQUIRED FOR 3 YEARS OF AGE OR YOUNGER.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29750	PR WEDGING OF CLUBFOOT CAST	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED. IF NOT INPATIENT HOSPITAL AND/OR MEMBER IS OLDER THAN 3 YEARS (21). AGE: PRIOR AUTH IS REQUIRED IF OLDER THAN 3 YEARS. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29799	PR CAST/STRAP PROCEDURE UNLISTED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29805	PR SHLDR ARTHROSCOP, DIAGNOSTIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29806	PR SHLDR ARTHROSCOP, SURG,CAPSUL ORRHAPHY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
29807	PR SHLDR ARTHROSCOP, SURG,REPAIR, SLAP LESION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29819	PR SHLDR ARTHROSCOP, SURG,W/REMOVAL,LOOSE/FB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29820	PR SHLDR ARTHROSCOP, PART SYNOVECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29821	PR SHLDR ARTHROSCOP, FULL SYNOVECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29822	PR SURGICAL ARTHROSCOPY SHOULDER LMTD DBRDMT 1/2	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29823	PR SURGICAL ARTHROSCOPY SHOULDER XTNSV DBRDMT 3+	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29824	PR SHLDR ARTHROSCOP, SURG,DIS CLAVICULECTOMY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29825	PR SHLDR ARTHROSCOP, LYSE ADHESNS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29826	PR SHOULDER SCOPE BONE SHAVING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
29827	PR SHLDR ARTHROSCOP, SURG,W/ROTA T CUFF REPR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29828	PR ARTHROSCOPY SHOULDER SURGICAL BICEPS TENODESIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29830	PR ELBOW ARTHROSCOP, DIAGNOSTIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29834	PR ELBOW ARTHROSCOP, REMV LOOSE BODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29835	PR ELBOW ARTHROSCOP, PART SYNOVECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29836	PR ELBOW ARTHROSCOP, FULL SYNOVECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29837	PR ELBOW ARTHROSCOP, PART DEBRIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29838	PR ELBOW ARTHROSCOP, EXTEN DEBRIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29840	PR WRIST ARTHROSCOP, DIAGNOSTIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29843	PR WRIST ARTHROSCOP, CLEAN/DRAIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
29844	PR WRIST ARTHROSCOP, PART SYNOVECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29845	PR WRIST ARTHROSCOP, FULL SYNOVECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29846	PR WRIST ARTHROSCOP, EXCIS TRIANG CART	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29847	PR WRIST ARTHROSCOP, I NTERN FIXATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29848	PR WRIST ARTHROSCOP, RELEASE XVERS LIG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29850	PR KNEE SCOPE/SURG/I NTERCOND FX AID	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29851	PR KNEE SCOPE/SURG/I NCOND FX AID +FIXAT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29855	PR TIBIAL SCOPE/SURG/F X AID, UNICONDY LR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29856	PR TIBIAL SCOPE/SURG/F X AID, BICONDYLAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29860	PR HIP ARTHROSCOPY, DX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
29861	PR HIP SCOPE/REMOV LOOSE/FOREIGN BODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29862	PR HIP SCOPE/REMOV BODY, PLASTY/ RESECTN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29863	PR HIP SCOPE/REMOV BODY, SYNOVECTOMY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29866	PR KNEE SCOPE, AUTOGRAFT IMPANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29867	PR KNEE SCOPE, ALLOGRAFT IMPANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29868	PR KNEE SCOPE, MENISC TRANSPLANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29870	PR KNEE SCOPE, DIAGNOSTIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29871	PR KNEE SCOPE, CLEAN/ DRAIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29873	PR KNEE SCOPE, W/LATERAL RELEASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29874	PR KNEE SCOPE, REMOV LOOSE BODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
29875	PR KNEE SCOPE,PART SYNOVECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29876	PR KNEE SCOPE,FULL SYNOVECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29877	PR KNEE SCOPE,SHAVE ARTICULAR CART	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29879	PR KNEE SCOPE,ABRASION ARTHROPLASTY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29880	PR ARTHRS KNEE W/MENISCECTOMY MED&LAT W/SHAVING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29881	PR ARTHRS KNE SURG W/MENISCECTOMY MED/LAT W/SHVG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29882	PR KNEE SCOPE,MED OR LAT MENIS REPAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29883	PR KNEE SCOPE,MED +LAT MENIS REPAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29884	PR KNEE SCOPE,LYSIS OF ADHESNS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
29885	PR KNEE SCOPE,DRILL OSTE DISSEC +GRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29886	PR KNEE SCOPE,DRILL OSTEIT DISSEC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29887	PR KNEE SCOPE,DRILL OSTE DISS+INT FIX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29888	PR KNEE SCOPE,AID ANT CRUCIATE REPAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29889	PR KNEE SCOPE,AID POST CRUC REPAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
29891	PR ANKLE SCOPE,EXCIS OSTEOCHON DEFCT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29892	PR ANKLE SCOPE,AID REPAIR FX,BONE DEFCT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29893	PR ANKLE SCOPE,PLANTA R FASCIOTOMY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29894	PR ANKLE SCOPE,REMLV LOOSE BODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29895	PR ANKLE SCOPE,PART SYNOVECTOMY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
29897	PR ANKLE SCOPE,PART DEBRIDEMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29898	PR ANKLE SCOPE,EXTENS DEBRIDEMNT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29899	PR ANKLE SCOPE,W/ANKLE ARTHRODESIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29900	PR ARTHROS MCP JNT,DIAG,W/SY NOVIAL BX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29901	PR ARTHROS MCP JNT,SURG,W/D EBRIDEMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29902	PR ARTHROS MCP JNT,SURG,W/R EDUCION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29904	PR ARTHROSCOPY SUBTALAR JOINT REMOVE LOOSE/FOREIGN BODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29905	PR ARTHROSCOPY SUBTALAR JOINT WITH SYNOVECTOMY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29906	PR ARTHROSCOPY SUBTALAR JOINT WITH DEBRIDEMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
29907	PR ARTHROSCOPY SUBTALAR JOINT SUBTALAR ARTHRODESIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29914	PR ARTHROSCOPY HIP W/FEMOROPLASTY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29915	PR ARTHROSCOPY HIP W/ACETABULOPLASTY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29916	PR ARTHROSCOPY HIP W/LABRAL REPAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
29999	PR UNLISTED PROC, ARTHROSCOPY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
30100	PR INTRANASAL BIOPSY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
30120	PR EXCISION SKIN OF NOSE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
30130	PR EXCISION TURBINATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
30140	PR EXCISION TURBINATE, SUBMUCOUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
30300	PR REMOVE NASAL FOREIGN BODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
30310	PR REMV NASAL FOR BODY,GEN ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
30320	PR REMV NASAL FOR BODY,LAT RHINOTOMY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
30400	PR RECONSTR NOSE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
30410	PR RECONSTR NOSE,COMPLETE+EXTERNAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
30420	PR RECONSTR NOSE+MAJ SEPTAL REPAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
30430	PR REVIS NOSE,SECONDARY,MINOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
30435	PR REVIS NOSE,SECONDARY,INTERMEDIATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
30450	PR REVIS NOSE,SECONDARY,MAJOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
30460	PR REVIS NOSE/CLEFT LIP/TIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
30462	PR REVIS NOSE/CLEFT LIP/TIP, SEPTUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
30468	PR RPR NSL VLV COLLAPSE SUBQ/SBMCSL LAT WALL IMPLT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
30469	PR REPAIR OF NASAL VALVE COLLAPSE WITH LOW ENERGY, TEMPERATURE-CONTROLLED (IE, RADIOFREQUENCY) SUBCUTANEOUS/SUBMUCOSAL REMODELING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
30520	PR REPAIR OF NASAL SEPTUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
30520	PR REPAIR OF NASAL SEPTUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
30580	PR REPAIR ORO-MAXILLARY FISTULA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
30620	PR INTRANASAL RECONSTRUCTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
3072F	LOW RISK FOR RETINOPATHY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
30801	PR CAUTER TURBINATE MUCOSA,SUPERFICIAL	<p>NO AUTHORIZATION REQUIRED</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
30802	PR CAUTER TURBINATE MUCOSA,INTRA MURAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
30901	PR CTRL NOSEBLEED,ANTER, SIMPLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
30903	PR CTRL NOSEBLEED,ANTER, COMPLETE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
30905	PR CTRL NOSEBLEED,POST, W/PACKS &/OR CAUT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
30906	PR REPEAT CONTROL OF NOSEBLEED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
30930	PR THERAPUTIC FRACTURE INFER TURBINATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
30930	PR THERAPUTIC FRACTURE INFER TURBINATE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
31030	PR EXPLOR MAXILL SINUS,RADICAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
31200	PR REMOV ETHMOID SINUS,INTRANA SAL,ANT	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
31231	PR NASAL ENDOSCOPY,D X	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
31233	PR NASAL/SINUS ENDOSCOPY DX MAXILLARY SINUSOSCOPY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31235	PR NASAL/SINUS ENDOSCOPY DX SPHENOID SINUSOSCOPY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31237	PR NASAL SCOPE,BX/RMV POLYP/DEBRID	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31238	PR NASAL/SINUS SCOPY,W/CONTROL NASAL HEM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31239	PR NASAL/SINUS SCOPY,SURG TEAR DUCT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31240	PR NASAL/SINUS SCOPY,RMV CONCHA BULL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31241	PR NASAL/SINUS NDSC W/LIG SPHENOPALATINE ARTERY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31242	DESTRUCTION OF NASAL NERVE BY HEAT USING AN ENDOSCOPE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
31243	DESTRUCTION OF NASAL NERVE BY FREEZING USING AN ENDOSCOPE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31253	PR NASAL/SINUS NDSC TOT W/FRNT SINS EXPL TISS RMVL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31254	PR NASAL/SINUS NDSC W/PARTIAL ETHMOIDECTOMY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31255	PR NASAL/SINUS NDSC W/TOTAL ETHOIDECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31256	PR NASAL SCOPY, OPEN MAXILL SINUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31257	PR NASAL/SINUS NDSC TOTAL WITH SPHENOIDOTOMY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31259	PR NASAL/SINUS NDSC TOT W/SPHENDT W/SPHEN TISS RMVL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31267	PR NASAL SCOPY, RMV TISS MAXILL SINUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
31276	PR NASAL/SINUS NDSC W/RMVL TISS FROM FRONTAL SINUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31287	PR NASAL SCOPY, SPHENOIDOTOMY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31288	PR NASAL SCOPY, REMV TISS SPHENOID	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31290	PR NASAL SCOPY, REPAIR CSF LEAK, ETHMOID	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31291	PR NASAL SCOPY, REPR CSF LEAK, SPHENOID	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31292	PR NASAL/SINUS NDSC SURG MEDIAL/INF ORB WALL DCMPRN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31293	PR NASAL/SINUS NDSC SURG MEDIAL&INF ORB WALL DCMPRN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31294	PR NASAL/SINUS NDSC SURG W/OPTIC NERVE DCMPRN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
31295	PR NASAL/SINUS NDSC SURG W/DILATION MAXILLARY SINUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31296	PR NASAL/SINUS NDSC SURG W/DILATION FRONTAL SINUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31297	PR NASAL/SINUS NDSC SURG W/DILATION SPHENOID SINUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31298	PR NASAL/SINUS NDSC SURG W/DILATION FRNT&SPHN SINUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
31505	PR LARYNGOSCOPI, INDIRECT,DX	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31510	PR LARYNGOSCOPI, INDIRECT WITH BIOPSY	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
31511	PR LARYNGOSCOPY, INDIRECT +REMOV FOR.BODY	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31511	PR LARYNGOSCOPY, INDIRECT +REMOV FOR.BODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31512	PR LARYNGOSCOPY, INDIRECT +REMOV LESN	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31513	PR LARYNGOSCOPY, INDIRECT +INJECT CORD	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31515	PR LARYNGOSCOPY, DIRECT FOR ASPIRATION	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31520	PR LARYNGOSCOPY, DIRECT, DIAGNOSIS, NEWBORN	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
31525	PR LARYNGOSCOPY, DIRECT, DIAGNOSTIC	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31526	PR LARYNGOSCOPY, DIRECT, DX, OP MICROSCOP	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31527	PR LARYNGOSCOPY, DIRECT, INSTRUMENT OBTURATOR	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31528	PR LARYNGOSCOPY DIRECT, W/DILATION, INITIAL	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31529	PR LARYNGOSCOPY DIRECT, W/DILATION, SUBSEQUENT	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31530	PR LARYNGOSCOPY, DIRECT, OP, FIBEROTIC REMOVAL	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
31531	PR LARYNGOSCOPY,DIRCT,OP SCOPE,FB REMV	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31535	PR LARYNGOSCOPY,DIRCT,OP,BIO PSY	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31536	PR LARYNGOSCOPY,DIRCT,OP SCOPE,BIOPSY	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31540	PR LARYNGOSCOPY,DIRCT,OP,EX C TUMOR	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31541	PR LARYNGOSCOPY,DIRCT,OP SCOP,EXC TUMR	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31545	PR LARYNGOSCOPY,DIR,OP,EXC TUMR,LCL FLAP	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
31546	PR LARYNGOSCOPY,DIR,OP,EXC TUMR,AUTGRF T	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31551	PR LARYNGOPLASTY LARYNGEAL STEN W/O STENT < 12 YRS	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31552	PR LARYNGOPLASTY LARYNGEAL STEN W/O STENT 12 YRS >	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31553	PR LARYNGOPLASTY LARYNGEAL STEN W/STENT < 12 YRS	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31554	PR LARYNGOPLASTY LARYNGEAL STEN W/STENT 12 YRS >	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31560	PR LARYNGOSCOPY,DIRCT,OP,RE MV ARYTENOD	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
31561	PR LARYNGOSCOPY, DIRECT, OPERATIVE, REMOVAL	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31570	PR LARYNGOSCOPY, DIRECT, INJECTION OF VOCAL CORDS	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31571	PR LARYNGOSCOPY, DIRECT, SCOPING, INJECTION OF CORDS	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31572	PR LARYNGOSCOPY FLEXIBLE ABLATION OF DESTROY LESION(S) UNILATERAL	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31573	PR LARYNGOSCOPY FLEXIBLE THERAPEUTIC INJECTION UNILATERAL	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31574	PR LARYNGOSCOPY FLEXIBLE WITH INJECTION AGUMENTATION UNILATERAL	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
31575	PR LARYNGOSCOPY FLEXIBLE DIAGNOSTIC	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31576	PR LARYNGOSCOPY FLEXIBLE W/BIOPSY(IES)	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31577	PR LARYNGOSCOPY FLX RMVL FOREIGN BODY (S)	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31578	PR LARYNGOSCOPY FLEXIBLE RMVL LESION (S) NON-LASER	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31579	PR LARYNGOSCOPY FLX/RGD TELESCOPIC W/STROBOSCOPY	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
31622	PR BRNCHSC INCL FLUOR GDNCE DX W/CELL WASHG SPX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
31623	PR BRNCHSC BRUSHING/PROTECTED BRUSHINGS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
31624	PR BRNCHSC W/BRNCL ALVEOLAR LAVAGE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
32151	PR THORCOM W/RMVL IPULFB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
32408	PR CORE NEEDLE BX LUNG/MEDIASTINUM PERQ W/IMG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
32854	PR LUNG TRANSPLANT, DBL W CP BYPASS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/6/2021
33270	PR INS/RPLCMNT PERM SUBQ IMPLTBL DFB W/SUBQ ELTRD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2022
33271	PR INSJ OF SUBQ IMPLANTABLE DEFIBRILLATOR ELECTRODE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2022
33272	PR RMVL OF SUBQ IMPLANTABLE DEFIBRILLATOR ELECTRODE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
33273	PR REPOS PREVIOUSLY IMPLANTED SUBQ IMPLANTABLE DFB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2022
33274	PR TCAT INSJ/RPL PERM LEADLESS PACEMAKER RV W/IMG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2022
33276	INSERTION OF PHRENIC NERVE STIMULATOR GENERATOR AND STIMULATING LEAD(S)	NO AUTHORIZATION REQUIRED DIAGOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
33276	INSERTION OF PHRENIC NERVE STIMULATOR GENERATOR AND STIMULATING LEAD(S)	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
33277	INSERTION OF PHRENIC NERVE STIMULATOR SENSING LEAD	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
33277	INSERTION OF PHRENIC NERVE STIMULATOR SENSING LEAD	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
33278	REMOVAL OF PHRENIC NERVE STIMULATOR GENERATOR AND LEAD(S)	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
33278	REMOVAL OF PHRENIC NERVE STIMULATOR GENERATOR AND LEAD(S)	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
33279	REMOVAL OF PHRENIC NERVE STIMULATOR STIMULATION OR SENSING LEAD(S)	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
33279	REMOVAL OF PHRENIC NERVE STIMULATOR STIMULATION OR SENSING LEAD(S)	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
33280	REMOVAL OF PHRENIC NERVE STIMULATOR PULSE GENERATOR	NO AUTHORIZATION REQUIRED DIAGOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
33280	REMOVAL OF PHRENIC NERVE STIMULATOR PULSE GENERATOR	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
33281	REPOSITIONIN G OF PHRENIC NERVE STIMULATOR LEAD(S)	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
33281	REPOSITIONING OF PHRENIC NERVE STIMULATOR LEAD(S)	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
33287	REMOVAL AND REPLACEMENT OF PHRENIC NERVE STIMULATOR PULSE GENERATOR	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
33287	REMOVAL AND REPLACEMENT OF PHRENIC NERVE STIMULATOR PULSE GENERATOR	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
33288	REMOVAL AND REPLACEMENT OF PHRENIC NERVE STIMULATOR STIMULATION OR SENSING LEADS	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
33288	REMOVAL AND REPLACEMENT OF PHRENIC NERVE STIMULATOR STIMULATION OR SENSING LEADS	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
33370	PR TRANSCATHETER PLACEMENT&S BSQ REMOVAL CEPD PERQ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2022
33509	PR ENDOSCOPIC HARVEST UXTR ARTERY 1 SEGMENT CAB PX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2022
33741	PR TAS CONGENITAL CARDIAC ANOMALIES ANY METHOD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
33745	PR TIS CRTJ ST CONGENITAL CARDIAC ANOMAL 1ST SHUNT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
33746	PR TIS CRTJ ST CONGENITAL CARDIAC ANOMAL EA ADDL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
33894	PR EVASC ST RPR COARCJ THRC/AA ACRS MAJ SIDE BRNCH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2022
33895	PR EVASC ST RPR COARCJ THRC/AA XCRSG MAJ SIDE BRNCH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2022
33897	PR PERQ TRANSLUMINAL ANGIOPLASTY NATIVE/RECR COA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2022
33945	PR TRANSPLANTATION OF HEART	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/6/2021
33995	PR INSJ PERQ VAD W/RS&I R HEART VENOUS ACCESS ONLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
33997	PR REMOVAL PERQ R HEART VAD VENOUS CANNULA SEP INSJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
36415	PR COLLECTION VENOUS BLOOD, VENIPUNCTURE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A CHILD ABUSE PEDIATRICS	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
36415	PR COLLECTION VENOUS BLOOD, VENIPUNCTURE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A CHILD ABUSE PEDIATRIC EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
36430	PR BLOOD TRANSFUSION SERVICE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2022
36460	PR TRANSFUSION FETAL, INTRAUTERINE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A MATERNAL-FETAL MEDICINE (MFM)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		5/10/2021
36460	PR TRANSFUSION FETAL, INTRAUTERINE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH REQUIRED IF REFERRED TO PROVIDER IS A NOT A MATERNAL-FETAL MEDICINE (MFM) EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
36468	PR INJECTIONS SCLEROSANT FOR SPIDER VEINS LIM/TRNK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
36469	PR INJECTION; SPIDER VEINS,FACE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
36470	PR INJECTION SCLEROSANT SINGLE INCMPTNT VEIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
36471	PR INJECTION SCLEROSANT MULTIPLE INCMPTNT VEINS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
36473	PR ENDOVEN ABLTJ INCMPTNT VEIN MCHNCHEM 1ST VEIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
36474	PR ENDOVEN ABLTJ INCMPNT VEIN MCHNCHEM SBSQ VEINS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
36475	PR ENDOVENOUS RF, 1ST VEIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
36476	PR ENDOVEN ABLTJ INCMPNT VEIN XTR RF 2ND+ VEINS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
36478	PR ENDOVENOUS LASER, 1ST VEIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
36479	PR ENDOVEN ABLTJ INCMPNT VEIN XTR LASER 2ND+ VEINS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
36589	PR REMOVAL TUNNELED CV CATH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
36590	PR RMVL TUN CTR VAD W/SUBQ PORT/PMP CTR/PRPH INSJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
37197	PR PRQ TRANSCATHET ER RTRVL INTRVAS FB WITH IMAGING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
37700	PR LIGATN LONG SAPHENOUS VEIN AT SEPH-FEM JUNC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
37780	PR LIGATN SHORT SAPHEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
37785	PR REVISE SECONDARY VARICOSITY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
38220	PR DIAGNOSTIC BONE MARROW ASPIRATIONS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
38221	PR DIAGNOSTIC BONE MARROW BIOPSIES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
38222	PR DIAGNOSTIC BONE MARROW BIOPSIES & ASPIRATIONS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
38241	PR TRNSPLJ AUTOLOGOUS HEMATOPOIETI C CELLS PER DONOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/6/2021
38500	PR BIOPSY/EXCISI ON, LYMPH NODE(S)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
38505	PR NEEDLE BIOPSY, LYMPH NODE(S)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
38510	PR BX/REMOV,LYMP H NODE,DEEP CERV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
38520	PR BX/REMOV,LYMP H NODE,DEEP CERV/SCAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
38525	PR BX/REMOV,LYMP H NODE,DEEP AXILL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
38530	PR BX/REMOV,LYMP H NODE,INTERN MAMM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
38531	PR OPEN BIOPSY/EXCISI ON INGUINOFEMO RAL NODES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
38542	PR EXPLORE DEEP NODE(S), NECK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
38550	PR REMOVAL CYST HYGROMA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
40490	PR BIOPSY OF LIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
40500	PR LIP SHAVE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
40510	PR PARTIAL EXCIS LIP,WEDGE PRIM CLOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
40520	PR PARTIAL EXCIS LIP,V-EXC PRIM CLOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
40525	PR FULL THICK EXCIS LIP,RECON W FLAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
40527	PR FULL THICK EXCIS LIP, FIX W XFLAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
40530	PR PARTIAL REMOVAL OF LIP, >1/4	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
40650	PR REPAIR LIP, FULL THICK, VERMILION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
40652	PR REPAIR LIP, <1/2 VERT HEIGHT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
40654	PR REPAIR LIP, >1/2 VERT HEIGHT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
40700	PR REPAIR CLEFT LIP/NASAL,UNIL AT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
40701	PR REPR CLEFT LIP,BILAT,1 STAGE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
40702	PR REPR CLEFT LIP,BILAT,1OF2 STAGE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
40761	PR REPR CLEFT LIP/NASAL,XLIP PED GRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
40799	PR LIP SURGERY PROC UNLISTED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
40800	PR DRAIN MOUTH ABSC/CYST/HE MATOMA,SIMPL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
40801	PR DRAIN MOUTH ABSC/CYST/HE MAT,COMPLX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
40804	PR REMOVAL FOREIGN BODY, MOUTH, SIMPLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
40805	PR REMOVAL FOREIGN BODY, MOUTH, COMPLEX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
40806	PR INCISION OF LIP FOLD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Lingular Frenulectomy): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Lingular-Frenulectomy.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
40808	PR BIOPSY OF MOUTH LESION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
40810	PR EXCIS MOUTH MUCOSA/SUB, NO REPAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
40812	PR EXCIS MOUTH MUCOSA/SUB, S IMPL REPAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
40814	PR EXCIS MOUTH MUCOSA/SUB,C OMLPX REPR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
40816	PR EXCIS MOUTH COMPLEX,EXC THRU MUSCLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
40818	PR EXCISE ORAL MUCOSA FOR GRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
40819	PR EXCISE LIP OR CHEEK FOLD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Lingular Frenulectomy): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Lingular-Frenulectomy.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
40820	PR DESTRUC MOUTH LESION/SCAR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
40830	PR REPAIR MOUTH LACERATION,< 2.5CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
40831	PR REPAIR MOUTH LACERATION,> 2.5CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
40840	PR RECONSTRUC MOUTH ANTERIOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
40842	PR RECONSTRUC MOUTH POSTER,UNILAT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
40843	PR RECONSTRUC MOUTH POSTER,BILAT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
40844	PR RECONSTRUC MOUTH ENTIRE ARCH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
40845	PR RECONSTRUC MOUTH COMPLEX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
41000	PR I&D MOUTH/TONG INTRA,LINGUAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41005	PR I&D MOUTH/TONG INTRA,SUBLING ,SUPERF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
41006	PR I&D MOUTH/TONG INTRA,SUBLING ,DEEP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41007	PR I&D MOUTH/TONG INTRA,SUBMEN TAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41008	PR I&D MOUTH/TONG INTRA,SUBMAN DIBULAR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41009	PR I&D MOUTH/TONG INTRA,MASTICA TOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
41010	PR INCISION OF TONGUE FOLD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Lingular Frenulectomy): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Lingular-Frenulectomy.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
41015	PR I&D MOUTH/TONG EXTRA,SUBLING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41016	PR I&D MOUTH/TONG EXTRA,SUBMENTAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41017	PR I&D MOUTH/TONG EXTRA,SUBMANDIBUL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
41018	PR I&D MOUTH/TONG EXTRA,MASTIC ATOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41100	PR BIOPSY TONGUE,ANTER 2/3	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41105	PR BIOPSY TONGUE,POSTER 1/3	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41108	PR BIOPSY OF FLOOR OF MOUTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41110	PR EXCIS TONGUE LESN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41112	PR EXCIS TONGUE LESN,ANT 2/3+CLOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
41113	PR EXCIS TONGUE LESN,POST 1/3	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41114	PR EXCIS TONGUE LESN,LOCAL FLAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41115	PR EXCIS TONGUE FOLD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Lingular Frenulectomy): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Lingular-Frenulectomy.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
41116	PR EXCIS FLOOR MOUTH LESION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
41120	PR PART REMOVAL TONGUE,<1/2	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41130	PR PART REMOVAL TONGUE, 1/2	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41135	PR PART EXC TONGUE,UNILA T RAD NECK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41140	PR REMOVAL OF TONGUE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41145	PR EXCIS TONGUE,UNILA T RAD NECK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
41150	PR EXCIS TONGUE,MOUTH,JAW	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41153	PR EXCIS TONGUE,MOUTH,NECK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41155	PR EXCIS TONGUE,MOUTH,JAW,RAD NECK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41510	PR TONGUE TO LIP SURGERY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
41520	PR RECONSTRUCTION, TONGUE FOLD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
41599	PR TONGUE AND MOUTH SURG UNLISTED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41800	PR DRAINAGE OF GUM LESION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41805	PR REMOVAL FOREIGN BODY, GUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41806	PR REMOVAL FOREIGN BODY, JAWBONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41820	PR EXCISION, GUM, EACH QUADRANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41821	PR EXCISION OF GUM FLAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
41822	PR EXCIS FIBROUS TUBER,DENTO ALV	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41823	PR EXCIS OSSEOUS TUBER,DENTO ALV	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41825	PR EXCIS DENTOALVEOL AR LESION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41826	PR EXCIS DENTOALV LESN,SIMPL REPR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41827	PR EXCIS DENTOALV LESN,COMPLX REP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
41828	PR EXCISION OF GUM LESION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41830	PR REMOVAL OF GUM TISSUE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41850	PR TREATMENT OF GUM LESION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41870	PR GUM GRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41872	PR REPAIR GUM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
41874	PR ALVEOLOPLASTY, EACH QUADRANT (SPECIFY)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
41899	PR DENTAL SURGERY PROCEDURE	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: K02.3, K02.51, K02.53, K02.61, K02.63, K02.7, K02.9-K03.9, K04.0 AGE: PRIOR AUTH IS REQUIRED IF 6 YEARS OF AGE OR YOUNGER. EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
41899	PR DENTAL SURGERY PROCEDURE	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: K02.3, K02.51, K02.53, K02.61, K02.63, K02.7, K02.9-K03.9, K04.0 AGE: NO AUTH REQUIRED IF OLDER THAN 6 YEARS. EXCLUSIONS: AUTH REQUIRED FOR CHIP LINE OF BUSINESS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	12/1/2023
42100	PR BIOPSY PALATE/UVULA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
42140	PR EXCISION OF UVULA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
42200	PR RECONST CLEFT PALATE,SOFT/HARD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
42205	PR RECONST CLEFT PALATE,CLOS ALVE RDG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
42210	PR RECONST CLEFT PALATE,BONE GRFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
42215	PR RECONST CLEFT PALATE,MAJOR REVIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
42220	PR RECONST CLEFT PALATE,LENGT HENING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
42225	PR RECONST CLEFT PALATE,ATTAC H PHAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
42226	PR LENGTHENING PALATE +PHARY FLAP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
42227	PR LENGTHENING PALATE +ISLAND FLAP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
42235	PR REPAIR ANTER PALATE W VOMER FLAP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
42260	PR REPAIR NOSE TO LIP FISTULA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2023
42300	PR DRAIN ABSCCESS PAROTID,SIMPL E	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
42305	PR DRAIN ABSCCESS PAROTID,COMPL IC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
42400	PR BIOPSY SALIVARY GLAND,NEEDLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
42410	PR EXC PAROTD LESN,LATER LOBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
42415	PR EXC PAROTD,LAT LOBE,DISSECT 5TH NERV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
42420	PR EXC PAROTD,TOTAL ,DISSECT 5TH NERV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
42425	PR EXC PAROTD,TOTAL ,SACRIFICE 5TH NERV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
42426	PR EXC PAROTD,TOTAL ,UNILAT RAD NECK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
42800	PR BIOPSY OROPHARYNX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
42809	PR REMOVE PHARYNX FOREIGN BODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
42810	PR EXCISION BRACH CLFT CYST,SUPERFICIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
42815	PR EXCISION BRANC CLFT CYST,DEEP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
42820	REMOVE TONSILS/ADENOIDS,<12 Y/O	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
42821	PR REMOVE TONSILS/ADENOIDS,12+ Y/O	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
42825	REMOVAL OF TONSILS,<12 Y/O	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
42826	PR REMOVAL OF TONSILS,12+ Y/O	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
42830	REMOVAL ADENOIDS,PRIMARY,<12 Y/O	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
42831	PR REMOVAL ADENOIDS,PRIMARY,12+ Y/O	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
42835	REMOVAL ADENOIDS,SEC OND,<12 Y/O	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
42836	PR REMOVAL ADENOIDS,SEC OND,12+ Y/O	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
42975	PR DISE DYN EVAL SLEEP DISORDERED BREATHING FLX DX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
43180	PR ESOPHAGOSCP RIG TRANSORAL HYPOPHARYNX CRV ESOPH	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43191	PR ESOPHAGOSC OPY RIGID TRANSORAL DIAGNOSTIC BRUSH	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43192	PR ESOPHAGOSC OPY RIGID TRANSORAL INJ SUBMUCOSAL	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
43193	PR ESOPHAGOSC OPY RIGID TRANSORAL WITH BIOPSY	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43194	PR ESOPHAGOSC OPY RIG TRANSORAL REMOVAL FOREIGN BODY	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43195	PR ESOPHAGOSC OPY RIGID TRANSORAL BALLOON DILATION	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43196	PR ESOPHAGOSC OPY RIG TRANSORAL GUIDE WIRE DILATION	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43197	PR ESOPHAGOSC OPY FLEXIBLE TRANSNASAL DIAGNOSTIC	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
43198	PR ESOPHAGOSC OPY FLEXIBLE TRANSNASAL WITH BIOPSY	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43200	PR ESOPHAGOSC OPY FLEXIBLE TRANSORAL DIAGNOSTIC	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43201	PR ESOPHAGOSC OPY FLEXIBLE TRANSORAL W SUBMUCOUS INJ	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43202	PR ESOPHAGOSC OPY FLEXIBLE TRANSORAL WITH BIOPSY	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43204	PR ESOPHAGOSC OPY FLEX TRANSORAL INJECTION VARICES	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
43205	PR ESPHGOSCOPY FLEX W/BAND LIGATION ESOPHGL VARICES	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43206	PR ESOPHAGOSC OPY TRANSORAL W/OPTICAL ENDOMICROSC OPY	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43210	PR EGD PARTIAL/COMP L ESOPHAGOGA STRIC FUNDOPLASTY	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43211	PR ESOPHAGOSC OPY FLEXIBLE TRANSORAL MUCOSAL RESEXN	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43212	PR ESOPHAGOSC OPY TRANSORAL STENT PLACEMENT	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
43213	PR ESOPHAGOSC OPY RETROGRADE DILATE BALLOON/OTH ER	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43214	PR ESOPHAGOSC OPY DILATE ESOPHAGUS BALLOON 30 MM	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43215	PR ESOPHAGOSC OPY FLEXIBLE REMOVAL FOREIGN BODY	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43216	PR ESPHAGOSCO PY FLEX LESION REMOVAL HOT BX FORCEPS	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43217	PR ESOPHAGOSC OPY FLEXIB LESION REMOVAL TUMOR SNARE	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
43219	PR ESOPHAGOSC OPY,INSERT TUBE/STENT	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43220	PR ESOPHAGOSC OPY FLEX BALLOON DILAT <30 MM DIAM	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43226	PR ESOPHAGOSC OPY FLEXIBLE GUIDE WIRE DILATION	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43227	PR ESOPHAGOSC OPY FLEXIBLE W/BLEEDING CONTROL	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43228	PR ESOPHAGOSC OPY,ABLATION TUMOR	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
43229	PR ESOPHAGOSCOPY FLEX TRANSORAL LESION ABLATION	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43231	PR ESOPHAGOSCOPY FLEXIBLE TRANSORAL ULTRASOUND EXAM	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43232	PR ESOPHAGOSCOPY INTRA/TRANSORAL NEEDLE ASPIRAT/BX	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43233	PR EGD ESOPHAGUS BALLOON DILATION 30 MM OR LARGER	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43234	PR UPPER GI ENDOSCOPY, EXAM	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
43235	PR ESOPHAGOGA STRODUODEN OSCOPY TRANSORAL DIAGNOSTIC	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43236	PR ESOPHAGOGA STRODUODEN OSCOPY SUBMUCOSAL INJECTION	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43237	PR ESOPHAGOGA STRODUODEN OSCOPY US SCOPE W/ADJ STRXRS	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43238	PR EGD INTRMURAL US NEEDLE ASPIRATE/BIOPSY ESOPHAGS	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43239	PR EGD TRANSORAL BIOPSY SINGLE/MULTIPLE	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
43240	PR EGD TRANSORAL TRANSMURAL DRAINAGE PSEUDOCYST	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43241	PR EGD INTRALUMINAL TUBE/CATHETER INSERTION	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43242	PR EGD INTRAMURAL NEEDLE ASPIR/BIOP ALTERED ANATOMY	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43243	PR EGD INJECTION SCLEROSIS ESOPHGEAL/GASTRIC VARICES	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43244	PR EGD BAND LIGATION ESOPHGEAL/GASTRIC VARICES	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
43245	PR EGD DILATION GASTRIC/DUODENAL STRICTURE	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43246	PR EGD PERCUTANEOUS PLACEMENT GASTROSTOMY TUBE	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43247	PR EGD FLEXIBLE FOREIGN BODY REMOVAL	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43247	PR EGD FLEXIBLE FOREIGN BODY REMOVAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
43248	PR EGD INSERT GUIDE WIRE DILATOR PASSAGE ESOPHAGUS	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
43249	PR EGD BALLOON DILATION ESOPHAGUS <30 MM DIAM	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43250	PR EGD FLEX REMOVAL LESION(S) BY HOT BIOPSY FORCEPS	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43251	PR EGD REMOVAL TUMOR POLYP/OTHER LESION SNARE TECH	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43252	PR EGD FLEX TRANSORAL W/OPTICAL ENDOMICROSCOPY	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43253	PR EGD US GUIDED TRANSMURAL INJXN/FIDUCIAL MARKER	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
43254	PR EGD TRANSORAL ENDOSCOPIC MUCOSAL RESECTION	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43255	PR EGD TRANSORAL CONTROL BLEEDING ANY METHOD	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43256	PR UPPER GI ENDOSCOPY, S TENT PLACEMENT	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43257	PR EGD DELIVER THERMAL ENERGY SPHNCTR/CAR DIA GERD	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43258	PR UPPER GI ENDOSCOPY, T UMOR ABLATN	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
43259	PR EDG US EXAM SURGICAL ALTER STOM DUODENUM/JE JUNUM	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43260	PR ERCP DX COLLECTION SPECIMEN BRUSHING/WASHING	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43261	PR ERCP W/BIOPSY SINGLE/MULTIPLE	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43262	PR ERCP W/SPHINCTER OTOMY/PAPILLOMOTOMY	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43263	PR ERCP W/PRESSURE MEASUREMENT SPHINCTER OF ODDI	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
43264	PR ERCP REMOVE CALCULI/DEBRIS BILIARY/PANCREAS DUCT	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43265	PR ERCP DESTRUCTION/LITHOTRIPSY CALCULI ANY METHOD	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43266	PR EGD ENDOSCOPIC STENT PLACEMENT W/WIRE& DILATION	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43267	PR ERCP,NASOBILIARY DRAIN TUBE	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43268	PR ERCP,INSERT STENT,BILIARY/PANCREAS	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
43269	PR ERCP,RMV F.B./CHANGE STENT	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43270	PR EGD ABLATE TUMOR POLYP/LESION W/DILATION& WIRE	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43271	PR ERCP,BALLOON DIL DUCTS	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43272	PR ERCP,ABLATION TUMOR	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43273	PR ENDOSCOPIC PAPANICOLAOU CANNULATION BILE/PANCREATIC	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
43274	PR ERCP STENT PLACEMENT BILIARY/PANCREATIC DUCT	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43275	PR ERCP REMOVE FOREIGN BODY/STENT BILIARY/PANCREATIC DUCT	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43276	PR ERCP BILIARY/PANCREATIC DUCT STENT EXCHANGE W/DIL&WIRE	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43277	PR ERCP BALLOON DILATE BILIARY/PANCREATIC DUCT/AMPULLA EA	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
43278	PR ERCP TUMOR/POLYP/ LESION ABLATION W/DILATION&WI RE	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
43644	PR LAP GASTRIC BYPASS/ROUX-EN-Y	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
43645	PR LAP GASTR BYPASS INCL SMLL INT RECON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
43653	PR LAP,GASTROST OMY,W/O TUBE CONSTR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
43770	LAP, PLACE ADJUST GAST RESTRICT DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
43775	LONGITUDINAL SLEEVE GASTRECTOMY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
43842	PR GASTROPLASTY, OBESITY, VERT BAND	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
43843	PR GASTROPLASTY, OBESITY, OTHER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
43845	PR GASTROPLASTY DUODENAL SWITCH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
43846	PR GASTRIC BYPASS, OBESITY <150CM ROUX-EN-Y	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
43847	PR GASTRIC BYPASS, OBESITY, W/SM BOWEL RECONS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
43848	REVISION GASTROPLASTY, OBESITY, NON-GAST RESTRICT DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
44100	PR BIOPSY OF BOWEL, PERORAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
44388	PR COLONOSCOPY STOMA DX INCLUDING COLLJ SPEC SPX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
44389	PR COLONOSCOPY STOMA W/BIOPSY SINGLE/MULTIPLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
44390	PR COLONOSCOPY STOMA W/RMVL FOREIGN BODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
44390	PR COLONOSCOPY STOMA W/RMVL FOREIGN BODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
44391	PR COLONOSCOPY STOMA CONTROL BLEEDING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
44392	PR COLONOSCOPY STOMA RMVLS BY HOT BIOPSY FORCEPS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
44393	PR COLONOSCOPY THRU STOMA, LESION REMOVAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
44394	PR COLONOSCOPY STOMA W/RMVL TUM POLYP/OTHER LES SNARE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
44397	PR COLONOSCOPY THRU STOMA, TRANS ENDOSC STENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
44401	PR COLONOSCOPY STOMA ABLATION LESION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
44402	PR COLONOSCOPY STOMA W/ENDOSCOPIC STENT PLCMT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
44403	PR COLONOSCOPY STOMA W/ENDOSCOPIC MUCOSAL RESCJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
44404	PR COLONOSCOPY STOMA W/SUBMUCOSAL INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
44405	PR COLONOSCOPY STOMA W/BALLOON DILATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
44406	PR COLONOSCOPY STOMA W/ENDOSCOPIC ULTRASOUND EXAM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
44407	PR COLONOSCOPY STOMA W/US GID NDL ASPIR/BX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
44408	PR COLONOSCOPY THROUGH STOMA WITH DECOMPRESSION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
45000	PR DRAINAGE OF PELVIC ABSCESS	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
45000	PR DRAINAGE OF PELVIC ABSCESS	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
45005	PR I&D RECTAL SUBMUCOSAL ABSCESS	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
45005	PR I&D RECTAL SUBMUCOSAL ABSCESS	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
45020	PR DRAINAGE OF DEEP RECTAL ABSCESS	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
45020	PR DRAINAGE OF DEEP RECTAL ABSCESS	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
45100	PR BIOPSY OF RECTUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
45330	PR SIGMOIDOSCOPY FLX DX W/COLLJ SPEC BR/WA IF PFRMD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
45378	PR COLONOSCOPY FLX DX W/COLLJ SPEC WHEN PFRMD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
45379	PR COLONOSCOPY FLX W/REMOVAL OF FOREIGN BODY(S)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
45380	PR COLONOSCOPY W/BIOPSY SINGLE/MULTIPLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
45381	PR COLSC FLX WITH DIRECTED SUBMUCOSAL NJX ANY SBST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
45382	PR COLSC FLEXIBLE W/CONTROL BLEEDING ANY METHOD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
45383	PR COLONOSCOPY, ABLATE LESION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
45384	PR COLSC FLX W/REMOVAL LESION BY HOT BX FORCEPS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
45385	PR COLSC FLX W/RMVL OF TUMOR POLYP LESION SNARE TQ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
45386	PR COLSC FLEXIBLE W/TRANSCENDOSCOPIC BALLOON DILAT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
45387	PR COLONOSCOPY, TRANSCENDOSCOPIC STENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
45388	PR COLONOSCOPY FLX ABLATION TUMOR POLYP/OTHER LES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
45389	PR COLONOSCOPY FLX WITH ENDOSCOPIC STENT PLACEMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
45390	PR COLONOSCOPY FLX W/ENDOSCOPIC MUCOSAL RESECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
45391	PR COLSC FLX W/NDSC US XM RCTM ET AL LMTD&ADJ STRUX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
45392	PR COLSC FLX W/US GUID NDL ASPIR/BX W/US RCTM ET AL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
45393	PR COLONOSCOPY FLEXIBLE WITH DECOMPRESSION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
45395	PR LAP, SURG PROCTECTOMY W COLOSTOMY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
45397	PR LAP, SURG PROCTECTOMY W J-POUCH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
45398	PR COLONOSCOPY FLEXIBLE WITH BAND LIGATION(S)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
46040	PR I&D PERIRECTAL ABSCESS	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
46040	PR I&D PERIRECTAL ABSCESS	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
46045	PR I&D RECTAL WALL ABSCESS W ANESTH	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
46045	PR I&D RECTAL WALL ABSCESS W ANESTH	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
46050	PR I&D PERIANAL ABSCESS,SUPERFICIAL	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
46050	PR I&D PERIANAL ABSCESS,SUPERFICIAL	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
46060	PR I&D RECTAL ABSCESS + FISTULECTOMY	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
46060	PR I&D RECTAL ABSCESS + FISTULECTOMY	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
46600	PR ANOSCOPY DX W/COLLJ SPEC BR/WA SPX WHEN PRFRMD	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A CHILD ABUSE PEDIATRIC EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
46600	PR ANOSCOPY DX W/COLLJ SPEC BR/WA SPX WHEN PRFRMD	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A CHILD ABUSE PEDIATRICS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
46910	PR ELECTRODESSI CATN,ANAL LESN(S)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
46916	PR CRYOSURGERY, ANAL LESION(S)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
46917	PR LASER SURGERY, ANAL LESION (S)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
46922	PR SURG EXCISION OF ANAL LESION (S)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
46924	PR DESTRUCTION, ANAL LESION (S),EXTENSIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
47000	PR BIOPSY LIVER NEEDLE PERCUTANEOUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
47001	PR NEEDLE BIOPSY LIVER, W OTHR PROC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
47100	PR WEDGE BIOPSY OF LIVER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
47135	PR TRANSPLANT LIVER, ALLOTRANSPLANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/6/2021
47562	PR LAP, CHOLECYSTECTOMY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
47563	PR LAP,CHOLECYS TECTOMY/GRA PH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
47564	PR LAP,CHOLECYS TECTOMY/EXPL ORE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
47570	PR LAP,CHOLECYS TOENTEROSTO MY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
47579	PR LAP,BILIARY TRACT,UNLISTED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
47600	PR REMOVAL GALLBLADDER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
47605	PR REMV GALLBLADDER W CHOLANGIOGRAM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
47610	PR REMV GALLBLADDER, EXPLOR COMMON DUCT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
47612	PR REMV GB,W CHOLEDOCHO ENTEROSTOMY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
47620	PR REMV GB,W TRANSDUOD SPHINCTEROT OMY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
48100	PR BIOPSY,PANCR EAS,OPEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
49180	PR PERCUT BIOPSY, ABDOMINAL MASS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
49402	PR REMOVE PERITONEAL FOREIGN BODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
49452	PR REPLACEMENT GASTRO-JEJUNOSTOMY TUBE PERCUTANEOUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
49491	REPAIR ING HERNIA,PRETERM INFANT,REDUC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
49492	REPAIR ING HERNIA,PRETERM INFANT,INCARC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
49495	REPAIR ING HERNIA,FULL/P RETERM INF,REDUC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
49496	REPAIR ING HERNIA,<6MO,STRANG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
49500	REPAIR ING HERNIA,6MO-5YR,REDUC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
49501	PR REPAIR ING HERNIA,6MO-5YR,STRANG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
49505	PR REPAIR ING HERNIA,5+Y/O, REDUCIBL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
49507	PR REPAIR ING HERNIA,5+Y/O, STRANG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
49520	PR REPAIR RECURR INGUIN HERN,REDUCIB L	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
49521	PR REPAIR RECURR INGUIN HERN,STRANG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
49525	PR REPAIR SLIDING INGUINAL HERNIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
49591	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPI C, ROBOTIC), INITIAL, INCLUDING IMPLANTATION OF MES	NO AUTHORIZATION REQUIRED AGE: NO AUTH REQUIRED IF 6 YEARS OF AGE AND OLDER.	MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
49591	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), INITIAL, INCLUDING IMPLANTATION OF MES	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 6 YEARS OF AGE.	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023
49592	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), INITIAL, INCLUDING IMPLANTATION OF MES	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 6 YEARS OF AGE.	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
49592	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), INITIAL, INCLUDING IMPLANTATION OF MES	NO AUTHORIZATION REQUIRED AGE: NO AUTH REQUIRED IF 6 YEARS OF AGE AND OLDER.	MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023
49593	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), INITIAL, INCLUDING IMPLANTATION OF MES	NO AUTHORIZATION REQUIRED AGE: NO AUTH REQUIRED IF 6 YEARS OF AGE AND OLDER.	MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
49593	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), INITIAL, INCLUDING IMPLANTATION OF MES	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 6 YEARS OF AGE.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023
49594	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), INITIAL, INCLUDING IMPLANTATION OF MES	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 6 YEARS OF AGE.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
49594	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), INITIAL, INCLUDING IMPLANTATION OF MES	NO AUTHORIZATION REQUIRED AGE: NO AUTH REQUIRED IF 6 YEARS OF AGE AND OLDER.	MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023
49595	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), INITIAL, INCLUDING IMPLANTATION OF MES	NO AUTHORIZATION REQUIRED AGE: NO AUTH REQUIRED IF 6 YEARS OF AGE AND OLDER.	MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
49595	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), INITIAL, INCLUDING IMPLANTATION OF MES	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 6 YEARS OF AGE.	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023
49596	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), INITIAL, INCLUDING IMPLANTATION OF MES	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 6 YEARS OF AGE.	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
49596	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), INITIAL, INCLUDING IMPLANTATION OF MES	NO AUTHORIZATION REQUIRED AGE: NO AUTH REQUIRED IF 6 YEARS OF AGE AND OLDER.	MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023
49613	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), RECURRENT, INCLUDING IMPLANTATION OF M	NO AUTHORIZATION REQUIRED AGE: NO AUTH REQUIRED IF 6 YEARS OF AGE AND OLDER.	MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
49613	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), RECURRENT, INCLUDING IMPLANTATION OF M	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 6 YEARS OF AGE.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023
49614	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), RECURRENT, INCLUDING IMPLANTATION OF M	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 6 YEARS OF AGE.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
49614	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), RECURRENT, INCLUDING IMPLANTATION OF M	NO AUTHORIZATION REQUIRED AGE: NO AUTH REQUIRED IF 6 YEARS OF AGE AND OLDER.	MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023
49615	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), RECURRENT, INCLUDING IMPLANTATION OF M	NO AUTHORIZATION REQUIRED AGE: NO AUTH REQUIRED IF 6 YEARS OF AGE AND OLDER.	MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
49615	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), RECURRENT, INCLUDING IMPLANTATION OF M	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 6 YEARS OF AGE.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023
49616	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), RECURRENT, INCLUDING IMPLANTATION OF M	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 6 YEARS OF AGE.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
49616	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), RECURRENT, INCLUDING IMPLANTATION OF M	NO AUTHORIZATION REQUIRED AGE: NO AUTH REQUIRED IF 6 YEARS OF AGE AND OLDER.	MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023
49617	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), RECURRENT, INCLUDING IMPLANTATION OF M	NO AUTHORIZATION REQUIRED AGE: NO AUTH REQUIRED IF 6 YEARS OF AGE AND OLDER.	MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
49617	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), RECURRENT, INCLUDING IMPLANTATION OF M	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 6 YEARS OF AGE.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023
49618	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), RECURRENT, INCLUDING IMPLANTATION OF M	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 6 YEARS OF AGE.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
49618	PR REPAIR OF ANTERIOR ABDOMINAL HERNIA(S) (IE, EPIGASTRIC, INCISIONAL, VENTRAL, UMBILICAL, SPIGELIAN), ANY APPROACH (IE, OPEN, LAPAROSCOPIC, ROBOTIC), RECURRENT, INCLUDING IMPLANTATION OF M	NO AUTHORIZATION REQUIRED AGE: NO AUTH REQUIRED IF 6 YEARS OF AGE AND OLDER.	MD GUIDELINE 1 (Umbilical Hernia Repair): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Umbilical-Hernia-Repair.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2023
49650	PR LAP,INGUINAL HERNIA REPR,INITIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
49651	PR LAP,INGUINAL HERNIA REPR,RECUR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
50200	PR RENAL BIOPSY PRQ TROCAR/NEEDLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
50205	PR BIOPSY OF KIDNEY,OPEN EXPOS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
50360	PR TRANSPLANTATION OF KIDNEY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/6/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
50365	PR TRANSPLANT KIDNEY+RECIP NEPHREC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/6/2021
50590	PR FRAGMENT KIDNEY STONE/ ESWL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
51600	PR INJECTION FOR BLADDER X-RAY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
51605	PR INJECT/PLACE CHAIN,BLADDER XRAY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
51610	PR INJECT FOR RETROGRADE URETHOCYSTO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
51701	PR INSERT, NON-INDWELLING BLADDER CATHETER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2021
51725	PR SIMPLE CYSTOMETROGRAM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
51726	PR COMPLEX CYSTOMETROGRAM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
51727	PR COMPLEX CYSTOMETROGRAM URETHRAL PRESS PROFILE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
51728	CYSTOMETROGRAM W / VP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
51729	PR COMPLX CYSTOMETRO W/VOID PRESS & URETHRAL PROFIL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
51736	PR URINE FLOW MEASUREMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
51741	PR ELECTRO-UROFLOWMETRY, FIRST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
51784	PR ANAL/URINARY MUSCLE STUDY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
51785	PR ANAL/URINARY MUSCLE STUDY,NEEDLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
51792	PR URINARY REFLEX STUDY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
51797	VOIDING PRESS STUDY INTRA-ABDOMINAL VOID	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
51798	PR MEAS,POST-VOID RES,US,NON-IMAGING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
52000	PR CYSTOURETHR OSCOPY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52001	PR CYSTOURETHR OSCOPY W/IRRIG & EVAC CLOTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52005	PR CYSTOURETHR OSCOPY, URETER CATHETER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52007	PR CYSTOURETHR OSCOPY, URETERAL BIOPSY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52010	PR CYSTOURETHR OSCOPY, EJAC DUCT CATH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52204	PR CYSTOURETHR OSCOPY, BIOPSIES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52214	PR CYSTOURETHR OSCOPY, FULGURATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52224	PR CYSTOURETHR OSCOPY, FULGUR <.5CM LESN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
52234	PR CYSTOURETHR OSCOPY,FULG UR .5-2CM LESN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52235	PR CYSTOURETHR OSCOPY,FULG UR 2-5CM LESN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52240	PR CYSTOURETHR OSCOPY,FULG UR >5CM LESN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52250	PR CYSTOURETHR OSCOPY,INSER T RADIOACTIV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52260	PR CYSTOSCOPY, DIL BLADDER,GEN ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52265	PR CYSTOSCOPY, DIL BLADDER,LOCA L ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52270	PR CYSTOSCOPY,I NTERN URETHROTOM Y,FEMALE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52275	PR CYSTOSCOPY,I NTERN URETHROTOM Y,MALE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52276	PR CYSTOSCOPY, DIR VIS INT URETHROTOM Y	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
52277	PR CYSTOSCOPY, RESEC EXTERN SPHINCTER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52281	PR CYSTOSCOPY, DIL URETHRAL STRICTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52282	PR CYSTOSCOPY, INSERT URETHRAL STENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52283	PR CYSTOSCOPY, STEROID INJ, STRICTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52284	CYSTO W/DILAT RX BALO CATH URTL STRIX/STEN MALE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52285	PR CYSTOSCOPY, RX FEMALE URETHRAL SYND	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52287	PR CYSTOURETHROSCOPY INJ CHEMODENERVATION BLADDER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52290	PR CYSTOSCOPY, URETERAL MEATOTOMY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
52300	PR CYSTOSCOPY, RESECT ORTHO URETEROCELE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52301	PR CYSTOSCOPY, RESECT ECTOPIC URETEROCEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52305	PR CYSTOSCOPY, I NCIS OPEN BLAD TIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52310	PR CYSTOSCOPY, REMV CALCULUS, SIM PLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52315	PR CYSTOSCOPY, REMV CALCULUS, CO MPLIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52317	PR REMOVE BLADDER STONE, <2.5CM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52318	PR REMOVE BLADDER STONE, >2.5CM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52320	PR CYSTOSCOPY, REMV URETERAL STONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52325	PR CYSTOSCOPY, FRAGMT URETERAL STONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
52327	PR CYSTOSCOPY, I NJECT IMPLNT MATERIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52330	PR CYSTOSCOPY, MANIPULATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52332	PR CYSTOSCOPY, I NSERT URETERAL STENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52334	PR CYSTOSCOPY, GUIDE, PERCUT NEPHROS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52341	PR CYSTOSCOPY, TX URETERAL STRICTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52342	PR CYSTOSCOPY, TX URETEROPELV C STRICTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52343	PR CYSTOSCOPY, TX INTRARENAL STRICTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52344	PR CYSTO/URETE ROSCOPY, TX URETER STRICT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52345	PR CYSTO/URETE ROSCOPY, TX URET/PELV STRICT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
52346	PR CYSTO/URETE ROSCOPY, TX INTRARENAL STRICT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52351	PR CYSTO/URETE RO/PYELOSCOPY, DX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52352	PR CYSTO/URETE RO/PYELOSCOPY, CALCULUS TX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52353	PR CYSTO/URETE RO/PYELOSCOPY W/LITHOTRIPSY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52354	PR CYSTO/URETE RO/PYELOSC, B X &/OR FULGLESN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52355	PR CYSTO/URETE RO/PYELOSCOPY, W/RESECT TUMOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52356	PR CYSTO/URETE RO W/LITHOTRIPSY & INDWELL STENT INSRT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
52441	PR CYSTO INSERTION TRANSPROSTATIC IMPLANT SINGLE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
52442	PR CYSTO INSERTION TRANSPROSTATIC IMPLANT EA ADDL	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
52601	PR TRANSURETHRAL ELEC-SURG PROSTATECTOMY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
52630	PR REMV RESID OBSTRUC PROSTATE,>1 YR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
52640	PR RELIEVE POSTOP BLADDER CONTRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
52649	PR LASER ENUCLEATION PROSTATE W MORCELLATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
53020	PR INCISION OF URETHRAL MEATUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
53200	PR BIOPSY OF URETHRA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
53400	PR REVISE URETHRA, 1ST STAGE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
53405	PR REVISE URETHRA, 2ND STAGE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
53410	PR RECONSTRUC ANT MALE URETHRA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
53415	PR RECONSTRUC PROSTATIC URETHRA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
53420	PR RECONSTRUC PROS URETHRA,1ST STAGE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
53425	PR RECONSTRUC PROS URETHRA,2ND STAGE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
53430	PR RECONSTRUC FEMALE URETHRA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
53431	PR URETHROPLAS TY,W/TUBULARI ZATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
53440	PR SLING OPERATION,CO RRECTION,MAL E INCONT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
53442	PR REVISION OF SLING FOR MALE INCONT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
53444	PR INSERTION TANDEM CUFF (DUAL)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
53445	PR INSERT,INFLAT ABLE SPHINCTER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
53446	PR REMOVAL,INFL ATABLE SPHINCTER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
53447	PR REMOVAL & REPLACE,INFL ATABLE SPHINCTER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
53850	PR PROSTATIC MICROWAVE THERMOTX	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
53852	PR PROSTATIC RADIOFREQ THERMOTX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
53854	PR TRURL DSTRJ PRST8 TISS RF WV THERMOTHERA PY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
53855	PR INSERT TEMP PROSTATIC URETH STENT W/MEASUREME NT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
54050	PR DESTR PENIS LESN,SIMPL,CH EMICAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
54055	PR DESTR PENIS LESN,SIMPL,EL EC-DESSIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
54056	PR DESTR PENIS LESN,SIMPL,CRYOSURG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
54060	PR DESTR PENIS LESN,SIMPL,SURG EXCIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
54065	PR DESTR PENIS LESN,EXTENSIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
54100	PR BX,PENIS (SEPARATE PROCEDURE)	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
54105	PR BIOPSY OF PENIS,DEEP STRUCT	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
54110	PR EXCIS PENILE PLAQUE	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
54111	PR EXCIS PENILE PLAQUE,GRAFT <5CM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
54112	PR EXCIS PENILE PLAQUE,GRAFT >5CM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
54115	PR REMV FOR.BODY DEEP PENILE TISS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
54120	PR REMOVAL PENIS,PARTIAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54125	PR REMOVAL PENIS,TOTAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54130	PR REMOVAL PENIS,RADICAL +NODES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54135	PR REMOVAL PENIS,RAD +EXTENSIV NODES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
54150	PR CIRCUMCISION, CLAMP, OTHER DEVICE WITH REGIONAL DORSAL PENILE OR RING BLOCK	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF OLDER THAN 1 YEAR. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54150	PR CIRCUMCISION, CLAMP, OTHER DEVICE WITH REGIONAL DORSAL PENILE OR RING BLOCK	NO AUTHORIZATION REQUIRED AGE: NO AUTH REQUIRED FOR 1 YEAR OF AGE OR YOUNGER.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54160	PR CIRCUMCISION, OTHER, <28 D/O	NO AUTHORIZATION REQUIRED AGE: NO AUTH REQUIRED FOR 1 YEAR OF AGE OR YOUNGER.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54160	PR CIRCUMCISION, OTHER, <28 D/O	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF OLDER THAN 1 YEAR. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54161	PR CIRCUMCISION, OTHER, 28+ D/O	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF OLDER THAN 1 YEAR. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
54161	PR CIRCUMCISION, OTHER, 28+ D/O	NO AUTHORIZATION REQUIRED AGE: NO AUTH REQUIRED FOR 1 YEAR OF AGE OR YOUNGER.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54162	PR LYSIS/EXCIS, PENILE POSTCIRCUM ADHESIONS	NO AUTHORIZATION REQUIRED AGE: NO AUTH REQUIRED FOR 1 YEAR OF AGE OR YOUNGER.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54162	PR LYSIS/EXCIS, PENILE POSTCIRCUM ADHESIONS	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF OLDER THAN 1 YEAR. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54163	PR REPAIR, INCOMPLETE CIRCUMCISION	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF OLDER THAN 1 YEAR. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54163	PR REPAIR, INCOMPLETE CIRCUMCISION	NO AUTHORIZATION REQUIRED AGE: NO AUTH REQUIRED FOR 1 YEAR OF AGE OR YOUNGER.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
54164	PR FRENULOTOMY ,PENIS	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
54300	PR STRAIGHTEN PENIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54304	PR HYOSPADIUS REPAIR,1ST STAGE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54312	PR HYOSPADIUS REPAIR,2ND STAGE,>3CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54316	PR HYOSPAD REPR,2ND STAGE,FREE GRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
54318	PR HYPOSPAD REPAIR,3RD STAGE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54322	PR HYPOSPAD REPAIR,1 STAGE,DISTAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54324	PR HYPOSPAD REPAIR,1 STAGE,DIST,PL ASTY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
54326	PR HYPOSPAD REPAIR,1 STAGE,DIST,PL ASTY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
54328	PR HYPOSPAD REPR,1 STAGE,DIST,EXTENSV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
54332	PR HYPOSPAD REPR,1 STAGE,PROX,EXTENSV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
54336	PR HYPOSPAD REPR,1 STAGE,PERINEAL,EXTEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
54340	PR RPR HYPOSPADIAS COMPLCTJS CLSR INC/EXC SIMPLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
54344	PR RPR HYPOSPADIAS COMPLCTJS MOBLJ FLAPS & URTP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
54348	PR RPR HYPOSPADIAS COMPLCTJS DSJ & URTP FLAP/GRF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
54352	PR REVISION PRIOR HYPOSPADIAS REPAIR DSJ&EXC RCNSTJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
54360	PR PENIS PLASTIC SURG,CORREC T ANGULATN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54380	PR REPAIR PENIS,EISPAD IUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54385	PR REPAIR PENIS,EISPAD IUS+INCONTIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
54390	PR REPAIR PENIS,EPISPAD +EXSTROPHY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54406	PR REMVL,INFLAT PENILE PROSTH W/O REPLACMT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54415	PR REMOVAL,PENILE PROSTHESIS W/O REPLACMT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54420	PR CORPORA-SAPHEN VEIN SHUNT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54430	PR CORPORA CAVER-SPONGIOSA SHUNT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
54435	PR CORPORA-GLANS FISTULIZATN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54437	PR REPAIR OF TRAUMATIC CORPOREAL TEAR(S)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54438	PR REPLANTATION PENIS COMP AMPUTATION W/URETH REP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54440	PR REPAIR PENIS POST INJURY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54500	PR BIOPSY OF TESTIS,NEEDLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
54505	PR BIOPSY OF TESTIS,INCISIONAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
54530	PR REMOVAL TESTIS,RADICAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
54550	PR EXPLORE UNDESC TESTIS,INGUINAL/SCROTAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
54600	PR REDUCE TESTIS TORSION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
54620	PR FIXATN OF TESTIS OPP TORSN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
54640	PR ORCHIOPEXY INGUINAL OR SCROTAL APPROACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
54650	PR ORCHIOPEXY,A ABD APPRCH,ABD TESTIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
54660	PR INSERT TESTICULAR PROSTHESIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
54670	PR REPAIR TESTIS INJURY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
54680	PR RELOCATION OF TESTIS(ES)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
54690	PR LAP,ORCHIECTOMY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
54692	PR LAP,ORCHIOPEXY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
54800	PR BIOPSY OF EPIDIDYMIS,NEEDLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
55250	PR REMOVAL OF SPERM DUCT(S)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2021
55700	PR BIOPSY OF PROSTATE,NEEDLE/PUNCH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
55705	PR BIOPSY OF PROSTATE,INCISIONAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
55706	PR BIOPSY OF PROSTATE,NEEDLE,TRANSPERINEAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
55867	PR LAPAROSCOPY , SURGICAL PROSTATECTOMY, SIMPLE SUBTOTAL (INCLUDING CONTROL OF POSTOPERATIVE BLEEDING, VASECTOMY, MEATOTOMY, URETHRAL CALIBRATION AND/OR DILATION, AND INTERNAL URETHROTOMY),	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
55970	PR SEX TRANSFORMATION, M TO F	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	12/30/2020
55980	PR SEX TRANSFORMATION, F TO M	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	12/30/2020

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
56405	PR I&D OF VULVA/PERINE UM ABSCESS	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
56405	PR I&D OF VULVA/PERINE UM ABSCESS	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
56420	PR I&D BARTHOLIN GLAND ABSCESS	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
56420	PR I&D BARTHOLIN GLAND ABSCESS	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
56440	PR MARSUP BARTHOLIN GLAND CYST	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
56440	PR MARSUP BARTHOLIN GLAND CYST	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED IF PERFORMED IN OUTPATIENT SETTING (22, 24). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
56501	PR DESTRUCTION, LESION (S), VULVA, SIMPLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
56515	PR DESTRUCTION, LESION (S), VULVA; EXTENSIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
56605	PR BIOPSY VULVA/PERINEUM, ONE LESN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
56606	PR BX, VULVA/PERINEUM, ADDL LESION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
56800	PR REPAIR OF VAGINA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
56805	PR REPAIR CLITORIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
56810	PR REPAIR OF PERINEUM, NON OBSTETRICAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
57100	PR BIOPSY OF VAGINA,SIMPLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
57105	PR BIOPSY OF VAGINA,EXTENSIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
57156	PR INSERT VAGINAL RADIATION DEVICE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
57291	PR CONSTRUCTION ARTIFICIAL VAGINA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
57292	PR CONSTRUCT ARTIFICIAL VAGINA W GRAFT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
57335	PR REVISE VAGINA FOR INTERSECTION STATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
57415	PR REMOVAL VAGINAL FOR.BODY W ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
57452	PR COLPOSCOPY, CERVIX W/ADJ VAGINA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
57452	PR COLPOSCOPY, CERVIX W/ADJ VAGINA	NO AUTHORIZATION REQUIRED	TMPPM RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A CHILD ABUSE PEDIATRICS	HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
57452	PR COLPOSCOPY, CERVIX W/ADJ VAGINA	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A CHILD ABUSE PEDIATRIC EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
57454	PR COLPOSC, CERVIX W/ADJ VAG, W/BX & CURRETAG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
57455	PR COLPOSCOPY, CERVIX W/ADJ VAGINA, W/BX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
57456	PR COLPOSCOPY, CERVIX W/ADJ VAGINA, CURETTAG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
57460	PR COLPOSCOPY, CERVIX W/ADJ VAG, W/LOOP BX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
57461	PR COLPOSCOPY, CERVIX W/ADJ VAG, W/LOOP CONIZ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
57500	PR BIOPSY CERVIX, 1 OR MORE, OR EXCISION OF LESION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
57505	PR ENDOCERVICAL CURETTAGE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
57510	PR CAUTERIZATION, CERVIX, ELECTRO/THERMAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
57511	PR CRYOCAUTERY OF CERVIX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
57513	PR LASER SURGERY OF CERVIX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
57520	PR CONIZATION CERVIX, KNIFE/LASER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
57522	PR CONIZATION CERVIX, LOOP ELECTRD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
57530	PR REMOVAL OF CERVIX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
57531	PR REMOVAL OF CERVIX, RADICAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
57540	PR REMV CERV STUMP, ABD APPRCH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
57545	PR REMV CERV STUMP, ABD, FIX PELV FLOOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
57550	PR REMV CERV STUMP,VAG APPRCH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
57555	PR REMV CERV STUMP,VAG,AN T/POST FIX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
57556	PR REMV CERV STUMP,VAG,FIX ENTEROCELE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
57558	PR D&C OF CERVIX STUMP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
57558	PR D&C OF CERVIX STUMP	<p>AUTHORIZATION REQUIRED</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: O01.9, O00.1-O00.2, O00.8-O00.9, O02.0, O02.1, O03.0, O03.1, O03.2, O03.30-O03.31, O03.33-O03.34, O03.37-O03.39, O03.4, O03.5, O03.6, O03.7, O03.80-O03.88, O03.9, O04.5, O04.6, O04.7, O04.80-O04.89, O07.0, O07.1, O07.2, O07.30-O07.39, O07.4, O20.0, O20.8-O20.9, O43.211-O43.213, O43.221-O43.223, O43.231-O43.233, O43.239, O44.00-O44.03, O44.10-O44.13, O45.001-O45.003, O45.011-O45.013, O45.021-O45.023, O45.091-O45.093, O45.8X1-O45.9-8X3, O45.8X9, O45.91-O45.93, O46.001-O46.003, O46.011-O46.013, O46.021-O46.023, O46.091-O46.093, O46.009, O46.029, O46.099, O46.19, O46.8X1-O46.8X3, O46.8X19, O46.91-O46.93, O67.0, O67.8-O67.9, O72.0, O72.1, O72.2, O72.3, O73.0, O73.1, Z33.2</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK,CP		2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
57558	PR D&C OF CERVIX STUMP	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH REQUIRED FOR THESE DIAGNOSIS CODES: O01.9, O00.1-O00.2, O00.8-O00.9, O02.0, O02.1, O03.0, O03.1, O03.2, O03.30-O03.31, O03.33-O03.34, O03.37-O03.39, O03.4, O03.5, O03.6, O03.7, O03.80-O03.88, O03.9, O04.5, O04.6, O04.7, O04.80-O04.89, O07.0, O07.1, O07.2, O07.30-O07.39, O07.4, O20.0, O20.8-O20.9, O43.211-O43.213, O43.221-O43.223, O43.231-O43.233, O43.239, O44.00-O44.03, O44.10-O44.13, O45.001-O45.003, O45.011-O45.013, O45.021-O45.023, O45.091-O45.093, O45.8X1-O45.9-8X3, O45.8X9, O45.91-O45.93, O46.001-O46.003, O46.011-O46.013, O46.021-O46.023, O46.091-O46.093, O46.009, O46.029, O46.099, O46.19, O46.8X1-O46.8X3, O46.8X19, O46.91-O46.93, O67.0, O67.8-O67.9, O72.0, O72.1, O72.2, O72.3, O73.0, O73.1, Z33.2		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		12/1/2022
57700	PR REVISION OF CERVIX, NON OBSTETRICAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
57720	PR PLASTIC REPR CERVIX, VAG APPRCH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
57800	PR DILATION OF CERVICAL CANAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
57820	PR D&C OF CERVIX STUMP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
58100	PR BIOPSY OF UTERUS LINING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
58150	PR TOTAL ABDOM HYSTERECTOM Y	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58152	PR TOTAL ABD HYSTERECTOM Y+BLAD REPR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58180	PR SUPRACERV ABD HYSTERECTOM Y	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
58200	PR TOTAL ABD HYSTEREC +LTD NODES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58210	PR RADICAL ABD HYSTEREC +PELV NODES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58240	PR PELVIC EXENTERATN,G YN MALIGNANCY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58260	PR VAGINAL HYSTERECTOM Y,UTERUS 250 GMS/<	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
58262	PR VAG HYST,RMV TUBE/OVARY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58263	PR VAG HYST,RMV TUBE/OVARY,FI X ENTEROCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58267	PR VAG HYST,REV VAG/URETHRA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58270	PR VAG HYST,REV VAG/URETHR,FI X ENTEROCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
58275	PR VAG HYST, W/VAGINECTOMY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58280	PR VAG HYST,RMV VAG, FIX ENTEROCELE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58285	PR VAG HYST RADICAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58290	PR VAG HYST, UTERUS >250 GMS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
58291	PR VAG HYST,UTERUS >250 GMS,REM TUBE/OVARY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58292	PR VAG HYST,>250 GMS,SOOPH,R EPR ENTEROCELE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58294	PR VAG HYST,>250 GMS,REPR ENTEROCELE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58300	PR INSERT INTRAUTERINE DEVICE	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	5/10/2021
58301	PR REMOVE INTRAUTERINE DEVICE	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
58340	PR CATH/INJECT HYSTEROSALPINGOGRAM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58555	PR HYSTEROSCOPY,DX,SEP PROC	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58558	PR HYSTEROSCOPY,W/ENDO BX	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58559	PR HYSTEROSCOPY,LYSIS ADHESIONS	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58560	PR HYSTEROSCOPY,RESECT SEPTUM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
58561	PR HYSTEROSCOPY, RMV MYOMA	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58562	PR HYSTEROSCOPY, RMV FB	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58563	PR HYSTEROSCOPY, W/ENDOMETRIAL ABLATION	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58565	PR HYSTEROSCOPY, STERILIZE W IMPLANTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	5/1/2022
58570	PR LAPAROSCOPY W TOT HYSTERECT UTERUS 250 GRAM OR LESS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
58571	PR LAPAROSCOPY W TOT HYSTERECTUT ERUS <=250 GRAM W TUBE/OVARY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58572	PR LAPAROSCOPY TOTAL HYSTERECTOM Y UTERUS > 250 GRAM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
58573	PR LAPAROSCOPY TOT HYSTERECTOM Y UTERUS >250 GRAM W TUBE/OVARY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
58600	PR LIGATE FALLOPIAN TUBE	NO AUTHORIZATION REQUIRED	<p>MD GUIDELINE 1 (BILATERAL TUBAL LIGATION WITH SALPINGECTOMY OR OOPHORECTOMY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BILATERAL-TUBAL-LIGATION-WITH-SALPINGECTOMY-OR-OOPHORECTOMY.PDF</p> <p>MD GUIDELINE 2 (BILATERAL TUBAL LIGATION WITH SALPINGECTOMY OR OOPHORECTOMY ATTESTATION.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BILATERAL-TUBAL-LIGATION-WITH-SALPINGECTOMY-OR-OOPHORECTOMY-ATTESTATION.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	5/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
58605	PR LIGATE FALLOPIAN TUBE,POSTPARTUM	NO AUTHORIZATION REQUIRED	<p>MD GUIDELINE 1 (BILATERAL TUBAL LIGATION WITH SALPINGECTOMY OR OOPHORECTOMY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BILATERAL-TUBAL-LIGATION-WITH-SALPINGECTOMY-OR-OOPHORECTOMY.PDF</p> <p>MD GUIDELINE 2 (BILATERAL TUBAL LIGATION WITH SALPINGECTOMY OR OOPHORECTOMY ATTESTATION.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BILATERAL-TUBAL-LIGATION-WITH-SALPINGECTOMY-OR-OOPHORECTOMY-ATTESTATION.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	5/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
58611	PR LIGATION,FALL OPIAN TUBE W/C-SECTION	NO AUTHORIZATION REQUIRED	<p>MD GUIDELINE 1 (BILATERAL TUBAL LIGATION WITH SALPINGECTOMY OR OOPHORECTOMY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BILATERAL-TUBAL-LIGATION-WITH-SALPINGECTOMY-OR-OOPHORECTOMY.PDF</p> <p>MD GUIDELINE 2 (BILATERAL TUBAL LIGATION WITH SALPINGECTOMY OR OOPHORECTOMY ATTESTATION.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BILATERAL-TUBAL-LIGATION-WITH-SALPINGECTOMY-OR-OOPHORECTOMY-ATTESTATION.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	5/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
58615	PR OCCLUDE FALLOPIAN TUBE BY DEVICE	NO AUTHORIZATION REQUIRED	<p>MD GUIDELINE 1 (BILATERAL TUBAL LIGATION WITH SALPINGECTOMY OR OOPHORECTOMY.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/BILATERAL-TUBAL-LIGATION-WITH-SALPINGECTOMY-OR-OOPHORECTOMY.PDF</p> <p>MD GUIDELINE 2 (BILATERAL TUBAL LIGATION WITH SALPINGECTOMY OR OOPHORECTOMY ATTESTATION.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/BILATERAL-TUBAL-LIGATION-WITH-SALPINGECTOMY-OR-OOPHORECTOMY-ATTESTATION.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	5/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
58661	PR LAP,RMV ADNEXAL STRUCTURE	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (BILATERAL TUBAL LIGATION WITH SALPINGECTOMY OR OOPHORECTOMY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BILATERAL-TUBAL-LIGATION-WITH-SALPINGECTOMY-OR-OOPHORECTOMY.PDF</p> <p>MD GUIDELINE 2 (BILATERAL TUBAL LIGATION WITH SALPINGECTOMY OR OOPHORECTOMY ATTESTATION.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BILATERAL-TUBAL-LIGATION-WITH-SALPINGECTOMY-OR-OOPHORECTOMY-ATTESTATION.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	8/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
58670	PR LAP,TUBAL CAUTERY	NO AUTHORIZATION REQUIRED	<p>MD GUIDELINE 1 (BILATERAL TUBAL LIGATION WITH SALPINGECTOMY OR OOPHORECTOMY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BILATERAL-TUBAL-LIGATION-WITH-SALPINGECTOMY-OR-OOPHORECTOMY.PDF</p> <p>MD GUIDELINE 2 (BILATERAL TUBAL LIGATION WITH SALPINGECTOMY OR OOPHORECTOMY ATTESTATION.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BILATERAL-TUBAL-LIGATION-WITH-SALPINGECTOMY-OR-OOPHORECTOMY-ATTESTATION.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	5/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
58671	PR LAP,TUBAL BLOCK BY DEVICE	NO AUTHORIZATION REQUIRED	<p>MD GUIDELINE 1 (BILATERAL TUBAL LIGATION WITH SALPINGECTOMY OR OOPHORECTOMY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BILATERAL-TUBAL-LIGATION-WITH-SALPINGECTOMY-OR-OOPHORECTOMY.PDF</p> <p>MD GUIDELINE 2 (BILATERAL TUBAL LIGATION WITH SALPINGECTOMY OR OOPHORECTOMY ATTESTATION.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BILATERAL-TUBAL-LIGATION-WITH-SALPINGECTOMY-OR-OOPHORECTOMY-ATTESTATION.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	5/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
58700	PR REMOVAL OF FALLOPIAN TUBE	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (BILATERAL TUBAL LIGATION WITH SALPINGECTOMY OR OOPHORECTOMY.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/BILATERAL-TUBAL-LIGATION-WITH-SALPINGECTOMY-OR-OOPHORECTOMY.PDF</p> <p>MD GUIDELINE 2 (BILATERAL TUBAL LIGATION WITH SALPINGECTOMY OR OOPHORECTOMY ATTESTATION.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/BILATERAL-TUBAL-LIGATION-WITH-SALPINGECTOMY-OR-OOPHORECTOMY-ATTESTATION.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	8/10/2021
58900	PR BIOPSY OF OVARY(S)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
59000	PR AMNIOCENTESIS,DIAGNOSTIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
59001	PR AMNIOCENTESIS, THER AMNIOTIC FLUID REDUCT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59012	PR FETAL CORD PUNCTURE, PR ENATAL	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A MATERNAL-FETAL MEDICINE (MFM)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		5/10/2021
59012	PR FETAL CORD PUNCTURE, PR ENATAL	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH REQUIRED IF REFERRED TO PROVIDER IS A NOT A MATERNAL-FETAL MEDICINE (MFM) EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		5/10/2021
59025	PR FETAL NON-STRESS TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		5/10/2021
59120	PR TREAT ECTOPIC PREG, RMV TUBE/OVARY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		9/1/2021
59121	PR TREAT ECTOPIC PREG, NON REMVAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		9/1/2021
59150	PR RX ECTOP PREG BY LAPAROSCOPE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		9/1/2021
59151	PR RX ECTOP PREG BY SCOPE, RMV TUBE/OVRY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		9/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59160	PR D&C AFTER DELIVERY	<p>NO AUTHORIZATION REQUIRED</p> <p>DIAGNOSIS CODES: NO AUTH REQUIRED FOR THESE DIAGNOSIS CODES: O01.9, O00.1-O00.2, O00.8-O00.9, O02.0, O02.1, O03.0, O03.1, O03.2, O03.30-O03.31, O03.33-O03.34, O03.37-O03.39, O03.4, O03.5, O03.6, O03.7, O03.80-O03.88, O03.9, O04.5, O04.6, O04.7, O04.80-O04.89, O07.0, O07.1, O07.2, O07.30-O07.39, O07.4, O20.0, O20.8-O20.9, O43.211-O43.213, O43.221-O43.223, O43.231-O43.233, O43.239, O44.00-O44.03, O44.10-O44.13, O45.001-O45.003, O45.011-O45.013, O45.021-O45.023, O45.091-O45.093, O45.8X1-O45.9-8X3, O45.8X9, O45.91-O45.93, O46.001-O46.003, O46.011-O46.013, O46.021-O46.023, O46.091-O46.093, O46.009, O46.029, O46.099, O46.19, O46.8X1-O46.8X3, O46.8X19, O46.91-O46.93, O67.0, O67.8-O67.9, O72.0, O72.1, O72.2, O72.3, O73.0, O73.1, Z33.2</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59160	PR D&C AFTER DELIVERY	<p>AUTHORIZATION REQUIRED</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: O01.9, O00.1-O00.2, O00.8-O00.9, O02.0, O02.1, O03.0, O03.1, O03.2, O03.30-O03.31, O03.33-O03.34, O03.37-O03.39, O03.4, O03.5, O03.6, O03.7, O03.80-O03.88, O03.9, O04.5, O04.6, O04.7, O04.80-O04.89, O07.0, O07.1, O07.2, O07.30-O07.39, O07.4, O20.0, O20.8-O20.9, O43.211-O43.213, O43.221-O43.223, O43.231-O43.233, O43.239, O44.00-O44.03, O44.10-O44.13, O45.001-O45.003, O45.011-O45.013, O45.021-O45.023, O45.091-O45.093, O45.8X1-O45.9-8X3, O45.8X9, O45.91-O45.93, O46.001-O46.003, O46.011-O46.013, O46.021-O46.023, O46.091-O46.093, O46.009, O46.029, O46.099, O46.19, O46.8X1-O46.8X3, O46.8X19, O46.91-O46.93, O67.0, O67.8-O67.9, O72.0, O72.1, O72.2, O72.3, O73.0, O73.1, Z33.2</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK,CP		2/1/2022
59320	PR REVISION CERVIX W PREG,VAG APPRCH	<p>AUTHORIZATION REQUIRED</p> <p>PLACE OF SERVICE: PRIOR AUTH IS REQUIRED FOR INPATIENT SETTING, (21).</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK,CP		5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59320	PR REVISION CERVIX W PREG,VAG APPRCH	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED FOR OUTPATIENT SETTING, (22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
59325	PR REVISION CERVIX W PREG,ABD APPRCH	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED FOR OUTPATIENT SETTING, (22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
59325	PR REVISION CERVIX W PREG,ABD APPRCH	AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS REQUIRED FOR INPATIENT SETTING, (21). EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
59400	PR FULL ROUT OBSTE CARE,VAGINAL DELIV	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED FOR UP TO 4 DAYS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59400	PR FULL ROUT OBSTE CARE,VAGINAL DELIV	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 4 DAYS.	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
59409	PR OBSTETRICAL CARE,VAG DELIV ONLY	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 4 DAYS.	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
59409	PR OBSTETRICAL CARE,VAG DELIV ONLY	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED FOR UP TO 4 DAYS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
59410	PR OBSTE CARE,VAG DELIV +POSTPARTUM	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED FOR UP TO 4 DAYS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59410	PR OBSTE CARE,VAG DELIV +POSTPARTUM	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 4 DAYS.	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
59430	PR CARE AFTER DELIVERY ONLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		8/1/2021
59510	PR FULL ROUT OBSTE CARE,CESARE AN DELIV	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED FOR UP TO 6 DAYS	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
59510	PR FULL ROUT OBSTE CARE,CESARE AN DELIV	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 6 DAYS	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59514	PR CESAREAN DELIVERY ONLY	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED FOR UP TO 6 DAYS	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
59514	PR CESAREAN DELIVERY ONLY	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 6 DAYS	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
59515	PR CESAREAN DELIVERY +POSTPARTUM CARE	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 6 DAYS	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59515	PR CESAREAN DELIVERY +POSTPARTUM CARE	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED FOR UP TO 6 DAYS	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
59610	PR ROUT OB CARE,VAG DELIV,PREV C-SEC	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 4 DAYS.	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
59610	PR ROUT OB CARE,VAG DELIV,PREV C-SEC	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED FOR UP TO 4 DAYS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
59612	PR VAG DELIV ONLY,PREV C-SECTN	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 4 DAYS.	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59612	PR VAG DELIV ONLY,PREV C-SECTN	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED FOR UP TO 4 DAYS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
59614	PR VAG DELIV +POSTPARTUM CARE,PREV C-SEC	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 4 DAYS.	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
59614	PR VAG DELIV +POSTPARTUM CARE,PREV C-SEC	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED FOR UP TO 4 DAYS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
59618	PR ROUT OB CARE,C-SEC,PREV C-SEC	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED FOR UP TO 6 DAYS	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59618	PR ROUT OB CARE,C-SEC,PREV C-SEC	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 6 DAYS	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
59620	PR C-SEC ONLY,PREV C-SEC	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED FOR UP TO 6 DAYS	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
59620	PR C-SEC ONLY,PREV C-SEC	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 6 DAYS	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59622	PR C-SEC +POSTPARTUM CARE,PREV C- SEC	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED FOR UP TO 6 DAYS	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
59622	PR C-SEC +POSTPARTUM CARE,PREV C- SEC	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 6 DAYS	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59812	PR SURG RX INCOMPLETE ABORTN	<p>AUTHORIZATION REQUIRED</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: O01.9, O00.1-O00.2, O00.8-O00.9, O02.0, O02.1, O03.0, O03.1, O03.2, O03.30-O03.31, O03.33-O03.34, O03.37-O03.39, O03.4, O03.5, O03.6, O03.7, O03.80-O03.88, O03.9, O04.5, O04.6, O04.7, O04.80-O04.89, O07.0, O07.1, O07.2, O07.30-O07.39, O07.4, O20.0, O20.8-O20.9, O43.211-O43.213, O43.221-O43.223, O43.231-O43.233, O43.239, O44.00-O44.03, O44.10-O44.13, O45.001-O45.003, O45.011-O45.013, O45.021-O45.023, O45.091-O45.093, O45.8X1-O45.9-8X3, O45.8X9, O45.91-O45.93, O46.001-O46.003, O46.011-O46.013, O46.021-O46.023, O46.091-O46.093, O46.009, O46.029, O46.099, O46.19, O46.8X1-O46.8X3, O46.8X19, O46.91-O46.93, O67.0, O67.8-O67.9, O72.0, O72.1, O72.2, O72.3, O73.0, O73.1, Z33.2</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK,CP		2/1/2022

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59812	PR SURG RX INCOMPLETE ABORTN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		12/1/2022
		DIAGNOSIS CODES: NO AUTH REQUIRED FOR THESE DIAGNOSIS CODES: O01.9, O00.1-O00.2, O00.8-O00.9, O02.0, O02.1, O03.0, O03.1, O03.2, O03.30-O03.31, O03.33-O03.34, O03.37-O03.39, O03.4, O03.5, O03.6, O03.7, O03.80-O03.88, O03.9, O04.5, O04.6, O04.7, O04.80-O04.89, O07.0, O07.1, O07.2, O07.30-O07.39, O07.4, O20.0, O20.8-O20.9, O43.211-O43.213, O43.221-O43.223, O43.231-O43.233, O43.239, O44.00-O44.03, O44.10-O44.13, O45.001-O45.003, O45.011-O45.013, O45.021-O45.023, O45.091-O45.093, O45.8X1-O45.9-8X3, O45.8X9, O45.91-O45.93, O46.001-O46.003, O46.011-O46.013, O46.021-O46.023, O46.091-O46.093, O46.009, O46.029, O46.099, O46.19, O46.8X1-O46.8X3, O46.8X19, O46.91-O46.93, O67.0, O67.8-O67.9, O72.0, O72.1, O72.2, O72.3, O73.0, O73.1, Z33.2					

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59820	PR SURG RX MISSED ABORTN,1ST TRI	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH REQUIRED FOR THESE DIAGNOSIS CODES: O01.9, O00.1-O00.2, O00.8-O00.9, O02.0, O02.1, O03.0, O03.1, O03.2, O03.30-O03.31, O03.33-O03.34, O03.37-O03.39, O03.4, O03.5, O03.6, O03.7, O03.80-O03.88, O03.9, O04.5, O04.6, O04.7, O04.80-O04.89, O07.0, O07.1, O07.2, O07.30-O07.39, O07.4, O20.0, O20.8-O20.9, O43.211-O43.213, O43.221-O43.223, O43.231-O43.233, O43.239, O44.00-O44.03, O44.10-O44.13, O45.001-O45.003, O45.011-O45.013, O45.021-O45.023, O45.091-O45.093, O45.8X1-O45.9-8X3, O45.8X9, O45.91-O45.93, O46.001-O46.003, O46.011-O46.013, O46.021-O46.023, O46.091-O46.093, O46.009, O46.029, O46.099, O46.19, O46.8X1-O46.8X3, O46.8X19, O46.91-O46.93, O67.0, O67.8-O67.9, O72.0, O72.1, O72.2, O72.3, O73.0, O73.1, Z33.2		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		12/1/2022

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date	
59820	PR SURG RX MISSED ABORTN,1ST TRI	<p>AUTHORIZATION REQUIRED</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: O01.9, O00.1-O00.2, O00.8-O00.9, O02.0, O02.1, O03.0, O03.1, O03.2, O03.30-O03.31, O03.33-O03.34, O03.37-O03.39, O03.4, O03.5, O03.6, O03.7, O03.80-O03.88, O03.9, O04.5, O04.6, O04.7, O04.80-O04.89, O07.0, O07.1, O07.2, O07.30-O07.39, O07.4, O20.0, O20.8-O20.9, O43.211-O43.213, O43.221-O43.223, O43.231-O43.233, O43.239, O44.00-O44.03, O44.10-O44.13, O45.001-O45.003, O45.011-O45.013, O45.021-O45.023, O45.091-O45.093, O45.8X1-O45.9-8X3, O45.8X9, O45.91-O45.93, O46.001-O46.003, O46.011-O46.013, O46.021-O46.023, O46.091-O46.093, O46.009, O46.029, O46.099, O46.19, O46.8X1-O46.8X3, O46.8X19, O46.91-O46.93, O67.0, O67.8-O67.9, O72.0, O72.1, O72.2, O72.3, O73.0, O73.1, Z33.2</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	TMPPM	<p>PROPRIETARY DISCLAIMER</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK,CP		2/1/2022

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date	
59821	PR SURG RX MISSED ABORTN,2ND TRI	<p>AUTHORIZATION REQUIRED</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: O01.9, O00.1-O00.2, O00.8-O00.9, O02.0, O02.1, O03.0, O03.1, O03.2, O03.30-O03.31, O03.33-O03.34, O03.37-O03.39, O03.4, O03.5, O03.6, O03.7, O03.80-O03.88, O03.9, O04.5, O04.6, O04.7, O04.80-O04.89, O07.0, O07.1, O07.2, O07.30-O07.39, O07.4, O20.0, O20.8-O20.9, O43.211-O43.213, O43.221-O43.223, O43.231-O43.233, O43.239, O44.00-O44.03, O44.10-O44.13, O45.001-O45.003, O45.011-O45.013, O45.021-O45.023, O45.091-O45.093, O45.8X1-O45.9-8X3, O45.8X9, O45.91-O45.93, O46.001-O46.003, O46.011-O46.013, O46.021-O46.023, O46.091-O46.093, O46.009, O46.029, O46.099, O46.19, O46.8X1-O46.8X3, O46.8X19, O46.91-O46.93, O67.0, O67.8-O67.9, O72.0, O72.1, O72.2, O72.3, O73.0, O73.1, Z33.2</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	TMPPM	<p>PROPRIETARY DISCLAIMER</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK,CP		2/1/2022

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59821	PR SURG RX MISSED ABORTN,2ND TRI	NO AUTHORIZATION REQUIRED	DIAGNOSIS CODES: NO AUTH REQUIRED FOR THESE DIAGNOSIS CODES: O01.9, O00.1-O00.2, O00.8-O00.9, O02.0, O02.1, O03.0, O03.1, O03.2, O03.30-O03.31, O03.33-O03.34, O03.37-O03.39, O03.4, O03.5, O03.6, O03.7, O03.80-O03.88, O03.9, O04.5, O04.6, O04.7, O04.80-O04.89, O07.0, O07.1, O07.2, O07.30-O07.39, O07.4, O20.0, O20.8-O20.9, O43.211-O43.213, O43.221-O43.223, O43.231-O43.233, O43.239, O44.00-O44.03, O44.10-O44.13, O45.001-O45.003, O45.011-O45.013, O45.021-O45.023, O45.091-O45.093, O45.8X1-O45.9-8X3, O45.8X9, O45.91-O45.93, O46.001-O46.003, O46.011-O46.013, O46.021-O46.023, O46.091-O46.093, O46.009, O46.029, O46.099, O46.19, O46.8X1-O46.8X3, O46.8X19, O46.91-O46.93, O67.0, O67.8-O67.9, O72.0, O72.1, O72.2, O72.3, O73.0, O73.1, Z33.2	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		12/1/2022

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59830	PR SURG RX SEPTIC ABORTN	<p>NO AUTHORIZATION REQUIRED</p> <p>DIAGNOSIS CODES: NO AUTH REQUIRED FOR THESE DIAGNOSIS CODES: O01.9, O00.1-O00.2, O00.8-O00.9, O02.0, O02.1, O03.0, O03.1, O03.2, O03.30-O03.31, O03.33-O03.34, O03.37-O03.39, O03.4, O03.5, O03.6, O03.7, O03.80-O03.88, O03.9, O04.5, O04.6, O04.7, O04.80-O04.89, O07.0, O07.1, O07.2, O07.30-O07.39, O07.4, O20.0, O20.8-O20.9, O43.211-O43.213, O43.221-O43.223, O43.231-O43.233, O43.239, O44.00-O44.03, O44.10-O44.13, O45.001-O45.003, O45.011-O45.013, O45.021-O45.023, O45.091-O45.093, O45.8X1-O45.9-8X3, O45.8X9, O45.91-O45.93, O46.001-O46.003, O46.011-O46.013, O46.021-O46.023, O46.091-O46.093, O46.009, O46.029, O46.099, O46.19, O46.8X1-O46.8X3, O46.8X19, O46.91-O46.93, O67.0, O67.8-O67.9, O72.0, O72.1, O72.2, O72.3, O73.0, O73.1, Z33.2</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59830	PR SURG RX SEPTIC ABORTN	<p>AUTHORIZATION REQUIRED</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: O01.9, O00.1-O00.2, O00.8-O00.9, O02.0, O02.1, O03.0, O03.1, O03.2, O03.30-O03.31, O03.33-O03.34, O03.37-O03.39, O03.4, O03.5, O03.6, O03.7, O03.80-O03.88, O03.9, O04.5, O04.6, O04.7, O04.80-O04.89, O07.0, O07.1, O07.2, O07.30-O07.39, O07.4, O20.0, O20.8-O20.9, O43.211-O43.213, O43.221-O43.223, O43.231-O43.233, O43.239, O44.00-O44.03, O44.10-O44.13, O45.001-O45.003, O45.011-O45.013, O45.021-O45.023, O45.091-O45.093, O45.8X1-O45.9-8X3, O45.8X9, O45.91-O45.93, O46.001-O46.003, O46.011-O46.013, O46.021-O46.023, O46.091-O46.093, O46.009, O46.029, O46.099, O46.19, O46.8X1-O46.8X3, O46.8X19, O46.91-O46.93, O67.0, O67.8-O67.9, O72.0, O72.1, O72.2, O72.3, O73.0, O73.1, Z33.2</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK, CP		2/1/2022
59840	PR INDUCED ABORTN BY D&C	<p>AUTHORIZATION REQUIRED</p>	<p>TMPPM</p> <p>PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	S, SK	C, CP	8/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59841	PR INDUCED ABORTN BY DIL/EVAC	AUTHORIZATION REQUIRED	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	8/10/2021
59850	PR INDUCED ABORTN BY INTRA-AMNIOT INJ	AUTHORIZATION REQUIRED	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	8/10/2021
59851	PR INDUCED AB BY INJECT +D&C/EVAC	AUTHORIZATION REQUIRED	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	8/10/2021
59852	PR INDUCED AB BY INJECT +OPEN UTERUS	AUTHORIZATION REQUIRED	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	8/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59855	PR INDUCED AB BY VAG SUPPOS	AUTHORIZATION REQUIRED	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	8/10/2021
59870	PR EVACUATE MOLE OF UTERUS	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH REQUIRED FOR THESE DIAGNOSIS CODES: O01.9, O00.1-O00.2, O00.8-O00.9, O02.0, O02.1, O03.0, O03.1, O03.2, O03.30-O03.31, O03.33-O03.34, O03.37-O03.39, O03.4, O03.5, O03.6, O03.7, O03.80-O03.88, O03.9, O04.5, O04.6, O04.7, O04.80-O04.89, O07.0, O07.1, O07.2, O07.30-O07.39, O07.4, O20.0, O20.8-O20.9, O43.211-O43.213, O43.221-O43.223, O43.231-O43.233, O43.239, O44.00-O44.03, O44.10-O44.13, O45.001-O45.003, O45.011-O45.013, O45.021-O45.023, O45.091-O45.093, O45.8X1-O45.9-8X3, O45.8X9, O45.91-O45.93, O46.001-O46.003, O46.011-O46.013, O46.021-O46.023, O46.091-O46.093, O46.009, O46.029, O46.099, O46.19, O46.8X1-O46.8X3, O46.8X19, O46.91-O46.93, O67.0, O67.8-O67.9, O72.0, O72.1, O72.2, O72.3, O73.0, O73.1, Z33.2	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		12/1/2022	

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59870	PR EVACUATE MOLE OF UTERUS	<p>AUTHORIZATION REQUIRED</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: O01.9, O00.1-O00.2, O00.8-O00.9, O02.0, O02.1, O03.0, O03.1, O03.2, O03.30-O03.31, O03.33-O03.34, O03.37-O03.39, O03.4, O03.5, O03.6, O03.7, O03.80-O03.88, O03.9, O04.5, O04.6, O04.7, O04.80-O04.89, O07.0, O07.1, O07.2, O07.30-O07.39, O07.4, O20.0, O20.8-O20.9, O43.211-O43.213, O43.221-O43.223, O43.231-O43.233, O43.239, O44.00-O44.03, O44.10-O44.13, O45.001-O45.003, O45.011-O45.013, O45.021-O45.023, O45.091-O45.093, O45.8X1-O45.9-8X3, O45.8X9, O45.91-O45.93, O46.001-O46.003, O46.011-O46.013, O46.021-O46.023, O46.091-O46.093, O46.009, O46.029, O46.099, O46.19, O46.8X1-O46.8X3, O46.8X19, O46.91-O46.93, O67.0, O67.8-O67.9, O72.0, O72.1, O72.2, O72.3, O73.0, O73.1, Z33.2</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK,CP		2/1/2022
59871	PR REMOVE CERCLAGE SUTURE	<p>AUTHORIZATION REQUIRED</p> <p>PLACE OF SERVICE: PRIOR AUTH IS REQUIRED FOR INPATIENT SETTING, (21).</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK,CP		5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
59871	PR REMOVE CERCLAGE SUTURE	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED FOR OUTPATIENT SETTING, (22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
60100	PR BIOPSY OF THYROID,PERCUT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
61570	PR REMOVE BRAIN FOREIGN BODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
61736	PR LITT LES ICR SINGLE TRAJECTORY 1 SIMPLE LESION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
61737	PR LITT LES ICR MLT TRAJECTORIES MLT/CPLX LESIONS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
61782	PR STEREOTACTIC COMP ASSIST PROC,CRANIAL ,EXTRADURAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
62322	PR NJX DX/THER SBST INTRLMNR LMBR/SAC W/O IMG GDN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
63052	PR LAM FACETEC/FORA MOT DRG ARTHRD LUMBAR 1 VRT SGM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2022
63053	PR LAM FACETEC/FORA MOT DRG ARTHRD LMBR EA ADDL SGM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2022
64445	PR INJECTION AA&/STRD SCIATIC NERVE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
64446	PR INJECTION AA&/STRD SCIATIC NERVE CONT NFS CATH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
64447	PR INJECTION AA&/STRD FEMORAL NERVE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
64470	PR INJ,PARAVERT EBRAL C/T,1 LEVEL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
64472	PR INJ,PARAVERT EBRAL C/T,ADDL LEVELS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
64475	PR INJ,PARAVERT EBRAL L/S,1 LEVEL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
64476	PR INJ,PARAVERT EBRAL L/S,ADDL LEVELS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
64479	PR NJX AA&/STRD TFRML EPI CERVICAL/THO RACIC 1 LEVEL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
64480	PR NJX AA&/STRD TFRML EPI CERVICAL/THO RACIC EA ADDL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
64483	PR NJX AA&/STRD TFRML EPI LUMBAR/SACR AL 1 LEVEL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
64484	PR NJX AA&/STRD TFRML EPI LUMBAR/SACR AL EA ADDL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
64486	PR TAP BLOCK UNILATERAL BY INJECTION (S)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
64487	PR TAP BLOCK UNILATERAL BY CONTINUOUS INFUSION(S)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
64488	PR TAP BLOCK BILATERAL BY INJECTION(S)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
64489	PR TAP BLOCK BILATERAL BY CONTINUOUS INFUSION(S)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
64490	PR NJX DX/THER AGT PVRT FACET JT CRV/THRC 1 LEVEL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
64491	PR NJX DX/THER AGT PVRT FACET JT CRV/THRC 2ND LEVEL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
64492	PR NJX DX/THER AGT PVRT FACET JT CRV/THRC 3+ LEVEL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
64493	PR NJX DX/THER AGT PVRT FACET JT LMBR/SAC 1 LEVEL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
64494	PR NJX DX/THER AGT PVRT FACET JT LMBR/SAC 2ND LEVEL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
64495	PR NJX DX/THER AGT PVRT FACET JT LMBR/SAC 3+ LEVEL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
64510	PR INJECT NERV BLCK,STELLAT E GANGLION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
64582	PR OPEN IMPLTJ HPGLSL NRV NSTIM RA PG&RESPIR SENSOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
64583	PR REVJ/RPLCMT HPGLSL NERVE NSTIM RA PG&RESPIR SNR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
64584	PR REMOVAL HYPOGLOSSAL NERVE NSTIM RA PG&RESPIR SNR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
64628	PR THERMAL DSTRJ INTRAOSSEOUS BVN 1ST 2 LMBR/SAC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2022
64716	PR REVISION OF CRANIAL NERVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
64732	PR TRANSECT SUPRAORBITAL NERV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
64734	PR TRANSECT INFRAORBITAL NERV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
64736	PR TRANSECT MENTAL NERV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
64738	PR TRANSECT OF JAW NERVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
64740	PR TRANSECT OF TONGUE NERVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
64742	PR TRANSECT OF FACIAL NERVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
64864	PR REPR FACIAL NERVE,EXTRACRANIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
64865	PR REPR FACIAL NERVE,INFRATEMP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
64866	PR ANAST FACIAL-SPINAL ACCESS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
64868	PR ANAST FACIAL-HYPOGLOSSAL NERVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
64870	PR ANAST FACIAL-PHRENIC NERVE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65091	PR REMOVE OCULAR CONTENTS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65093	PR REMOVE OCULAR CONTENTS W IMPLANT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65101	PR REMOVAL OF EYE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65103	PR REMOVE EYE W IMPLANT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65105	PR REMOVE EYE W MUSC TO IMPLANT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65110	PR REMOVAL OF ORBITAL CONTENTS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65112	PR REMOVE ORBIT/REMOV BONE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65114	PR REMOVE ORBIT W MUSC FLAP	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65125	PR MODIFY OCULAR IMPLANT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65130	PR LATE OCULAR IMPLANT POST EVISC	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65135	PR LATE OCUL IMPLNT POST ENUCL,NO MUSC	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65140	PR LATE OCUL IMPLNT POST ENUCL,W MUSC	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65150	PR REINSERT OCULAR IMPLANT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65155	PR REINSERT OCULAR IMPLANT, REINFORCED	AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
		<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>					

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65175	PR REMOVAL OF OCULAR IMPLANT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65205	PR REMV F.B.,EYE,SUPE RF CONJUNC	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
65205	PR REMV F.B.,EYE,SUPE RF CONJUNC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65210	PR REMV F.B.,EYE,EMBE D CONJUNC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
65210	PR REMV F.B.,EYE,EMBE D CONJUNC	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65220	PR REMV F.B.,EYE,CORN EA,NO SLIT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
65220	PR REMV F.B.,EYE,CORN EA,NO SLIT	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65222	PR REMV F.B.,EYE,CORN EA,SLIT LAMP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
65222	PR REMV F.B.,EYE,CORN EA,SLIT LAMP	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65235	PR REMOVAL,FB,IN TRAOCULAR,A NT CHAMBER/LEN S	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
65235	PR REMOVAL,FB,IN TRAOCULAR,A NT CHAMBER/LEN S	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65260	PR REMV F.B.,EYE,POST SGMT,MAGNETI C	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
65260	PR REMV F.B.,EYE,POST SGMT,MAGNETI C	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65265	PR REMV F.B.,EYE,POST SGMT,NONMAG NETIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
65265	PR REMV F.B.,EYE,POST SGMT,NONMAG NETIC	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65270	PR REPAIR CONJUNC LACERATN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65272	PR REPAIR CONJUNC LAC,REARRAN G,NO HOSP	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65273	PR REPAIR CONJUNC LAC,REARRAN G,IN HOSP	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65275	PR REPAIR CORNEA LAC,NONPERFORATING	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65280	PR REPAIR CORNEA LAC,PERF,NO UVEAL	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65285	PR REPAIR CORNEA LAC,PERF,RES EC UVEAL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65286	PR REPAIR CORNEA LAC,APPLY GLUE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65290	PR REPAIR EXTRAOCULAR MUSC WOUND	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65400	PR EXCIS CORNEA LESN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65410	PR BIOPSY OF CORNEA	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65420	PR EXCIS PTERYGIUM	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65426	PR EXCIS PTERYGIUM,W GRAFT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65430	PR CORNEAL SMEAR	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65435	PR CURETTE/TREAT CORNEA	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65436	PR CURETTE/TREAT CORNEA,APPLY CHELATE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65450	PR DESTR CORNEAL LESN,CRYO,PH OTO,THERM	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65600	PR MULT PUNC ANTER CORNEA	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65710	PR CORNEAL TRANSPLANT,L AMELLAR	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65730	PR CORNEAL TRANSPLANT, PENETRATING	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65750	PR CORNEAL TRANSPLANT, PENETRAT, APHA KIA	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65755	PR CORNEAL TRANSPLANT, PEN,PSEUDOAP HAK	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65756	PR CORNEAL TRANSPLANT, ENDOTHELIAL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65757	PR PREP CORNEAL ENDOTHEL ALLOGRAFT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65760	PR KERATOMILEUSIS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65765	PR KERATOPHAKIA	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65767	PR EPIKERATOPLA STY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65770	PR REVISE CORNEA WITH IMPLANT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65771	PR RADIAL KERATOTOMY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65772	PR CORNEAL RELAX INCIS,CORREC ASTIG	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65775	PR CORNEAL WEDGE,CORRECT ASTIGMATISM	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65778	PR PLACE AMNIOTIC MEMBRA OCULAR SURFACE W/O SUTURES	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65779	PR PLACE AMNIOTIC MEMBRANE OCULAR SURFACE SUTURED	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65780	PR OCULAR SURF RECONST, AMNIOTIC TRANSPLANT, MULTIPLE LAYERS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65781	PR OCULAR RECONST, TRANSPLANT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65782	PR OCULAR RECONST, TRANSPLANT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65785	PR IMPLANTATION INTRASTROMAL CORNEAL RING SEGMENTS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65800	PR PARACENTESIS ANT CHAMB EYE ASPIR AQUEOUS SPX	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65810	PR DRAIN ANT CHMBR,REMV VITREOUS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65815	PR DRAIN ANT CHMBR,REMV BLOOD	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65820	PR RELIEVE INNER EYE PRESSURE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65850	PR INCISION OF EYE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65855	PR TRABECULOPLASTY BY LASER SURGERY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65860	PR INCISE INNER EYE ADHESNS,LASER	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65865	PR INCISE INNER EYE ADHESNS,INCI SN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65870	PR INCISE ANT SYNECHIAE,EYE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65875	PR INCISE POST SYNECHIAE,EYE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65880	PR INCISE CORNEO-VITREAL ADHESIONS,EYE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65900	PR REML,EPITH DOWNGROWTH ,ANT CHAMBER,EYE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65920	PR REML,IMPLAN T MATERIAL,ANT SEGMENT,EYE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
65930	PR REMOVAL,BLO OD CLOT,ANT SEGMENT,EYE	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66020	PR INJECTION,ANT CHAMBER,EYE, AIR/LIQUID	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66030	PR INJECT ANTER CHMBR EYE,MEDICATN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66130	PR REMOVE EYE LESION,SCLERA	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66150	PR GLAUCOMA SURG,TREPHIN ATN/IRIDECT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66155	PR GLAUCOMA SURG,THERMO CAUT/IRIDECT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66160	PR GLAUCOMA SURG,SCLERE CT,PUNCH/SCISS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66170	PR GLAUCOMA SURG, TRABEC U AB EXTERNO	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66172	PR GLAUCOMA SURG, TRAB AB EXT, PREV SCAR	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66174	PR TRANSLUMINAL DILATION AQUEOUS CANAL, W/O RETENTION DEVICE/STENT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66175	PR TRANSLUMINAL DILATION AQUEOUS CANAL, W RETENTION DEVICE/STENT	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66179	PR AQUEOUS SHUNT EXTRAOCULAR RESERVOIR W/O GRAFT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66180	PR AQUEOUS SHUNT EXTRAOC EQUAT PLATE RSVR W/GRAFT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66183	PR INSERT ANTER DRAINAGE DEV W/O EXTRAOC RESERVOIR	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66184	PR REVJ SHUNT EXTRAOCULAR RESERVOIR W/O GRAFT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66185	PR REVJ AQUEOUS SHUNT EXTRAOCULAR RESERVOIR W/GRAFT	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66225	PR REPAIR SCLERA STAPHYLOMA W GRAFT	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66250	PR REVIS/REPAIR OP WOUND ANTER SGMT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66500	PR INCISION OF IRIS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66505	PR INCISION OF IRIS,W TRANSFIXATN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66600	PR REMV IRIS/LESION	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66605	PR REMV IRIS,CYCLECTO MY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66625	PR REMV IRIS,PERIPH FOR GLAUCOMA	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66630	PR REMV IRIS,SECTOR FOR GLAUCOMA	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66635	PR REMV IRIS,OPTICAL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66680	PR REPAIR IRIS/CILIARY BODY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66682	PR SUTURE IRIS/CILIARY BODY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66700	PR DESTRUC,CILIA RY BODY,DIATHER MY	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66710	PR DESTRUC,CILIA RY BODY,CYCLOP HOTOCOAG	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66711	PR ECP CILIARY BODY DSTRJ W/O RMVL CRYSTALLINE LENS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66720	PR CILIARY BODY DESTRUCTION CRYOTHERAPY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66740	PR DESTRUC,CILIA RY BODY,CYCLODI ALYSIS	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66761	PR IRIDOTOMY/IRIDECTOMY BY LASER, PER SESSION	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66762	PR IRIDOPLASTY BY PHOTOCOAG	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66770	PR RESEC CYST/LESN IRIS/CILIARY BODY	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66820	PR DISCISSION,2ND CATARACT,INCISIONS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66821	PR DISCISSION,2ND CATARACT,LASER	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66825	PR REPOSITION INTRAOCULAR LENS W INCIS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66830	PR REMV 2ND CATARACT, CO RN-SCLER SECTN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66840	PR REMV LENS MATERIAL,ASPI RATN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66850	PR REMV LENS MATERIAL,PHA COFRAGMT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66852	PR REMV LENS MATERIAL,PAR S PLANAR APPRC	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66920	PR EXTRACT LENS,INTRACA PSULAR	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66930	PR EXTRACT LENS,INTRACA P,DISLOC LENS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66940	PR EXTRACT LENS,EXTRACAPSULAR	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66982	PR XCAPSL CTRC RMVL INSJ IO LENS PROSTH CPLX WO ECP	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66983	PR REMV CATARACT INTRACAP,INSE RT LENS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66984	PR XCAPSL CTRC RMVL INSJ IO LENS PROSTH W/O ECP	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
66984	PR XCAPSL CTRC RMVL INSJ IO LENS PROSTH W/O ECP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66985	PR INSERT LENS PROSTHESIS ONLY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66986	PR EXCHANGE LENS PROSTHESIS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66987	PR XCAPSL CTRC RMVL INSJ IO LENS PROSTH CPLX W/ECP	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66988	PR XCAPSL CTRC RMVL INSJ IO LENS PROSTH W/ECP	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
		<p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>					

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66989	PR XCAPSL CTRC RMVL INSJ IO LENS PRSTH CPLX INSJ 1+	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66990	PR OPHTHALMIC ENDOSCOPE USE	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66991	PR XCAPSL CTRC RMVL INSJ IO LENS PROSTH INSJ 1+	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX . ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
66999	PR EYE SURG ANT SGMT PROC UNLISTED	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67005	PR PART REMV VITREOUS,ANT APPRCH	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67010	PR SUBTOT REMV VITREOUS,MEC H VIRECTOMY	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67015	PR RELEAS VITREOUS,SUB RET/CHOROID FLUID	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67025	PR REPLACE EYE FLUID	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67027	PR IMPLANT EYE DRUG SYSTEM	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67028	PR INJECT INTRAVITREAL PHARMCOLOGI C	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67030	PR INCISE INNER VITREOUS STRANDS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67031	PR LASER SURGERY,SEVER VITREOUS STRANDS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67036	PR VITRECTOMY,M ECHANICAL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67039	PR VITRECTOMY,F OCAL LASER RX RETINA	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67040	PR VITRECTOMY,P ANRETINAL LASER RX	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67041	PR VITRECTOMY PARS PLANA REMOVE PRERETINAL MEMBRANE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67042	PR VITRECTOMY PARS PLANA REMOVE INT MEMB RETINA	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67043	PR VITRECTOMY PARS PLANA REMOVE SUBRETINAL MEMBRANE	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67101	PR RPR RETINAL DTCHMNT DRG SUBRETINAL FLUID CRTX	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67105	PR RPR RETINAL DTCHMNT DRG SUBRETINAL FLUID PC	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67107	PR REPAIR RETINAL DETACHMENT SCLERAL BUCKLING	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67108	PR RPR RETINAL DTCHMNT W/VITRECTOM Y ANY METH	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67110	PR REPAIR DETACD RETINA,INJECT AIR/GAS	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67113	PR RPR COMPLEX RETINA DETACH VITRECT &MEMBRANE PEEL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67115	PR RELEASE ENCIRCL MATERIAL,POST SGMT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67120	PR REMV POST EYE IMPLNT MATER,EXTRA OCUL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67121	PR REMV POST EYE IMPLNT MATER,INTRAOCUL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67141	PR PROPH RETINAL DTCHMNT W/O DRG CRTX DIATHERMY	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67145	PR PROPH RETINAL DTCHMNT W/O DRG PHOTOCOAGU LATION	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67208	PR DESTRUC RETINAL LESN,CRYOTH ERAPY	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67210	PR DESTRUC RETINAL LESN,PHOTOC OAG	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67218	PR DESTRUC RETINAL LESN,RADN IMPLNT	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67220	PR DEST,CHOROID LESION,PHOTO COAG	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67221	PR DEST,CHOROID LESN,PHOTOD YNAMIC THERAPY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67225	PR DEST,CHOROID LESN,PHOTOD YN THER,2ND EYE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67227	PR DESTRUCTION RETINOPATHY CRYOTHERAPY DIATHERMY	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67228	PR TREATMENT EXTENSIVE RETINOPATHY PHOTOCOAGULATION	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67229	PR TX EXTENSIVE RETINOPATHY, PRETERM INFANT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67250	PR REINFORCE SCLERA EYE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67255	PR REINFORCE SCLERA EYE W GRAFT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67299	PR EYE SURG POST SGMT PROC UNLISTED	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67311	PR STRABISMUS SURG,ONE HORIZ MUSCLE	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
		<p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>					

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67312	PR STRABISMUS SURG,TWO HORIZ MUSCLE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67314	PR STRABISMUS SURG,ONE VERT MUSCLE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67316	PR STRABISMUS SURG,2+ VERT MUSCLE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67318	PR STRABISMUS SURG,SUPER-OBLIQ MUSC	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67320	PR TRANSPPOSITIO N ANY EXTRAOCUL MUSC	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67331	PR STRABISM SURG,PREV EYE SURG,NOT MUSC	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67332	PR STRABISMUS SURG, SCAR EXTRAOCUL MUSC	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67334	PR STRABISMUS SURG,POST FIXATN SUTURE	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67335	PR STRABISMUS SURG,PLACE ADJUST SUTURE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67340	PR STRABISMUS SURG,REPAIR DETACH MUSC	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67343	PR RELEASE EXTEN SCAR TISSUE EYE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67345	PR DESTROY NERVE OF EYE MUSCLE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67346	PR BIOPSY OF EXTRAOCULAR MUSCLE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67399	PR UNLISTED PROCEDURE EXTRAOCULAR MUSCLE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67400	PR EXPLORE EYE SOCKET	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67405	PR EXPLORE EYE SOCKET,DRAIN AGE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67412	PR EXPLORE EYE SOCKET,REMOV LESN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67413	PR EXPLORE EYE SOCKET,REMOV F.B.	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67414	PR EXPLORE EYE SOCKET,DECO MPRESS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67415	PR NEEDLE ASPIR ORBITAL CONTENTS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67420	PR LAT EXPLOR EYE SOCK,REMV LESN	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67430	PR LAT EXPLOR EYE SOCK,REMV F.B.	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67440	PR LAT EXPLOR EYE SOCK,DRAINAGE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67445	PR LAT EXPLOR EYE SOCK,DECOMP RESS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67450	PR LAT EXPLOR EYE SOCK	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67500	PR RETROBULBAR INJECT,MEDICA TN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67505	PR RETROBULBAR INJECT,ALCOH OL	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67515	PR INJ,THER AGENT INTO TENON'S CAPSULE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67550	PR INSERT EYE SOCKET IMPLANT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67560	PR REVISE EYE SOCKET IMPLANT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67570	PR DECOMPRESS OPTIC NERVE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67599	PR ORBIT SURGERY PROC UNLISTED	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67700	PR DRAINAGE OF EYELID ABSCESS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67710	PR INCISION OF EYELID	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67715	PR INCISION OF EYELID FOLD	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67800	PR EXCIS CHALAZION,SINGLE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67800	PR EXCIS CHALAZION,SINGLE	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
67801	PR EXCIS CHALAZION,MULTI,SAME LID	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67801	PR EXCIS CHALAZION,MU LT,SAME LID	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67805	PR EXCIS CHALAZION,MU LT,BOTH LIDS	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67805	PR EXCIS CHALAZION,MU LT,BOTH LIDS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67808	PR EXCIS CHALAZION,GE N ANESTHESIA	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
67808	PR EXCIS CHALAZION,GE N ANESTHESIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67810	PR INCISIONAL BIOPSY EYELID SKIN & LID MARGIN	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67810	PR INCISIONAL BIOPSY EYELID SKIN & LID MARGIN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67820	PR REVISE EYELASHES,FO RCEPS	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67820	PR REVISE EYELASHES,FO RCEPS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67825	PR REVISE EYELASHES	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67825	PR REVISE EYELASHES	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67830	PR REVISE EYELASHES,IN CIS LID MARGIN	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67830	PR REVISE EYELASHES,IN CIS LID MARGIN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67835	PR REVISE EYELASHES,IN CIS LID+GRFT	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67835	PR REVISE EYELASHES,IN CIS LID+GRFT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67840	PR REMOVE EYELID LESN (NOT CHALAZION)	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67840	PR REMOVE EYELID LESN (NOT CHALAZION)	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67850	PR DESTRUC EYELID LESN, <1 CM	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67850	PR DESTRUC EYELID LESN, <1 CM	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67850	PR DESTRUC EYELID LESN, <1 CM	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67875	PR TEMP CLOSURE EYELID BY SUTURE	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67875	PR TEMP CLOSURE EYELID BY SUTURE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67880	PR REVISION OF EYELID	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67880	PR REVISION OF EYELID	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67882	PR REVISION EYELID,XPOSITION TARSAL PLATE	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67882	PR REVISION EYELID,XPOSITION TARSAL PLATE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67900	PR REPAIR BROW PTOSIS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
67900	PR REPAIR BROW PTOSIS	<p>NO AUTHORIZATION REQUIRED</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67901	PR FIX LID PTOSIS,FRONT ALIS MUSC,SUT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
67901	PR FIX LID PTOSIS,FRONT ALIS MUSC,SUT	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67902	PR FIX LID PTOSIS,FRONT MUSC,FAS SLNG	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
67902	PR FIX LID PTOSIS,FRONT MUSC,FAS SLNG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67903	PR FIX LID PTOSIS,LEVAT R RESEC,INTERN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
67903	PR FIX LID PTOSIS,LEVAT R RESEC,INTERN	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67904	PR FIX LID PTOSIS,LEVAT R RESEC,EXTERN	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
67904	PR FIX LID PTOSIS,LEVAT R RESEC,EXTERN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67906	PR FIX LID PTOSIS,SUPER RECTUS TECH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
67906	PR FIX LID PTOSIS,SUPER RECTUS TECH	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67908	PR FIX LID PTOSIS,FASAN ELLA-SERVAT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
67908	PR FIX LID PTOSIS,FASAN ELLA-SERVAT	<p>NO AUTHORIZATION REQUIRED</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67909	PR REDN OVERCORRECT N OF LID PTOSIS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67911	PR CORRECT LID RETRACTN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67912	PR CORRECTION EYELID W/ IMPLANT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67914	PR FIX ECTROPION,SUTURE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67915	PR FIX ECTROPION,TH ERMOCAUT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67916	PR FIX ECTROPION,EX CIS TARSAL WEDGE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67917	PR FIX ECTROPION, EN TENSV LID REPAIR	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67921	PR FIX ENTROPION,SUTURE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67922	PR FIX ENTROPION,TH ERMOCAUT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67923	PR FIX ENTROPION,EX CIS TARSAL WEDGE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67924	PR FIX ENTROPION,EXTENSV LID REPAIR	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67930	PR SUTURE EYELID WOUND,PARTIAL THICK	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67935	PR SUTURE EYELID WOUND,FULL THICK	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67938	PR REMOVE EYELID FOREIGN BODY,EMBEDDED	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67950	PR CANTHOPLAST Y	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67961	PR REVISION OF EYELID,< 1/4 LID MARGIN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67966	PR REVISION OF EYELID,> 1/4 LID MARGIN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67971	PR RECONSTRUC EYELID,<2/3,ON E STAGE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67973	PR RECONSTRUC EYELID,TOT LOWER,1 STAGE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67974	PR RECONSTRUC EYELID,TOT UPPER,1 STAGE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67975	PR RECONSTRUC EYELID,SECOND STAGE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
67999	PR REVISION EYELID UNLISTED	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68020	PR INCISE/DRAIN CONJUNCTIVA	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68040	PR EXPRESS CONJUNC FOLLICLES	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68100	PR BIOPSY OF CONJUNCTIVA	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68110	PR EXCIS CONJUNC LESN,=<1 CM	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX . ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68115	PR EXCIS CONJUNC LESN,>1 CM	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68130	PR EXCIS CONJUNC LESN+ADJ SCLERA	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68135	PR DESTRUC CONJUNC LESN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68200	PR SUBCONJUNCT IVAL INJECTN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68320	PR REVISE CONJUNC,CONJUNC GRFT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68325	PR REVISE CONJUNC,BUC CAL MEMBR GRFT	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68326	PR REVISE CONJUNC, FIX CUL-DE-SAC +GRFT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68328	PR REVISE CONJUNC, FIX CUL-DE-SAC=BUCCAL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68330	PR REPAIR SYMBLEPHARON	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68335	PR REPAIR SYMBLEPHARO N+FREE GRFT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68340	PR DIVISION OF SYMBLEPHARON	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68360	PR CONJUNC FLAP,BRIDGE/PARTIAL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68362	PR CONJUNC FLAP,TOTAL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68371	PR HARVEST EYE TISSUE, ALOGRAFT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68399	PR CONJUNCTIVAL SURGERY UNLISTED	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68400	PR INCISE/DRAIN TEAR GLAND	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68420	PR INCISE/DRAIN TEAR SAC	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68440	PR INCISE TEAR DUCT OPENING	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68500	PR REMOVAL TEAR GLAND,TOTAL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68505	PR REMOVAL TEAR GLAND,PARTIAL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68510	PR BIOPSY OF TEAR GLAND	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68520	PR REMOVAL OF TEAR SAC	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68525	PR BIOPSY OF TEAR SAC	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68530	PR REMV F.B./STONE IN TEAR DUCT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68540	PR REMV TEAR GLAND LESN,FRONT APPRCH	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68550	PR REMV TEAR GLAND LESN,W OSTEOTOMY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68700	PR REPAIR TEAR DUCTS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68705	PR REVISE TEAR DUCT OPENING	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68720	PR CREATE TEAR SAC-NASAL FISTULA	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68745	PR CREATE CONJUNC-NASAL FISTULA	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68760	PR CLOSE TEAR DUCT OPENING	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68761	PR CLOSE TEAR DUCT OPENING BY PLUG,EA	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68770	PR CLOSE TEAR SYSTEM FISTULA	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68801	PR DILATION NASOLACRIMAL DUCT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68810	PR PROBE NASOLACRIMAL DUCT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68811	PR PROBE NASOLAC DUCT W GEN ANESTH	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68815	PR PROBE NASOLAC DUCT,INSERT TUBE/STENT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68816	PR PROBE NASOLAC DUCT WITH CATHETER DILATION	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68840	PR EXPLORE LACRIMAL CANALICULI	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68850	PR INJECTION FOR TEAR SAC X-RAY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
68899	PR TEAR DUCT SYSTEM SURG UNLISTED	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
69090	PR PIERCE EARLOBES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
69100	PR BIOPSY OF EXTERNAL EAR	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE SETTING (11).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
69105	PR BIOPSY OF EXT AUDITORY CANAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
69110	PR REMOVAL EXTERNAL EAR,PARTIAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
69120	PR REMOVAL EXTERNAL EAR,TOTAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
69140	PR REMV EXT CANAL EXOSTOSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
69145	PR REMV EXT CANAL SOFT TISSUE LESN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
69150	PR RAD EXCIS EXT CANAL LESN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
69155	PR RAD EXCIS EXT CANAL LESN+NECK DISSEC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
69200	PR REMV EXT CANAL FOREIGN BODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2021
69205	PR REMV EXT CANAL F.B.,GEN ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
69209	PR REMOVAL IMPACTED CERUMEN IRRIGATION/LV G UNILAT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2021
69210	PR REMOVAL IMPACTED CERUMEN INSTRUMENTATION UNILAT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2021
69300	PR OTOPLASTY PROTRUDING EAR W/WO SIZE RDCTJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
69420	PR INCISION EARDRUM,ASPI R	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
69421	PR INCISION EARDRUM,ASPI R,GEN ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
69424	PR VENT TUBE REMVL REQ GEN ANESTHESIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
69433	PR CREATE EARDRUM OPENING,LOCAL ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
69436	PR CREATE EARDRUM OPENING,GEN ANESTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
69440	PR EXPLORATION OF MIDDLE EAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
69450	PR EARDRUM REVISION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
69610	PR REPAIR TYMPANIC MEMBRANE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
69620	PR MYRINGOPLASTY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
69631	PR TYMPANOPLASTY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
69632	PR TYMPANOPLASTY,REBUILD OSSICUL CHAIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
69633	PR TYMPANOPLASTY,REBLD OSSIC CHAIN +PROS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
69635	PR TYMPANOPLAS /ANTROTOMY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
69636	PR TYMPANOPLAS /ANTROT,REBLD OSSIC CHAIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
69637	PR TYMPANOPLAS /ANTROT,REBLD OSSIC +PROST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
69641	PR TYMPANOPLAS /MASTOIDECTOMY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
69642	PR TYMPANOPLAS /MASTOIDEC,R EBLD OSSICLES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
69643	PR TYMPANOPLAS /MASTOIDEC,IN TACT WALL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
69644	PR TYMPANOPLAS /MASTOID,INTC T WALL,REBLD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
69645	PR TYMPANOPLAS /MASTOIDEC,R ADICAL/COMPL E	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
69646	PR TYMPANOPLAS /MASTOIDEC,R AD,REBLD OSSI	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
69705	PR SURG NASOPHARYNG OSCOPY DILAT EUSTACHIAN TUBE UNI	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
69706	PR SURG NASOPHARYNG OSCOPY DILAT EUSTACHIAN TUBE BI	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
69710	PR IMPLANT/REPL ACE HEAR AID,TEMP BONE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
69711	PR REMOVE/REPAIR HEAR AID,TEMP BONE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
69714	PR IMPLTJ OI IMPLT SKULL PERQ ATTACHMENT ESP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
69716	PR IMPLTJ OI IMPLT SKULL MAG TC ATTACHMENT ESP W/ THE MASTOID AND/OR RESULTING IN REMOVAL OF <100 SQ MM SURFACE AREA OF BONE DEEP TO THE OUTER CRANIAL CORTEX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
69719	PR RPLCMT OI IMPLT SKULL MAG TC ATTACHMENT ESP W/THE MASTOID AND/OR INVOLVING A BONY DEFECT <100 SQ MM SURFACE AREA OF BONE DEEP TO THE OUTER CRANIAL CORTEX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
69726	PR REMOVAL ENTIRE OI IMPLT SKULL PERQ ATTACHMENT ESP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
69727	PR REMOVAL ENTIRE OI IMPLT SKULL MAG TC ATTACHMENT ESP W/ THE MASTOID AND/OR INVOLVING A BONY DEFECT <100 SQ MM SURFACE AREA OF BONE DEEP TO THE OUTER CRANIAL CORTEX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
69728	PR REMOVAL, ENTIRE OSSEOINTEGRATED IMPLANT, SKULL; WITH MAGNETIC TRANSCUTANEOUS ATTACHMENT TO EXTERNAL SPEECH PROCESSOR, OUTSIDE THE MASTOID AND INVOLVING A BONY DEFECT GREATER THAN OR EQUA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
69729	PR TRANSLUMINAL DILATION OF AQUEOUS OUTFLOW CANAL (EG, CANALOPLASTY); WITH MAGNETIC TRANSCUTANEOUS ATTACHMENT TO EXTERNAL SPEECH PROCESSOR, OUTSIDE OF THE MASTOID AND RESULTING IN REMOVAL OF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
69730	PR REPLACEMENT (INCLUDING REMOVAL OF EXISTING DEVICE), OSSEOINTEGRATED IMPLANT, SKULL; WITH MAGNETIC TRANSCUTANEOUS ATTACHMENT TO EXTERNAL SPEECH PROCESSOR, OUTSIDE THE MASTOID AND INVOLVIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
69799	PR MIDDLE EAR SURGERY PROC UNLISTED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
69930	PR IMPLANT COCHLEAR DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
69955	PR DECOMPRESS FACIAL NERVE, TOTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70010	PR MYELOGRAPHY POST FOSSA	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70015	PR CISTERNOGRA PHY,POS CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70030	PR X-RAY EYE FOR FOREIGN BODY	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70100	PR X-RAY JAW <4 VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70110	PR X-RAY JAW 4+ VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70120	PR X-RAY MASTOIDS <3 VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70130	PR X-RAY MASTOIDS 3+ VW	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					
70134	PR X-RAY MIDDLE EAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70140	PR X-RAY FACIAL BONES <3 VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70150	PR X-RAY FACIAL BONES 3+ VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70160	PR X-RAY NASAL BONES	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70170	PR X-RAY TEAR DUCT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70190	PR X-RAY OPTIC FORAMEN	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70200	PR X-RAY ORBITS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70210	PR X-RAY SINUSES <3 VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70220	PR X-RAY SINUSES 3+ VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70240	PR X-RAY EXAM SELLA	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70250	PR X-RAY SKULL <4 VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70260	PR X-RAY SKULL 4+ VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70300	PR X-RAY TEETH SINGLE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70310	PR X-RAY TEETH PARTIAL	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70320	PR FULL MOUTH X-RAY OF TEETH	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70328	PR X-RAY TMJ UNILAT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70330	PR X-RAY TMJ BILAT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70332	PR X-RAY TMJ ARTHROGRAM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70336	PR MRI, TMJ	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70350	PR X-RAY HEAD FOR ORTHODONTIA	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70355	PR ORTHOPANTOGRAM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70360	PR X-RAY NECK SOFT TISSUE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70370	PR THROAT X-RAY & FLUOROSCOPY	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70371	PR SPEECH EVALUATION, COMPLEX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70380	PR X-RAY SALIVARY GLAND	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70390	PR X-RAY SIALOGRAM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70450	PR CT SCAN,HEAD/BR AIN,W/O CONTRAST MATL	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70460	PR CT SCAN HEAD CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70470	PR CT SCAN HEAD COMBO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					
70480	PR CT SCAN,ORBIT/SE LLA/POST FOSSA/EAR,W/O	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70481	PR CT SCAN SKULL CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70482	PR CT SCAN SKULL COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70486	PR CT SCAN,MAXILLO FACIAL AREA,W/O CONTRAST	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70487	PR CT SCAN, FACE/JAW CONTRAST	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70488	PR CT SCANS FACE/JAW COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70490	PR CT SCAN,SOFT TISSUE NECK,W/O CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70491	PR CT NECK TISSUE CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70492	PR CT NECK TISSUE COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70496	PR CT ANGIO,HEAD COMBO,INCL IMAGE PROCESS	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70498	PR CT ANGIO,NECK COMBO,INCL IMAGE PROCESS	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70540	PR MRI, FACE, NECK	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70542	PR MRI, FACE, NECK W/CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70543	PR MRI, FACE, NECK, COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70544	PR MR ANGIO, HEAD	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70545	PR MR ANGIO, HEAD W/CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70546	PR MR ANGIO, HEAD, COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70547	PR MR ANGIO, NECK	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70548	PR MR ANGIO, NECK W/CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70549	PR MR ANGIO, NECK, COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70551	PR MRI BRAIN	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70552	PR MRI BRAIN CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70553	PR MRI BRAIN COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70554	PR FUNCTIONAL MRI BRAIN BY TECH	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70555	PR FUNCTIONAL MRI BRAIN BY PHYS/PSYCH	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70557	PR MRI BRAIN W/O DYE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
70558	PR MRI BRAIN W/ DYE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
70559	PR MRI BRAIN W/O & W/ DYE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
71045	CHG RADIOLOGIC EXAM CHEST SINGLE VIEW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
71046	CHG RADIOLOGIC EXAM CHEST 2 VIEWS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
71047	CHG RADIOLOGIC EXAM CHEST 3 VIEWS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
71048	CHG RADIOLOGIC EXAM CHEST 4+ VIEWS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
71100	PR X-RAY RIBS 2 VW UNILAT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
71101	PR X-RAY RIBS, CHEST 3+ VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
71110	PR X-RAY RIBS 3 VW BILAT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
71111	PR X-RAY RIBS, CHEST 4+ VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
71120	PR X-RAY STERNUM 2+ VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
71130	PR X-RAY STERNO-CLAVICULAR JT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
71250	CHG DIAGNOSTIC COMPUTED TOMOGRAPHY THORAX W/O CNTRST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
71260	CHG DIAGNOSTIC COMPUTED TOMOGRAPHY THORAX W/CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
71270	CHG DIAGNOSTIC COMPUTED TOMOGRAPHY THORAX C-/C+	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
71271	CHG COMPUTED TOMOGRAPHY THORAX LW DOSE LNG CA SCR C-	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
71275	PR CT ANGIO, CHEST (NON-CORON), COMBO, INCL IMG PROC	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
71550	PR MRI, CHEST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
71551	PR MRI, CHEST, W/CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
71552	PR MRI, CHEST, COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
71555	PR MR ANGIO CHEST (MRA)	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72020	PR X-RAY SPINE ONE VIEW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72040	CHG RADEX SPINE CERVICAL 2 OR 3 VIEWS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72050	CHG RADEX SPINE CERVICAL 4 OR 5 VIEWS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72052	CHG RADEX SPINE CERVICAL 6 OR MORE VIEWS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72070	PR X-RAY THORACIC SPINE 2 VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72072	PR X-RAY THORACIC SPINE+SWIM 3 VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72074	PR X-RAY THORACIC SPINE 4 VW	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					
72080	CHG RADEX SPINE THORACOLUM BAR JUNCTION MIN 2 VIEWS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72081	CHG RADEX ENTIR THRC LMBR CRV SAC SPI W/SKULL 1 VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72082	CHG RADEX ENTIR THRC LMBR CRV SAC SPI W/SKULL 2/3 VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72083	CHG RADEX ENTIR THRC LMBR CRV SAC SPI W/SKULL 4/5 VW	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72084	CHG RADEX ENTIR THRC LMBR CRV SAC SPI W/SKULL 6/> VW	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72100	PR X-RAY LUMBAR SPINE 2/3 VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72110	PR X-RAY LUMBAR SPINE 4 VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72114	PR RADEX SPINE LUMBSCL COMPL W/BENDING VIEWS MIN 6	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					
72120	PR RADEX SPINE LUMBOSACRAL ONLY BENDING 2/3 VIEWS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72125	PR CT SCAN,CERVICAL SPINE,W/O CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72126	PR CT SCAN CERV SPINE CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72127	PR CT SCAN CERV SP COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72128	PR CT SCAN,THORACI C SPINE,W/O CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72129	PR CT SCAN DORSAL SP CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72130	PR CT SCAN DORSAL SP COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72131	PR CT SCAN,LUMBAR SPINE,W/O CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72132	PR CT SCAN LUMBAR SP CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72133	PR CT SCAN LUMBAR SP COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72141	PR MRI, CERV SPINE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72142	PR MRI, CERV SPINE CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72146	PR MRI, DORSAL SPINE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72147	PR MRI, DORSAL SPINE CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72148	PR MRI, LUMBAR SPINE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72149	PR MRI, LUMBAR SPINE CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72156	PR MRI, CERV SPINE COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72157	PR MRI, DORSAL SPINE COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72158	PR MRI, LUMBAR SPINE COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72159	PR MR ANGIO SPINE (MRA)	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72170	PR X-RAY PELVIS 1/2 VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72190	PR X-RAY PELVIS 3+ VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72191	PR CT ANGIO, PELVIS, COMBO, INCL IMAGE PROC	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72192	PR CT SCAN, PELVIS, W/O CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72193	PR CT SCAN OF PELVIS CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72194	PR CT SCAN OF PELVIS COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72195	PR MRI, PELVIS, W/O CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72196	PR MRI, PELVIS W/CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72197	PR MRI, PELVIS, COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72198	PR MR ANGIO PELVIS(MRA)	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72200	PR X-RAY SACROILIAC JTS <3 VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72202	PR X-RAY SACROILIAC JTS 3+ VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72220	PR X-RAY SACRUM/COCC YX 2+ VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72240	PR MYELOGRAPHY CERV SPINE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72255	PR MYELOGRAPHY THORAX SPINE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72265	PR MYELOGRAPHY LUMBAR SPINE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72270	PR MYELOGRAPHY OF ENTIRE SPINE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
72285	PR X-RAY,C/T,DISC,SUPERV/INTERPRET	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
72295	PR DISCOGRAPHY LUMBAR SPINE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73000	PR X-RAY CLAVICLE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73010	PR X-RAY SCAPULA	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73020	PR X-RAY SHOULDER 1 VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73030	PR X-RAY SHOULDER 2+ VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73040	PR ARTHROGRAM OF SHOULDER	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73050	PR X-RAY AC JTS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73060	PR X-RAY HUMERUS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73070	PR X-RAY ELBOW 2 VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73080	PR X-RAY ELBOW 3+ VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73085	PR ARTHROGRAM OF ELBOW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73090	PR X-RAY FOREARM 2 VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73092	PR X-RAY ARM, INFANT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73100	PR X-RAY WRIST 2 VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73110	PR X-RAY WRIST 3+ VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73115	PR ARTHROGRAM OF WRIST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73120	PR X-RAY HAND 2 VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73130	PR X-RAY HAND 3+ VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73140	PR X-RAY EXAM OF FINGER(S)	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73200	PR CT SCAN,UPPER EXTREMITY,W/O CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73201	PR CT SCAN OF ARM CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73202	PR CT SCAN OF ARM COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73206	PR CT ANGIO,UPPER EXTREM,COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73218	PR MRI, UPPER EXTREM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73219	PR MRI, UPPER EXTREM W/CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73220	PR MRI UPPER EXTR, W/CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73221	PR MRI, JOINT UPPER EXTREM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73222	PR MRI, JOINT UPPER EXTREM W/CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73223	PR MRI, JOINT UPPER EXTREM COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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73225	PR MR ANGIO UPPER EXTREM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73501	CHG RADEX HIP UNILATERAL WITH PELVIS 1 VIEW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73502	CHG RADEX HIP UNILATERAL WITH PELVIS 2-3 VIEWS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73503	CHG RADEX HIP UNILATERAL WITH PELVIS MINIMUM 4 VIEWS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73521	CHG RADEX HIPS BILATERAL WITH PELVIS 2 VIEWS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73522	CHG RADEX HIPS BILATERAL WITH PELVIS 3-4 VIEWS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73523	CHG RADEX HIPS BILATERAL WITH PELVIS MINIMUM 5 VIEWS	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73525	PR ARTHROGRAM OF HIP	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73551	CHG RADIOLOGIC EXAMINATION FEMUR 1 VIEW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73552	CHG RADIOLOGIC EXAMINATION FEMUR MINIMUM 2 VIEWS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73560	PR X-RAY KNEE 1 OR 2 VIEW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73562	PR X-RAY KNEE 3 VIEW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73564	PR X-RAY KNEE 4+ VIEW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73565	PR X-RAY KNEE BILAT STANDING	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73580	PR ARTHROGRAM OF KNEE JOINT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73590	PR X-RAY TIB + FIB, 2VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73592	PR X-RAY LEG, INFANT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73600	PR X-RAY ANKLE 2 VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73610	PR X-RAY ANKLE 3+ VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73615	PR ARTHROGRAM OF ANKLE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73620	PR X-RAY FOOT 2 VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73630	PR X-RAY FOOT 3+ VW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73650	PR X-RAY HEEL	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73660	PR X-RAY TOE (S)	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73700	PR CT SCAN,LOWER EXTREMITY,W/O CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73701	PR CT SCAN OF LEG CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73702	PR CT SCAN OF LEG COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73706	PR CT ANGIO,LOWER EXTREM,COMBO,IMAGE PRC	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73718	PR MRI, LOWER EXTREM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73719	PR MRI, LOWER EXTREM W/CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73720	PR MRI, LOWER EXTR, W/O CONTRAST F/U BY CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73721	PR MRI LOWER EXTREM JT, W/O CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73722	PR MRI, JOINT OF LEG W/CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
73723	PR MRI, JOINT OF LEG. COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
73725	PR MR ANGIO LOWER EXTREM (MRA)	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74018	CHG RADIOLOGIC EXAM ABDOMEN 1 VIEW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74019	CHG RADIOLOGIC EXAM ABDOMEN 2 VIEWS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74021	CHG RADIOLOGIC EXAM ABDOMEN 3+ VIEWS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74022	CHG RADIOLOGIC EXAM COMPLETE ACUTE ABDOMEN SERIES	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	MD GUIDELINE 1 (Mobile X Ray Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Mobile-X-Ray-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74150	PR CT SCAN,ABDOMEN,W/O CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74160	PR CT SCAN OF ABDOMEN CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74170	PR CT SCAN OF ABDOMEN COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74174	PR CT ANGIO ABD&PLVIS CNTRST MTRL W/WO CNTRST IMGES	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74175	PR CT ANGIO, ABD, COMBO,INCL IMAGE PROC	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74176	CHG CT SCAN, ABDOMEN AND PELVIS, W/O CONTRAST	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74177	CHG CT SCAN, ABDOMEN AND PELVIS, W/O CONTRAST	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74178	CHG CT SCAN, ABDOMEN AND PELVIS, COMBO	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74181	PR MRI, ABDOMEN (MRI)	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74182	PR MRI, ABDOMEN W/CONTRAST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74183	PR MRI, ABDOMEN, COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74185	PR MR ANGIO ABDOMEN (MRA)	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74190	PR X-RAY PERITONEUM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74210	CHG RADIOLOGIC EXAM PHRNX&CRV ESOPH CONTRAST STUDY	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74220	CHG RADIOLOGIC EXAM ESOPHAGUS SINGLE CONTRAST STUDY	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74221	CHG RADIOLOGIC EXAM ESOPHAGUS DOUBLE CONTRAST STUDY	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74230	CHG RADIOLOGIC EXAM SWALLOW FUNCTION CONTRAST STUDY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
74235	PR REMOVE ESOPHAGUS OBSTRUCTION	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74240	CHG RADIOLOGIC EXAM UPR GI TRC SINGLE CONTRAST STUDY	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74246	CHG RADIOLOGIC EXAM UPR GI TRC DOUBLE CONTRAST STUDY	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74248	CHG RADIOLOGIC SMALL INTESTINE FOLLOW- THROUGH STUDY	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74250	CHG RADIOLOGIC EXAM SMALL INT SINGLE CONTRAST STUDY	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74251	CHG RADIOLOGIC EXAM SMALL INT DOUBLE CONTRAST STUDY	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74261	CHG CT COLONOGRPH Y DX IMAGE POSTPROCESS W/O CONTRAST	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74262	CHG CT COLONOGRPH Y DX IMAGE POSTPROCESS W/CONTRAST	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74263	CHG CT COLONOGRAP HY SCREENING IMAGE POSTPROCESS ING	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74270	CHG RADIOLOGIC EXAM COLON SINGLE CONTRAST STUDY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74280	CHG RADIOLOGIC EXAM COLON DOUBLE CONTRAST STUDY	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74283	PR X-RAY B.E. REDUCTN INTUSS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74290	PR X-RAY GALLBLADDER SINGLE DOSE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74300	PR X-RAY OPER CHOLANGIOGR AM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74301	PR X-RAY OPER CHOLANGIO ADDNL SET	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74328	PR X-RAY FOR BILE DUCT ENDOSCOPY	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74329	PR X-RAY FOR PANCREAS ENDOSCOPY	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74330	PR X-RAY BILE/PANCREAS ENDOSCOPY	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74340	CHG INTRO LONG GI TUBE W/MULT FLUORO & IMAGES RS&I	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74355	PR X-RAY GUIDE ENTEROCLYSIS TUBE	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74360	PR X-RAY GUIDE, GI DILATION	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74363	PR PERCUT TRANSHEPAT DILAT,BILE DUCT STRICT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74400	PR X-RAY IV PYELOGRAM (IVP)	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74410	PR X-RAY IV PYELOGRAM +DRIP INFUSN	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74415	PR X-RAY IV PYELOGRAM +TOMOGRAPHY	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74420	PR X-RAY RETROGRADE PYELOGRAM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74425	CHG ANTEGRADE UROGRAPHY RADIOLOGICAL SUPVJ & INTERPJ	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74430	X-RAY CYSTOGRAM, MIN 3 VIEW	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74440	PR X-RAY VESICULOGM MALE GENL TRCT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74445	PR X-RAY PENIS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74450	PR X-RAY URETHROCYST OGRAM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74455	PR X-RAY URETHROCYST OGRAM +VOIDING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
74470	PR X-RAY RENAL CYST XLUMBAR +CONTRST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74485	CHG DILATION URETERS/URET HRA RS&I	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74710	PR X-RAY PELVIMETRY	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74712	CHG FETAL MRI W/PLACNTL MATRNL PLVC IMG SING/1ST GES	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74713	CHG FETAL MRI W/PLACNTL MATRNL PLVC IMG EA ADDL GES	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
74740	PR X-RAY HYSTEROSALPINGOGRAM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
74740	PR X-RAY HYSTEROSALPINGOGRAM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
74775	PR X-RAY PERINEOGRAM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75557	CHG CARDIAC MRI MORPHOLOGY & FUNCTION W/O CONTRAST	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75559	CHG CARDIAC MRI W/O CONTRAST W STRESS IMAGING	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75561	CHG CARDIAC MRI W/W/O CONTRAST & FURTHER SEQ	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75563	CHG CARDIAC MRI W/W/O CONTRAST W STRESS	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75565	CARD MRI VELOC FLOW MAPPING	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75571	PR UNDER DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING) PROCEDURES OF THE HEART	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75572	PR CT HRT W/3D IMAGE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75573	CHG CT HEART C+ CARDIAC STRUX&MORPH CGEN HRT DS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75574	PR CT ANGIO HRT W/3D IMAGE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75580	N-INVAS EST C FFR AUGMNT SW ALYS CTA I&R PHY/QHP	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75600	PR ANGIO AORTOGRAM THORACIC	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75605	PR ANGIO AORTOGRAM THOR SERIAL	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75625	PR ANGIO AORTOGRAM ABD SERIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					
75630	PR ANGIO AORTOBIFEMO RAL W CATH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75635	PR CT ANGIO AORTOBIFEMORAL, COMBO	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75705	PR ANGIO SPINAL SELECTV	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75710	PR ANGIO EXTREMITY UNILAT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75716	PR ANGIO EXTERMINITY BILAT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75726	PR ANGIO VISCERAL SELECTV/SUBS ELEC	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75731	PR ANGIO ADRENAL UNILAT SELECT	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75733	PR ANGIO ADRENAL BILAT SELECT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75736	PR ANGIO PELVIS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75741	PR ANGIO PULMON UNILAT SELECT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75743	PR ANGIO PULMON BILAT SELECT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75746	PR ANGIO PULMON BILAT NONSELEC	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75756	PR ANGIO INTERN MAMMARY	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75774	PR ANGIO EA ADDNL SELECTV VESSEL	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75801	PR LYMPHANGIO EXTREM UNILAT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75803	PR LYMPHANGIO EXTREM BILAT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75805	PR LYMPHANGIO ABD/PELV UNILAT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75807	PR LYMPHANGIO ABD/PELV BILAT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75809	PR NONVASCULAR SHUNTOGRAM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75810	PR VENOGRAM SPLENOPORTOGRAM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75820	PR VENOGRAM EXTREM UNILAT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75822	PR VENOGRAM EXTREM BILAT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					
75825	PR VENOGRAM INFER VENA CAVA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75827	PR VENOGRAM SUPER VENA CAVA	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75831	PR VENOGRAM RENAL UNILAT	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75833	PR VENOGRAM RENAL BILAT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75840	PR VENOGRAM ADRENAL UNILAT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75842	PR VENOGRAM ADRENAL BILAT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					
75860	PR VENOGRAM SINUS/JUGULAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75870	PR VENOGRAM SUPER SAG SINUS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75872	PR VENOGRAM EPIDURAL	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75880	PR VENOGRAM ORBITAL	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75885	PR PERCUT XHEPATIC PORTO +DYNAMIC	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75887	PR PERCUT XHEPATIC PORTOGRAM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75889	PR VENOGRAM HEPATIC W HEMODYNAMIC S	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75891	PR VENOGRAM HEPATIC	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75893	PR VENOUS SAMPLING BY CATHETER	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75894	PR TRANSCATHET ER RX EMBOLIZATN	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75898	CHG ANGRPH CATH F-UP STD TCAT OTHER THAN THROMBYLSIS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75901	PR REMOVE,OBST MATL,CVA DEV VIA SEP VEN ACC	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75902	PR REMOVE,OBST MATL,CVA DEVICE VIA LUMEN	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75956	PR ENDOVASC REPAIR THOR AORTA INCL SUBCLAVIAN	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75957	PR ENDOVASC REPAIR THOR AORTA EXCL SUBCLAVIAN	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75958	PR PROXIMAL EXTENS DURNG ENDOVASC REPR THOR AORTA	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75959	PR DELAYED PROX EXTENS ENDOVASC REPR THOR AORTA	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75970	PR VASCULAR BIOPSY	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
75984	CHANGE PERCUT TUBE/DRAIN CATH W CONTRAST MONIT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
75989	PR RAD GUIDED,PERCUT DRAINAGE,W/CATH PLACE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76000	CHG FLUOROSCOPY UP TO 1 HOUR PHYSICIAN/QHP TIME	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76010	PR X-RAY NOSE-RECTUM CHILD F.B.	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76080	PR X-RAY FISTULA,ABSC ESS,SINUS TRACT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76098	PR X-RAY EXAM, BREAST SPECIMEN	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76100	PR X-RAY TOMOGRAM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76120	PR CINE/VIDEORA DIOLOGY,EXC WHERE SPEC INCL	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76125	PR CINE/VIDEORA DIOGRAPHY W/ROUTINE EXAM	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76145	CHG MEDICAL PHYSICS DOSE EVAL RADIATION EXPOS W/RPRT	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76376	CHG 3D RENDERING W/INTERP & POSTPROCESS SUPERVISION	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76377	CHG 3D RENDERING W/INTERP&POS TPROC DIFF WORK STATION	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76380	PR CT SCAN,LIMITED/ LOCALIZED F/U STUDY	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76390	PR MRI SPECTROSCOPY	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76391	CHG MAGNETIC RESONANCE ELASTOGRAPHY	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76496	CHG UNLISTED FLUOROSCOPI C PROCEDURE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76497	PR UNLISTED CT PROCEDURE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76498	PR UNLISTED MR PROCEDURE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76499	CHG UNLISTED DX RADIOGRAPHIC PROCEDURE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76506	US, HEAD, REAL TIME	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76510	US, EYE, B-SCAN & QUANT A-SCAN	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76510	US, EYE, B-SCAN & QUANT A-SCAN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76511	US, EYE A-SCAN	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76512	US, EYE B-SCAN	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76512	US, EYE B-SCAN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76513	CHG DX OPHTHALMIC US ANT SEGMENT IMMERSION UNI/BI	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76513	CHG DX OPHTHALMIC US ANT SEGMENT IMMERSION UNI/BI	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76514	US, EYE, FOR CORNEAL THICKNESS	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76514	US, EYE, FOR CORNEAL THICKNESS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76516	US, EYE BIOMETRY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76516	US, EYE BIOMETRY	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76519	US, EYE BIOMETRY W LENS CALC	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76519	US, EYE BIOMETRY W LENS CALC	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76529	US, EYE F.B. LOCALIZATION	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76536	US, HEAD/NECK TISSUES,REAL TIME	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76700	US, ABDOM,B-SCAN &/OR REAL TIME,COMPLETE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76705	US, ABDOMEN LIMITED	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76706	CHG US ABDOMINAL AORTA REAL TIME SCREEN STUDY AAA	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76770	PR US,RETROPERIT,REAL TIME,COMPLETE	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76775	US, RETROPERITNL ABD, LTD	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76800	US, SPINAL CANAL & CONTENTS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76801	US, OB < 14 WKS, SINGLE FETUS	<p>NO AUTHORIZATION REQUIRED</p> <p>LIMITS: NO AUTH IS REQUIRED IF 4 OR LESS US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE</p> <p>RENDERING PROVIDER: NO AUTH REQUIRED FOR UNLIMITED QUANTITY OF US IF REFERRED TO PROVIDER IS A MATERNAL-FETAL MEDICINE (MFM)</p>	<p>TMPPM</p> <p>HTTPS://WWW.TMHP.COM/</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK,CP		8/1/2021
76801	US, OB < 14 WKS, SINGLE FETUS	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 4 US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE</p> <p>RENDERING PROVIDER: IF MORE THAN 4 US, AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A MATERNAL-FETAL MEDICINE (MFM)</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTPS://WWW.TMHP.COM/</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK,CP		8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76802	US, OB < 14 WKS, ADD'L FETUS	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 4 US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE</p> <p>RENDERING PROVIDER: IF MORE THAN 4 US, AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A MATERNAL-FETAL MEDICINE (MFM)</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTPS://WWW.TMHP.COM/</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK,CP		8/1/2021
76802	US, OB < 14 WKS, ADD'L FETUS	<p>NO AUTHORIZATION REQUIRED</p> <p>LIMITS: NO AUTH IS REQUIRED IF 4 OR LESS US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE</p> <p>RENDERING PROVIDER: NO AUTH REQUIRED FOR UNLIMITED QUANTITY OF US IF REFERRED TO PROVIDER IS A MATERNAL-FETAL MEDICINE (MFM)</p>	<p>TMPPM</p> <p>HTTPS://WWW.TMHP.COM/</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK,CP		8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76805	US, OB >= 14 WKS, SNGL FETUS	<p>NO AUTHORIZATION REQUIRED</p> <p>LIMITS: NO AUTH IS REQUIRED IF 4 OR LESS US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE</p> <p>RENDERING PROVIDER: NO AUTH REQUIRED FOR UNLIMITED QUANTITY OF US IF REFERRED TO PROVIDER IS A MATERNAL-FETAL MEDICINE (MFM)</p>	<p>TMPPM</p> <p>HTTPS://WWW.TMHP.COM/</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK,CP		8/1/2021
76805	US, OB >= 14 WKS, SNGL FETUS	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 4 US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE</p> <p>RENDERING PROVIDER: IF MORE THAN 4 US, AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A MATERNAL-FETAL MEDICINE (MFM)</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTPS://WWW.TMHP.COM/</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK,CP		8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76810	US, OB >= 14 WKS, ADDL FETUS	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 4 US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE RENDERING PROVIDER: IF MORE THAN 4 US, AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A MATERNAL-FETAL MEDICINE (MFM) EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTPS://WWW.TMHP.COM/	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		8/1/2021
76810	US, OB >= 14 WKS, ADDL FETUS	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED IF 4 OR LESS US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE RENDERING PROVIDER: NO AUTH REQUIRED FOR UNLIMITED QUANTITY OF US IF REFERRED TO PROVIDER IS A MATERNAL-FETAL MEDICINE (MFM)	TMPPM HTTPS://WWW.TMHP.COM/	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76811	PR US,PREG UTER,FET & MAT,+ DETL FET EXM	<p>NO AUTHORIZATION REQUIRED</p> <p>LIMITS: NO AUTH IS REQUIRED IF 4 OR LESS US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE</p> <p>RENDERING PROVIDER: NO AUTH REQUIRED FOR UNLIMITED QUANTITY OF US IF REFERRED TO PROVIDER IS A MATERNAL-FETAL MEDICINE (MFM)</p>	<p>TMPPM</p> <p>HTTPS://WWW.TMHP.COM/</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK,CP		8/1/2021
76811	PR US,PREG UTER,FET & MAT,+ DETL FET EXM	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 4 US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE</p> <p>RENDERING PROVIDER: IF MORE THAN 4 US, AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A MATERNAL-FETAL MEDICINE (MFM)</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTPS://WWW.TMHP.COM/</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK,CP		8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76812	PR US,PREG UTER,FET & MAT,+ DETL FET,ADDL	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 4 US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE</p> <p>RENDERING PROVIDER: IF MORE THAN 4 US, AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A MATERNAL-FETAL MEDICINE (MFM)</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTPS://WWW.TMHP.COM/</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK,CP		8/1/2021
76812	PR US,PREG UTER,FET & MAT,+ DETL FET,ADDL	<p>NO AUTHORIZATION REQUIRED</p> <p>LIMITS: NO AUTH IS REQUIRED IF 4 OR LESS US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE</p> <p>RENDERING PROVIDER: NO AUTH REQUIRED FOR UNLIMITED QUANTITY OF US IF REFERRED TO PROVIDER IS A MATERNAL-FETAL MEDICINE (MFM)</p>	<p>TMPPM</p> <p>HTTPS://WWW.TMHP.COM/</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK,CP		8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76813	CHG US FETAL NUCHAL TRANSLUCENCY 1ST GESTATION	<p>NO AUTHORIZATION REQUIRED</p> <p>LIMITS: NO AUTH IS REQUIRED IF 4 OR LESS US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE</p> <p>RENDERING PROVIDER: NO AUTH REQUIRED FOR UNLIMITED QUANTITY OF US IF REFERRED TO PROVIDER IS A MATERNAL-FETAL MEDICINE (MFM)</p>	<p>TMPPM</p> <p>HTTPS://WWW.TMHP.COM/</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK,CP		8/1/2021
76813	CHG US FETAL NUCHAL TRANSLUCENCY 1ST GESTATION	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 4 US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE</p> <p>RENDERING PROVIDER: IF MORE THAN 4 US, AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A MATERNAL-FETAL MEDICINE (MFM)</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTPS://WWW.TMHP.COM/</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK,CP		8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76814	CHG US FETAL NUCHAL TRANSLUCENCY EA ADDL GESTATION	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 4 US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE RENDERING PROVIDER: IF MORE THAN 4 US, AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A MATERNAL-FETAL MEDICINE (MFM) EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTPS://WWW.TMHP.COM/	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		8/1/2021
76814	CHG US FETAL NUCHAL TRANSLUCENCY EA ADDL GESTATION	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED IF 4 OR LESS US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE RENDERING PROVIDER: NO AUTH REQUIRED FOR UNLIMITED QUANTITY OF US IF REFERRED TO PROVIDER IS A MATERNAL-FETAL MEDICINE (MFM)	TMPPM HTTPS://WWW.TMHP.COM/	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76815	PR US,PREGNANT UTERUS,LIMITED, 1/> FETUSES	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED IF 4 OR LESS US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE RENDERING PROVIDER: NO AUTH REQUIRED FOR UNLIMITED QUANTITY OF US IF REFERRED TO PROVIDER IS A MATERNAL-FETAL MEDICINE (MFM)	TMPPM HTTPS://WWW.TMHP.COM/	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		8/1/2021
76815	PR US,PREGNANT UTERUS,LIMITED, 1/> FETUSES	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 4 US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE RENDERING PROVIDER: IF MORE THAN 4 US, AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A MATERNAL-FETAL MEDICINE (MFM) EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTPS://WWW.TMHP.COM/	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76816	PR US,PREGNANT UTERUS,F/U,TR ANSABD APP	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 4 US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE RENDERING PROVIDER: IF MORE THAN 4 US, AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A MATERNAL-FETAL MEDICINE (MFM) EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTPS://WWW.TMHP.COM/	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		8/1/2021
76816	PR US,PREGNANT UTERUS,F/U,TR ANSABD APP	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED IF 4 OR LESS US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE RENDERING PROVIDER: NO AUTH REQUIRED FOR UNLIMITED QUANTITY OF US IF REFERRED TO PROVIDER IS A MATERNAL-FETAL MEDICINE (MFM)	TMPPM HTTPS://WWW.TMHP.COM/	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76817	PR US,PREGNANT UTERUS,TRANS VAGINAL	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED IF 4 OR LESS US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE RENDERING PROVIDER: NO AUTH REQUIRED FOR UNLIMITED QUANTITY OF US IF REFERRED TO PROVIDER IS A MATERNAL-FETAL MEDICINE (MFM)	TMPPM HTTPS://WWW.TMHP.COM/	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		8/1/2021
76817	PR US,PREGNANT UTERUS,TRANS VAGINAL	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 4 US, 5 OR GREATER US REQUESTS MAY BE SUBMITTED VIA THE PROVIDER PORTAL UTILIZING THE REFERRAL REASON CODE "OB ULTRASOUND > 4" OR MAY BE SUBMITTED VIA FAX OR PHONE RENDERING PROVIDER: IF MORE THAN 4 US, AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A MATERNAL-FETAL MEDICINE (MFM) EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTPS://WWW.TMHP.COM/	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		8/1/2021
76818	PR FETAL BIOPHYSICAL PROFILE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76819	PR FETAL BIOPHYS PROF,W/O NST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
76820	CHG US DOPPLER FETAL UMBILICAL ARTERY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A MATERNAL-FETAL MEDICINE (MFM)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		7/1/2021
76820	CHG US DOPPLER FETAL UMBILICAL ARTERY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
76820	CHG US DOPPLER FETAL UMBILICAL ARTERY	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A MATERNAL-FETAL MEDICINE (MFM)	TMPPM HTTPS://WWW.TMHP.COM/	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		7/1/2021
76821	CHG US DOPPLER FETAL MID CEREBRAL ARTERY	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A MATERNAL-FETAL MEDICINE (MFM)	TMPPM HTTPS://WWW.TMHP.COM/	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		7/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76821	CHG US DOPPLER FETAL MID CEREBRAL ARTERY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A MATERNAL-FETAL MEDICINE (MFM)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		7/1/2021
76825	PR SONO FETAL HEART	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
76827	PR SONO FETAL HEART DOPPLER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
76830	PR ECHOGRAPHY, TRANSVAGINAL	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76831	PR SONO EXAM, HYSTEROSONOGRAPHY	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76831	PR SONO EXAM, HYSTEROSONOGRAPHY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
76856	PR US, PELVIC (NONOBSTETRIC), REAL TIME, COMPLETE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76857	PR US, PELVIC (NONOBSTETRIC), REAL TIME, LIMITED	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76870	PR ECHO, SCROTUM & CONTENTS	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76872	PR ECHO,TRANSR ECTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					
76873	PR ECHO,TRANSR ECTAL,PROSTA TE VOL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76881	CHG US COMPL JOINT R-T W/IMAGE DOCUMENTATION	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76882	CHG US LMTD JOINT/ FOCAL EVALUATION OTH NONVASC XTR STRUX R-T W/IMG	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76883	PR ULTRASOUND, NERVE(S) AND ACCOMPANYIN G STRUCTURES THROUGHOUT THEIR ENTIRE ANATOMIC COURSE IN ONE EXTREMITY, COMPREHENSIVE, INCLUDING REAL-TIME CINE	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76885	CHG US INFT HIPS R-T IMG DYNAMIC REQ PHYS/QHP MANJ	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76886	CHG US INFT HIPS R-T IMG LMTD STATIC PHYS/QHP MANJ	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76932	PR SONO GUIDE HEART BIOPSY	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76936	PR US GUID,COMP REPAIR,PSEUDO-ANEUR/AV FIST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76937	PR US GUIDE, VASCULAR ACCESS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76940	PR US GUIDE, TISSUE ABLATION	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76941	PR SONO GUIDE INTRAUTER XFUSN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A MATERNAL-FETAL MEDICINE (MFM)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
76941	PR SONO GUIDE INTRAUTER XFUSN	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH REQUIRED IF REFERRED TO PROVIDER IS A NOT A MATERNAL-FETAL MEDICINE (MFM) EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76942	PR SONO GUIDE NEEDLE BIOPSY	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76945	PR SONO GUIDE CHOR VILL SAMPLING	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76946	PR SONO GUIDE AMNIOCENTESIS	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76946	PR SONO GUIDE AMNIOCENTESIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
76948	PR SONO GUIDE OVA ASPIRATION	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76965	PR SONO GUIDE RADIOELEMT APPLIC	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76975	PR GI ENDOSCOPIC ULTRASOUND	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76977	PR SONO BONE DENSITY MEASURE, PERIPHERAL	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76978	CHG ULTRASOUND TRGT DYNAMIC MICROBUBBLE 1ST LESION	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76979	CHG ULTRASOUND TRGT DYNAMIC MICROBUBBLE EA ADDL LES	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76981	CHG ULTRASOUND ELASTOGRAPH Y PARENCHYMA	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76982	CHG ULTRASOUND ELASTOGRAPH Y FIRST TARGET LESION	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76983	CHG ULTRASOUND ELASTOGRAPH Y EA ADDL TAGET LESION	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76984	ULTRASOUND OF CHEST AORTA DURING SURGERY	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76987	ULTRASOUND OF HEART DURING SURGERY TO EVALUATE FOR CONGENITAL HEART DISEASE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76988	ULTRASOUND OF HEART DURING SURGERY TO EVALUATE FOR CONGENITAL HEART DISEASE, INCLUDING PLACEMENT AND MANIPULATION OF TRANSDUCER AND IMAGE ACQUISITION	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76989	ULTRASOUND OF HEART DURING SURGERY TO EVALUATE FOR CONGENITAL HEART DISEASE, INTERPRETATION AND REPORT OF RESULTS ONLY	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
76998	PR ULTRASONIC GUIDANCE, INTRAOPERATIVE	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
76999	UNLISTED ULTRASOUND PROCEDURE (EG, DIAGNOSTIC, INTERVENTIONAL)	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77012	PR CT GUIDANCE NEEDLE PLACEMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77046	CHG MRI BREAST WITHOUT CONTRAST MATERIAL UNILATERAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					
77047	CHG MRI BREAST WITHOUT CONTRAST MATERIAL BILATERAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77048	CHG MRI BREAST W/OUT&WITH CONTRAST W/CAD UNILATERAL	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77049	CHG MRI BREAST WITHOUT&WITH CONTRAST W/CAD BILATERAL	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77053	PR MAMMARY DUCTOGRAM, SINGLE	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77054	PR MAMMARY DUCTOGRAM, MULTIPLE	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77065	CHG DIAGNOSTIC MAMMOGRAPH Y COMPUTER- AIDED DETCJ UNI	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77066	CHG DIAGNOSTIC MAMMOGRAPH Y COMPUTER- AIDED DETCJ BI	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77067	CHG SCREENING MAMMOGRAPHY BI 2-VIEW BREAST INC CAD	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77072	PR X-RAYS FOR BONE AGE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77078	PR CT BONE DENS STUDY, 1+ SITE, AXIAL	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77080	PR DEXA, BONE DENSITY, AXIAL SKELETON	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77081	PR DEXA,BONE DENSITY,APPE NDICULR SKELTN	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77084	PR MRI, BONE MARROW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77085	CHG DXA BONE DENSITY STUDY AXIAL SKELETON	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77086	CHG VERTEBRAL FRACTURE ASSESSMENT VIA DXA	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77261	CHG RADIATION THERAPY PLAN SIMPLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77262	CHG RADIATION THERAPY PLAN INTERM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77263	CHG RADIATION THERAPY PLAN COMPLEX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77280	CHG SET RADN THERAPY FIELD SIMPLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77285	CHG SET RADN THERAPY FIELD INTERME	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77290	CHG SET RADN THERAPY FIELD COMPLEX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77293	CHG RESPIRATORY MOTION MANAGEMENT SIMULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77295	CHG 3-D RADIOTHERAPY PLAN DOSE-VOLUME HISTOGRAMS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77299	CHG RADN THERAPY PLANNING UNLISTED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77300	CHG RADIATION THERAPY, DOSIMETRY PLAN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77301	CHG INTEN MOD RADIOTHER PLAN W/DOSE VOL HIST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77305	CHG TELEETHER ISODOSE PLAN SIMPLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77306	CHG TELETHX ISODOSE PLN SMPL W/DOSIMETRY CALCULATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77307	CHG TELETHX ISODOSE PLN CPLX W/BASIC DOSIMETRY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77310	CHG TELETHER ISODOSE PLAN INTERM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77315	CHG TELETHER ISODOSE PLAN COMPLX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77316	CHG BRACHYTX ISODOSE PLN SMPL W/DOSIMETRY CAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77317	CHG BRACHYTX ISODOSE PLN INTERMED W/DOSIMETRY CAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77318	CHG BRACHYTX ISODOSE PLN CPLX W/DOSIMETRY CAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77321	CHG TELETHER ISO-PORT PLAN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77326	CHG BRACHYTHER DOSE PLAN SIMPLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77327	CHG BRACHYTHER DOSE PLAN INTERM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77328	CHG BRACHYTHER DOSE PLAN COMPLX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77331	CHG SPECIAL RADIATION DOSIMETRY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77332	CHG RADN TREATMENT AID(S) SIMPLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77333	CHG RADN TREATMENT AID(S) INTERM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77334	CHG RADN TREATMENT AID(S) COMPLX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77336	CHG RADN PHYSICS CONSULT CONTINUING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
77338	CHG MLC IMRT DESIGN & CONSTRUCTION PER IMRT PLAN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77370	CHG RADN PHYSICS CONSULT SPECIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77371	CHG RADIATION DELIVERY STEREOTACTIC CRANIAL COBALT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77372	RADIATION DELIVERY STEREOTACTIC CRANIAL LINEAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77373	PR RADN RX DELIV,BODY, EACH FRACTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77385	CHG INTENSITY MODULATED RADIATION TX DLVR SIMPLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77386	CHG INTENSITY MODULATED RADIATION TX DLVR COMPLEX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77387	CHG GUIDANCE FOR LOCLZJ TARGET VOL FOR RADJ TX DLVR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77399	CHG RADIATION DOSIMETRY UNLISTED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77401	CHG RADIATION TX DELIVERY SUPERFICIAL&/ ORTHO VOLTA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77402	CHG RADIATION TREATMENT DELIVERY 1 MEV+ SIMPLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77403	CHG RADN RX DELIVERY SIMPLE 6-10 MEV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77404	CHG RADN RX DELIVERY SIMPLE 11-19 MEV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77406	CHG RADN RX DELIVERY SIMPLE 20+ MEV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77407	CHG RADIATION TREATMENT DELIVERY 1 MEV+ INTERMEDIATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77408	CHG RADN RX DELIVERY INTERM 6-10 MEV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77409	CHG RADN RX DELIVERY INTERM 11-19 MEV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77411	CHG RADN RX DELIVERY INTERM 20+ MEV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77412	CHG RADIATION TREATMENT DELIVERY 1 MEV+ COMPLEX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77413	CHG RADN RX DELIVERY COMPLX 6-10 MEV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77414	CHG RADN RX DELIVERY COMPLX 11-19 MEV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77416	CHG RADN RX DELIVERY COMPLX 20+ MEV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77417	CHG THERAPEUTIC RADIOLOGY PORT IMAGES (S)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77418	CHG INTEN MOD RADIOTHER PLAN, SIN/MULT FIELD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77421	PR STEREOSCOPI C X-RAY GUIDANCE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77423	PR NEUTRON BEAM TREATMENT, COMPLEX	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77424	PR INTRAOP RADIAJ TX DELIVER XRAY SINGLE TX SESSION	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77425	PR INTRAOP RADIAJ TX DELIVER ELECTRONS SNGL TX SESS	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77427	CHG RADIATION,MANAGEMENT,5 TX'S	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77431	CHG RADIATION THERAPY MANAGEMENT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77432	STEREOTACTIC RADIATION TX MANAGEMENT CRANIAL LESION	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77435	PR RADN RX DELIV,BODY, MANAGEMENT, PER COURSE	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77469	PR INTRAOPERATIVE RADIATION TREATMENT MANAGEMENT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77470	PR SPECIAL TREATMENT PROCEDURE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77499	CHG RADIATION,MANAGEMENT,THE RAP-OTH	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77520	CHG PROTON BEAM DEL,SIMPLE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77525	CHG PROTON BEAM DEL,MULTIPLE, COMPLEX	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77750	CHG INFUSE RADIOACTIVE MATERIALS	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77761	CHG INTRACAV RADIOELEM APPL SIMPLE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77762	CHG INTRACAV RADIOELEM APPL INTERM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77763	CHG INTRACAV RADIOELEM APPL COMPLX	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77767	CHG HDR RDNCL SKN SURF BRACHYTX LES </2CM/1 CHAN	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77768	CHG HDR RDNCL SK SRF BRCHYTX LES >2CM&2CHAN/ MLT LES	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77770	CHG HDR RDNCL NTRSTL/INTRC AV BRACHYTX 1 CHANNEL	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77771	CHG HDR RDNCL NTRSTL/INTRC AV BRACHYTX 2-12 CHANNEL	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77772	CHG HDR RDNCL NTRSTL/INTRC AV BRACHYTX >12 CHANNELS	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77778	CHG INTERSTITIAL RADIATION SOURCE APPLIC COMPLEX	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77786	CHG REMOTE AFTLD RADIONUC BRACHYTHERAPY,2-12 CHANNEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
77789	CHG SURFACE APPLIC LOW DOSE RATE RADIONUCLIDE SOURCE	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
77790	PR RADIOELEMENT HANDLING	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
77799	PR RADIUM/RADIOISOTOPE THERAPY UNLIST	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78012	CHG THYROID UPTAKE SINGLE/MULTIPLE QUANT MEASUREMENT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78013	CHG THYROID IMAGING WITH VASCULAR FLOW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78014	CHG THYROID UPTAKE W/BLOOD FLOW SNGL/MULT QUAN MEAS	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78015	PR THYROID MET IMAGING LTD	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78016	PR THYROID MET IMAGING ADDN LTD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					
78018	PR THYROID MET IMAGING BODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78020	PR THYROID MET UPTAKE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78070	CHG PARATHYROID PLANAR IMAGING	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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78071	CHG PARATHYROID PLANAR IMAGING W/WO SUBTRACTION	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78072	CHG PARATHYROID IMAGING W/TOMOGRAP HIC SPECT & CT	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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78075	PR ADRENAL NUCLEAR IMAGING	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78099	PR ENDOCRINE NUCLEAR PROCEDURE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78102	PR BONE MARROW IMAGING, LTD	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78103	PR BONE MARROW IMAGING, MULT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78104	PR BONE MARROW IMAGING, BODY	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78110	PR PLASMA VOLUME, SINGLE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78111	PR PLASMA VOLUME, MULTIPLE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78120	PR RED CELL MASS, SINGLE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78121	PR RED CELL MASS, MULTIPLE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78122	PR BLOOD VOLUME	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78130	CHG RED CELL SURVIVAL STUDY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					
78140	PR RED CELL SEQUESTRATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
		EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)					

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78185	PR SPLEEN IMAGING	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78191	PR PLATELET SURVIVAL	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78195	PR LYMPHATICS & LYMPH GLANDS IMAGING	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78199	PR BLOOD/LYMPH NUCLEAR EXAM UNLISTED	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78201	PR LIVER IMAGING	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78202	PR LIVER IMAGING WITH FLOW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78215	PR LIVER AND SPLEEN IMAGING	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78216	PR LIVER & SPLEEN IMAGE, FLOW	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78226	PR HEPATOBIILIAR Y SYST IMAGING INCLUDING GALLBLADDER	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78227	CHG HEPATOBI SYST IMAG INC GB W/PHARMA INTERVENJ	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78230	PR SALIVARY GLAND IMAGING	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78231	PR SERIAL SALIVARY IMAGING	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78232	PR SALIVARY GLAND FUNCTION EXAM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78258	PR ESOPHAGEAL MOTILITY STUDY	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78261	PR GASTRIC MUCOSA IMAGING	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78262	PR GASTROESOPH AGEAL REFLUX EXAM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78264	CHG GASTRIC EMPTYING IMAGING STUDY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78267	PR BREATH TEST,ACQUIRE/ ANALYZE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78268	PR BREATH TEST,ANALYZE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78278	PR ACUTE GI BLOOD LOSS IMAGING	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78282	PR GI PROTEIN LOSS EXAM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78290	PR BOWEL IMAGING	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78291	PR LEVEEN/SHUNT PATENCY EXAM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78299	PR GI NUCLEAR PROCEDURE UNLISTED	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78300	PR BONE IMAGING, LIMITED AREA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78305	PR BONE IMAGING, MULTIPLE AREAS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78306	PR BONE IMAGING, WHOLE BODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78315	PR BONE IMAGING, 3 PHASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78320	PR BONE IMAGING (SPECT)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78350	PR BONE MINERAL, SINGLE PHOTON	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78399	PR MUSCULOSKELETAL NUCLEAR EXAM	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
78414	PR NON-IMAGING HEART FUNCTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78428	PR CARDIAC SHUNT IMAGING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78429	CHG MYOCDR IMG PET METAB EVAL SINGLE STUDY CNCRNT CT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78430	CHG MYOCDR IMG PET PRFUJ 1STD REST/STRESS CNCRNT CT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78431	CHG MYOCDR IMG PET PRFUJ MLT STD RST&STRS CNCRNT CT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78432	CHG MYOCDR IMG PET PRFUJ W/METAB DUAL RADIOTRACER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78433	CHG MYOCDR IMG PET PRFUJ W/METAB 2RTRACER CNCRNT CT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78434	CHG AQMBF PET REST AND PHARMACOLOGIC STRESS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78445	PR VASCULAR FLOW IMAGING, NONC ARDIAC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78451	HT MUSCLE IMAGE SPECT SING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78452	HT MUSCLE IMAGE SPECT MULT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78453	HEART MUSCLE IMAGE PLANAR SING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78454	CHG MYOCARDIAL PERFUSION PLANAR MULTIPLE STUDIES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78455	CHG VENOUS THROMBOSIS STUDY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78456	PR IMAG,ACUTE VENOUS THRMBSIS,PEP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78457	PR IMAG,ACUTE VENOUS THRMBSIS,UNIL AT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78458	PR VEN THROMBOSIS IMAGES, BILAT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
78466	PR HEART INFARCT IMAGE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78468	PR HEART INFARCT IMAGE W EF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78472	PR GATED HEART, PLANAR SINGLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78473	PR GATED HEART, MULTIPLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78481	PR HEART FIRST PASS SINGLE, PLANAR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78483	PR HEART FIRST PASS MULTIPLE, PLANAR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78494	PR HEART IMAGE, SPECT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78496	PR HEART FIRST PASS ADD-ON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78499	PR CARDIOVASC NUCL EXAM UNLISTED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78579	PR PULMONARY VENTILATION IMAGING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78580	PR PULMONARY PERFUSION IMAGING PARTICULATE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78582	PR PULMONARY VENTILATION & PERFUSION IMAGING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78597	PR QUANT DIFFERENTIAL PULM PERFUSION W/WO IMAGING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78598	PR QUANT DIFF PULM PRFUSION & VENTLAJ W/WO IMAGING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78599	PR RESP NUCLEAR EXAM UNLISTED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78600	BRAIN IMAGING < 4 STATIC VIEWS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78601	BRAIN IMAGING < 4 STATIC VIEWS W VASCULAR FLOW	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78605	BRAIN IMAGING MIN 4 STATIC VIEWS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78606	BRAIN IMAGING MIN 4 STATIC VIEWS W VASCULAR FLOW	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78608	PR BRAIN IMAGING PET METABOLIC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78609	PR BRAIN IMAGING PET PERFUSION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78610	PR BRAIN FLOW IMAGING ONLY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78630	PR CSF FLUID SCAN CISTERNOGRAPHY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78635	PR CSF VENTRICULOGRAPHY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78645	PR CSF SHUNT EVALUATION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78650	PR CSF LEAKAGE DETECTION & LOCALIZATION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78660	PR NUCLEAR TEAR FLOW	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78699	PR NERV SYS NUCL EXAM UNLISTED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78700	PR RENAL IMAGING, MORPHOLOGY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78701	PR RENAL IMAGING, MORPH W/ FLOW	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78707	PR RENAL IMAGING, MORPH W/ FLOW/FUNC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78708	PR RENAL IMAGING, MORPH W/ FLOW/FUNC, PHARM, SINGLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78709	PR RENAL IMAGING, MORPH W/ FLOW/FUNC, PHARM, MULTI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78725	PR RENAL FUNCTION STUDY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78730	PR URINARY BLADDER RESIDUAL, ADD-ON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78740	PR URETERAL REFLUX STUDY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78761	PR TESTICULAR IMAGING & FLOW	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78799	PR GU NUCLEAR EXAM UNLISTED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78800	CHG RP LOCLZJ TUM PLNR 1 AREA SINGLE DAY IMAGING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78801	CHG RP LOCLZJ TUM PLNR 2+AREA 1+D IMG/1 AREA IMG>2+D	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78802	CHG RP LOCLZJ TUM PLNR WHOLE BODY SINGLE DAY IMAGING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78803	CHG RP LOCLZJ TUM SPECT 1 AREA SINGLE DAY IMAGING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78804	CHG RP LOCLZJ TUM PLNR WHOLE BODY 2+ DAYS IMAGING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78811	PET IMAGING LIMITED AREA CHEST HEAD/NECK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78812	PET IMAGING SKULL BASE TO MID-THIGH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78813	PET IMAGING WHOLE BODY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78814	PET IMAGING CT FOR ATTENUATION LIMITED AREA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
78815	PET IMAGING CT ATTENUATION SKULL BASE MID-THIGH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78816	PET IMAGING FOR CT ATTENUATION WHOLE BODY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
78999	CHG NUCLEAR DIAGNOSTIC EXAM UNLISTED	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
79005	CHG NUC THERAPY INTRACAVITARY RADIOCOLLOID	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
79101	CHG NUC THERAPY INTRA-ARTERIAL	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
79200	PR NUCLEAR THERAPY, INTRACAVITARY	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
79300	PR NUCLEAR THERAPY, INTERSTITIAL	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
79403	PR NUCLEAR THERAPY, MONOCLONAL AB	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
79440	PR NUCLEAR THERAPY, INTRA-ARTICULAR	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
79445	PR NUCLEAR THERAPY, INTRA-ARTERIAL	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
79999	PR NUCLEAR THERAPY, UNLISTED	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80047	CHG BASIC METABOLIC PANEL CALCIUM IONIZED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80048	BASIC METABOLIC PANEL CALCIUM TOTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
80050	CHG GENERAL HEALTH PANEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80051	CHG ELECTROLYTE PANEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80053	CHG METABOLIC PANEL,COMPREHENSIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80055	CHG OBSTETRIC PANEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80061	CHG LIPID PANEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80069	CHG RENAL FUNCTION PANEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80074	CHG HEPATITIS PANEL,ACUTE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80076	CHG HEPATIC FUNCTION PANEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80081	CHG OBSTETRIC PANEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80143	CHG DRUG ASSAY ACETAMINOPHEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
80145	CHG DRUG ASSAY ADALIMUMAB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80150	CHG ASSAY OF AMIKACIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80151	CHG DRUG ASSAY AMIODARONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80155	CHG DRUG SCREEN QUANTITATIVE CAFFEINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80156	ASSAY OF CARBAMAZEPI NE TOTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80157	ASSAY OF ASSAY CARBAMAZEPI NE, FREE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80158	CHG ASSAY OF CYCLOSPORIN E	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80159	CHG DRUG SCREEN QUANTITATIVE CLOZAPINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80161	CHG DRUG ASSAY CARBAMAZEPI NE -10,11-EPOXIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80162	CHG DRUG SCREEN QUANTITATIVE DIGOXIN TOTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
80163	CHG DRUG SCREEN QUANTITATIVE DIGOXIN FREE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80164	CHG DRUG SCREEN QUANT DIPROPYLACETIC ACID TOTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80165	CHG DRUG SCREEN QUANT DIPROPYLACETIC ACID FREE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80167	CHG DRUG ASSAY FELBAMATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80168	CHG ASSAY OF ETHOSUXIMIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80169	CHG DRUG SCREEN QUANTITATIVE EVEROLIMUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80170	ASSAY OF GENTAMICIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80171	CHG DRUG SCREEN QUANTITATIVE GABAPENTIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80173	ASSAY OF HALOPERIDOL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80175	CHG DRUG SCREEN QUANTITATIVE LAMOTRIGINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
80176	ASSAY OF LIDOCAINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80177	CHG DRUG SCREEN QUANTITATIVE LEVETIRACETAM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80178	ASSAY OF LITHIUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80179	CHG DRUG ASSAY SALICYLATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80180	CHG DRUG SCREEN QUANTITATIVE MYCOPHENOLATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80181	CHG DRUG ASSAY FLECAINIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80182	ASSAY OF NORTRIPTYLIN E	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80183	CHG DRUG SCREEN QUANTITATIVE OXCARBAZEPINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80184	ASSAY OF PHENOBARBITAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
80185	ASSAY OF PHENYTOIN, TOTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80186	ASSAY OF PHENYTOIN, FREE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80187	CHG DRUG ASSAY POSACONAZOLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80188	ASSAY OF PRIMIDONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80189	CHG DRUG ASSAY ITRACONAZOLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80190	ASSAY OF PROCAINAMIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80192	ASSAY OF PROCAINAMIDE W METABOLITES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80193	CHG DRUG ASSAY LEFLUNOMIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80194	ASSAY OF QUINIDINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80195	PR ASSAY OF SIROLIMUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
80197	ASSAY OF TACROLIMUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80198	ASSAY OF THEOPHYLLINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80199	CHG DRUG SCREEN QUANTITATIVE TIAGABINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80200	ASSAY OF TOBRAMYCIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80201	ASSAY OF TOPIRAMATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80202	ASSAY OF VANCOMYCIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80203	CHG DRUG SCREEN QUANTITATIVE ZONISAMIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80204	CHG DRUG ASSAY METHOTREXATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80210	CHG DRUG ASSAY RUFINAMIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80220	CHG DRUG ASSAY HYDROXYCHLOROQUINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
80230	CHG DRUG ASSAY INFLIXIMAB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80235	CHG DRUG ASSAY LACOSAMIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80280	CHG DRUG ASSAY VEDOLIZUMAB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80285	CHG DRUG ASSAY VORICONAZOLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80299	CHG QUANTITATION DRUG NOT ELSEWHERE SPECIFIED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80305	CHG DRUG TEST PRSMV READ DIRECT OPTICAL OBS PR DATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80306	CHG DRUG TST PRSMV READ INSTRMNT ASSTD DIR OPT OBS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80306	DRUG TEST TOXICOLOGY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80307	CHG DRUG TST PRSMV INSTRMNT CHEM ANALYZERS PR DATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
80320	CHG DRUG SCREEN QUANTITATIVE ALCOHOLS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80321	CHG DRUG SCREEN QUANT ALCOHOLS BIOMARKERS 1 OR 2	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80322	CHG DRUG SCREEN QUANT ALCOHOLS BIOMARKERS 3 OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80323	CHG ALKALOIDS NOT OTHERWISE SPECIFIED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80324	CHG DRUG SCREEN QUANT AMPHETAMINE S 1 OR 2	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80325	CHG DRUG SCREEN QUANT AMPHETAMINE S 3 OR 4	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80326	CHG DRUG SCREEN QUANT AMPHETAMINE S 5 OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80327	CHG DRUG SCREEN QUANT ANABOLIC STEROID 1 OR 2	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
80328	CHG DRUG SCREEN QUANT ANABOLIC STEROID 3 OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80329	CHG DRUG SCREEN ANALGESICS NON-OPIOID 1 OR 2	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80330	CHG DRUG SCREEN ANALGESICS NON-OPIOID 3-5	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80331	CHG DRUG SCREEN ANALGESICS NON-OPIOID 6 OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80332	CHG ANTIDEPRESSANTS SEROTONERGIC CLASS 1 OR 2	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80333	CHG ANTIDEPRESSANTS SEROTONERGIC CLASS 3-5	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80334	CHG ANTIDEPRESSANTS SEROTONERGIC CLASS 6 OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80335	CHG ANTIDEPRESSANTS TRICYCLIC OTHER CYCLICALS 1 OR 2	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
80336	CHG ANTIDEPRESSANTS TRICYCLIC OTHER CYCLICALS 3-5	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80337	CHG ANTIDEPRESSANTS TRICYCLIC OTHER CYCLICALS 6/MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80338	CHG ANTIDEPRESSANTS NOT OTHERWISE SPECIFIED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80339	CHG ANTIPILEPTICS NOT OTHERWISE SPECIFIED 1-3	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80340	CHG ANTIPILEPTICS NOT OTHERWISE SPECIFIED 4-6	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80341	CHG ANTIPILEPTICS NOT OTHERWISE SPECIFIED 7/MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80342	CHG ANTIPSYCHOTICS NOT OTHERWISE SPECIFIED 1-3	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80343	CHG ANTIPSYCHOTICS NOT OTHERWISE SPECIFIED 4-6	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
80344	CHG ANTIPSYCHOTICS NOT OTHERWISE SPECIFIED 7/MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80345	CHG DRUG SCREENING BARBITURATES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80346	CHG DRUG SCREENING BENZODIAZEPINES 1-12	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80347	CHG DRUG SCREENING BENZODIAZEPINES 13 OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80348	CHG DRUG SCREENING BUPRENORPHINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80349	CHG DRUG SCREENING CANNABINOIDS NATURAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80350	CHG DRUG SCREENING CANNABINOIDS SYNTHETIC 1-3	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80351	CHG DRUG SCREENING CANNABINOIDS SYNTHETIC 4-6	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80352	CHG DRUG SCREENING CANNABINOIDS SYNTHETIC 7/MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
80353	CHG DRUG SCREENING COCAINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80354	CHG DRUG SCREENING FENTANYL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80355	CHG DRUG SCREENING GABAPENTIN NON-BLOOD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80356	CHG DRUG SCREENING HEROIN METABOLITE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80357	CHG DRUG SCREENING KETAMINE AND NORKETAMINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80358	CHG DRUG SCREENING METHADONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80359	CHG DRUG SCREENING METHYLENEDI OXYAMPHETAMINES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80360	CHG DRUG SCREENING METHYLPHENIDATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80361	CHG DRUG SCREENING OPIATES 1 OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
80362	CHG DRUG SCREENING OPIOIDS AND OPIATE ANALOGS 1 OR 2	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80363	CHG DRUG SCREENING OPIOIDS AND OPIATE ANALOGS 3 OR 4	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80364	CHG DRUG SCREENING OPIOIDS & OPIATE ANALOGS 5/MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80365	CHG DRUG SCREENING OXYCODONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80366	CHG DRUG SCREENING PREGABALIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80367	CHG DRUG SCREENING PROPOXYPHEN E	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80368	CHG DRUG SCREENING SEDATIVE HYPNOTICS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80369	CHG DRUG SCREENING SKELETAL MUSCLE RELAXANTS 1 OR 2	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
80370	CHG DRUG SCREENING SKEL MUSCLE RELAXANTS 3 OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80371	CHG DRUG SCREENING STIMULANTS SYNTHETIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80372	CHG DRUG SCREENING TAPENTADOL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80373	CHG DRUG SCREENING TRAMADOL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80374	CHG DRUG SCREEN STEREOISOMER ANALYSIS 1 DRUG CLASS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80375	CHG DRUG/SUBSTANCE DEFINITIVE QUAL/QUANT NOS 1-3	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80376	CHG DRUG/SUBSTANCE DEFINITIVE QUAL/QUANT NOS 4-6	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80377	CHG DRUG/SUBSTANCE DEFINITIVE QUAL/QUANT NOS 7/MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
80400	CHG ACTH STIM PANEL, ADR INSUFF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80402	CHG ACTH STIM PANEL, 21 HYDROX DEF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80406	CHG ACTH STIM PANEL, 3 BETAHYDROX DEF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80408	CHG ALDOSTERONE SUPPRESSION EVAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80410	CHG CALCITONIN STIMUL PANEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80412	CHG CRH STIMULATION PANEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80414	CHG TESTOSTERON E RESPONSE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80415	CHG CHORNC GONAD STIMJ PNL TOTAL ESTRADIOL RESPONSE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80416	CHG RENIN STIM PANEL VEIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80417	CHG RENIN STIM PANEL PERIPH VEIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
80418	CHG PITUITARY EVALUATION PANEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80420	CHG DEXAMETHASONE PANEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80422	CHG GLUCAGON TOLERANCE PANEL, INSULINOMA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80424	CHG GLUCAGON TOLERANCE PANEL, PHEOCHROMOCYTOMA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80426	CHG GONADOTROPIN HORMONE PANEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80428	CHG GROWTH HORMONE STIMULATION PANEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80430	CHG GROWTH HORMONE SUPPRESSION PANEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80432	CHG INSULIN SUPPRESSION PANEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80434	CHG INSULIN TOLERANCE PANEL, ACTH INSUFFICIENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80435	CHG INSULIN TOLERANCE PANEL, GROWTH HORMONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
80436	CHG METYRAPONE PANEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80438	CHG TRH STIM PANEL, 1 HR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80439	CHG TRH STIM PANEL, 2 HR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80503	CHG PATHOLOGY CLINICAL CONSULTATION SF MDM 5-20 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80504	CHG PATHOLOGY CLINICAL CONSULTATION MOD MDM 21-40MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80505	CHG PATHOLOGY CLINICAL CONSULTATION HI MDM 41-60 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
80506	CHG PATHOLOGY CLINICAL CONSLTJ PROLNG SVC EA ADDL 30	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
81000	CHG URINALYSIS, NONAUTO, W/SCOPE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81001	CHG URINALYSIS, AUTO, W/SCOPE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
81002	CHG URINALYSIS NONAUTO W/O SCOPE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
81003	CHG URINALYSIS, AUTO, W/O SCOPE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
81005	CHG URINALYSIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
81007	CHG URINE SCREEN FOR BACTERIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
81015	CHG MICROSCOPIC EXAM OF URINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
81020	CHG URINALYSIS, GLASS TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
81025	CHG URINE PREGNANCY TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
81050	CHG URINALYSIS, VOLUME MEASURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
81099	CHG URINALYSIS TEST PROCEDURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81105	CHG HPA-1 GENOTYPING GENE ANALYSIS COMMON VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81106	CHG HPA-2 GENOTYPING GENE ANALYSIS COMMON VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81107	CHG HPA-3 GENOTYPING GENE ANALYSIS COMMON VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81108	CHG HPA-4 GENOTYPING GENE ANALYSIS COMMON VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81109	CHG HPA-5 GENOTYPING GENE ANALYSIS COMMON VARIANT	<p>AUTHORIZATION REQUIRED</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF</p> <p>MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81110	CHG HPA-6 GENOTYPING GENE ANALYSIS COMMON VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81111	CHG HPA-9 GENOTYPING GENE ANALYSIS COMMON VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81112	CHG HPA-15 GENOTYPING GENE ANALYSIS COMMON VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81120	CHG IDH1 COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81120	CHG IDH1 COMMON VARIANTS	NO AUTHORIZATION REQUIRED	MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81121	CHG IDH2 COMMON VARIANTS	<p>AUTHORIZATION REQUIRED</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF</p> <p>MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81161	CHG DMD DUPLICATION/DELETION ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81163	CHG BRCA1 BRCA2 GENE ANALYSIS FULL SEQUENCE ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81164	CHG BRCA1 BRCA2 GENE ANALYSIS FULL DUP/DEL ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81165	CHG BRCA1 GENE ANALYSIS FULL SEQUENCE ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81166	CHG BRCA1 GENE ANALYSIS FULL DUP/DEL ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81167	CHG BRCA2 GENE ANALYSIS FULL DUP/DEL ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81168	CHG CCND1/IGH TRANSLOCATIONS ALYS MAJOR BP QUAL&QUAN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81170	CHG ABL1 GENE ANALYSIS KINASE DOMAIN VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81171	PR GENE ANALYSIS (FRAGILE X INTELLECTUAL DISABILITY 2) FOR DETECTION OF ABNORMAL ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81172	PR GENE ANALYSIS (FRAGILE X INTELLECTUAL DISABILITY 2) FOR CHARACTERIZATION OF ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81173	CHG AR GENE ANALYSIS FULL GENE SEQUENCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81174	CHG AR GENE ANALYSIS KNOWN FAMILIAL VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81175	CHG ASXL1 GENE ANALYSIS FULL GENE SEQUENCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81176	CHG ASXL1 GENE ANALYSIS TARGETED SEQ ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81177	CHG ATN1 GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81177	CHG ATN1 GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81178	CHG ATXN1 GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81179	CHG ATXN2 GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81180	CHG ATXN3 GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81183	CHG ATXN10 GENE ANALYSIS EVAL DETC ABNORMAL ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81184	CHG CACNA1A GENE ANALYSIS EVAL DETECT ABNOR ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81185	CHG CACNA1A GENE ANALYSIS FULL GENE SEQUENCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81186	CHG CACNA1A GENE ANALYSIS KNOWN FAMILIAL VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81187	CHG CNBP GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81188	CHG CSTB GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81189	CHG CSTB GENE ANALYSIS FULL GENE SEQUENCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81190	CHG CSTB GENE ANALYSIS KNOWN FAMILIAL VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81191	CHG NTRK1 TRANSLOCATI ON ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81192	CHG NTRK2 TRANSLOCATI ON ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81193	CHG NTRK3 TRANSLOCATI ON ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81194	CHG NTRK TRANSLOCATI ON ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81200	PR ASPA GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81201	CHG APC GENE ANALYSIS FULL GENE SEQUENCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81202	CHG APC GENE ANALYSIS KNOWN FAMILIAL VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81203	CHG APC GENE ANALYSIS DUPLICATION/DELETION VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81204	CHG AR GENE ANALYSIS CHARACTERIZATION OF ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

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81205	PR BCKDHB GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81206	PR BCR/ABL1 MAJOR BREAKPNT QUALITATIVE/Q UANTITATIVE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81207	PR BCR/ABL1 MINOR BREAKPNT QUALITATIVE/Q UANTITATIVE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81209	PR BLM GENE ANALYSIS 2281DEL6INS7 VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81210	CHG BRAF GENE ANALYSIS V600 VARIANT(S)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81212	CHG BRCA1 BRCA 2 GEN ALYS 185DELAG 5385INSC 6174DELT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81215	CHG BRCA1 GENE ANALYSIS KNOWN FAMILIAL VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81216	CHG BRCA2 GENE ANALYSIS FULL SEQUENCE ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81217	CHG BRCA2 GENE ANALYSIS KNOWN FAMILIAL VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81218	CHG CEBPA GENE ANALYSIS FULL GENE SEQUENCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81219	CHG CALR GENE ANALYSIS COMMON VARIANTS IN EXON 9	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81220	PR CFTR GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (Cystic Fibrosis): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Cystic-Fibrosis.pdf MD GUIDELINE 2 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 3 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81220	PR CFTR GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Cystic Fibrosis): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Cystic-Fibrosis.pdf</p> <p>MD GUIDELINE 2 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF</p> <p>MD GUIDELINE 3 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81221	PR CFTR GENE ANALYSIS KNOWN FAMILIAL VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (Cystic Fibrosis): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Cystic-Fibrosis.pdf MD GUIDELINE 2 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 3 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81222	PR CFTR GENE ANALYSIS DUPLICATION/DELETION VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (Cystic Fibrosis): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Cystic-Fibrosis.pdf MD GUIDELINE 2 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 3 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81223	PR CFTR GENE ANALYSIS FULL GENE SEQUENCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Cystic Fibrosis): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Cystic-Fibrosis.pdf MD GUIDELINE 2 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 3 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81224	PR CFTR GENE ANALYSIS INTRON 8 POLY-T ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81225	PR CYP2C19 GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81226	PR CYP2D6 GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81227	PR CYP2C9 GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81228	CHG CYTOG Alys CHRMOML ABNOR COPY NUMBER VRNT CGH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81229	CHG CYTOG ALYS CHROMML ABNOR CPY NUMBER&SNP VRNT CGH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81229	CHG CYTOG ALYS CHROMOML ABNOR CPY NUMBER&SNP VRNT CGH	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF</p> <p>MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023
81230	CHG CYP3A4 GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED	<p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.</p> <p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81231	CHG CYP3A5 GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81232	CHG DYPD GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81233	CHG BTK GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81234	CHG DMPK GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81235	CHG EGFR GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023
81236	CHG EZH2 GENE ANALYSIS FULL GENE SEQUENCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81237	CHG EZH2 GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81238	CHG F9 FULL GENE SEQUENCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023
81239	CHG DMPK GENE ANALYSIS CHARACTERIZATION OF ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81240	PR F2 GENE ANALYSIS 20210G >A VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81241	PR F5 COAGULATION FACTOR V ANAL LEIDEN VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81242	PR FANCC GENE ANALYSIS COMMON VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81243	PR GENE ANALYSIS (FRAGILE X SYNDROME, X-LINKED INTELLECTUAL DISABILITY) FOR DETECTION OF ABNORMAL ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81244	CHG FMR1 GENE ANALYSIS CHARACTERIZATION OF ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81245	CHG FLT3 GENE ANALYSIS INTERNAL TANDEM DUP VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81246	CHG FLT3 GENE ANALYSIS TYROSINE KINASE DOMAIN VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81247	CHG G6PD GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81248	CHG G6PD GENE ANALYSIS KNOWN FAMILIAL VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81249	CHG G6PD GENE ANALYSIS FULL GENE SEQUENCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81250	PR G6PC GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81252	CHG GJB2 GENE ANALYSIS FULL GENE SEQUENCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81253	CHG GJB2 GENE ANALYSIS KNOWN FAMILIAL VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81254	CHG GJB6 GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81255	PR HEXA GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81256	PR HFE HEMOCHROMA TOSIS GENE ANAL COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81257	CHG HBA1/HBA2 GENE ANALYSIS COMMON DELETIONS/ VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81258	CHG HBA1/HBA2 GENE ANALYSIS KNOWN FAMILIAL VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81259	CHG HBA1/HBA2 GENE ANALYSIS FULL GENE SEQUENCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81260	PR IKBKAP GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81261	PR IGH@ REARRANGE ABNORMAL CLONAL POP AMPLIFIED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81262	PR IGH@ REARRANGE ABNORMAL CLONAL POP DIRECT PROBE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81263	PR IGH@ VARIABLE REGION SOMATIC MUTATION ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81264	PR IGK@ GENE REARRANGE DETECT ABNORMAL CLONAL POP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81266	PR COMPARATIVE ANAL STR MARKERS EA ADDL SPECIMEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81267	PR CHIMERISM W/COMP TO BASELINE W/O CELL SELECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81268	PR CHIMERISM W/COMP TO BASELINE W/CELL SELECTION EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81269	CHG HBA1/HBA2 GENE ANALYSIS DUP/DEL VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81270	PR JAK2 GENE ANALYSIS P.VAL617PHE VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81271	CHG HTT GENE ANALYSIS DETECT ABNORMAL ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81272	CHG KIT GENE ANALYSIS TARGETED SEQUENCE ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81273	CHG KIT GENE ANALYSIS D816 VARIANT(S)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81274	CHG HTT GENE ANALYSIS CHARACTERIZATION ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGES/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81275	CHG KRAS GENE ANALYSIS VARIANTS IN EXON 2	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81276	CHG KRAS GENE ANALYSIS ADDITIONAL VARIANT(S)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81277	CHG CYTOGENOMIC NEOPLASIA MIRCROARRAY ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81278	CHG IGH@/BCL2 TLCJ ALYS MBR & MCR BP QUAL/QUAN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81279	CHG JAK2 TARGETED SEQUENCE ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81283	CHG IFNL3 GENE ANALYSIS RS12979860 VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81284	CHG FXN GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81285	CHG FXN GENE ANALYSIS CHARACTERIZATION ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81286	CHG FXN GENE ANALYSIS FULL GENE SEQUENCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81287	CHG MGMT GENE PROMOTER METHYLATION ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81288	CHG MLH1 GENE ANALYSIS PROMOTER METHYLATION ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81289	CHG FXN GENE ANALYSIS KNOWN FAMILIAL VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGES/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81290	PR MCOLN1 MUCOLIPIN1 GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81291	PR MTHFR GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81292	PR MLH1 GENE ANALYSIS FULL SEQUENCE ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81293	PR MLH1 GENE ANALYSIS KNOWN FAMILIAL VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81294	PR MLH1 GENE ANALYSIS DUPLICATION/DELETION VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81295	PR MSH2 GENE ANALYSIS FULL SEQUENCE ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81296	PR MSH2 GENE ANALYSIS KNOWN FAMILIAL VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81297	PR MSH2 GENE ANALYSIS DUPLICATION/DELETION VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81298	PR MSH6 GENE ANALYSIS FULL SEQUENCE ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81299	PR MSH6 GENE ANALYSIS KNOWN FAMILIAL VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81300	PR MSH6 GENE ANALYSIS DUPLICATION/DELETION VARIATION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81302	PR MECP2 GENE ANALYSIS FULL SEQUENCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81303	PR MECP2 GENE ANALYSIS KNOWN FAMILIAL VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81304	PR MECP2 GENE ANALYSIS DUPLICATION/DELETION VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81305	CHG MYD88 GENE ANALYSIS P.LEU265 (L265P) VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81306	CHG NUDT15 GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81307	CHG PALB2 GENE ANALYSIS FULL GENE SEQUENCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81308	CHG PALB2 GENE ANALYSIS KNOWN FAMILIAL VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81309	CHG PIK3CA GENE ANALYSIS TARGETED SEQUENCE ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81310	PR NPM1 NUCLEOPHOS MIN GENE ANAL EXON 12 VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81311	CHG NRAS GENE ANALYSIS VARIANTS IN EXON 2&3	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81312	CHG PABPN1 GENE ANALYSIS EVAL DETC ABNORMAL ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81313	CHG PCA3/KLK3 PROSTATE SPECIFIC ANTIGEN RATIO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81314	CHG PDGFRA GENE ANALYSIS TARGETED SEQUENCE ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81315	PR PML/RARALPHA COMMON BREAKPOINTS QUAL/QUANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81316	PR PML/RARALPHA SINGLE BREAKPOINT QUAL/QUAN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81317	PR PMS2 GENE ANALYSIS FULL SEQUENCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81318	PR PMS2 GENE ANALYSIS KNOWN FAMILIAL VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81319	PR PMS2 GENE ANALYSIS DUPLICATION/DELETION VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81320	CHG PLCG2 GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81321	CHG PTEN GENE ANALYSIS FULL SEQUENCE ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81322	CHG PTEN GENE ANALYSIS KNOWN FAMILIAL VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81323	CHG PTEN GENE ANALYSIS DUPLICATION/DELETION VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81324	CHG PMP22 GENE ANAL DUPLICATION/DELETION ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81325	CHG PMP22 GENE ANALYSIS FULL SEQUENCE ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81326	CHG PMP22 GENE ANALYSIS KNOWN FAMILIAL VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81327	CHG SEPT9 GENE PROMOTER METHYLATION ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81328	CHG SLCO1B1 GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81329	CHG SMN1 GENE ANALYSIS DOSAGE/DELETIONS W/SMN2 ALYS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81330	PR SMPD1 GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81332	PR SERPINA1 GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81333	CHG TGFBI GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81334	CHG RUNX1 GENE ANALYSIS TARGETED SEQUENCE ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023
81335	CHG TPMT GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81336	CHG SMN1 GENE ANALYSIS FULL GENE SEQUENCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81337	CHG SMN1 GENE ANALYSIS KNOWN FAMILIAL SEQ VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81338	CHG MPL GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81339	CHG MPL GENE ANALYSIS SEQUENCE ANALYSIS EXON 10	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81340	PR TRB@ REARRANGEMENT ANAL AMPLIFICATION METHOD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81342	PR TRG@ GENE REARRANGEM ENT ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81343	CHG PPP2R2B GENE ANALYSIS EVAL DETC ABNORMAL ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81344	CHG TBP GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81345	CHG TERT GENE ANALYSIS TARGETED SEQUENCE ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81346	CHG TYMS GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81347	CHG SF3B1 GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81348	CHG SRSF2 GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81349	CHG CYTOG ALYS CHROMML ABNOR LOW- PASS SEQ ALYS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81350	CHG UGT1A1 GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81351	CHG TP53 GENE ANALYSIS FULL GENE SEQUENCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81352	CHG TP53 GENE ANALYSIS TARGETED SEQUENCE ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81353	CHG TP53 GENE ANALYSIS KNOWN FAMILIAL VARIANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81355	CHG VKORC1 GENE ANALYSIS COMMON VARIANT(S)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81357	CHG U2AF1 GENE ANALYSIS COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81360	CHG ZRSR2 GENE ANALYSIS COMMON VARIANT(S)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81361	CHG HBB COMMON VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81362	CHG HBB KNOWN FAMILIAL VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81363	CHG HBB DUPLICATION/DELETION VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81364	CHG HBB FULL GENE SEQUENCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81370	PR HLA CLASS I&II LOW HLA-A -B -C -DRB1/3/4/5&-DQB1	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81371	CHG HLA I&LI LOW RESOLUTION HLA-A -B&- DRB1	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81372	PR HLA CLASS I TYPING LOW RESOLUTION COMPLETE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81373	PR HLA CLASS I TYPING LOW RESOLUTION ONE LOCUS EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81374	PR HLA I LOW RESOLUTION ONE ANTIGEN EQUIVALENT EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81375	PR HLA II LOW RESOLUTION HLA-DRB1/3/4/5 AND -DQB1	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81376	CHG HLA CLASS II TYPING LOW RESOLUTION ONE LOCUS EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81377	PR HLA II LOW RESOLUTION ONE ANTIGEN EQUIVALENT EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81378	PR HLA I&II HIGH RESOLUTION HLA-A -B -C AND -DRB1	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81379	PR HLA CLASS I TYPING HIGH RESOLUTION COMPLETE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81380	PR HLA CLASS I TYPING HIGH RESOLUTION ONE LOCUS EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81381	PR HLA I TYPING HIGH RESOLUTION 1 ALLELE/ALLELE GRP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81382	CHG HLA CLASS II TYPING HIGH RESOLUTION ONE LOCUS EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81383	PR HLA II HIGH RESOLUTION 1 ALLELE/ALLELE GROUP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81400	CHG MOLECULAR PATHOLOGY PROCEDURE LEVEL 1	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81401	CHG MOLECULAR PATHOLOGY PROCEDURE LEVEL 2	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81402	CHG MOLECULAR PATHOLOGY PROCEDURE LEVEL 3	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81403	CHG MOLECULAR PATHOLOGY PROCEDURE LEVEL 4	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81404	CHG MOLECULAR PATHOLOGY PROCEDURE LEVEL 5	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81405	CHG MOLECULAR PATHOLOGY PROCEDURE LEVEL 6	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81406	CHG MOLECULAR PATHOLOGY PROCEDURE LEVEL 7	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81407	CHG MOLECULAR PATHOLOGY PROCEDURE LEVEL 8	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81408	CHG MOLECULAR PATHOLOGY PROCEDURE LEVEL 9	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81410	CHG AORTIC DYSFUNCTION/DILATION GENOMIC SEQ ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81411	CHG AORTIC DYSFUNCTION/ DILATION DUP/DEL ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023
81412	CHG ASHKENAZI JEWISH ASSOC DSRDRS GEN SEQ ANAL 9 GEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81413	CARDIAC ION CHANNELOPATHIES (EG, BRUGADA SYNDROME, LONG QT SYNDROME, SHORT QT SYNDROME, CATECHOLAMINERGIC POLYMORPHIC VENTRICULAR TACHYCARDIA)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81414	GENOMIC SEQUENCING PROCEDURES/ MOLECULAR ASSAY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81415	CHG EXOME SEQUENCE ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81416	CHG EXOME SEQUENCE ANALYSIS EACH COMPARATOR EXOME	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81417	CHG EXOME RE-EVAL OF PREVIOUSLY OBTAINED EXOME SEQ	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81419	CHG EPILEPSY GENOMIC SEQUENCE ANALYSIS PANEL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81420	CHG FETAL CHROMOSOMAL ANEUPLOIDY GENOMIC SEQ ANALYS	NO AUTHORIZATION REQUIRED	<p>MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF</p> <p>MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023
81422	CHG FETAL CHROMOSOMAL MICRODELTA GENOMIC SEQ ANALYS	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81425	CHG GENOME SEQUENCE ANALYSIS	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81426	CHG GENOME SEQUENCE ANALYSIS EACH COMPARATOR GENOME	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81427	CHG GENOME RE-EVALUATION OF PREC OBTAINED GENOME SEQ	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81430	CHG HEARING LOSS GENOMIC SEQUENCE ANALYSIS 60 GENES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81431	CHG HEARING LOSS DUP/DEL ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81432	CHG HEREDITARY BRST CA-RELATED GEN SEQ ANALYS 10 GEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81433	CHG HEREDITARY BRST CA-RELATED DUP/DEL ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81434	CHG HEREDITARY RETINAL DSRDRS GEN SEQ ANALYS 15 GEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81435	CHG HEREDITARY COLON CA DSRDRS GEN SEQ ANALYS 10 GEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81436	CHG HEREDITARY COLON CA DSRDRS DUP/DEL ANALYS 5 GEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

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81437	CHG HEREDTRY NURONDCRN TUM DSRDRS GEN SEQ ANAL 6 GEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81438	CHG HEREDTRY NURONDCRN TUM DSRDRS DUP/DEL ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81439	CHG HEREDITARY CARDIOMYOPA THY GEN SEQ ANALYS 5 GEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81440	CHG NUCLEAR MITOCHONDRIAL 100 GENE GENOMIC SEQ	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81442	CHG NOONAN SPECTRUM DISORDERS GEN SEQ ANALYS 12 GEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81443	CHG GENETIC TESTING FOR SEVERE INHERITED CONDITIONS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81445	CHG GEN SEQ ANALYS SOLID ORGAN NEOPLASM 5-50 GENE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81448	CHG HEREDITARY PERIPHERAL NEUROPATHY GEN SEQ PNL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81449	PR TARGETED GENOMIC SEQUENCE ANALYSIS PANEL, SOLID ORGAN NEOPLASM, 5-50 GENES (EG, ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, MET, NRAS, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), INTERROGATI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81450	CHG GEN SEQ ANALYS HEMATOLymph OID NEO 5-50 GENE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81451	PR GENOMIC SEQUENCE ANALYSIS PANEL OF RNA OF 5-50 GENES ASSOCIATED WITH BLOOD AND LYMPHATIC SYSTEM DISORDERS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81455	CHG GEN SEQ ANALYS SOL ORG/HEMTOLM PHOID NEO 51/> GEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81456	PR TARGETED GENOMIC SEQUENCE ANALYSIS PANEL, SOLID ORGAN OR HEMATOLYMPHOID NEOPLASM OR DISORDER, 51>GREATER GENES (EG, ALK, BRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, ID	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023
81457	GENOMIC SEQUENCE ANALYSIS PANEL OF DNA FOR MICROSATELLITE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2021
81458	GENOMIC SEQUENCE ANALYSIS PANEL OF DNA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81459	GENOMIC SEQUENCE ANALYSIS PANEL OF DNA OR COMBINED DNA A	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2021
81460	CHG WHOLE MITOCHONDRIAL GENOME	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81462	GENOMIC SEQUENCE ANALYSIS OF DNA OR COMBINED DNA AND RNA IN PLASMA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2021
81463	GENOMIC SEQUENCE ANALYSIS OF DNA IN PLASMA FOR COPY NUMBER VARIANTS AND MICROSATELLITE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81464	GENOMIC SEQUENCE ANALYSIS OF DNA OR COMBINED DNA AND RNA IN PLASMA FOR COPY NUMBER VARIANTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2021
81465	CHG WHOLE MITOCHONDRIAL GENOME ANALYSIS PANEL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81470	CHG X-LINKED INTELLECTUAL DBLT GENOMIC SEQ ANALYS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81471	CHG X-LINKED INTELLECTUAL DBLT DUP/DEL GENE ANALYS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81479	CHG UNLISTED MOLELCULAR PATHOLOGY PROCEDURE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81490	CHG AUTOIMMUNE RHEUMATOID ARTHRTS ANALYS 12 BIOMRKRS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81493	CHG COR ART DISEASE MRNA GENE EXPRESSION 23 GENES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81500	CHG ONCO (OVARIAN) BIOCHEMICAL ASSAY TWO PROTEINS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81503	CHG ONCO (OVARIAN) BIOCHEMICAL ASSAY FIVE PROTEINS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81504	CHG ONCOLOGY TISSUE OF ORIGIN SIMILAR SCOR ALGORITHM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81506	CHG ENDOCRINOLOGY BIOCHEMICAL ASSAY SEVEN ANAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81507	CHG FETAL ANEUPLOIDY 21 18 13 SEQ ANALY TRISOM RISK	NO AUTHORIZATION REQUIRED	MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81508	CHG FETAL CONGENITAL ABNOR ASSAY TWO PROTEINS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81509	CHG FETAL CONGENITAL ABNOR ASSAY 3 PROTEINS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81510	CHG FETAL CONGENITAL ABNOR ASSAY THREE ANAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81511	CHG FETAL CONGENITAL ABNOR ASSAY FOUR ANAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81512	CHG FETAL CONGENITAL ABNOR ASSAY FIVE ANAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81513	CHG NFCT DS BACTERAL VAGINOSIS RNA VAGINAL-FLUID ALG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81514	CHG NFCT DS BCT VAGINOSIS&VA GINITIS DNA VAG FLU ALG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
81518	CHG ONCOLOGY BREAST MRNA GENE EXPRESSION 11 GENES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81519	CHG ONCOLOGY BREAST MRNA GENE EXPRESSION 21 GENES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81520	CHG ONC BREAST MRNA GENE XPRSN PRFL HYBRD 58 GENES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023
81521	CHG ONC BREAST MRNA MICRORA GENE XPRSN PRFL 70 GENES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81522	CHG ONCOLOGY BREAST MRNA GENE XPRSN PRFL 12 GENES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81523	CHG ONC BRST MRNA NEXT GNRJ SEQ GEN XPRSN 70 CNT&31	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81525	CHG ONCOLOGY COLON MRNA GENE EXPRESSION 12 GENES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81528	CHG ONCOLOGY COLORECTAL SCREENING QUAN 10 DNA MARKRS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023
81529	CHG ONC CUTAN MLNMA MRNA GENE XPRS PRFL 31 GENES ALG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81535	CHG ONCOLOGY GYNE LIVE TUM CELL CLTR&CHEMO RESP 1ST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81536	CHG ONCOLOGY GYNE LIVE TUM CELL CLTR&CHEMO RESP ADD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81538	CHG ONCOLOGY LUNG MS 8- PROTEIN SIGNATURE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81539	CHG ONCOLOGY PROSTATE BIOCHEMICAL ASSAY 4 PROTEINS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81540	CHG ONCOLOGY TUM UNKNOWN ORIGIN MRNA 92 GENES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81541	CHG ONC PRST8 MRNA GENE XPRSN PRFL RT-PCR 46 GENES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81542	CHG ONC PRST8 MRNA MICRORA GENE XPRSN PRFL 22 GENES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81546	CHG ONC THYR MRNA 10,196 GENES FINE NDL ASPIRATE ALG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81551	CHG ONC PRST8 PRMTR METHYLATION PRFL R-T PCR 3 GENES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81552	CHG ONC UVEAL MLNMA MRNA GENE XPRSN PRFL 15 GENES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81554	CHG PULM DS IPF MRNA 190 GENE TRANSBRONCHIAL BX ALG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81560	CHG TRNSPLJ PED LVR&BWL MES CD154+T CLL WHL PRPH BLD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
81595	CHG CARDIOLOGY HRT TRNSPL MRNA GENE EXPRESS 20 GENES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81596	CHG NFCT DS CHRNC HCV 6 BIOCHEM ASSAY SRM ALG LVR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
81599	CHG UNLISTED MULTIANALYTE ASSAY ALGORITHMIC ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	2/1/2023
82009	CHG KETONE BODIES SERUM QUALITATIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
82010	CHG KETONE BODIES SERUM QUANTITATIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82013	CHG ACETYLCHOLIN ESTERASE ASSAY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82016	CHG ACYLCARNITIN ES, QUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82017	CHG ACYLCARNITIN ES,QUANT,EACH SPEC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82024	ASSAY OF ACTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82030	ASSAY OF ADP & AMP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82040	ASSAY OF SERUM ALBUMIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82042	CHG OTHER SOURCE ALBUMIN QUANTITATIVE EACH SPECIMEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82043	CHG URINE ALBUMIN QUANTITATIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82044	CHG URINE ALBUMIN SEMIQUANTITATIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
82045	PR ALBUMIN, ISCHEMIA MODIFIED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82075	CHG ASSAY OF ALCOHOL (ETHANOL) BREATH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82077	CHG ASSAY OF ALCOHOL (ETHANOL) SPEC XCP UR&BREATH IA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82085	CHG ASSAY OF ALDOLASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82088	ASSAY OF ALDOSTERONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82103	CHG ALPHA-1-ANTITRYPSIN, TOTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82104	CHG ALPHA-1-ANTITRYPSIN, PHENO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82105	CHG ALPHA-FETOPROTEIN, SERUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82106	CHG ALPHA-FETOPROTEIN; AMNIOTIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82107	PR ALPHA-FETOPROTEIN L3	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
82108	ASSAY OF ALUMINUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82120	CHG AMINES,VAGINAL FLUID,QUALITATIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82127	CHG AMINO ACID, SINGLE QUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82128	CHG AMINO ACIDS, MULTIPLE QUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82131	CHG AMINO ACIDS, SINGLE QUANTITATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82135	CHG ASSAY, AMINOLEVULINIC ACID	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82136	CHG AMINO ACIDS, 2-5 QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82139	CHG AMINO ACIDS, 6+ QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82140	CHG ASSAY OF AMMONIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82143	CHG AMNIOTIC FLUID SCAN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
82150	CHG ASSAY OF AMYLASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82154	CHG ANDROSTANED IOL GLUCURONIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82157	CHG ASSAY OF ANDROSTENED IONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82160	ASSAY OF ANDROSTERON E	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82163	CHG ASSAY OF ANGIOTENSIN II	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82164	CHG ANGIOTENSIN I ENZYME TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82166	ANTI-MULLERIAN HORMONE (AMH)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82172	ASSAY OF APOLIPOPROT EIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82175	CHG ASSAY OF ARSENIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82180	CHG ASSAY OF ASCORBIC ACID	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
82190	CHG ATOMIC ABSORPTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82232	CHG BETA-2 PROTEIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82239	CHG BILE ACIDS, TOTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82240	CHG BILE ACIDS, CHOLYLGLYCINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82247	CHG BILIRUBIN TOTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82248	CHG BILIRUBIN DIRECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82252	CHG FECAL BILIRUBIN TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82261	CHG ASSAY BIOTINIDASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82270	BLOOD OCCULT, BY PEROXID, FECS, SINGLE, COLORECTAL SCREEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
82271	PR BLOOD, OCCULT, BY PEROXID, FECES, OTHER SOURCES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82272	BLOOD OCCULT, BY PEROXID, FECES, 1-3 SIMULT, NON CA SCREEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82274	CHG BLOOD, OCCULT, FECAL HGB, FECES, 1-3 SIMULT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82286	CHG ASSAY OF BRADYKININ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82300	ASSAY OF CADMIUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82306	CHG ASSAY OF VIT D, CALCIFEDIOL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82308	CHG ASSAY OF CALCITONIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82310	ASSAY OF CALCIUM, TOTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82330	ASSAY OF CALCIUM, IONIZED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

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82331	CHG CALCIUM INFUSION TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82340	ASSAY OF CALCIUM IN URINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82355	CHG CALCULUS,QUANTITATIVE ANALYSIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82360	CHG CALCULUS ASSAY,QUANTITATIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82365	CHG CALCULUS ASSAY,INFRARED SPECTR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82370	CHG X-RAY ASSAY, CALCULUS (STONE)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82373	CHG ASSAY CARBOHYDRATE DEF TRANSFERRIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82374	CHG ASSAY BLOOD CARBON DIOXIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82375	CHG ASSAY BLOOD CARBON MONOXIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82376	CHG TEST FOR CARBON MONOXIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
82378	CHG CARCINOEMBR YONIC ANTIGEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82379	ASSAY OF CARNITINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82380	ASSAY OF CAROTENE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82382	ASSAY, URINE CATECHOLAMINES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82383	ASSAY, BLOOD CATECHOLAMINES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82384	ASSAY, THREE CATECHOLAMINES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82387	ASSAY OF CATHEPSIN-D	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82390	ASSAY OF CERULOPLASMIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82397	CHG CHEMILUMINESCENT ASSAY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82415	ASSAY OF CHLORAMPHE NICOL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
82435	ASSAY OF BLOOD CHLORIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82436	ASSAY OF URINE CHLORIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82438	CHG ASSAY OTHER FLUID CHLORIDES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82441	CHG TEST FOR CHLOROHYDR OCARBONS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82465	ASSAY, BLD/SERUM CHOLESTEROL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82480	ASSAY, SERUM CHOLINESTER ASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82482	ASSAY, RBC CHOLINESTER ASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82485	CHG ASSAY CHONDROITIN SULFATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82495	ASSAY OF CHROMIUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82507	ASSAY OF CITRATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
82523	CHG ASSAY FOR COLLAGEN CROSS LINKS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82525	ASSAY OF COPPER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82528	ASSAY OF CORTICOSTER ONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82530	CHG CORTISOL, FREE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82533	CHG TOTAL CORTISOL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82540	ASSAY OF CREATINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82542	CHG COL-CHR/MS NONDRUG ANALYTE NES QUAL/QUAN EA SPEC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82550	ASSAY OF CK (CPK)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82552	ASSAY OF CPK IN BLOOD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82553	CHG CREATINE, MB FRACTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
82554	CHG CREATINE, ISOFORMS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82565	CHG CREATININE BLOOD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82570	ASSAY OF URINE CREATININE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82575	CHG CREATININE CLEARANCE TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82585	ASSAY OF CRYOFIBRINOGEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82595	ASSAY OF CRYOGLOBULIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82600	ASSAY OF CYANIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82607	CHG VITAMIN B-12	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82608	CHG B-12 BINDING CAPACITY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82610	CHG CYSTATIN C	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
82615	CHG TEST FOR URINE CYSTINES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82626	CHG DEHYDROEPIA NDROSTERONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82627	CHG DEHYDROEPIA NDROSTERONE -SULFATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82633	CHG DESOXYCORTI COSTERONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82634	CHG DEOXYCORTIS OL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82638	ASSAY OF DIBUCAINE NUMBER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82642	CHG DIHYDROTEST OSTERONE (DHT)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82652	CHG ASSAY, DIHYDROXYVIT AMIN D	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82653	CHG ELASTASE PANCREATIC FECAL QUANTITATIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82656	CHG ELASTASE PANCREATIC FECAL QUAL/SEMI-QUANTITATIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
82657	CHG ENZYME CELL ACTIVITY, EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82658	CHG ENZYME CELL ACTIVITY RADIOACTV,EA CH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82664	CHG ELECTROPHOR ETIC TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82668	ASSAY OF ERYTHROPOIE TIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82670	CHG ASSAY OF TOTAL ESTRADIOL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82671	ASSAY OF ESTROGENS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82672	ASSAY OF ESTROGEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82677	ASSAY OF ESTRIOL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82679	ASSAY OF ESTRONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82681	CHG ASSAY OF DIRECT MEASUREMENT FREE ESTRADIOL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
82693	ASSAY OF ETHYLENE GLYCOL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82696	ASSAY OF ETIOCHOLANO LONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82705	CHG FATS/LIPIDS, FECES, QUALITATIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82710	CHG FATS/LIPIDS, FECES, QUANTITATIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82715	ASSAY OF FECAL FAT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82725	ASSAY OF BLOOD FATTY ACIDS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82726	CHG LONG CHAIN FATTY ACIDS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82728	ASSAY OF FERRITIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82731	ASSAY OF FETAL FIBRONECTIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82735	ASSAY OF FLUORIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
82746	CHG BLOOD FOLIC ACID SERUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82747	ASSAY OF FOLIC ACID, RBC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82757	ASSAY OF SEMEN FRUCTOSE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82759	ASSAY OF RBC GALACTOKINASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82760	ASSAY OF GALACTOSE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82775	CHG ASSAY GALACTOSE TRANSFERASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82776	CHG GALACTOSE TRANSFERASE TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82784	ASSAY OF GAMMAGLOBULIN IGM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82785	ASSAY OF GAMMAGLOBULIN IGE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82787	CHG IGG1, 2, 3 OR 4, EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
82800	CHG BLOOD PH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82803	CHG BLOOD GASES: PH, PO2 & PCO2	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82805	CHG BLOOD GASES W/O2 SATURATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82810	CHG BLOOD GASES, O2 SAT ONLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82820	CHG HEMOGLOBIN-OXYGEN AFFINITY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82930	CHG GASTRIC ACID ANALYSIS W/PH EA SPECIMEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82938	PR GASTRIN SECRETIN STIM TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82941	CHG ASSAY OF GASTRIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82943	CHG ASSAY OF GLUCAGON	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82945	CHG ASSAY GLUCOSE, BODY FLUID	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
82946	CHG GLUCAGON TOLERANCE TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82947	ASSAY QUANTITATIVE, BLOOD GLUCOSE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82948	CHG REAGENT STRIP/BLOOD GLUCOSE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82950	CHG GLUCOSE TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82951	CHG GLUCOSE TOLERANCE TEST (GTT)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82952	CHG GTT-ADDED SAMPLES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82955	ASSAY OF G6PD ENZYME	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82960	CHG TEST FOR G6PD ENZYME	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82963	ASSAY OF GLUCOSIDASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82965	ASSAY OF GDH ENZYME	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
82977	CHG ASSAY OF GGT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82977	CHG ASSAY OF GGT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82978	ASSAY OF GLUTATHIONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82978	ASSAY OF GLUTATHIONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82979	ASSAY, RBC GLUTATHIONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82979	ASSAY, RBC GLUTATHIONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82985	CHG GLYCATED PROTEIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
82985	CHG GLYCATED PROTEIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83001	CHG GONADOTROPIN (FSH)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83002	CHG GONADOTROPIN (LH)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
83003	CHG ASSAY GROWTH HORMONE (HGH)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83006	CHG GROWTH STIMULATION EXPRESSED GENE 2	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83009	PR H PYLORI , BLOOD UREASE ACTIV, NON-ISOTOPE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83010	ASSAY OF HAPTOGLOBIN, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83012	ASSAY OF HAPTOGLOBIN S	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83013	H. PYLORI;BREAT H TEST, NON-ISOTOPE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83014	PR H PYLORI DRUG ADMIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83015	CHG HEAVY METAL QUALITATIVE ANY ANALYTES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83018	CHG HEAVY METAL QUANTATIVE EACH NES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83020	CHG HEMOGLOBIN ELECTROPHOR ESIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
83021	CHG HEMOGLOBIN CHROMOTOGR APHY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83026	CHG HEMOGLOBIN, COPPER SULFATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83030	CHG FETAL HEMOGLOBIN ASSAY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83033	CHG HEMOGLOBIN F	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83036	PR GLYCOSYLATE D HEMOGLOBIN TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83037	PR GLYCOSYLATE D HEMOGLOBIN, HOME DEVICE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83045	PR BLOOD METHEMOGLOBIN, QUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83050	PR BLOOD METHEMOGLOBIN, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83051	ASSAY OF PLASMA HEMOGLOBIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83060	CHG BLOOD SULFHEMOGLOBIN ASSAY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
83065	ASSAY OF HEMOGLOBIN HEAT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83068	CHG HEMOGLOBIN STABILITY SCREEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83069	ASSAY OF URINE HEMOGLOBIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83070	ASSAY OF HEMOSIDERIN, QUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83080	ASSAY OF B HEXOSAMINIDASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83088	ASSAY OF HISTAMINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83090	ASSAY OF HOMOCYSTINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83150	ASSAY OF FOR HVA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83491	CHG ASSAY OF CORTICOSTEROIDS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83497	ASSAY OF 5-HIAA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
83498	ASSAY OF PROGESTERON E 17-D	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83500	ASSAY, FREE HYDROXYPROLINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83505	ASSAY, TOTAL HYDROXYPROLINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83516	CHG IMMUNOASSAY , NON ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83518	CHG IMMUNOASSAY , DIPSTICK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83519	CHG IMMUNOASSAY NONANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83520	CHG IMMUNOASSAY , RIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83521	CHG IMMUNOGLOBULIN LIGHT CHAINS FREE EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83525	CHG ASSAY OF INSULIN,TOTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83527	CHG ASSAY OF INSULIN,FREE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
83528	ASSAY OF INTRINSIC FACTOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83529	CHG ASSAY OF INTERLEUKIN-6 (IL-6)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83540	ASSAY OF IRON	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83550	CHG IRON BINDING TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83570	ASSAY OF IDH ENZYME	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83582	ASSAY OF KETOGENIC STEROIDS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83586	CHG ASSAY 17-(17-KS)KETOSTEROIDS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83593	CHG FRACTIONATION KETOSTEROIDS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83605	ASSAY OF LACTIC ACID	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83615	CHG LACTATE (LD) (LDH) ENZYME	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
83625	ASSAY OF LDH ISOENZYMES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83630	PR LACTOFERRIN, FECAL, QUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83631	PR LACTOFERRIN, FECAL, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83632	CHG PLACENTAL LACTOGEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83633	CHG TEST URINE FOR LACTOSE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83655	ASSAY OF LEAD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83661	CHG ASSAY L/S RATIO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83662	CHG L/S RATIO, FOAM STABILITY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83663	CHG L/S RATIO, FLUORESCENCE POLARIZATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83664	CHG L/S RATIO, LAMELLAR BODY DENSITY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
83670	ASSAY OF LAP ENZYME	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83690	ASSAY OF LIPASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83695	PR ASSAY OF LIPOPROTEIN (A)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83698	PR ASSAY LIPOPROTEIN PLA2	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83700	PR LIOPRO BLOOD, ELECTROPHOR / QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83701	PR LIPOPROTEIN BLOOD, HIGH RES FRACTION/ QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83704	CHG LIPOPROTEIN BLOOD QUAN NUMBERS & SUBCLASSES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83718	ASSAY OF BLOOD LIPOPROTEIN,H DL CHOLEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83719	ASSAY OF BLOOD LIPOPROTEIN,V LDL CHOLEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83721	ASSAY OF BLOOD LIPOPROTEIN,L DL CHOLEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
83722	CHG DIR MEAS LIPOPROTEIN SMALL DENSE LDL CHOLESTEROL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83727	ASSAY OF LRH HORMONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83735	ASSAY OF MAGNESIUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83775	CHG ASSAY OF MD ENZYME	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83785	CHG ASSAY OF MANGANESE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83789	CHG MASS SPECT&TANDEM MASS SPECT NONDRG ANALNES EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83825	ASSAY OF MERCURY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83857	ASSAY OF METHHEMALBUMIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83861	CHG MICROFLUID ANALYSIS, TEAR OSMOLARITY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
83864	CHG MUCOPOLYSA CCHARIDES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83872	CHG ASSAY SYNOVIAL FLUID MUCIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83873	CHG MYELIN BASIC PROTEIN,CSF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83874	ASSAY OF MYOGLOBIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83876	CHG ASSAY OF MYELOPEROXIDASE (MPO)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83880	CHG NATRIURETIC PEPTIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83883	CHG NEPHELOMETRY, NOT SPECIFIED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83885	ASSAY OF NICKEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83915	ASSAY OF NUCLEOTIDASE 5'	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83916	CHG OLIGOCLONAL IMMUNOGLOBULIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
83918	CHG ASSAY ORGANIC ACIDS QUANTITATIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83919	CHG ASSAY ORGANIC ACIDS QUALITATIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83921	CHG ASSAY SNGL ORGANIC ACID, QUANTITATIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83930	ASSAY OF BLOOD OSMOLALITY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83935	ASSAY OF URINE OSMOLALITY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83937	ASSAY OF OSTEOCALCIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83945	ASSAY OF OXALATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83970	CHG ASSAY OF PARATHORMONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83986	ASSAY OF BODY FLUID ACIDITY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
83992	CHG ASSAY FOR PHENCYCLIDINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
83993	CHG ASSAY FOR CALPROTECTIN FECAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84030	ASSAY OF BLOOD PKU	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84035	ASSAY OF PHENYLKETONES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84060	ASSAY PHOSPHATASE ACID, TOTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84066	ASSAY PHOSPHATASE ACID PROSTATIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84075	CHG ASSAY ALKAL PHOSPHATASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84078	ASSAY ALKAL PHOSPHATASE, HEAT STABLE W/O TOTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84080	CHG ASSAY ALKAL PHOSPHATASE, ISOENZYMES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84081	PHOSPHATIDYL GLYCEROL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84085	ASSAY OF RBC PG6D ENZYME	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
84087	ASSAY PHOSPHOHEX OSE ISOMERASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84100	ASSAY OF INORGANIC PHOSPHORUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84105	ASSAY OF URINE PHOSPHORUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84106	ASSAY OF PORPHOBILINO GEN URINE QUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84110	ASSAY OF PORPHOBILINO GEN URINE QUAN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84112	CHG EVAL C/V AMNIOTIC FLUID PROTEIN QUAL EA SPECIMEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84119	ASSAY OF PORPHYRINS URINE QUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84120	ASSAY OF PORPHYRINS URINE QUAN&FXJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84126	ASSAY OF PORPHYRINS FECES QUAN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84132	ASSAY OF SERUM POTASSIUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
84133	ASSAY OF URINE POTASSIUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84134	ASSAY OF PREALBUMIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84135	ASSAY OF PREGNANEDIOL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84138	ASSAY OF PREGNANETRIOL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84140	ASSAY OF PREGNENOLONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84143	ASSAY OF 17-HYDROXYPREGNENOLONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84144	ASSAY OF PROGESTERONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84145	PROCALCITONIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84146	ASSAY OF PROLACTIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84150	CHG ASSAY OF PROSTAGLANDIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
84152	CHG PROSTATE SPECIFIC ANTIGEN, COMPLEXED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84153	CHG PROSTATE SPECIFIC ANTIGEN, TOTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84154	CHG PROSTATE SPECIFIC ANTIGEN, FREE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84155	PROTEIN TOTAL XCPT REFRACTOMETRY SERUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84156	PROTEIN TOTAL XCPT REFRACTOMETRY URINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84157	PROTEIN TOTAL XCPT REFRACTOMETRY OTHER SRC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84160	PROTEIN TOTAL REFRACTOMETRY ANY SRC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84163	PR PREG ASSOC PLAS PRO-A(PAPP-A), SERUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84165	CHG PROTEIN E-PHORESIS, SERUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84166	PR PROTEIN E-PHORESIS/URINE/CSF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
84181	PR PROTEIN, WESTERN BLOT TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84182	PR PROTEIN, WESTERN BLOT TEST, W BAND ID	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84202	CHG ASSAY RBC PROTOPORPHY RIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84203	CHG TEST RBC PROTOPORPHY RIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84206	CHG ASSAY OF PROINSULIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84207	ASSAY OF VITAMIN B-6	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84210	ASSAY OF PYRUVATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84220	ASSAY OF PYRUVATE KINASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84228	ASSAY OF QUININE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84233	ASSAY OF ESTROGEN RECEPTOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
84234	ASSAY OF PROGESTERONE RECEPTOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84235	ASSAY OF ENDOCRINE HORMONE RECEPTOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84238	ASSAY, NON-ENDOCRINE RECEPTOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84244	CHG ASSAY OF RENIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84252	ASSAY OF VITAMIN B-2	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84255	ASSAY OF SELENIUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84260	ASSAY OF SEROTONIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84270	ASSAY OF SEX HORMONE BINDING GLOBULIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84275	ASSAY OF SIALIC ACID	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84285	ASSAY OF SILICA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
84295	ASSAY OF SERUM SODIUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84300	ASSAY OF URINE SODIUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84302	ASSAY OF SODIUM, OTHER SOURCE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84305	ASSAY OF SOMATOMEDIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84307	ASSAY OF SOMATOSTATIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84311	CHG SPECTROPHOTOMETRY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84315	CHG BODY FLUID SPECIFIC GRAVITY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84375	CHROMATOGRAM ASSAY, SUGARS, TLC OR PAPER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84376	SUGARS SINGLE QUALITATIVE, EACH SPECIMEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84377	SUGARS MULTIPLE QUALITATIVE, EACH SPECIMEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
84378	SUGARS SINGLE QUANTITATIVE, EACH SPECIMEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84379	SUGARS MULTIPLE QUANTITATIVE, EACH SPECIMEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84392	ASSAY OF URINE SULFATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84402	ASSAY OF TESTOSTERONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84403	ASSAY OF TOTAL TESTOSTERONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84425	ASSAY OF VITAMIN B-1	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84430	ASSAY OF THIOCYANATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84431	CHG THROMBOXANE METABOLITE W/WO THROMBOXANE URINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84432	ASSAY OF THYROGLOBULIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
84433	PR THIOPURINE S-METHYLTRANSFERASE (TPMT)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84436	ASSAY OF TOTAL THYROXINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84437	ASSAY OF NEONATAL THYROXINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84439	ASSAY OF FREE THYROXINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84442	ASSAY OF THYROXINE BINDING GLOBULIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84443	CHG ASSAY THYROID STIM HORMONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84445	ASSAY OF THYROID STIM IMMUNOGLOBULINS (TSI)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84446	ASSAY OF VITAMIN E	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84449	ASSAY OF TRANSCORTIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84450	TRANSFERASE ASPARTATE AMINO (AST) (SGOT)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
84460	TRANSFERASE ALANINE AMINO (ALT) (SGPT)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84466	ASSAY OF TRANSFERRIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84478	ASSAY OF TRIGLYCERIDES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84479	THYROID HORM UPTAKE/THYR HORM BINDING RATIO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84480	CHG TRIIODOTHYRONE TOTAL ASSAY, TT-3	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84481	CHG TRIIODOTHYRONE FREE ASSAY (FT-3)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84482	CHG TRIIODOTHYRONE T3 REVERSE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84484	ASSAY OF TROPONIN, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84485	CHG ASSAY DUODENAL FLUID TRYPSIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84488	TRYPSIN FECES QUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
84490	TRYPsin FECES QUAN 24-HR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84510	CHG ASSAY TYROSINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84512	CHG ASSAY TROPONIN, QUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84520	ASSAY UREA NITROGEN, QUAN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84525	CHG UREA NITROGEN SEMI-QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84540	CHG ASSAY URINE UREA-N	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84545	CHG UREA-N CLEARANCE TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84550	ASSAY OF URIC ACID, BLOOD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84560	ASSAY OF URIC ACID, BLOOD, OTHER SOURCE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84577	ASSAY OF UROBILINOGEN FECES QUAN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
84578	ASSAY OF UROBILINOGEN URINE QUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84580	ASSAY OF UROBILINOGEN URINE QUAN TMD SPEC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84583	ASSAY OF UROBILINOGEN URINE SEMIQUAN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84585	ASSAY OF URINE VMA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84586	ASSAY OF VIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84588	ASSAY OF VASOPRESSIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84590	ASSAY OF VITAMIN A	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84591	ASSAY OF NOS VITAMIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84597	ASSAY OF VITAMIN K	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84600	CHG ASSAY OF VOLATILES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
84620	CHG XYLOSE TOLERANCE TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84630	ASSAY OF ZINC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84681	ASSAY OF C-PEPTIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84702	CHORIONIC GONADOTROPIN, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84703	CHORIONIC GONADOTROPIN, QUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
84704	CHG CHORIONIC GONADOTROPIN, FREE BETA CHAIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85002	CHG BLEEDING TIME TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85004	CHG AUTOMATED DIFFERENTIAL WBC COUNT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85007	CHG BLOOD SMEAR, MICRO EXAM, MANUAL DIFF WBC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85008	CHG BLOOD SMEAR MICRO EXAM W/O MANUAL DIFF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
85009	CHG MANUAL DIFF WBC COUNT,BUFFY COAT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85013	CHG MICROHEMATO CRIT,SPUN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85014	CHG HEMATOCRIT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85018	CHG HEMOGLOBIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85025	CHG COMPLETE CBC & AUTO DIFF WBC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85027	CHG COMPLETE CBC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85032	CHG MANUAL CELL COUNT,EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85041	CHG RED BLOOD CELL (RBC) COUNT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85044	CHG RETICULOCYTE COUNT,MANUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85045	PR RETICULOCYTE COUNT, AUTO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
85046	PR RETICULOCYTE COUNT, AUTO, W CELL PARAM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85048	CHG LEUKOCYTE (WBC) COUNT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85049	CHG PLATELET COUNT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85055	CHG RETICULATED PLATELET ASSAY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85060	CHG BLOOD SMEAR INTERPRETATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85097	CHG BONE MARROW, SMEAR INTERPRETATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85130	CHG CHROMOGENIC SUBSTRATE ASSAY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85170	CHG BLOOD CLOT RETRACTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85175	CHG BLOOD CLOT LYSIS TIME	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85210	CHG BLOOD CLOT FACTOR II TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
85220	CHG BLOOD CLOT FACTOR V TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85230	CHG BLOOD CLOT FACTOR VII TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85240	CHG BLOOD CLOT FACTOR VIII TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85244	CHG BLOOD CLOT FACTOR VIII TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85245	CHG BLOOD CLOT FACTOR VIII TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85246	CHG BLOOD CLOT FACTOR VIII TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85247	CHG BLOOD CLOT FACTOR VIII TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85260	CHG BLOOD CLOT FACTOR X TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85270	CHG BLOOD CLOT FACTOR XI TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85280	CHG BLOOD CLOT FACTOR XII TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
85290	CHG BLOOD CLOT FACTOR XIII TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85291	CHG BLOOD CLOT FACTOR XIII TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85292	CHG BLOOD CLOT FACT PREKALLIKREIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85293	CHG BLOOD CLOT FACT KINIOGEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85300	CHG ANTITHROMBIN III TEST,ACTIV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85301	CHG ANTITHROMBIN III TEST,ANTIGEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85302	CHG CLOT INHIB PROTEIN C,ANTIGEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85303	CHG CLOT INHIB PROTEIN C,ACTIV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85305	CHG CLOT INHIB PROTEIN S,TOTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85306	CHG CLOT INHIB PROTEIN S,FREE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
85307	CHG ACTIVATED PROT C (APC) RESISTNCE ASSAY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85335	CHG FACTOR INHIBITOR TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85337	CHG THROMBOMODULIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85345	CHG COAGULATION TIME, LEE-WHITE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85347	CHG COAGULATION TIME, ACTIVATED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85348	CHG COAGULATION TIME, OTHR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85360	CHG EUGLOBULIN LYSIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85362	FIBRIN DEGRAD PRODUCTS, AGGLUTINATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85366	FIBRIN DEGRAD PRODUCTS, PARACOAG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85370	FIBRIN DEGRAD PRODUCTS, QUANTITATIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
85378	FIBRIN DEGRADPRODUCTS,D-DIMER, QUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85379	FIBRIN DEGRADPRODUCTS,D-DIMER, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85380	FIBRIN DEGRADPRODUCTS,D-DIMER, ULTRASENS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85384	CHG FIBRINOGEN, ACTIVITY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85385	CHG FIBRINOGEN, ANTIGEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85390	CHG FIBRINOLYSINS SCREEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85396	CHG CLOTTING ASSAY, WHOLE BLOOD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85397	CHG CLOTTING FUNCTION ACTIVITY NOS, EA ANALYT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85400	CHG FIBRINOLYTIC PLASMIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85410	CHG FIBRINOLYTIC ANTIPLASMIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
85415	CHG FIBRINOLYTIC PLASMINOGEN, ACTIVTR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85420	CHG FIBRINOLYTIC PLASMINOGEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85421	CHG FIBRINOLYTIC PLASMINOGEN, ANTIGEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85441	CHG HEINZ BODIES; DIRECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85445	CHG HEINZ BODIES; INDUCED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85460	CHG HEMOGLOBIN FETAL,DIFF LYSIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85461	CHG HEMOGLOBIN FETAL,ROSETT E	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85475	CHG HEMOLYSIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85520	CHG HEPARIN ASSAY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85525	CHG HEPARIN NEUTRALIZATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
85530	CHG HEPARIN-PROTAMINE TOLERANCE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85536	CHG IRON STAIN, PERIPHERAL BLOOD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85540	CHG WBC ALKALINE PHOSPHATASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85547	CHG RBC MECHANICAL FRAGILITY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85549	CHG MURAMIDASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85555	CHG RBC OSMOTIC FRAGILITY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85557	CHG RBC OSMOTIC FRAGILITY, INCUBATED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85576	CHG BLOOD PLATELET AGGREGATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85597	CHG PHOSPHOLIPID NEUTRALIZATION, PLATELET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85598	CHG PHOSPHOLIPID NEUTRALIZATION, HEXAGONAL PHOSPHOLIPID	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
85610	CHG PROTHROMBIN TIME	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85611	CHG PROTHROMBIN TEST,SUBSTI,F RACTN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85612	CHG VIPER VENOM PROTHROMBIN TIME	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85613	CHG RUSSELL VIPER VENOM, DILUTED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85635	CHG REPTILASE TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85651	CHG RBC SED RATE, NONAUTO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85652	CHG RBC SED RATE, AUTO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85660	CHG RBC SICKLE CELL TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85670	CHG THROMBIN TIME, PLASMA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85675	CHG THROMBIN TIME, TITER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
85705	CHG THROMBOPLAS TIN INHIBITION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85730	CHG THROMBOPLAS TIME PARTIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85732	CHG THROMBOPLAS TIME PART PLASMA FRAC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85810	CHG BLOOD VISCOSITY EXAMINATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
85999	CHG HEMATOLOGY PROCEDURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86000	CHG AGGLUTININS; FEBRILE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86001	CHG ALLERGEN SPEC IGG QUANT,EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86001	CHG ALLERGEN SPEC IGG QUANT,EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
86003	CHG ALLERGEN SPEC IGE CRUDE ALLERGEN EXTRACT EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86003	CHG ALLERGEN SPEC IGE CRUDE ALLERGEN EXTRACT EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86005	CHG ALLERGEN SPEC IGE QUAL MULTIALLERGEN SCREEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86005	CHG ALLERGEN SPEC IGE QUAL MULTIALLERGEN SCREEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
86008	CHG ALLERGEN SPEC IGE RECOMBINANT/PURIFIED COMPNT EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86015	CHG ACTIN SMOOTH MUSCLE ANTIBODY EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86021	CHG WBC ANTIBODY IDENTIFICATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86022	CHG PLATELET ANTIBODIES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86023	CHG IMMUNOGLOBULIN ASSAY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86036	CHG ANTINEUTROP HIL CYTOPLASMIC ANTB SCREEN EA ANTB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86037	CHG ANTINEUTROP HIL CYTOPLASMIC ANTB TITER EA ANTB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86038	CHG ANTINUCLEAR ANTIBODIES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86039	CHG ANTINUCLEAR ANTIBODIES TITER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86041	ACETYLCHOLIN E RECEPTOR (ACHR); BINDING ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86042	ACETYLCHOLIN E RECEPTOR (ACHR); BLOCKING ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86043	ACETYLCHOLIN E RECEPTOR (ACHR); MODULATING ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86051	CHG AQUAPORIN-4 ANTIBODY ELISA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86052	CHG AQUAPORIN-4 ANTIBODY CELL-BASED IMFLUOR ASSAY EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86053	CHG AQUAPORIN-4 ANTIBODY FLOW CYTOMETRY EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86060	CHG ANTISTREPTOL YSIN O TITER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86063	CHG ANTISTREPTOL YSIN O SCREEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86077	CHG PHYS BLD BANK SERV,DIFF XMTCH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86078	CHG PHYS BLD BANK SERV,XFUSN RX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86079	CHG PHYS BLD BANK SERV,DEV STD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86140	CHG C- REACTIVE PROTEIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86141	CHG C- REACTIVE PROTEIN,HIGH SENSITIVITY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86146	CHG BETA 2 GLYCOPROTEIN ANTIBODY,EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86147	CHG CARDIOLIPIN ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86148	CHG PHOSPHOLIPID ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86152	CHG CELL ENUMERATION IMMUNE SELECTJ & ID FLUID SPEC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86153	CHG CELL ENUMERATION IMMUNE SELECTJ & ID PHYS INTERP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86160	CHG COMPLEMENT, ANTIGEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86161	CHG COMPLEMENT/ FUNCTION ACTIVITY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86162	CHG COMPLEMENT, TOTAL (CH50)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86171	CHG COMPLEMENT FIXATION, EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86200	PR CYCLIC CIRULLINATED PEPTIDE ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86215	CHG DEOXYRIBONUCLEASE, ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86225	CHG DNA ANTIBODY, NATV/2 STRAND	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86226	CHG DNA ANTIBODY, SINGLE STRAND	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86231	CHG ENDOMYSIAL ANTIBODY EACH IMMUNOGLOBULIN CLASS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86235	CHG NUCLEAR ANTIGEN ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86255	CHG FLUORESCENT ANTIBODY; SCREEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86256	CHG FLUORESCENT ANTIBODY; TITER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86258	CHG GLIADIN ANTIBODY EACH IMMUNOGLOBULIN CLASS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86277	CHG GROWTH HORMONE ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86280	CHG HEMAGGLUTINATION INHIBITION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86294	CHG IMMUNOASSAY , TUMOR ANTIGEN, QUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86300	CHG IMMUNOASSAY , TUMOR ANTIGEN, CA 15-3	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86301	CHG IMMUNOASSAY , TUMOR ANTIGEN, CA 19-9	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86304	CHG IMMUNOASSAY , TUMOR ANTIGEN, CA 125	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86305	CHG HUMAN EPIDIDYMIS PROTEIN 4 (HE4)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86308	CHG HETEROPHILE ANTIBODIES,SC REEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86309	CHG HETEROPHILE ANTIBODIES,TI TER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86310	CHG HETEROPHILE ANTIBODIES,TI TER+	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86316	PR IMMUNOASSAY , TUMOR ANTIGEN, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86317	CHG IMMUNOASSAY ,INFECT AGENT,QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86318	CHG IA INFECTIOUS AGT ANTIBODY QUAL/SEMIQ 1STEP METH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86318	CHG IA INFECTIOUS AGT ANTIBODY QUAL/SEMIQ 1STEP METH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		5/12/2023
86320	CHG SERUM IMMUNOELECT ROPHORESIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86325	CHG IMMUNOELECT ROPHOR,OTHE R FLUIDS W/CONC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86327	CHG IMMUNOELECT ROPHORESIS ASSAY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86328	CHG IA INFECTIOUS AGT ANTIBODY SARS-COV-2 COVID-19	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		5/12/2023
86329	CHG IMMUNODIFFU SION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86331	CHG IMMUNODIFFUSION OUCHTERLONY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86332	CHG IMMUNE COMPLEX ASSAY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86334	CHG IMMUNOFIX E-PHORESIS, SERUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86335	CHG MONOCLONAL PROTEIN, URINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86336	CHG INHIBIN A	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86337	CHG INSULIN ANTIBODIES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86340	CHG INTRINSIC FACTOR ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86341	CHG ISLET CELL ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86343	CHG LEUKOCYTE HISTAMINE RELEASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86344	CHG LEUKOCYTE PHAGOCYTOSIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86352	CHG CELLULAR FUNCTION ASSAY STIMUL&DETECT BIOMARKE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86353	CHG LYMPHOCYTE TRANSFORMATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86355	PR B CELLS, TOTAL COUNT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86356	CHG MONONUCLEAR CELL ANTIGEN, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86357	PR NK CELLS, TOTAL COUNT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86359	CHG T CELLS, TOTAL COUNT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86360	CHG T CELL ABSOLUTE COUNT/RATIO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86361	CHG T CELL ABSOLUTE COUNT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86362	CHG MOG-IGG1 ANTIBODY CELL-BASED IMFLUOR ASSAY EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86363	CHG MOG-IGG1 ANTIBODY FLOW CYTOMETRY EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86364	CHG TISSUE TRANSGLUTAMINASE EA IMMUNOGLOBULIN CLASS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86366	MUSCLE-SPECIFIC KINASE (MUSK) ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86367	PR STEM CELLS, TOTAL COUNT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86376	CHG MICROSOMAL ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86381	CHG MITOCHONDRIAL ANTIBODY EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86382	CHG NEUTRALIZATION TEST, VIRAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86384	CHG NITROBLUE TETRAZOLIUM DYE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86386	PR NUCLEAR MATRIX PROTEIN 22 NMP22 QUALITATIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86403	CHG PARTICLE AGGLUTINATION TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86406	CHG PARTICLE AGGLUTINATION TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86408	CHG NEUTRALIZING ANTIBODY SARS-COV-2 SCREEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86408	CHG NEUTRALIZING ANTIBODY SARS-COV-2 SCREEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		5/12/2023
86409	CHG NEUTRALIZING ANTIBODY SARS-COV-2 TITER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		5/12/2023
86409	CHG NEUTRALIZING ANTIBODY SARS-COV-2 TITER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86413	CHG SEV AQT RESPIR SYND CORONAVIRUS 2 ANTIBODY QUAN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86413	CHG SEV AQT RESPIR SYND CORONAVIRUS 2 ANTIBODY QUAN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		5/12/2023
86430	CHG RHEUMATOID FACTOR TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86431	CHG RHEUMATOID FACTOR, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86480	CHG TB TEST, CELL MEDIATED ANTIGEN RESPONSE, GA MMA INTERFRON	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86481	CHG TB TEST, CELL MEDIATED ANTIGEN RESPONSE, ENUM GAMMA INTERFRON T-CELLS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86485	CHG SKIN TEST, CANDIDA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86486	CHG SKIN TEST UNLISTED ANTIGEN EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86490	CHG COCCIDIOIDOMYCOSIS SKIN TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86510	CHG HISTOPLASMO SIS SKIN TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86580	CHG TB INTRADERMAL TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86590	CHG STREPTOKINASE, ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86592	CHG BLOOD SEROLOGY, QUALITATIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86593	CHG BLOOD SEROLOGY, QUANTITATIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86596	CHG VOLTAGE-GATED CALCIUM CHANNEL ANTIBODY EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86602	CHG ANTINOMYCES ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86603	CHG ADENOVIRUS, ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86606	CHG ASPERGILLUS ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86609	CHG BACTERIUM, ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86611	CHG BARTONELLA, ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86612	CHG BLASTOMYCES , ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86615	CHG BORDETELLA ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86617	CHG LYME DISEASE ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86618	CHG LYME DISEASE ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86619	CHG BORRELIA ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86622	CHG BRUCELLA, ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86625	CHG CAMPYLOBACTER, ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86628	CHG CANDIDA, ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86631	CHG CHLAMYDIA, ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86632	CHG CHLAMYDIA, IGM, ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86635	CHG COCCIDIOIDES, ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86638	CHG Q FEVER ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86641	CHG CRYPTOCOCCUS ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86644	CHG CMV ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86645	CHG CMV ANTIBODY, IGM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86648	CHG DIPHTHERIA ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86651	CHG ENCEPHAL ANTIBODY CALIF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86652	CHG ENCEPHAL ANTIBODY EAST EQU	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86653	CHG ENCEPHAL ANTIBODY ST LOUIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86654	CHG ENCEPHAL ANTIBODY WEST EQU	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86658	CHG ENTEROVIRUS, ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86663	CHG EPSTEIN-BARR ANTIBODY,EARLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86664	CHG EPSTEIN-BARR ANTIBODY,NUCLEAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86665	CHG EPSTEIN-BARR ANTIBODY,V CAPSID	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86666	CHG EHRlichia, ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86668	CHG FRANCISELLA TULARENSIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86671	CHG FUNGUS, ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86674	CHG GIARDIA LAMBLIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86677	CHG HELICOBACTER PYLORI	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86682	CHG HELMINTH, ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86684	CHG HEMOPHILUS INFLUENZA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86687	CHG HTLV I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86688	CHG HTLV-II	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86689	CHG HTLV/HIV CONFIRMATORY TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86692	CHG HEPATITIS, DELTA AGENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86694	CHG HERPES SIMPLEX TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86695	CHG HERPES SIMPLEX TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86696	CHG HERPES SIMPLEX TEST, TYPE 2	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86698	CHG HISTOPLASMA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86701	CHG HIV-1	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86702	CHG HIV-2	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86703	PR ANTIBODY HIV-1&HIV-2 SINGLE RESULT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86704	CHG HEP B CORE AB TEST, TOTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86705	CHG HEP B CORE AB TEST, IGM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86706	CHG HEPATITIS B SURFACE AB TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86707	CHG HEPATITIS BE AB TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86708	CHG HEPATITIS A ANTIBODY HAAB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86709	CHG HEPATITIS ANTIBODY HAAB IGM ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86710	CHG INFLUENZA VIRUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86711	CHG ANTIBODY JOHN CUNNINGHAM VIRUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86713	CHG LEGIONELLA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86717	CHG LEISHMANIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86720	CHG LEPTOSPIRA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86723	CHG LISTERIA MONOCYTOGENES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86727	CHG LYMPH CHORIOMENINGITIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86732	CHG MUCORMYCOSIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86735	CHG MUMPS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86738	CHG MYCOPLASMA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86741	CHG NEISSERIA MENINGITIDIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86744	CHG NOCARDIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86747	CHG PARVOVIRUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86750	CHG MALARIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86753	CHG PROTOZOA, NOT ELSEWHERE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86756	CHG RESPIRATORY VIRUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86757	CHG RICKETTSIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86759	CHG ROTAVIRUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86762	CHG RUBELLA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86765	CHG RUBEOLA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86768	CHG SALMONELLA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86769	CHG ANTB SEVERE AQT RESPIR SYND SARS-COV-2 COVID-19	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86769	CHG ANTB SEVERE AQT RESPIR SYND SARS-COV-2 COVID-19	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		5/12/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86771	CHG SHIGELLA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86774	CHG TETANUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86777	CHG TOXOPLASMA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86778	CHG TOXOPLASMA, IGM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86780	CHG ANTIBODY TREPONEMA PALLIDUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86784	CHG TRICHINELLA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86787	CHG VARICELLA-ZOSTER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86788	PR WEST NILE VIRUS AB, IGM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86789	PR WEST NILE VIRUS ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86790	CHG VIRUS, NOT SPECIFIED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86793	CHG YERSINIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86794	CHG ZIKA VIRUS IGM ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86800	CHG THYROGLOBULIN ANTIBODY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86803	CHG HEPATITIS C AB TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86804	CHG HEP C AB TEST, CONFIRM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86805	CHG LYMPHOCYTOTOXICITY ASSAY, TITRATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86806	CHG LYMPHOCYTOTOXICITY ASSAY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86807	CHG CYTOTOXIC ANTIBODY SCREEN STD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86808	CHG CYTOTOXIC ANTIBODY SCREEN QUICK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86812	CHG HLA TYPING, A,B,OR C /SINGLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86813	CHG HLA TYPING, A,B,OR C /MULTI	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86816	CHG HLA TYPING, DR/DQ,SINGLE ANTIGEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86817	CHG HLA TYPING, DR/DQ,MULTI ANTGN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86821	CHG LYMPHOCYTE CULTURE, MIXED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86825	CHG HLA CROSSMATCH NONCYTOTOXI C 1ST SERUM/DILUTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86826	CHG HLA CROSSMATCH NONCYTOTOXI C ADDL SERUM/DILUTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86828	CHG ANTIBODY HLA CLASS I & CLASS II ANTIGENS QUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86829	CHG ANTIBODY HLA CLASS I OR CLASS II ANTIGENS QUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86830	CHG ANTIBODY HLA CLASS I PHENOTYPE PANEL QUALITATIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86831	CHG ANTIBODY HLA CLASS II PHENOTYPE PANEL QUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86832	CHG ANTIBODY HLA CLASS I HIGH DEFINITION PANEL QUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86833	CHG ANTIBODY HLA CLASS II HIGH DEFINITION PANEL QUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86834	CHG ANTIBODY HLA CLASS I SEMIQUANTITATIVE PANEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86835	CHG ANTIBODY HLA CLASS II SEMIQUANTITATIVE PANEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86849	CHG IMMUNOLOGY PROCEDURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86850	CHG RBC ANTIBODY SCREEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86860	CHG RBC ANTIBODY ELUTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86870	CHG RBC ANTIBODY IDENTIFICATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86880	ANTI HUMAN GLOBULIN DIRECT ANTISERUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86885	ANTI HUMAN GLOBULIN INDIRECT ANTISERUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86886	ANTI HUMAN GLOBULIN INDIRECT ANTIBODY TITER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86890	CHG AUTOLOGOUS BLOOD PROCESS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86891	CHG AUTOLOGOUS BLOOD, OP SALVAGE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86900	CHG BLOOD TYPING SEROLOGIC ABO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86901	CHG BLOOD TYPING SEROLOGIC RH (D)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86902	CHG BLOOD TYPE ANTIGEN DONOR REAGENT SERUM EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86904	CHG BLOOD TYPING ANTIGEN SCREEN PATIENT SERUM/UNIT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86905	CHG BLOOD TYPING RBC ANTIGENS OTH/THN ABO/RH D EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86906	CHG BLOOD TYPING SEROLOGIC RH PHENOTYPING COMPLETE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86910	CHG BLOOD TYPING, PATERNITY TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86911	CHG BLOOD TYPING, ANTIGEN SYSTEM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86920	CHG COMPATIBILITY TEST,SPIN TECH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86921	CHG COMPATIBILITY TEST,INCUB TECH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86922	CHG COMPATIBILITY TEST,ANTIGLO B TECH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86923	PR COMPATIBILITY TEST, ELECTRONIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86927	CHG PLASMA, FRESH FROZEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86930	CHG FROZEN BLOOD, FREEZING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86931	CHG FROZEN BLOOD, THAWING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86932	CHG FROZEN BLOOD, FREEZING & THAWING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86940	CHG HEMOLYSINS/AGGLUTININS AUTO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86941	CHG HEMOLYSINS/AGGLUTININS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86945	CHG BLOOD PRODUCT/IRRADIATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86950	CHG LEUKOCYTE TRANSFUSION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86960	PR VOL REDUCTION BLOOD/ BLOOD PROD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86965	CHG POOLING BLOOD PLATELETS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
86970	CHG RBC PRETREATMENT/CHEM OR DRUGS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86971	CHG RBC PRETREATMENT/ENZYM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86972	CHG RBC PRETREATMENT/DEN GRAD SEP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86975	CHG RBC PRETREATMENT,SERUM W DRUGS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86976	CHG RBC PRETREATMENT,SERUM DILUTN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86977	CHG RBC PRETREATMENT,SERUM INHIB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86978	CHG RBC PRETREAT,SERUM DIFF RBC ABSO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86985	CHG SPLIT BLOOD OR PRODUCTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
86999	CHG TRANSFUSION PROCEDURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87003	CHG SMALL ANIMAL INOC W OBSERV/DISSE C	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87015	CHG SPECIMEN CONCENTRAT, INFECT AGENTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87040	CHG BLOOD CULTURE FOR BACTERIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87045	CHG STOOL CULTURE,SALMONELLA & SHIGELLA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87046	CHG STOOL CULTURE, ADDL PATHOGENS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87070	CHG CULTURE SPEC, BACTERIA, NOT URINE,STOOL,BLOOD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87071	CHG CULTURE SPEC, BACTERIA,QUANT,AEROBIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87073	CHG CULTURE SPEC, BACTERIA,QUANT,ANAEROBIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87075	CHG CULTURE SPECIMEN, ANAEROBIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87076	CHG CULT SPEC, ANAEROBIC W/ADDN METHODS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87077	CHG BACTERIA IDENTIFICATION, AEROBIC ISOLATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87081	CHG BACTERIA CULTURE SCREEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87084	CHG CULTURE OF SPEC,KIT,COLO NY EST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87086	CHG URINE CULTURE, COLONY COUNT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87088	PR URINE BACT CULT ID, EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87101	CHG CULTURE FUNGI-SKIN HAIR NAILS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87102	CHG FUNGUS ISOLATION CULTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87103	CHG BLOOD FUNGUS CULTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87106	CHG CULTURE FUNGI-IDENTIF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87107	CHG FUNGUS IDENTIFICATION, MOLD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87109	CHG MYCOPLASMA CULTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87110	CHG CULTURE, CHLAMYDIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87116	CHG MYCOBACT CULTURE, ISOL ATN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87118	CHG MYCOBACTERIA IDENTIFICATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87140	CHG CULTURE TYPING, FLUORESCENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87143	CHG CULTURE TYPING, GLC METHOD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87147	CHG CULTURE TYPING, SEROLOGIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87149	CHG CULTURE TYPING, NUCLEIC ACID PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87150	CHG CULTYP NUC ACID AMP PRB CULT/ISOLATE EA ORGNISM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87152	CHG CULTURE TYPING, PULSE FIELD GEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87153	CHG CULTYP NUCLEIC ACID SEQUENCING METH EA ISOLATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87154	CHG CULTURE TYPING ID BLD PTHGN&RESIST TYPING 6+TRGT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87158	CHG CULTURE TYPING, ADDED METHOD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87164	CHG DARK FIELD EXAM W SPEC COLLECTN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87166	CHG DARK FIELD EXAM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87168	CHG MACROSCOPIC EXAM, ARTHROPOD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87169	CHG MACROSCOPIC EXAM, PARASITE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87172	CHG PINWORM EXAM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87176	CHG HOMOGENIZATI ON, TISSUE FOR CULTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87177	CHG OVA AND PARASITES SMEARS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87181	CHG ANTIBIOTIC SENS,AGAR DIFFUSN,EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87184	CHG ANTIBIOTIC SENS,DISK,EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87185	CHG ANTIBIOTIC SENS,ENZYME DETECTION,EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87186	CHG ANTIBIOTIC SENS,MIC,EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87187	CHG ANTIBIOTIC SENS,MLC,EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87188	CHG ANTIBIOTIC SENS,MACROTUB DIL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87190	CHG TB ANTIBIOTIC SENSITIVITY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87197	CHG BACTERICIDAL LEVEL, SERUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87205	CHG SMEAR,PRIMARY W/INTERP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87206	CHG SMEAR,FLUOR STAIN,INTERP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87207	CHG SMEAR,INCLUSION BODIES/PARASITES,INTERP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87209	PR SMEAR, COMPLEX STAIN, FOR OVA/ PARA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87210	CHG SMEAR,STAIN, WET MNT,INTERP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87220	CHG TISSUE EXAM BY KOH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87230	CHG ASSAY, TOXIN OR ANTITOXIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87250	CHG VIRUS ID,INOC TEST,OBS/DISSECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87252	CHG VIRUS ID,INOC TEST,OBSERV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87253	CHG VIRUS ID,INOC TEST,ADDNL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87254	CHG VIRUS ID;CENTRIF ENH TECH,W/IMMUNOFLUOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87255	CHG VIRUS ID,NON-IMMUNOLOGIC METHOD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87260	CHG INF AGENT, FLUOR, ADENOVIRUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87265	CHG PERTUSSIS AG, DFA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87267	CHG ENTEROVIRUS AG,DFA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87269	CHG GIARDIA AG, IF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87270	CHG CHYLMD TRACH AG, DFA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87271	CHG CYTOMEGALOVIRUS AG,DFA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87272	CHG CRYPTOSPORIDIUM AG, DFA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87273	CHG HERPES SIMPLEX TYPE 2 AG, DFA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87274	CHG HERPES SIMPLEX I AG, FLUOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87275	CHG INFLUENZA B AG, DFA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87276	CHG INFLUENZA AG, DFA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87278	CHG LEGION PNEUMO AG, DFA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87279	CHG PARAINFLUENZA AG, DFA, EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87280	CHG RESP SYNCYTIAL AG, DFA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87281	CHG PNEUMOCYSTIS CARINII AG, DFA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87283	CHG RUBEOLA AG, DFA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87285	CHG TREPON PALLIDUM AG, DFA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87290	CHG VARICELLA AG, DFA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87299	CHG AG DETECTION NOS, FLUOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87300	CHG INFECTIOUS AG, DFA, POLYVALENT, EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87301	CHG IAAD IA ADENOVIRUS ENTERIC TYP 40/41	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87305	CHG IAAD IA ASPERGILLUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87320	CHG IAAD IA CHLAMYDIA TRACHOMATIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87324	CHG IAAD IA CLOSTRIDIUM DIFFICILE TOXIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87327	CHG IAAD IA CRYPTOCOCCUS NEOFORMANS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87328	CHG IAAD IA CRYPTOSPORIDIUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87329	CHG IAAD IA GIARDIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87332	CHG IAAD IA CYTOMEGALOVIRUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87335	CHG IAAD IA ESCHERICHIA COLI 0157	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87336	CHG IAAD IA ENTAMOEBAHISTOLYTICA DISPAR GRP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87337	CHG IAAD IA ENTAMOEBA HISTOLYTICA GRP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87338	CHG IAAD IA HPYLORI STOOL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87339	CHG IAAD IA HPYLORI	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87340	CHG IAAD IA HEPATITIS B SURFACE ANTIGEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87341	CHG IAAD IA HEPATITIS B SURFACE AG NEUTRALIZATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87350	CHG IAAD IA HEPATITIS BE ANTIGEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87380	CHG IAAD IA HEPATITIS DELTA ANTIGEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87385	CHG IAAD IA HISTOPLASM CAPSULATUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87389	CHG IAAD IA HIV-1 AG W/HIV-1 & HIV-2 ANTBDY SINGLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87390	CHG IAAD IA HIV-1	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87391	CHG IAAD IA HIV-2	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87400	CHG IAAD IA INFLUENZA A/B EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87420	CHG IAAD IA RESPIRATORY SYNCIAL VIRUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87425	CHG IAAD IA ROTAVIRUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87426	CHG IAAD IA SEVERE AQT RESPIR SYND CORONAVIRUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87426	CHG IAAD IA SEVERE AQT RESPIR SYND CORONAVIRUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		5/12/2023
87427	CHG IAAD IA SHIGA-LIKE TOXIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87428	CHG IAAD IA SARSCOV & INFLUENZA VIRUS TYPES A&B	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87428	CHG IAAD IA SARSCOV & INFLUENZA VIRUS TYPES A&B	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		5/12/2023
87430	CHG IAAD IA STREPTOCOCC US GROUP A	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87449	CHG IAAD IA NOT OTHERWISE SPECIFIED EACH ORGANISM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87451	CHG IAAD IA POLYV MLT ORGANISMS EA POLYV ANTISERUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87467	PR HEPATITIS B SURFACE ANTIGEN (HBSAG), QUANTITATIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87468	PR INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); ANAPLASMA PHAGOCYTOPHILUM, AMPLIFIED PROBE TECHNIQUE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87469	PR BABESIA MICROTI, AMPLIFIED PROBE TECHNIQUE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87478	PR BORRELIA MIYAMOTOI, AMPLIFIED PROBE TECHNIQUE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87480	CHG CANDIDA, DNA, DIR PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87481	CHG CANDIDA, DNA, AMP PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87482	CHG CANDIDA, DNA, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87483	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87484	PR EHRLICHIA CHAFFEENSIS, AMPLIFIED PROBE TECHNIQUE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87485	CHG CHYLM D PNEUM, DNA, DIR PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87486	CHG CHYLM D PNEUM, DNA, AMP PROBE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
87487	CHG CHYLM D PNEUM, DNA, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87490	CHG CHYLM D TRACH, DNA, DIR PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87491	CHG CHYLM D TRACH, DNA, AMP PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87492	CHG CHYLM D TRACH, DNA, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87493	CLOSTRIDIUM DIFFICILE, TOXIN GENE, PCR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87495	CHG CYTOMEG, DNA, DIR PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87496	CHG CYTOMEG, DNA, AMP PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87497	CHG CYTOMEG, DNA, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87498	CHG IADNA ENTEROVIRUS AMPLIF PROBE & REVRSE TRNSCRIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87500	CHG INFECTIOUS AGENT DNA/RNA VANCOMYCIN RESISTANCE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87501	CHG INFECTIOUS AGENT DNA/RNA INFLUENZA EA TYPE	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR UP TO 3 TESTS PER CODE WITHIN 12 MONTHS		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87501	CHG INFECTIOUS AGENT DNA/RNA INFLUENZA EA TYPE	AUTHORIZATION REQUIRED ALERT: AUTH IS REQUIRED FOR MORE THAN 3 TESTS PER CODE WITHIN 12 MONTHS. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
87502	CHG INFECTIOUS AGENT DNA/RNA INFLUENZA 1ST 2 TYPES	AUTHORIZATION REQUIRED ALERT: AUTH IS REQUIRED FOR MORE THAN 3 TESTS PER CODE WITHIN 12 MONTHS. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
87502	CHG INFECTIOUS AGENT DNA/RNA INFLUENZA 1ST 2 TYPES	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR UP TO 3 TESTS PER CODE WITHIN 12 MONTHS		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
87503	CHG NFCT AGENT DNA/RNA INFLUENZA >2 TYPES EA ADDL	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR UP TO 3 TESTS PER CODE WITHIN 12 MONTHS		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87503	CHG NFCT AGENT DNA/RNA INFLUENZA >2 TYPES EA ADDL	AUTHORIZATION REQUIRED ALERT: AUTH IS REQUIRED FOR MORE THAN 3 TESTS PER CODE WITHIN 12 MONTHS. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
87505	CHG NFCT AGENT DNA/RNA GASTROINTESTINAL PATHOGEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87506	CHG IADNA-DNA/RNA GI PTHGN MULTIPLEX PROBE TQ 6-11	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87507	CHG IADNA-DNA/RNA GI PTHGN MULTIPLEX PROBE TQ 12-25	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
87510	CHG GARDNER VAG, DNA, DIR PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87511	CHG GARDNER VAG, DNA, AMP PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87512	CHG GARDNER VAG, DNA, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87520	CHG HEPATITIS C , RNA, DIR PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87521	CHG IADNA HEPATITIS C AMPLIFIED PROBE&REVRSE TRANSCR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87522	CHG IADNA HEPATITIS C QUANT & REVERSE TRANSCRIPTIO N	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87523	DETECTION OF HEPATITIS D (DELTA)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87525	CHG HEPATITIS G , DNA, DIR PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87526	CHG HEPATITIS G, DNA, AMP PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87527	CHG HEPATITIS G, DNA, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87528	CHG HSV, DNA, DIR PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87529	CHG HSV, DNA, AMP PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87530	CHG HSV, DNA, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87531	CHG HHV-6, DNA, DIR PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87532	CHG HHV-6, DNA, AMP PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87533	CHG HHV-6, DNA, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87534	CHG HIV-1, DNA, DIR PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87535	CHG IADNA HIV-1 AMPLIFIED PROBE & REVERSE TRANSCRIPJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87536	CHG IADNA HIV-1 QUANT & REVERSE TRANSCRIPTIO N	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87537	CHG HIV-2, DNA, DIR PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87538	CHG IADNA HIV-2 AMPLIFIED PROBE & REVERSE TRANSCRIPJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87539	CHG IADNA HIV-2 QUANT & REVERSE TRANSCRIPTIO N	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87540	CHG LEGION PNEUMO, DNA, DIR PROB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87541	CHG LEGION PNEUMO, DNA, AMP PROB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87542	CHG LEGION PNEUMO, DNA, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87550	CHG MYCOBACTERI A, DNA, DIR PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87551	CHG MYCOBACTERI A, DNA, AMP PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87552	CHG MYCOBACTERI A, DNA, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87555	CHG M.TUBERCULO, DNA, DIR PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87556	CHG M.TUBERCULO, DNA, AMP PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87557	CHG M.TUBERCULO, DNA, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87560	CHG M.AVIUM-INTRA, DNA, DIR PROB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87561	CHG M.AVIUM-INTRA, DNA, AMP PROB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87562	CHG M.AVIUM-INTRA, DNA, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87563	CHG IADNA MYCOPLASMA GENITALIUM AMPLIFIED PROBE TECH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87563	CHG IADNA MYCOPLASMA GENITALIUM AMPLIFIED PROBE TECH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
87580	CHG M.PNEUMON, DNA, DIR PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87581	CHG M.PNEUMON, DNA, AMP PROBE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Respiratory and GI Molecular PCR Panel Testing): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Respiratory-and-GI-Molecular-PCR-Panel-Testing.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87582	CHG M.PNEUMON, DNA, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87590	CHG N.GONORRHOE AE, DNA, DIR PROB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87591	CHG N.GONORRHOE AE, DNA, AMP PROB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87592	CHG N.GONORRHOE AE, DNA, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87593	IADNA ORTHOPOXVIR US AMPLIFIED PROBE TECHNIQUE EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87623	CHG IADNA HUMAN PAPILLOMAVIR US LOW-RISK TYPES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87624	CHG IADNA HUMAN PAPILLOMAVIR US HIGH-RISK TYPES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87625	CHG IADNA HUMAN PAPILLOMAVIR US TYPES 16 & 18 ONLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87631	CHG IADNA RESPIRATRY PROBE & REV TRNSCR 3-5 TARGETS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87632	CHG IADNA RESPIRATORY PROBE & REV TRNSCR 6-11 TARGETS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87633	CHG IADNA RESPIRATORY PROBE & REV TRNSCR 12-25 TARGET	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Respiratory and GI Molecular PCR Panel Testing): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Respiratory-and-GI-Molecular-PCR-Panel-Testing.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
87634	CHG IADNA DNA/RNA RSV AMPLIFIED PROBE TECHNIQUE	NO AUTHORIZATION REQUIRED AGE: NO AUTH REQUIRED IF 12 MONTHS OF AGE OR YOUNGER.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Respiratory and GI Molecular PCR Panel Testing): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Respiratory-and-GI-Molecular-PCR-Panel-Testing.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87634	CHG IADNA DNA/RNA RSV AMPLIFIED PROBE TECHNIQUE	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF OLDER THAN 12 MONTHS. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Respiratory and GI Molecular PCR Panel Testing): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Respiratory-and-GI-Molecular-PCR-Panel-Testing.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
87635	CHG IADNA SARS-COV-2 COVID-19 AMPLIFIED PROBE TQ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		5/12/2023
87635	CHG IADNA SARS-COV-2 COVID-19 AMPLIFIED PROBE TQ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87636	CHG IADNA SARSCOV2& INF A&B MULT AMPLIFIED PROBE TQ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87636	CHG IADNA SARSCOV2& INF A&B MULT AMPLIFIED PROBE TQ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		5/12/2023
87637	CHG IADNA SARSCOV2 & INF A&B & RSV MULT AMP PROBE TQ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		5/12/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87637	CHG IADNA SARSOCV2 & INF A&B & RSV MULT AMP PROBE TQ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87640	PR STAPH A, DNA, AMP PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87641	PR MRSA, DNA, AMP PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87650	CHG STREP A, DNA, DIR PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87651	CHG STREP A, DNA, AMP PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
87652	CHG STREP A, DNA, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87653	PR STREP B, DNA, AMP PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87660	CHG TRICHOMONAS VAGIN, DIR PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87661	CHG IADNA TRICHOMONAS VAGINALIS AMPLIFIED PROBE TECH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87662	CHG IADNA DNA/RNA ZIKA VIRUS AMPLIFIED PROBE TQ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87797	CHG DETECT AGENT NOS, DNA, DIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87798	CHG DETECT AGENT NOS, DNA, AMP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
87799	CHG DETECT AGENT NOS, DNA, QUANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87800	CHG DETECT AGENT, MULT ORGS, DNA, DIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87801	CHG DETECT AGENT, MULT ORGS, DNA, AMP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87802	CHG IAADIADOO STREPTOCOCCUS GROUP B	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87803	CHG IAADIADOO CLOSTRIDIUM DIFFICILE TOXIN A	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87804	CHG IAADIADOO INFLUENZA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87806	CHG IAADIADOO HIV1 ANTIGEN W/HIV1 & HIV2 ANTIBODIES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87807	CHG IAADIADOO RESPIRATORY SYNCTIAL VIRUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87808	CHG IAADIADOO TRICHOMONAS VAGINALIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87809	CHG IAADIADOO ADENOVIRUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87809	CHG IAADIADOO ADENOVIRUS	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX . ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
87810	CHG IAADIADOO CHLAMYDIA TRACHOMATIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87811	CHG IAADIADOO SEVERE AQT RESPIR SYND CORONAVIRUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87811	CHG IAADIADOO SEVERE AQT RESPIR SYND CORONAVIRUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		5/12/2023
87850	CHG IAADIADOO NEISSERIA GONORRHOEA E	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87880	CHG IAADIADOO STREPTOCOCC US GROUP A	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87899	CHG IAADIADOO NOT OTHERWISE SPECIFIED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87900	PR INFECT AGENT DRUG SUSEPT BY PHENOTYPE PREDICT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87901	CHG HIV 1 GENOTYPE, DNA/RNA,REVE RSE TRANSCRIPTAS E/PROTEASE REGIONS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87902	CHG HEPATITIS C VIRUS, GENOTYPE ANAL DNA/RNA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87903	CHG HIV 1,PHENOTYP ANALYS DNA/RNA,1-10 DRUGS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87904	PR HIV 1,PHENOTY ANALY DNA/RNA,EA ADDL DRUG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87905	CHG INFECT AGENT ENZYMATIC ACTIVITY NON-VIRUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87906	CHG HIV 1 GENOTYPE, DNA/RNA, OTHER REGIONS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87910	CHG NFCT AGT GENOTYPE NUCLEIC ACID CYTOMEGALOV IRUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87912	CHG NFCT AGENT GENOTYPE HEPATITIS B VIRUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
87913	INFECTIOUS AGENT GENOTYPE ANALYSIS BY NUCLEIC ACID (DNA OR RNA); SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2) (CORONAVIRUS DISEASE COVID-19), MUTATION IDENTIFICATION IN TA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
87913	INFECTIOUS AGENT GENOTYPE ANALYSIS BY NUCLEIC ACID (DNA OR RNA); SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2) (CORONAVIRUS DISEASE COVID-19), MUTATION IDENTIFICATION IN TA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		5/12/2023
87999	CHG MICROBIOLOGY PROCEDURE UNLISTED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88000	CHG AUTOPSY GROSS,W/O CNS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88005	CHG AUTOPSY GROSS,W BRAIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88007	CHG AUTOPSY GROSS,W BRAIN/SP CORD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88012	CHG AUTOPSY GROSS,INFANT W BRAIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88014	CHG AUTOPSY GROSS,NEWBO RN W BRAIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88016	CHG AUTOPSY GROSS,MACER ATED STILLBORN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88020	CHG AUTOPSY COMPL,W/O CNS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88025	CHG AUTOPSY COMPL,W BRAIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88027	CHG AUTOPSY COMPL,W BRAIN/SP CORD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88028	CHG AUTOPSY COMPL,INFANT W BRAIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88029	CHG AUTOPSY COMPL,NEWBOR N W BRAIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88036	CHG LTD AUTOPSY,REGIONAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88037	CHG LTD AUTOPSY,SINGLE ORGAN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88040	CHG FORENSIC AUTOPSY (NECROPSY)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88045	CHG CORONER'S AUTOPSY (NECROPSY)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88099	CHG NECROPSY (AUTOPSY) UNLISTED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88104	CHG CYTOPATH FLUIDS,SMEAR, INTERP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88106	CHG CYTOPATH FLUIDS,FILTER, INTERP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88108	CHG CYTOPATH FLUIDS,CONCE NTRATN,INTER P	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88112	CHG CYTOPATH, CELL ENHANCE TECH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88120	CHG CYTOPATH, INSITU HYBRID URINE SPEC 3- 5 PROBES EACH,MANUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88121	CHG CYTOPATH, INSITU HYBRID URINE SPEC 3- 5 PROBES EACH,COMPUT ER ASSIST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88125	CHG FORENSIC CYTOPATHOLOGY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88130	CHG SEX CHROMATIN ID,BARR BODIES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88140	CHG SEX CHROMATIN ID,PMN DRUMSTICK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88141	CHG CYTOPATH CERV/VAG INTERPRET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88142	CHG CYTOPATH CERV/VAG THIN LAYER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88143	CHG CYTOPATH CERV/VAG THIN LAYER REDO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88147	CHG CYTOPATH SMEAR CERV/VAG AUTOMATED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88148	CHG CYTOPATH,C/V, AUTO/MAN RESCREEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88150	CHG CYTOPATH SMEAR CERV/VAG,MAN UAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88152	CHG CYTOPATH SMEAR CERV/VAG,AUT O REDO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88153	CHG CYTOPATH SMEAR CERV/VAG REDO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88155	CHG CYTOPATH SMEAR CERV/VAG,IND EX ADD-ON	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88160	CHG CYTOPATH,OT HR SOURC,SCREE N,INTERP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88161	CHG CYTOPATH,OT HR SOURC,PREP,S CRN,INTERP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88162	CHG CYTOPATH,OT HR SOURC,EXTEN SIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88164	CHG CYTOPATH TBS CERV/VAG MANUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88165	CHG CYTOPATH TBS CERV/VAG REDO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88166	CHG CYTOPATH TBS CERV/VAG AUTO REDO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88167	CHG CYTOPATH TBS CERV/VAG SELECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88172	CHG EVALUATION OF FNA SMEAR TO DETERMINE ADEQUACY, FIRST EVAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88173	CHG INTERPRETATI ON OF FNA SMEAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88174	CHG CYTOPATH,CE RV/VAG,AUTO THIN LAYER,INTERP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88175	PR CYTOPAT,CER/ VAG,THIN LAYER,MAN RES,INTER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88177	CHG EVALUATION OF FNA SMEAR TO DETERMINE ADEQUACY, EA ADD EVAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88182	CHG CELL MARKER STUDY,DNA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88184	CHG LYMPHOCYTE CD3/100 CELLS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88185	PR FLOWCYTOME TRY/TECH COMPONENT, ADD-ON	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88187	PR FLOWCYTOME TRY/READ, 2-8 MARKERS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88188	PR FLOWCYTOME TRY/READ, 9-15 MARKERS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88189	PR FLOWCYTOME TRY/READ, 16 & > MARKERS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88199	CHG CYTOPATH PROCEDURE UNLISTED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88230	CHG TISSUE CULTURE, LYMPHOCYTE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88233	CHG TISSUE CULTURE, SKIN/BIOPSY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88235	CHG TISSUE CULTURE, PLACENTA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88237	CHG TISSUE CULTURE, BONE MARROW	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88239	CHG TISSUE CULTURE, TUMOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88240	CHG CELL CRYOPRESERVE/STORAGE	<p>AUTHORIZATION REQUIRED</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF</p> <p>MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88241	CHG FROZEN CELL PREPARATION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88245	CHG CHROMOSOME ANAL:BREAKGE ,20-25 CELLS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88248	CHG CHROMOSOME ANAL:BREAKGE ,50-100 CELLS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88261	CHG CHROMOSOME ANAL:5 CELLS,1 KARYOTYPE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88262	CHG CHROMOSOME ANAL:15-20,2 KARYOTYPES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88263	CHG CHROMOSOME ANAL:45 CELLS,MOSAICI SM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88264	CHG CHROMOSOME ANALYSIS:20-25	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88267	CHG CHROMOSOME ANALY:PLACEN TA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88269	CHG CHROMOSOME ANALY:AMNIOTI C	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88271	CHG CYTOGENETIC S, DNA PROBE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88272	CHG CYTOGENETIC S, 3-5	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88273	CHG CYTOGENETIC S, 10-30	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88274	CHG CYTOGENETIC S, 25-99	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88275	CHG CYTOGENETIC S, 100-300	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88280	CHG CHROMOSOME KARYOTYPE STUDY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88283	CHG CHROMOSOME BANDING STUDY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88285	CHG CHROMOSOME COUNT:ADDN CELLS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/GE NETIC-TESTING-FOR SUSPECTED DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/USI NG-LARGE-GENETIC-TESTING- PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88289	CHG CHROMOSOME STUDY:ADDN HI RES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (GENETIC TESTING FOR SUSPECTED DISABILITY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/GENETIC-TESTING-FOR-SUSPECTED-DISABILITY.PDF MD GUIDELINE 2 (USING LARGE GENETIC TESTING PANELS.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/USING-LARGE-GENETIC-TESTING-PANELS.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
88291	CHG CYTO/MOLECULAR REPORT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88299	CHG CYTOGENETIC STUDY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88300	CHG SURG PATH,GROSS,LEVEL I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88302	CHG SURG PATH,LEVEL II	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88304	CHG SURG PATH,LEVEL III	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88305	CHG SURG PATH,LEVEL IV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88307	CHG SURG PATH,LEVEL V	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88309	CHG SURG PATH,LEVEL VI	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88311	CHG DECALCIFY TISSUE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88312	PR SPECIAL STAIN GROUP 1 MICROORGANI SMS I&R	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88313	PR SPCL STN 2 I&R EXCPT MICROORG/ENZYME/IIMCYT&I MHIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88314	PR SPECIAL STAIN I&R HISTOCHEMICAL W/FROZEN TISSUE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88319	PR SPECIAL STAIN I&R GROUP III ENZYME CONSITUENTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88321	CHG MICROSLIDE CONSULT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88323	CHG MICROSLIDE CONSULT W SLIDE PREP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88325	CHG COMPREHENSIVE REVIEW OF DATA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88329	CHG PATH CONSULT IN SURGERY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88331	CHG PATH CONSULT IN SURG,W FRZ SEC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88332	CHG PATH CONSULT IN SURG,W ADDN FRZ SEC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88333	PR INTRAOPERATIVE CYTO PATH CONSULT, INITIAL SITE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88334	CHG INTRAOPERATIVE CYTO PATH CONSULT, ADD SITES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88341	CHG IMHISTOCHEM/ CYTCHM EA ADDL ANTIBODY SLIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88342	CHG IMHISTOCHEM/ CYTCHM INIT ANTIBODY STAIN PROCEDURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88344	CHG IMHISTOCHEM/ CYTCHM EA MULTIPLEX ANTIBODY SLIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88346	CHG IMMUNOFLUORESCENCE PER SPEC 1ST SINGL ANTB STAIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88348	CHG ELECTRON MICROSCOPY, DIAGNOSTIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88350	CHG IMMUNOFLUOR ESCENCE PER SPEC ADD SINGL ANTB STAIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88355	CHG ANALYSIS, SKELETAL MUSCLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88356	CHG ANALYSIS, NERVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88358	CHG ANALYSIS, TUMOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88360	CHG M/PHMTRC ALYS TUMOR IMHCHEM EA ANTIBODY MANUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88361	CHG M/PHMTRC ALYS TUMOR IMHCHEM EA ANTBDY CMPTR ASST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88362	CHG NERVE TEASING PREPARATION S	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88363	CHG EXAM & SELECT ARCHIVE TISSUE MOLECULAR ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88364	CHG IN SITU HYBRIDIZATION EA ADDL PROBE STAIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88365	CHG IN SITU HYBRIDIZATION 1ST PROBE STAIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88366	CHG IN SITU HYBRIDIZATION EA MULTIPLEX PROBE STAIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88367	CHG M/PHMTRC ALYS ISH CPTR-ASST TECH 1ST PROBE STAIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88368	CHG M/PHMTRC ALYS IN SITU HYBRIDIZATION EA PROBE MNL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88369	CHG M/PHMTRC ALYS ISH QUANT/SEMIQ MNL PER SPEC EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88371	CHG PROTEIN, WESTERN BLOT TISSUE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88372	CHG PROTEIN ANALYSIS W/PROBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88373	CHG M/PHMTRC ALYS ISH QUANT/SEMIQ CPTR PER SPEC EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88374	CHG M/PHMTRC ALYS ISH QUANT/SEMIQ CPTR EACH MULTIPRB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88375	CHG OPTICAL ENDOMICROSC OPIC IMAGE INTERP & REPORT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88377	CHG M/PHMTRC ALYS ISH QUANT/SEMIQ MNL EACH MULTIPRB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88380	MICRODISSECT ION, LASER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88381	CHG MICRODISSECT ION, MANUAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88387	CHG MACRO EXAM DISSECT&PREP TISS NONMICRO STD EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88388	CHG MACR EXM DISS&PRP NONMICR IMPRNT/CONSL T/FRZ SE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88399	CHG SURGICAL PATH PROCEDURE UNLISTED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88720	CHG BILIRUBIN TOTAL TRANSCUTANEOUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
88738	CHG HGB QUANTITATIVE TRANSCUTANEOUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88740	CHG CARBOXYHEMOGLOBIN, TRANSCUTANEOUS, PER DAY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
88741	CHG METHEMOGLOBIN, TRANSCUTANEOUS, PER DAY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
88749	CHG UNLISTED IN VIVO LAB SERVICE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
89049	PR CAFFEINE HALOTHNE CONTRCTN TEST MAL HYPERTHRM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
89050	CHG CELL COUNT,MISC BODY FLUIDS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
89051	CHG BODY FLUID CELL COUNT W DIFF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
89055	CHG LEUKOCYTE COUNT,FECAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
89060	CHG EXAM,SYNOVIAL FLUID CRYSTALS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
89125	CHG SPECIMEN FAT STAIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
89160	CHG EXAM FECES FOR MEAT FIBERS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
89190	CHG NASAL SMEAR FOR EOSINOPHILS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
89220	CHG SPUTUM SPECIMEN COLLECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
89230	CHG SWEAT CHLORIDE TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
89240	CHG PATHOLOGY LAB PROCEDURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
89250	CHG CULTURE/FERTILIZATION OF OOCYTE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89251	CHG CULTURE OOCYTE W/EMBRYOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
89253	CHG EMBRYO HATCHING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89254	CHG OOCYTE IDENTIFICATION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89255	CHG PREPARE EMBRYO FOR TRANSFER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
89257	CHG SPERM IDENTIFICATION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89258	CHG CRYOPRESERVATION, EMBRYO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89259	CHG CRYOPRESERVATION, SPERM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
89260	CHG SPERM ISOLATION, SIMPLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89261	CHG SPERM ISOLATION, COMPLEX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89264	CHG SPERM TISSUE IDENTIFY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
89268	CHG INSEMINATION OF OOCYTES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89272	CHG EXTENDED CULTURE OF OOCYTES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89280	CHG ASSIST OOCYTE FERTILIZATION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
89281	CHG ASSIST OOCYTE FERTILIZATION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89290	CHG BIOPSY, OOCYTE POLAR BODY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89291	CHG BIOPSY, OOCYTE POLAR BODY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
89300	CHG SEMEN ANALYSIS, PRESENCE OR MOTIL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89310	CHG SEMEN ANALYSIS, MOTIL & COUNT W/O HUHNER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89320	SEMEN ANALYSIS, VOLUME, COUNT, MOTILITY, DIFF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
89321	SEMEN ANALYSIS, SPERM PRESENCE AND MOTILITY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89322	CHG SEMEN ANALYSIS, STRICT MORPHOLOGIC CRITERIA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89325	CHG SPERM ANTIBODY TEST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
89329	CHG SPERM EVALUATION TEST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89330	CHG EVALUATION, CERVICAL MUCUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89331	CHG RETROGRADE EJACULATION ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
89335	CHG CRYOPRESERV E TESTICULAR TISS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89337	CHG CRYOPRESERV ATION MATURE OOCYTE(S)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89342	CHG STORAGE/YEA R; EMBRYO(S)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
89343	CHG STORAGE/YEAR; SPERM/SEMEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89344	CHG STORAGE/YEAR; REPROD TISSUE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89346	CHG STORAGE/YEAR; OOCYTE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
89352	CHG THAWING CRYOPRESRVE D; EMBRYO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89353	CHG THAWING CRYOPRESRVE D; SPERM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89354	CHG THAW CRYOPRSVRD; REPROD TISS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
89356	CHG THAWING CRYOPRESERVE D; OOCYTE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
89398	CHG UNLISTED REPRODUCTIVE MEDICINE LAB PROCEDURE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	10/1/2023
90371	PR HEPB IG, IM	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90375	PR RABIES IG, IM/SUBCUT	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90376	PR RABIES IG, HEAT TREATED	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90377	PR RABIES IG HEAT&SOLVENT/DETERGENT HUMAN IM&/SUBQ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
90380	RESPIRATORY SYNCYTIAL VIRUS, MONOCLONAL ANTIBODY, SEASONAL DOSE; 0.5 ML DOSAGE, FOR INTRAMUSCULAR USE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90381	RESPIRATORY SYNCYTIAL VIRUS, MONOCLONAL ANTIBODY, SEASONAL DOSE; 1 ML DOSAGE, FOR INTRAMUSCULAR USE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90384	PR RH IG, FULL-DOSE, IM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		5/10/2021
90385	PR RH IG, MINIDOSE, IM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		5/10/2021
90460	PR IM ADM THRU 18YR ANY RTE 1ST/ONLY COMPT VAC/TOX	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90461	PR IM ADM THRU 18YR ANY RTE ADDL VAC/TOX COMPT	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90471	PR IMMUNIZ ADMIN,1 SINGLE/COMB VAC/TOXOID	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90472	PR IMMUNIZ,ADMIN,EACH ADDL	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90473	PR IMMUNIZ ADMIN,INTRAN ASAL/ORAL,1 VAC/TOX	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90474	PR IMMUNIZ ADMIN,INTRAN ASAL/ORAL,EACH ADDL	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90476	PR ADENOVIRUS VACCINE, TYPE 4	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90477	PR ADENOVIRUS VACCINE, TYPE 7	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90480	IMMUNIZATION ADMINISTRATI ON BY INTRAMUSCUL AR INJECTION OF SEVERE ACUTE RESPIRATORY SYNDROME	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
90581	PR ANTHRAX VACCINE SUBCUTANEOU S/IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90585	PR BCG VACCINE, PERCUT	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90611	SMALLPOX AND MONKEYPOX VACCINE, ATTENUATED VACCINIA VIRUS, LIVE, NON- REPLICATING, PRESERVATIVE FREE, 0.5 ML DOSAGE, SUSPENSION, FOR SUBCUTANEOU S USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
90619	PR MENACWY- TT CONJ VACC SEROGROUPS ACWY FOR IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90620	PR MENB-4C RECOMBNT PROT & OUTER MEMB VESIC VACC IM	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90621	PR MENB-FHBP RECOMBNT LIPOPROTEIN VACC 2/3 DOSE IM	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90622	VACCINIA (SMALLPOX) VIRUS VACCINE, LIVE, LYOPHILIZED, 0.3 ML DOSAGE, FOR PERCUTANEOUS USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
90623	CHIKUNGUNYA VIRUS VACCINE LIVE FOR IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90625	PR CHOLERA VACCINE ADULT 1 DOSE LIVE FOR ORAL USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90626	PR TICK-BORNE ENCEPH VACC INACTIVATED 0.25ML IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90627	PR TICK-BORNE ENCEPH VACC INACTIVATED 0.5ML IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90630	PR INFLUENZA VACC IIV4 SPLIT VIRUS PRSRV FREE ID	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90632	PR HEPA VACCINE ADULT DOSE FOR INTRAMUSCULAR USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90633	PR HEPA VACCINE 2 DOSE SCHEDULE PED/ADOLESC IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90636	PR HEPA/HEPB VACCINE ADULT IM	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90647	PR HIB PRP-OMP VACCINE 3 DOSE SCHEDULE IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90648	PR HIB PRP-T VACCINE 4 DOSE SCHEDULE IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90651	PR 9VHPV VACC 2/3 DOSE SCHED IM USE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90654	PR INFLUENZA VACC IIV3 SPLIT VIRUS PRSRV FREE ID	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90655	PR IIV3 VACC PRESRV FREE 0.25 ML DOSAGE IM USE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90656	PR IIV3 VACC PRESERVATIVE FREE 0.5 ML DOSAGE IM USE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90657	PR IIV3 VACCINE SPLIT VIRUS 0.25 ML DOSAGE IM USE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90658	PR IIV3 VACCINE SPLIT VIRUS 0.5 ML DOSAGE IM USE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90660	PR LAIV3 VACCINE LIVE FOR INTRANASAL USE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90661	PR CCIIV3 VACCINE PRESERVATIVE FREE 0.5 ML IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90662	PR IIV VACCINE PRESERV FREE INCREASED AG COUNT IM	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90670	PR PCV13 VACCINE FOR INTRAMUSCULAR USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90671	PR PCV15 VACCINE FOR INTRAMUSCULAR USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90672	PR LAIV4 VACCINE FOR INTRANASAL USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90673	PR RIV3 VACCINE PRESERVATIVE FREE FOR IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90674	PR CCIIV4 VACCINE PRESERVATIVE FREE 0.5 ML IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90675	PR RABIES VACCINE, IM	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90676	PR RABIES VACCINE, ID	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90677	PR PCV20 VACCINE FOR INTRAMUSCULAR USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90678	PR RESPIRATORY SYNCYTIAL VIRUS VACCINE, PREF, SUBUNIT, BIVALENT, FOR INTRAMUSCULAR USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90679	RESPIRATORY SYNCYTIAL VIRUS VACCINE, PREF, RECOMBINANT, SUBUNIT, ADJUVANTED, INTRAMUSCULAR USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90680	PR RV5 VACCINE 3 DOSE SCHEDULE LIVE FOR ORAL USE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90681	PR RV1 VACCINE 2 DOSE SCHEDULE LIVE FOR ORAL USE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90682	PR RIV4 VACC RECOMBINANT DNA PRSRV ANTIBIO FREE IM	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90685	PR IIV4 VACC PRSRV FREE 0.25 ML DOS FOR IM USE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90686	PR IIV4 VACC PRESRV FREE 0.5 ML DOS FOR IM USE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90687	PR IIV4 VACC SPLIT VIRUS 0.25 ML DOS FOR IM USE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90688	PR IIV4 VACC SPLIT VIRUS 0.5 ML DOS FOR IM USE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90690	PR TYPHOID VACCINE, ORAL	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90691	PR TYPHOID VACCINE, IM	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90694	PR AIIV4 VACC INACTIVATED PRSRV FR 0.5ML DOS IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90696	PR DTAP-IPV VACCINE CHILD 4-6 YRS FOR IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90697	PR DTAP-IPV-HIB-HEPB VACCINE INTRAMUSCULAR	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90698	PR DTAP-IPV/HIB VACCINE FOR INTRAMUSCULAR USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90700	DTAP IMMUNIZATION, IM, <7 YO	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90702	PR DT VACCINE YOUNGER THAN 7 YRS FOR IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90707	PR MMR VIRUS IMMUNIZATION, SUBCUT	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90710	PR COMBINED VACCINE,MMR +VARICELLA,SU B-Q	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90713	PR POLIOMYELITIS IMMUNIZATN,IN ACTV,SUB-Q	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90714	PR TD VACCINE PRSRV FREE 7 YRS OR OLDER FOR IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90715	PR TDAP VACCINE >7 YO, IM	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90716	PR VAR VACCINE LIVE FOR SUBCUTANEOUS USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90717	PR YELLOW FEVER IMMUNIZATN, LIVE,SUB-Q	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90723	PR DTAP-HEPB-IPV VACCINE INTRAMUSCULAR	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90732	PR PPSV23 VACCINE 2 YRS OR OLDER FOR SUBQ/IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90734	PR MENACWYD/MENACWY-CRM CONJ VACC GRPS ACWY IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90738	PR JAPANESE ENCEPH VACC, INACTIVATED, IM	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90739	HEPATITIS VACCINE (HEPB), CPG-ADJUVANTED, ADULT DOSAGE, 2 DOSE OR 4 DOSE SCHEDULE, FOR INTRAMUSCULAR USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		9/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90739	HEPATITIS VACCINE (HEPB), CPG-ADJUVANTED, ADULT DOSAGE, 2 DOSE OR 4 DOSE SCHEDULE, FOR INTRAMUSCULAR USE	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		9/1/2021
90740	PR HEPB VACCINE DIALYSIS/IMMUNOSUPPAT 3 DOSE IM	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90743	PR HEPB VACCINE ADOLESCENT 2 DOSE SCHEDULE IM	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90744	PR HEPB VACCINE PED/ADOLESC 3 DOSE SCHEDULE IM	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90746	PR HEPB VACCINE ADULT 3 DOSE SCHEDULE FOR IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90747	PR HEPB VACCINE DIALYSIS/IMMUNOSUPPAT 4 DOSE IM	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90756	PR CCIIV4 VACCINE ANTIBIOTIC FREE 0.5 ML DOS IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90758	PR ZAIRE EBOLAVIRUS VACCINE LIVE FOR IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90759	PR HEP B VACC 3 AG 10 MCG 3 DOSE SCHED FOR IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
90791	PR PSYCHIATRIC DIAGNOSTIC EVALUATION	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO 1 SERVICE PER ROLLING YEAR.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
90791	PR PSYCHIATRIC DIAGNOSTIC EVALUATION	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF MORE THAN 1 SERVICE PER ROLLING YEAR. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90792	PR PSYCHIATRIC DIAGNOSTIC EVAL W/MEDICAL SERVICES	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF MORE THAN 1 SERVICE PER ROLLING YEAR. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
90792	PR PSYCHIATRIC DIAGNOSTIC EVAL W/MEDICAL SERVICES	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO 1 SERVICE PER ROLLING YEAR.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
90832	PR PSYCHOTHERAPY W/PATIENT 30 MINUTES	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
90832	PR PSYCHOTHERAPY W/PATIENT 30 MINUTES	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90833	PR PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 30 MIN	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
90833	PR PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 30 MIN	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
90834	PR PSYCHOTHERAPY W/PATIENT 45 MINUTES	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
90834	PR PSYCHOTHERAPY W/PATIENT 45 MINUTES	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90836	PR PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 45 MIN	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
90836	PR PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 45 MIN	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
90837	PR PSYCHOTHERAPY W/PATIENT 60 MINUTES	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
90837	PR PSYCHOTHERAPY W/PATIENT 60 MINUTES	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90838	PR PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 60 MIN	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
90838	PR PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 60 MIN	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
90846	PR FAMILY PSYCHOTHERAPY W/O PATIENT PRESENT 50 MINS	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
90846	PR FAMILY PSYCHOTHERAPY W/O PATIENT PRESENT 50 MINS	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90847	PR FAMILY PSYCHOTHERAPY W/PATIENT PRESENT 50 MINS	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
90847	PR FAMILY PSYCHOTHERAPY W/PATIENT PRESENT 50 MINS	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
90853	PR GROUP PSYCHOTHERAPY	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
90853	PR GROUP PSYCHOTHERAPY	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90870	PR ELECTROCONV ULSIVE THERAPY,1 SEIZ	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
90870	PR ELECTROCONV ULSIVE THERAPY,1 SEIZ	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
90875	PR INDIV PSYCHOPHYS BIOFEED TRAIN W/PSYTX 30 MIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
90876	PR INDIV PSYCHOPHYS BIOFEED TRAIN W/PSYTX 45 MIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
90899	PR PSYCHIATRIC SERVICE/THER APY	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90899	PR PSYCHIATRIC SERVICE/THER APY	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
90901	PR BIOFEEDBACK TRAINING,ANY MODALITY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
90911	PR BIOFEEDBACK PERI/URO/REC TAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
90912	PR BFB TRAINING W/EMG &MANOMETRY 1ST 15 MIN CNTCT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
90913	PR BFB TRAINING W/EMG&MANOMETRY EA ADDL 15 MIN CNTCT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90935	PR HEMODIALYSIS PROCEDURE W/ PHYS/QHP EVALUATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90937	PR HEMODIALYSIS , REPEATED EVAL.	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90940	PR HEMODIA ACC FLOW STUDY BY INDICAT METH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90945	PR DIALYSIS OTHER/THAN HEMODIALYSIS 1 PHYS/QHP EVAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90947	PR DIALYSIS OTH/THN HEMODIALY REPEAT PHYS/QHP EVALS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90951	PR ESRD RELATED SVC MONTHLY & <2 YR OLD 4/> VISITS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90952	PR ESRD RELATED SVC MONTHLY <2 YR OLD 2/3 VISITS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90953	PR ESRD RELATED SVC MONTHLY <2 YR OLD 1 VISIT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90954	PR ESRD RELATED SVC MONTHLY 2-11 YR OLD 4/> VISITS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90955	PR ESRD RELATED SVC MONTHLY 2-11 YR OLD 2/3 VISITS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90956	PR ESRD RELATED SVC MONTHLY 2-11 YR OLD 1 VISIT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90957	PR ESRD RELATED SVC MONTHLY 12-19 YR OLD 4/> VISITS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90958	PR ESRD RELATED SVC MONTHLY 12-19 YR OLD 2/3 VISITS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90959	PR ESRD RELATED SVC MONTHLY 12-19 YR OLD 1 VISIT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90960	PR ESRD RELATED SVC MONTHLY 20&/> YR OLD 4/> VISITS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90961	PR ESRD RELATED SVC MONTHLY 20/>YR OLD 2/3 VISITS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90962	PR ESRD RELATED SVC MONTHLY 20&/>YR OLD 1 VISIT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90963	PR ESRD SERVICES, HOME DIALYSIS, PER MONTH, < 2 YR OLD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90964	PR ESRD SERVICES, HOME DIALYSIS, PER MONTH, 2-11 YR OLD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90965	PR ESRD SERVICES, HOME DIALYSIS, PER MONTH, 12-19 YR OLD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90966	PR ESRD SERVICES, HOME DIALYSIS, PER MONTH, 20+ YR OLD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90967	PR ESRD SERVICES, PER DAY, < 2 YR OLD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90968	PR ESRD SERVICES, PER DAY, 2-11 YR OLD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90969	PR ESRD SERVICES, PER DAY, 12-19 YR OLD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
90970	PR ESRD SERVICES, PER DAY,20+ YR OLD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90989	PR DIALYSIS TRAINING/COMPLETE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90993	PR DIALYSIS TRAINING/INCOMPLETE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90997	PR HEMOPERFUSION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
90999	PR DIALYSIS PROCEDURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
91010	PR ESOPHAGEAL MOTILITY STUDY W/INTERP&RPT	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
91035	PR GERD TST W/ MUCOS PH ELECTROD	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2022
91065	PR BREATH HYDROGEN/METHANE TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
91113	PR GI TRACT IMAGING INTRALUMINAL COLON I&R	NO AUTHORIZATION REQUIRED DIAGOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: K63.5, K92.1, K92.2, R19.5, Z53.09, Z53.8		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
91113	PR GI TRACT IMAGING INTRALUMINAL COLON I&R	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: K63.5, K92.1, K92.2, R19.5, Z53.09, Z53.8 EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
91200	PR LIVER ELASTOGRAPHY W/O IMAG W/I&R	AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2023
91300	PR SARSCOV2 VACCINE DIL RECON 30 MCG/0.3 ML IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
91301	PR SARSCOV2 VACCINE 100 MCG/0.5 ML IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		8/12/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
91303	PR SARSCOV2 VACCINE AD26 5X1010VP/0.5ML IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		8/12/2021
91304	PR SARSCOV2 VACC SAPONIN-BSD ADJT 5MCG/0.5ML IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		12/1/2022
91306	SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV2) (CORONAVIRUS DISEASE COVID-19) VACCINE, MRNA-LNP, SPIKE PROTEIN, PRESERVATIVE FREE, 50 MCG/0.25 ML DOSAGE, FOR INTRAMUSCULAR USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
91307	PR COVID 5-11 PEDIATRIC SARSCOV2 VACCINE 10MCG/0.2ML TRIS-SUCROSE IM USE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
91308	PR PFIZER 2 (SARS-COV-2) (CORONAVIRUS DISEASE COVID-19) VACCINE, MRNA-LNP, SPIKE PROTEIN, PRESERVATIVE FREE, 3 MCG/0.2 ML DOSAGE, DILUENT RECONSTITUTE D	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		1/1/2024
91309	SARSCOV2 VAC 50MCG/0.5ML IM	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		1/1/2024
91309	SARSCOV2 VAC 50MCG/0.5ML IM	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
91311	SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2) (CORONAVIRUS DISEASE COVID-19) VACCINE, MRNA-LNP, SPIKE PROTEIN, PRESERVATIVE FREE, 25 MCG/0.25 ML DOSAGE, FOR INTRAMUSCULAR U	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		3/1/2023
91312	SARSCOV2 VAC BVL 30MCG/0.3M	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
91313	SARSCOV2 VAC BVL 50MCG/0.5ML	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
91314	SARSCOV2 VAC BVL 25MCG/0.25ML	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
91315	SARSCO2 VAC BVL 10MCG/0.2ML	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
91316	MODERNA COVID-19 VACCINE AGED 6 MONTHS THROUGH 5YRS	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		3/1/2023
91317	PFIZER- BIONTECH COVID-19 VACCINE, BIVALENT PRODUCT AGED 6MOS TO 4YRS	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		1/1/2024
91318	SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 3 MCG/0.2 ML DOSAGE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		1/1/2024
91319	SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 10 MCG/0.2 ML DOSAGE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
91320	SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 30 MCG/0.3 ML DOSAGE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024
91321	SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 25 MCG/0.25 ML DOSAGE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		1/1/2024
91322	SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 50 MCG/0.5 ML DOSAGE	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS. EXCLUSIONS: FQHC, RHC	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92002	PR EYE EXAM, NEW PATIENT, INTER MED	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92004	PR EYE EXAM, NEW PATIENT,COMP REHESV	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92012	PR EYE EXAM ESTABLISHED PT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92014	PR EYE EXAM & TREATMENT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92015	PR REFRACTION	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92018	PR NEW EYE EXAM & TREATMENT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92020	PR SPECIAL EYE EVAL,GONISCOPY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92025	PR CORNEAL TOPOGRAPHY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92060	PR SPECIAL EYE EVAL,SENSORI MOTOR	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92065	PR ORTHOPTIC TRAINING; PERFORMED BY A PHYS OR OTHER QUALIFIED HEALTH CARE PROF	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92071	PR FIT CONTACT LENS TX OCULAR SURFACE DISEASE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92072	PR FITTING CONTACT LENS FOR MNGT OF KERATOCONUS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92081	PR VISUAL FIELD EXAM,LIMITED	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92082	PR VISUAL FIELD EXAM,INTERMED	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92083	PR VISUAL FIELD EXAM, EXTENDED	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92100	PR SERIAL TONOMETRY EXAM(S)	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92133	PR COMPUTERIZE D OPTHALMIC IMAGING OPTIC NERVE	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92134	PR COMPUTERIZE D OPTHALMIC IMAGING RETINA	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92135	OPHTHALMIC DIAG IMAGING, POST SEGMENT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92136	PR OPHTHAL BIOMETRY,INT RAOC LENS POW CALC	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX . ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92201	PR OPSCPY EXTND RTA DRAWING & SCL DEPRSN I&R UNI/BI	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92202	PR OPSCPY EXTND OPTIC NRV/MACULA DRAWING I&R UNI/BI	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92225	PR SPECIAL EYE EXAM, INITIAL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92226	PR SPECIAL EYE EXAM, SUBSEQUENT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92227	PR IMG RETINA DETCJ/MNTR DS REM CLIN STAFF UNI/BI	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92228	PR IMG RETINA DETCJ/MNTR DS REM PHYS/QHP I&R UNI/BI	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92229	PR ORTHOPTIC TRAINING; POINT-OF-CARE AUTONOMOUS ANALYSIS AND REPORT, UNILATERAL OR BILATERAL	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92230	PR FLUORESCEIN ANGIOSCOPY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92235	PR FLUORESCIN ANGRPH W/MULTIFRAME I&R UNI/BI	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92240	PR INDOCYANINE- GREEN ANGRPH W/MULTIFRAME I&R UNI/BI	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92242	PR FLUORESCCEIN ICG ANGRPH W/MULTIFRAME I&R UNI/BI	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92250	PR FUNDAL PHOTOGRAPHY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92260	PR OPHTHALMOSC OPY/DYNAMOM ENTRY	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92274	PR MULTIFOCAL ELECTRORETIN OGRAPHY W/I&R	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92313	PR CONTACT LENS FIT,CORNEOSC LERAL LENS	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX . ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
92502	PR EAR AND THROAT EXAMINATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92504	PR EAR MICROSCOPY EXAMINATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
92507	PR SPEECH/HEARING THERAPY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Therapy-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92507	PR SPEECH/HEARING THERAPY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-TELEHEALTH.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92508	PR SPEECH/HEARING THERAPY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-TELEHEALTH.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92508	PR SPEECH/HEARING THERAPY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/THERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
92517	PR CERVICAL VEMP TESTING W/I&R	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
92518	PR OCULAR VEMP TESTING W/I&R	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92519	PR CERVICAL & OCULAR VEMP TESTING W/I&R	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
92521	PR EVALUATION OF SPEECH FLUENCY (STUTTER CLUTTER)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Therapy-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92521	PR EVALUATION OF SPEECH FLUENCY (STUTTER CLUTTER)	NO AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92522	PR EVALUATION OF SPEECH SOUND PRODUCTION ARTICULATE	NO AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92522	PR EVALUATION OF SPEECH SOUND PRODUCTION ARTICULATE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92523	PR EVAL SPEECH SOUND PRODUCT LANGUAGE COMPREHENSION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92523	PR EVAL SPEECH SOUND PRODUCT LANGUAGE COMPREHENSION	NO AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-TELEHEALTH.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92524	PR BEHAVIORAL & QUALIT ANALYSIS VOICE AND RESONANCE	NO AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92524	PR BEHAVIORAL & QUALIT ANALYSIS VOICE AND RESONANCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92526	PR ORAL FUNCTION THERAPY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92526	PR ORAL FUNCTION THERAPY	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
92531	PR SPONTANEOUS NYSTAGMUS STUDY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
92532	PR POSITIONAL NYSTAGMUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92533	PR CALORIC VESTIBULAR TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
92534	PR OPTOKINETIC NYSTAGMUS TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
92540	PR VSTBLR FUNCJ NYSTAG FOVL&PERPH STIMJ OSCIL TRK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
92541	PR SPONTANEOUS NYSTAGMUS TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
92542	PR POSITIONAL NYSTAGMUS TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
92543	PR CALORIC VESTIBULAR TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
92544	PR OPTOKINETIC NYSTAGMUS TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
92545	PR OSCILLATING TRACKING TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
92546	PR SINUSOIDAL ROTATIONAL TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92550	PR TYMPANOMETRY AND REFLEX THRESHOLD MEASUREMENTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92551	PR PURE TONE SCREEN, AIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92552	PR PURE TONE AUDIOMETRY, AIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92553	PR AUDIOMETRY, AIR & BONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92555	PR SPEECH THRESHOLD AUDIOMETRY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92556	PR SPEECH AUDIOMETRY, COMPLETE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92557	PR COMPREHENSIVE HEARING TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92558	PR EVOKED OTOACOUSTIC EMISSIONS SCREEN AUTO ANALYSIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92562	PR LOUDNESS BALANCE TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92563	PR TONE DECAY HEARING TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92565	PR STENGER TEST, PURE TONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92567	PR TYMPANOMETRY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92568	PR ACOUSTIC REFLEX TESTING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92569	PR ACOUSTIC REFLEX DECAY TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92570	PR ACOUSTIC IMMIT TEST TYMPANOM/Acoustic REFLX/DECAY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92571	PR FILTERED SPEECH HEARING TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92572	PR STAGGERED SPONDAIC WORD TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92573	PR LOMBARD TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92575	PR SENSORINEURAL ACUITY TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92576	PR SYNTHETIC SENTENCE TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92577	PR STENGER TEST, SPEECH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92579	PR VISUAL AUDIOMETRY (VRA)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92582	PR CONDITIONING PLAY AUDIOMETRY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92583	PR SELECT PICTURE AUDIOMETRY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92584	PR ELECTROCOCHLEOGRAPHY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92587	PR DISTORT PRODUCT EVOKED OTOACOUSTIC EMISNS LIMITD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92588	PR DISTRT PROD EVOKD OTOACOUSTIC EMSNS COMP/DX EVAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92590	PR HEARING AID EXAM, ONE EAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92591	PR HEARING AID EXAM, BOTH EARS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92592	PR HEARING AID CHECK, ONE EAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92593	PR HEARING AID CHECK, BOTH EARS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92601	DX ANAL COCHLEAR IMP,PT <7 YRS,W/PROG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
92602	DX ANAL COCHLEAR IMP,PT <7 YRS,REPROG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
92603	PR DX ANAL COCHLEAR IMP,PT >7 YRS,W/PROG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92604	PR DX ANAL COCHLEAR IMP,PT >7 YRS,REPROG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
92610	PR EVAL,ORAL & PHARYNGEAL SWALLOW FUNCTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/The-rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/The-rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/The-rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/TH-ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92610	PR EVAL,ORAL & PHARYNGEAL SWALLOW FUNCTION	NO AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021
92611	PR EVAL,SWALLOW FUNCTION,CINE/VIDEO RECORD	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92612	PR FLEXIBLE ENDOSCOPIC EVAL SWALLOW C/V REC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
92614	PR FLEXIBLE ENDOSCOPIC EVAL LARYN SENSORY C/V REC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
92616	PR FLEXIBLE NDSC EVAL SWLNG&LARYN SENS C/V REC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
92622	ANALYSIS, PROGRAMMING, AND VERIFICATION OF SOUND PROCESSOR FOR BONE-ANCHORED INNER EAR IMPLANT, FIRST HOUR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92623	ANALYSIS, PROGRAMMING, AND VERIFICATION OF SOUND PROCESSOR FOR BONE-ANCHORED INNER EAR IMPLANT, EACH ADDITIONAL 15 MINUTES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PROPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
92650	PR AEP SCR AUDITORY POTENTIAL W/STIMULI AUTO ALYS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92651	PR AEP HEARING STATUS DETER BROADBAND STIMULI I&R	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92652	PR AEP THRESHOLD ESTIMATION MLT FREQUENCIES I&R	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92653	PR AEP NEURODIAGNOSTIC INTERPRETATION AND REPORT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
92920	PR PRQ TRLUML CORONARY ANGIOPLASTY ONE ART/BRANCH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
92928	PR PRQ TRLUML CORONARY STENT W/ANGIO ONE ART/BRNCH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
92986	PR PRQ BALLOON VALVULOPLAS TY AORTIC VALVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
92990	PR PERCUT PULMONARY VALVULOPLAS TY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
92997	PR PUL ART BALLOON ANGIOPLASTY, PERC,1ST VESL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
92998	PR PUL ART BALLOON REPAIR,PERC,A DDN VES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93000	PR ELECTROCARD IOGRAM, COMPLETE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
93005	PR ELECTROCARD IOGRAM, TRACING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
93010	PR ELECTROCARD IOGRAM REPORT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
93012	PR TELEPH TRAN,POST- SYMPTOM ECG STRIPS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93014	PR REPORT ON TRANSMITTED ECG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
93015	PR CV STRS TST XERS&/OR RX CONT ECG W/SI&R	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
93016	PR CV STRS TST XERS&/OR RX CONT ECG W/O I&R	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
93017	PR CARDIAC STRESS TST,TRACING ONLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
93018	PR CARDIAC STRESS TST,INTERP/REPORT ONLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
93024	PR CARDIAC DRUG STRESS TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
93025	PR MICROVOLT T-WAVE ALTERNANS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
93040	PR RHYTHM ECG WITH REPORT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
93041	PR RHYTHM ECG, TRACING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
93042	PR RHYTHM ECG, REPORT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93050	PR ART PRESS WAVEFORM ANALYS CENTRAL ART PRESSURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
93150	THER ACTIVATION IMPL PHRENIC NRV STIMULATOR SYS	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
93150	THER ACTIVATION IMPL PHRENIC NRV STIMULATOR SYS	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93151	EVALUATION AND PROGRAMMING OF IMPLANTED PHRENIC NERVE STIMULATOR SYSTEM	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
93151	EVALUATION AND PROGRAMMING OF IMPLANTED PHRENIC NERVE STIMULATOR SYSTEM	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
93153	EVALUATION OF IMPLANTED PHRENIC NERVE STIMULATOR SYSTEM	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93153	EVALUATION OF IMPLANTED PHRENIC NERVE STIMULATOR SYSTEM	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: G12.20, G12.22, G12.23-G12.25, G12.29, G12.8, G12.9, G47.35, G82.50-G82.54, G83.89, J96.10-J96.12, J96.20-J91.22, R06.81, Z99.11 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
93224	PR XTRNL ECG & 48 HR RECORD SCAN STOR W/R&I	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93225	PR EXT ECG RECORD CONTIN 48 HR, RECORD	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93226	PR EXT ECG RECORD CONTIN 48 HR, SCAN ANALYSIS W REPORT	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93227	PR XTRNL ECG CONTINUOUS RHYTHM W/I&R UP TO 48 HRS	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93228	PR XTRNL MOBILE CV TELEMETRY W/I&REPORT 30 DAYS	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93229	PR XTRNL MOBILE CV TELEMETRY W/TECHNICAL SUPPORT	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93241	PR EXTERNAL ECG REC>48HR<7D SCAN ALYS REPORT R&I	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93242	PR EXTERNAL ECG REC>48HR<7D RECORDING	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93243	PR EXTERNAL ECG REC>48HR<7D SCANNING ALYS W/REPORT	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93244	PR EXTERNAL ECG REC>48HR<7D REVIEW & INTERPRETATION	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93245	PR EXTERNAL ECG REC>7D<15D SCAN ALYS REPORT R&I	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93246	PR EXTERNAL ECG REC>7D<15D RECORDING	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93247	PR EXTERNAL ECG REC>7D<15D SCANNING ALYS W/REPORT	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93248	PR EXTERNAL ECG REC>7D<15D REVIEW & INTERPRETATION	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93268	PR XTRNL PT ACTIV ECG TRANSMIS W/R&I </30 DAYS	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93280	PR PROGRAM EVAL IMPLANTABLE IN PERSN DUAL LD PACER	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93281	PR PROGRAM EVAL IMPLANTABLE IN PRSN MULTI LD PACER	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93282	PR PRGRMNG DEV EVAL IMPLANTABLE IN PERSN 1 LD DFB	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93283	PR PRGRMG EVAL IMPLANTABLE IN PRSN DUAL LEAD DFB	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93284	PR PRGRMG EVAL IMPLANTABLE IN PERSON MULTI LEAD DFB	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93285	PR PRGRMG DEV EVAL SCRMS PHYS/QHP IN PERSON	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93286	PR PERI-PX DEV EVAL PM/LDLS PM PHYS/QHP IN PERSON	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93287	PR PERI-PX DEV EVAL & PROG SING/DUAL/MU LTI LEAD DFB	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93287	PR PERI-PX DEV EVAL & PROG SING/DUAL/MU LTI LEAD DFB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93288	PR INTERROG DEV EVAL PM/LDLS PM PHYS/QHP IN PERSON	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93289	PR INTERROG EVAL F2F 1/DUAL/MLT LEADS IMPLTBL DFB	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93290	PR INTERROG DEV EVAL ICPMS PHYS/QHP IN PERSON	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2022
93296	PR REM INTERROG PM/LDLS PM/IDS <90 D PHYS/QHP	NO AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93303	PR ECHO XTHORACIC,CO NG ANOM,COMPLETE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
93304	PR ECHO XTHORACIC,CO NG ANOM,LIMITED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
93306	PR ECHO HEART XTHORACIC,COMPLETE W DOPPLER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
93307	PR ECHO HEART XTHORACIC,COMPLETE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
93308	PR ECHO HEART XTHORACIC,LIMITED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
93312	PR ECHO TRANSESOPHAG R-T 2D W/PRB IMG ACQUISJ I&R	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
93313	PR ECHO R-T 2D W/PROBE PLACEMENT ONLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
93314	PR ECHO TRANSESOPHAG R-T 2D IMG ACQUISJ I&R ONLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
93315	PR ECHO TRANSESOPHAG CONGEN PROBE PLCMT IMGNG I&R	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93316	PR ECHO TRANSESOPHA G CONGEN PROBE PLCMT ONLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
93317	PR ECHO TRANSESOPHA G IMAGE ACQUISJ INTERP&REPO RT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
93318	PR ECHO TRANSESOPHA G MONTR CARDIAC PUMP FUNCTJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
93319	PR 3D ECHO IMG&PST- PXESSING TEE/TTE CGEN CAR ANOMAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
93320	PR DOPPLER ECHO HEART,COMPL ETE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
93321	PR DOPPLER ECHO HEART,LIMITED ,F/U	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
93325	PR DOPPLER COLOR FLOW VELOCITY MAP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
93325	PR DOPPLER COLOR FLOW VELOCITY MAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93350	PR ECHO HEART, FULL STRESS/REST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
93351	PR ECHO TTHRC R-T 2D W/WO M-MODE REST&STRS CONT ECG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
93352	PR ECHO CONTRAST AGENT DURING STRESS ECHO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
93355	PR ECHO TEE GUID TCAT ICAR/VESSEL STRUCTURAL INTVN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
93451	PR RIGHT HEART CATH O2 SATURATION & CARDIAC OUTPUT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93452	PR L HRT CATH W/NJX L VENTRICULOG RAPHY IMG S&I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93454	PR CATH PLACEMENT & NJX CORONARY ART ANGIO IMG S&I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93455	PR CATH PLMT & NJX CORONARY ART/GRFT ANGIO IMG S&I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93458	PR CATH PLMT L HRT & ARTS W/NJX & ANGIO IMG S&I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93460	PR R & L HRT CATH WINJX HRT ART& L VENTR IMG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93463	PR MEDICATION ADMIN & HEMODYNAMIC MEASUREMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93503	PR INSERT/PLACE FLOW DIRECT CATH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93505	PR ENDOMYOCAR DIAL BIOPSY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93563	PR NJX SEL HRT ART CONGENITAL HRT CATH W/S&I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93564	PR NJX SEL HRT ART/GRFT CONGENITAL HRT CATH W/S&I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93565	PR NJX SEL L VENT/ATRIAL ANGIO HRT CATH W/S&I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93565	PR NJX SEL L VENT/ATRIAL ANGIO HRT CATH W/S&I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93566	PR NJX SEL R VENT/ATRIAL ANGIO HRT CATH W/S&I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93567	PR NJX SUPRAVALV AORTOG HRT CATH W/S&I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93568	PR NJX PULMONARY ANGIO HRT CATH W/S&I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93569	PR INJ DURING CARDIAC CATH PULMONARY ARTERIAL ANGIO, UNILATERAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93573	PR INJ DURING CARDIAC CATH PULMONARY ARTERIAL ANGIO BIL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93580	PR PERC CLOS, CONG INTERATRIAL COMMUN W/IMPL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93582	PR PERCUTAN TRANSCATH CLOSURE PAT DUCT ARTERIOSUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93593	PR R HRT CATH CHD W/IMG CATH TRGT ZONE NML NT CONNJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93594	PR R HRT CATH CHD W/IMG CATH TRGT ZON ABNL NT CONNJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93595	PR L HRT CATH CHD IMG CATH TRGT ZON NML/ABNL NT CNJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93596	PR R&L HRT CATH CHD IMG CATH TRGT ZONE NML NT CONNJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93597	PR R&L HRT CATH CHD IMG CATH TRGT ZON ABNL NT CONNJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93598	PR CAR OUTP MEAS DRG CAR CATH EVAL CGEN HRT DEFECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93613	PR INTRACARDIAC ELECTROPHYSI OLOGIC 3D MAPPING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93621	PR COMPRE ELECTROPHYSI OL XM W/LEFT ATRIAL PACNG/REC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93622	PR COMPRE ELECTROPHYSI OL XM W/LEFT VENTR PACNG/REC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93623	PR STIM/PACING HEART POST IV DRUG INFU	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93653	PR COMPRE EP EVAL ABLTJ 3D MAPG TX SVT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93655	PR ICAR CATHETER ABLATION ARRHYTHMIA ADD ON	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93656	PR COMPRE EP EVAL ABLTJ ATR FIB PULM VEIN ISOLATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
93880	PR DUPLEX SCAN EXTRACRANIAL ,BILAT	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93882	PR DUPLEX SCAN EXTRACRANIAL ,LIMITED	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
93886	PR TRANSCRAN DOPPLER INTRACRAN ART	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93888	PR TRANSCRAN DOPPLER INTRACRAN,LI MITED	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
93890	PR TRANSCRAN DOPPL INTRACRAN, VASOREACT	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93892	PR TRANSCRAN DOPP INTRACRAN, EMBOLI W/O INJ	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
93893	PR TRANSCRAN DOPP INTRACRAN, EMBOLI W/INJ	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
93895	PR CAROTID INTIMA MEDIA & CAROTID ATHEROMA EVAL BI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	5/10/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93922	PR NON-INVASIVE PHYSIOLOGIC STD EXTREMITY ART 1-2 LEVEL	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
93923	PR NON-INVASIVE PHYSIOLOGIC STUDY EXTREMITY 3 LEVELS	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93924	PR NON-INVASIVE LOWER EXTREM ART STRESS/REST, COMPLETE,BILATERAL	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
93925	PR DUPLEX LO EXTREM ART BILAT	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93926	PR DUPLEX LO EXTREM ART UNILAT/LTD	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
93930	PR DUPLEX UP EXTREM ART BILAT	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93931	PR DUPLEX UP EXTREM ART UNILAT/LTD	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
93970	PR DUPLEX EXTREM VENOUS,BILAT	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93971	PR DUPLEX EXTREM VENOUS,UNI OR LTD	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
93975	PR DUPLEX ABD/PEL VASC STUDY,COMPL ETE	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93976	PR DUPLEX ABD/PEL VASC STUDY,LIMITD	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
93978	PR DUPLEX LARGE VESSEL (S),COMPLETE	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93979	PR DUPLEX LARGE VESSEL (S),LIMITED	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
93980	PR PENILE VASCULAR STUDY,COMPL ETE	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93981	PR PENILE VASCULAR STUDY,LTD OR F/U	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
93985	PR DUPLEX SCAN ARTL INFL&VEN O/F HEMO COMPL BI STD	NO AUTHORIZATION REQUIRED	EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
93986	PR DUPLEX SCAN ARTL INFL&VEN O/F HEMO COMPL UNI STD	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
93990	PR DUPLEX HEMODIALYSIS ACCESS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
93998	PR UNLISTED NONINVASIVE VASCULAR DIAGNOSTIC STUDY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
94010	PR BREATHING CAPACITY TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94011	PR MEAS SPIROMTRC FORCD EXPIRATORY FLO INFANT&/2 Y	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94012	PR MEAS SPIRO FRCD EXP FLO PRE&POST BRONCH INF/2YRS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94013	PR MEASUREMENT LUNG VOLUMES INFANT/CHILD/2 YRS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94014	PR PT-INITIATE SPIROMETRIC RECORDING PHYS/QHP R&I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94015	PR PT RECORDED SPIROMETRY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94016	PR PATIENT-INITIATED SPIROMETRIC PHYS/QHP R&I ONLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94060	PR EVAL OF BRONCHOSPASM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
94070	PR EVAL OF BRONCHOSPASM, PROLONGED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94150	PR VITAL CAPACITY TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94200	PR LUNG FUNCTION TEST (MBC/MVV)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94375	PR RESPIRATORY FLOW VOLUME LOOP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94450	PR HYPOXIA RESPONSE CURVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94452	PR HIGH ALTITUDE SIMULATJ TEST W/PHYS INTERP&REPORT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94453	PR HIGH ALTITUDE SIMULATJ W/PHYS I&R W/O2 TITRATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94610	PR INTRAPULMONARY SURFACTANT ADMINISTJ PHYS/QHP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
94617	PR XERS TST BRNCSPSM PRE&POST SPMTRY&PLS OX W/ECG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94618	PR PULMONARY STRESS TESTING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94619	PR XERS TST BRNCSPSM PRE&POST SPMTRY&PLS OX WO /ECG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94620	PR PULMONARY STRESS TESTING SIMPLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94621	PR CARDIOPULMO NARY EXERCISE TESTING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94625	PR PHYS/QHP SVCS OP PULM REHAB WO CONT OXIMTRY MNTR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94626	PR PHYS/QHP SVCS OP PULM REHAB W/CONT OXIMTRY MNTR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94640	PR PRESSURIZED/ NONPRESSURI ZED INHALATION TREATMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
94642	PR AEROSOL INHALATION TREATMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94644	PR CONTINUOUS INHALATION TX, 1ST HR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94645	PR CONTINUOUS INHALATION TX, EACH ADD HR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94656	PR INITIAL VENTILATOR MGMT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94657	PR CONT. VENTILATOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94660	PR POS AIRWAY PRESSURE, CPAP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94662	PR NEG PRESSURE VENTILATION, CNP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94664	PR DEMO &/OR EVAL,PT USE,AEROSOL DEVICE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94667	PR CHEST WALL MANIPULATION ,INITIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94668	PR CHEST WALL MANIPULATION ,SUBSEQUENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
94669	PR MECHANICAL CHEST WALL OSCILLATION LUNG FUNCTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94680	PR EXHALED AIR ANALYSIS: O2	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94681	PR EXHALED AIR ANALYSIS: O2, CO2	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94690	PR EXHALED AIR ANALYSIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94720	PR CARBON MONOXIDE DIFFUSING CAPACITY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94725	PR MEMBRANE DIFFUSION CAPACITY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94726	PR PLETHYSMOGRAPHY LUNG VOLUMES W/WO AIRWAY RESIST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94727	PR GAS DILUT/WASHOUT LUNG VOL W/WO DISTRIB VENT&VOL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94728	PR AIRWAY RESISTANCE BY OSCILLOMETRY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
94729	PR DIFFUSING CAPACITY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94760	PR NONINVASV OXYGEN SATUR;SINGLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94761	PR NONINVASV OXYGEN SATUR,MULTIPLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94762	PR NONINVASV OXYGEN SATUT,CONTINUOUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94772	BREATH RECORDING, INFANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
94774	PR PEDIATRIC APNEA MONITOR ATTACHMENT PHYS I&R	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
95004	PR PERCUTANEOUS TESTS W/ALLERGENIC EXTRACTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95010	PR PERCUT SKIN TESTS,DRUGS, BIOL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95012	PR NITRIC OXIDE EXPIRED GAS DETERMINATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95015	PR INTRACUTANEOUS TESTS, DRUGS, BIOL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95017	PR ALLG TSTG PERQ & IC VENOMS IMMEDIATE REACT W/ I&R	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95018	PR ALLG TEST PERQ & IC DRUG/BIOLOGICAL IMMEDIATE REACT W/ I&R	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95024	PR INTRACUTANEOUS TESTS W/ALLERGENIC EXTRACTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95027	PR INTRACUTANEOUS TESTS W/ALLERGENIC XTRACTS AIRBORNE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95028	PR ALLERGY SKIN TESTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95044	PR ALLERGY PATCH TESTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95052	PR PHOTO PATCH TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95056	PR PHOTSENSITIVITY TESTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95060	PR EYE ALLERGY TESTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95065	PR NOSE ALLERGY TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95070	PR INHLJ BRNCL CHALLENGE TSTG W/HISTAM/MET HACHOL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95076	PR INGESTION CHALLENGE TEST INITIAL 120 MINUTES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95079	PR INGESTION CHALLENGE TEST EACH ADDL 60 MINUTES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95115	PR IMMUNOTHERAPY, ONE INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95117	PR IMMUNOTHERAPY, 2+ INJECTIONS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95120	PR PROF SVCS ALLG IMMNTX W/PRV ALLGIC XTRC 1 NJX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95125	PR PROF SVCS ALLG IMMNTX W/PRV ALLGIC XTRC 2/> NJX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95130	PR PROF SVCS ALLG IMMNTX W/PRV XTRC 1 STING INSECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95131	PR PROF SVCS ALLG IMMNTX W/PRV XTRC 2 STING INSECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95132	PR PROF SVCS ALLG IMMNTX W/PRV XTRC 3 STING INSECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95133	PR PROF SVCS ALLG IMMNTX W/PRV XTRC 4 STING INSECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95134	PR PROF SVCS ALLG IMMNTX W/PRV XTRC 5 STING INSECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95144	PR PROFES SVC,IMMUNOT HERAPY,1 DOSE VIALS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95145	PR PROFES SVC,IMMUNOT HERAPY,1 INSECT VENOM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95146	PR ANTIGEN RX SERV,INSECT,2 VENOMS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95147	PR ANTIGEN RX SERV,INSECT,3 VENOMS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95148	PR ANTIGEN RX SERV,INSECT,4 VENOMS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95149	PR ANTIGEN RX SERV,INSECT,5 VENOMS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95165	PR PROFES SVC,IMMUNOT HER,SINGLE/M ULT AGS	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED FOR 1-160/YEAR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95170	PR ANTIGEN RX SERV,WHOLE EXTRACT INSECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95180	PR RAPID DESENSITIZATI ON PROC,EACH HOUR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95199	PR ALLERGY IMMUNOLOGY SERV,UNLISTE D	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
95250	PR CONT GLUC MNTR PHYSICIAN/QH P PROVIDED EQUIPMENT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95251	PR CONTINUOUS GLUCOSE MONITORING ANALYSIS I&R	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
95700	PR EEG CONT REC W/VIDEO BY TECH MIN 8 CHANNELS	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM, INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS. HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95700	PR EEG CONT REC W/VIDEO BY TECH MIN 8 CHANNELS	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
		DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2					

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95705	PR EEG W/O VIDEO BY TECH 2-12 HR UNMONITORED	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
		DIAGOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2					

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95705	PR EEG W/O VIDEO BY TECH 2-12 HR UNMONITORED	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95706	PR EEG W/O VIDEO BY TECH 2-12 HR INTERMITTENT MNTR	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95706	PR EEG W/O VIDEO BY TECH 2-12 HR INTERMITTENT MNTR	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
		DIAGOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2					

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95707	PR EEG W/O VIDEO BY TECH 2-12HR CONTINUOUS R-T MNTR	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
		DIAGOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2					

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95707	PR EEG W/O VIDEO BY TECH 2-12HR CONTINUOUS R-T MNTR	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95708	PR EEG W/O VID BY TECH EA INCR 12-26HR UNMONITORED	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95708	PR EEG W/O VID BY TECH EA INCR 12-26HR UNMONITORED	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
		DIAGOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2					

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95709	PR EEG W/O VID BY TECH EA INCR 12-26 HR INTMT MNTR	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
		DIAGOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2					

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95709	PR EEG W/O VID BY TECH EA INCR 12-26 HR INTMT MNTR	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95710	PR EEG W/O VID TECH EA INCR 12-26 HR CONT R-T MNTR	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95710	PR EEG W/O VID TECH EA INCR 12-26 HR CONT R-T MNTR	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS DIAGOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95711	PR VEEG BY TECH 2-12 HOURS UNMONITORED	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
		DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2					

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95711	PR VEEG BY TECH 2-12 HOURS UNMONITORED	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95712	PR VEEG BY TECH 2-12 HR INTERMITTENT MONITORING	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95712	PR VEEG BY TECH 2-12 HR INTERMITTENT MONITORING	<p>NO AUTHORIZATION REQUIRED</p> <p>LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95713	PR VEEG BY TECH 2-12 HR CONTINUOUS R-T MONITORING	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
		DIAGOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2					

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95713	PR VEEG BY TECH 2-12 HR CONTINUOUS R-T MONITORING	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95714	PR VEEG BY TECH EA INCR 12-26 HR UNMONITORED	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95714	PR VEEG BY TECH EA INCR 12-26 HR UNMONITORED	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
		DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2					

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95715	PR VEEG BY TECH EA INCR 12-26 HR INTERMITTENT MNTR	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
		DIAGOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2					

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95715	PR VEEG BY TECH EA INCR 12-26 HR INTERMITTENT MNTR	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95716	PR VEEG BY TECH EA INCR 12-26 HR CONT R-T MNTR	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95716	PR VEEG BY TECH EA INCR 12-26 HR CONT R-T MNTR	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
		DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2					

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95717	PR EEG PHYS/QHP 2-12 HR WITHOUT VIDEO	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
		DIAGOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2					

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95717	PR EEG PHYS/QHP 2-12 HR WITHOUT VIDEO	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95718	PR EEG PHYS/QHP 2-12 HR WITH VEEG	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95718	PR EEG PHYS/QHP 2-12 HR WITH VEEG	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
		DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2					

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95719	PR EEG PHYS/QHP EA INCR>12HR<26 HR AFTER 24HR WO VID	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS DIAGOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95719	PR EEG PHYS/QHP EA INCR>12HR<26 HR AFTER 24HR WO VID	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95720	PR EEG PHYS/QHP EA INCR>12HR<26 HR AFTER 24HR W/VEEG	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95720	PR EEG PHYS/QHP EA INCR>12HR<26 HR AFTER 24HR W/VEEG	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS DIAGOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95721	PR EEG COMPLETE STD PHYS/QHP>36 HR<60 HR W/O VIDEO	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95721	PR EEG COMPLETE STD PHYS/QHP>36 HR<60 HR W/O VIDEO	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95722	PR EEG COMPLETE STD PHYS/QHP>36 HR<60 HR W/VEEG	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95722	PR EEG COMPLETE STD PHYS/QHP>36 HR<60 HR W/VEEG	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95723	PR EEG COMPLETE STD PHYS/QHP>60 HR<84 HR W/O VIDEO	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95723	PR EEG COMPLETE STD PHYS/QHP>60 HR<84 HR W/O VIDEO	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95724	PR EEG COMPLETE STD PHYS/QHP>60 HR<84 HR W/VEEG	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95724	PR EEG COMPLETE STD PHYS/QHP>60 HR<84 HR W/VEEG	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95725	PR EEG COMPLETE STD PHYS/QHP>84 HR W/O VID	NO AUTHORIZATION REQUIRED	LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95725	PR EEG COMPLETE STD PHYS/QHP>84 HR W/O VID	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95726	PR EEG COMPLETE STD PHYS/QHP>84 HR W/VEEG	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 3 SERVICES WITHIN 6 MONTHS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM, INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95726	PR EEG COMPLETE STD PHYS/QHP>84 HR W/VEEG	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED FOR UP TO 3 SERVICES WITHIN 6 MONTHS DIAGNOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: F05, F06.0, F06.8, G25.3, G31.01, G31.09, G31.83, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801-G40.804, G40.811-G40.814, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G40.C01, G40.C09, G40.C11, G40.C19, G91.2, O99.351-O99.355, P90, P91.2, R41.0, R41.82, R56.01, R56.1, R56.9, S06.0X1A, S06.0X1D, S06.0X1S, Z05.2		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
95782	PR POLYSOM <6 YRS SLEEP STAGE 4/> ADDL PARAM ATTND	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Pediatric Sleep Study): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Pediatric-Sleep-Study.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95783	PR POLYSOM <6 YRS SLEEP W/CPAP/BILVL VENT 4/> PARAM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Pediatric Sleep Study): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Pediatric-Sleep-Study.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
95800	PR SLEEP STUDY, UNATTENDED, RECORD HEART RATE/O2 SAT/RESP ANAL/SLEEP TIME	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
95801	PR SLEEP STUDY, UNATTENDED, RECORD HEART RATE/O2 SAT/RESP ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
95803	PR ACTIGRAPHY TESTING, 3-14 DAY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95805	PR MULTIPLE SLEEP LATENCY TEST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
95806	PR SLEEP STUDY, UNATTENDED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/6/2016
95807	PR SLEEP STUDY, ATTENDED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
95808	PR POLYSOM ANY AGE SLEEP STAGE 1 -3 ADDL PARAM ATTND	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Pediatric Sleep Study): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Pediatric-Sleep-Study.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95810	PR POLYSOM 6/>YRS SLEEP 4/> ADDL PARAM ATTND	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Pediatric Sleep Study): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Pediatric-Sleep-Study.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
95811	PR POLYSOM 6/>YRS SLEEP W/CPAP 4/> ADDL PARAM ATTND	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Pediatric Sleep Study): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Pediatric-Sleep-Study.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
95812	PR EEG, EXTENDED MONITORING, 4 1-60 MINUTES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
95813	PR EEG EXTENDED MONITORING 61-119 MINUTES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
95816	PR EEG, W/AWAKE & DROWSY RECORD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95819	PR EEG,W/AWAKE & ASLEEP RECORD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
95822	PR EEG,COMA/SLEEP RECORD ONLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
95824	PR EEG EVAL CEREBRAL DEATH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
95827	PR EEG,ALL NIGHT RECORD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
95829	PR SURGERY ELECTROCORTICOGRAM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
95830	PR INSERTION SPHENOIDAL ELECTRODES EEG PHYS/QHP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
95860	PR EMG, NEEDLE, ONE LIMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95861	PR EMG, NEEDLE, TWO LIMBS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95863	PR EMG, NEEDLE, 3 LIMBS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95864	PR EMG, NEEDLE, 4 LIMBS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95865	PR EMG, NEEDLE, LARYNX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95866	PR EMG, NEEDLE, HEMIDIAPHRAGM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95867	PR EMG, NEEDLE, CRANIAL NERVE SUPP MUS, UNILAT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95868	PR EMG, NEEDLE, HEAD OR NECK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95869	PR EMG, NEEDLE, THOR PARASPIN MUS, EXC T1/T12	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95870	PR EMG, 1 EXTREM, NONPARASPINAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95872	PR EMG, NEEDLE, ONE FIBER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95873	PR ELECTRIC STIM GUIDANCE FOR CHEMOTHERAPY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95874	PR NEEDLE EMG GUIDANCE FOR CHEMOTHERAPY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95875	PR ISCHEM LIMB EXERCIS,MUSCLE METABOLITE(S)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95885	PR NEEDLE EMG EA EXTREMITY W/PARASPINL AREA LIMITED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95886	PR NEEDLE EMG EA EXTREMTY W/PARASPINL AREA COMPLETE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95887	PR NEEDLE EMG NONEXTREMTY MSCLES W/NERVE CONDUCTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95900	PR NERVE CONDUCTION TEST,MOTOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95903	PR MOTOR NERVE CONDUCT TEST, W F-WAVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95904	PR NERVE CONDUCTION,E A NERVE,MOTOR, SENSORY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95905	PR MOTOR &SENS NRV CNDJ PRECONF ELTRD ARRAY LIMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95907	PR MOTOR &/SENS 1-2 NRV CNDJ PRECONF ELTRODE LIMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95908	PR MOTOR &/SENS 3-4 NRV CNDJ PRECONF ELTRODE LIMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95909	PR MOTOR &/SENS 5-6 NRV CNDJ PRECONF ELTRODE LIMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95910	PR MOTOR &/SENS 7-8 NRV CNDJ PRECONF ELTRODE LIMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95911	PR MOTOR &/SENS 9-10 NRV CNDJ PRECONF ELTRODE LIMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95912	PR MOTOR &/SENS 11-12 NRV CNDJ PRECONF ELTRODE LIMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95913	PR MOTOR &/SENS 13/> NRV CNDJ PRECONF ELTRODE LIMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95919	PR QUANTITATIVE PUPILLOMETRY WITH PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95920	PR INTRAOPERATIVE NERVE TESTING ADD-ON	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2021
95928	PR C MOTOR EVOKED, UPPR LIMBS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
95929	PR C MOTOR EVOKED, LWR LIMBS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
95930	PR VISUAL EP TESTING CNS EXCEPT GLAUCOMA W/I&R	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95930	PR VISUAL EP TESTING CNS EXCEPT GLAUCOMA W/I&R	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
95933	PR BLINK REFLEX TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95934	PR H REFLEX TEST,GASTROC /SOLEUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
95936	PR H REFLEX TEST,OTHR MUSC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
95937	PR NEUROMUSCULAR JUNCTION TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
95938	PR SHORT-LATENCY SOMATOSENS EP STD UPR & LOW LIMBS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
95939	PR CTR MOTR EP STD TRANSCRNL MOTR STIM UPR&LOW LIMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
95940	PR IONM 1 ON 1 IN OR W/ATTENDANCE EACH 15 MINUTES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
95941	PR IONM REMOTE/NEAR BY/>1 PATIENT IN OR PER HOUR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
95954	PR RX/PHYSICAL EEG ACTIVAJ PHYS/QHP ATTENDANCE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
95955	PR EEG DURING SURGERY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
95956	PR EEG MONITORING/C OMPUTER, EA 24 HOURS, ATTENDED BY TECH/NURSE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
95957	PR EEG DIGITAL ANALYSIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
95958	PR EEG MONITORING/F UNCTION TEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
95961	PR FUNCJAL CORT&SUBCOR T MAPG PHYS/QHP ATTND INIT HR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
95962	PR FUNCJAL CORT&SUBCOR T MAPG PHYS/QHP ATTND ADDL HR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
95965	PR MEG, SPONTAN EOUS BRAIN MAGNETIC ACTIVITY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
95966	PR MEG, EVOKED MAGNET FIELDS, SINGLE MODAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022
95967	PR MEG, EVOKED MAGNET FIELDS, EA ADDL MODAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
96040	PR GENETIC COUNSELING, EACH 30 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96105	PR ASSESSMENT OF APHASIA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2021
96110	PR DEVELOPMENTAL SCREEN W/SCORING & DOC STD INSTRM	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO 1 SERVICE PER ROLLING YEAR.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96110	PR DEVELOPMENTAL SCREEN W/SCORING & DOC STD INSTRM	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF MORE THAN 1 SERVICE PER ROLLING YEAR. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96112	PR DEVELOPMENTAL TST ADMIN PHYS/QHP 1ST HOUR	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO 2 SERVICES PER ROLLING YEAR.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96112	PR DEVELOPMENTAL TST ADMIN PHYS/QHP 1ST HOUR	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF MORE THAN 2 SERVICES PER ROLLING YEAR.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
96113	PR DEVELOPMENT AL TST ADMIN PHYS/QHP EA ADDL 30 MIN	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF MORE THAN 2 SERVICES PER ROLLING YEAR.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96113	PR DEVELOPMENT AL TST ADMIN PHYS/QHP EA ADDL 30 MIN	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO 2 SERVICES PER ROLLING YEAR.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96116	PR NEUROBEHAVI ORAL STATUS XM PHYS/QHP 1ST HOUR	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED IF LESS THAN 2		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96116	PR NEUROBEHAVI ORAL STATUS XM PHYS/QHP 1ST HOUR	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 1 EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96121	PR NEUROBEHAVI ORAL STATUS XM PHYS/QHP EA ADDL HOUR	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED IF LESS THAN 8		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
96121	PR NEUROBEHAVIORAL STATUS XM PHYS/QHP EA ADDL HOUR	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 7 EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96127	PR BEHAV ASSMT W/SCORE & DOCD/STAND INSTRUMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96130	PR PSYCHOLOGICAL TST EVAL SVC PHYS/QHP FIRST HOUR	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED IF 1 HOUR OR LESS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96130	PR PSYCHOLOGICAL TST EVAL SVC PHYS/QHP FIRST HOUR	AUTHORIZATION REQUIRED ALERT: AUTH IS REQUIRED IF OVER 1 HOUR. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96131	PR PSYCHOLOGICAL TST EVAL SVC PHYS/QHP EA ADDL HOUR	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED IF 7 HOURS OR LESS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
96131	PR PSYCHOLOGICAL TST EVAL SVC PHYS/QHP EA ADDL HOUR	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER 7 HOURS. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96132	PR NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP 1ST HOUR	AUTHORIZATION REQUIRED ALERT: AUTH IS REQUIRED IF OVER 1 HOUR. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96132	PR NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP 1ST HOUR	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED IF 1 HOUR OR LESS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96133	PR NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP EA ADDL HR	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED IF 7 HOURS OR LESS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
96133	PR NEUROPSYCH OLOGICAL TST EVAL PHYS/QHP EA ADDL HR	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER 7 HOURS. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96136	PR PSYL/NRPSYCL TST PHYS/QHP 2+ TST 1ST 30 MIN	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER 7 HOURS. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96136	PR PSYL/NRPSYCL TST PHYS/QHP 2+ TST 1ST 30 MIN	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED IF 7 HOURS OR LESS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96137	PR PSYCL/NRPSYC L TST PHYS/QHP 2+ TST EA ADDL 30 MIN	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED IF 7 HOURS OR LESS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
96137	PR PSYCL/NRPSYCL TST PHYS/QHP 2+ TST EA ADDL 30 MIN	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER 7 HOURS. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96156	PR HEALTH BEHAVIOR ASSESSMENT/ RE-ASSESSMENT	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
96156	PR HEALTH BEHAVIOR ASSESSMENT/ RE-ASSESSMENT	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
96158	PR HEALTH BEHAVIOR IVNTJ INDIV F2F 1ST 30 MIN	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
96158	PR HEALTH BEHAVIOR IVNTJ INDIV F2F 1ST 30 MIN	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
96159	PR HEALTH BEHAVIOR IVNTJ INDIV F2F EA ADDL 15 MIN	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
96159	PR HEALTH BEHAVIOR IVNTJ INDIV F2F EA ADDL 15 MIN	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
96164	PR HEALTH BEHAVIOR IVNTJ GROUP F2F 1ST 30 MIN	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
96164	PR HEALTH BEHAVIOR IVNTJ GROUP F2F 1ST 30 MIN	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
96165	PR HEALTH BEHAVIOR IVNTJ GROUP F2F EA ADDL 15 MIN	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
96165	PR HEALTH BEHAVIOR IVNTJ GROUP F2F EA ADDL 15 MIN	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
96167	PR HEALTH BEHAVIOR IVNTJ FAM W/PT F2F 1ST 30 MIN	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
96167	PR HEALTH BEHAVIOR IVNTJ FAM W/PT F2F 1ST 30 MIN	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
96168	PR HEALTH BEHAVIOR IVNTJ FAM W/PT F2F EA ADD 15 MIN	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
96168	PR HEALTH BEHAVIOR IVNTJ FAM W/PT F2F EA ADD 15 MIN	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
96170	PR HEALTH BEHAVIOR IVNTJ FAM W/O PT F2F 1ST 30 MIN	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
96170	PR HEALTH BEHAVIOR IVNTJ FAM W/O PT F2F 1ST 30 MIN	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
96171	PR HEALTH BEHAVIOR IVNTJ FAM W/O PT F2F EA ADDL 15	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
96171	PR HEALTH BEHAVIOR IVNTJ FAM W/O PT F2F EA ADDL 15	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED UP TO BENEFIT LIMITS; REFER TO TMPPM FOR ADDITIONAL INFORMATION AND BENEFIT LIMITS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2022
96360	PR IV INFUSION, HYDRATION, 31 -60 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2021
96361	PR IV INFUSION, HYDRATION, EA ADD HOUR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2021
96365	PR IV INFUSION, THERAP/PROP H/DIAGNOST,IN ITIAL,1ST HOUR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
96366	PR IV INFUSION, THERAP/PROPH/DIAGNOST, INITIAL, EA ADD HOUR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2021
96367	PR IV INFUSION THER PROPH ADDL SEQUENTIAL TO 1 HR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2021
96368	PR IV INFUSION, THERAP/PROPH/DIAGNOST, CONCURRENT INFUSION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2021
96369	PR SUBCUT INFUSION, THERAP/PROPH/DIAGNOST, INITIAL, 1ST HOUR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2021
96370	PR SUBCUT INFUSION, THERAP/PROPH/DIAGNOST, EA ADD HOUR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2021
96371	PR SUBCUT INFUSION, THERAP/PROPH/DIAGNOST, ADD PUMP SET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2021
96372	PR INJECTION, THERAP/PROPH/DIAGNOST, IM OR SUBCUT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		5/10/2021
96373	PR INJECTION, THERAP/PROPH/DIAGNOST, INTRA-ARTERIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
96374	PR INJECTION,THE RAP/PROPH/DI AGNOST, IV PUSH, INITIAL DRUG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2021
96375	PR INJECTION,THE RAP/PROPH/DI AGNOST, IV PUSH, EA ADD, NEW DRUG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2021
96376	PR INJECTION,THE RAP/PROPH/DI AGNOST, IV PUSH, EA ADD, SAME DRUG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2021
96377	PR APPL ON-BODY INJECTOR FOR TIMED SUBQ INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2021
96379	PR INJECTION,THE RAP/PROPH/DI AGNOST, IV OR INTRA-ARTERIAL, NOS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
96380	ADMINISTRATI ON OF RESPIRATORY SYNCYTIAL VIRUS, MONOCLONAL ANTIBODY, SEASONAL DOSE BY INTRAMUSCUL AR INJECTION, WITH COUNSELING BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONA L	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
96381	ADMINISTRATI ON OF RESPIRATORY SYNCYTIAL VIRUS, MONOCLONAL ANTIBODY, SEASONAL DOSE BY INTRAMUSCUL AR INJECTION	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
96401	PR CHEMOTHER,N ON-HORMONE ANTI-NEOPL, SUB-Q/IM	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
96402	PR CHEMOTHER HORMON ANTINEOPL SUB-Q/IM	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96405	PR INTRALESIONA L CHEMO ADMIN,<8 LESN	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96406	PR INTRALESIONA L CHEMO ADMIN,8+ LESN	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96408	PR CHEMOTHER,IV PUSH TECHNIQUE	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96409	PR CHEMOTHER, IV PUSH, SNGL DRUG	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
96410	PR CHEMOTHER,IV INFUSN TECH,<1 HR	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96411	PR CHEMOTHER, IV PUSH,EA ADD DRUG	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96412	PR CHEMOTHER,IV INFUSN TECH,EA HR,1-8HR	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96413	PR CHEMOTHER, IV INFUSION, 1 HR	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96414	PR CHEMOTHER,IV INFUSN TECH,>8 HR	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
96415	PR CHEMOTHER, IV INFUSION, EA HR	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96416	PR CHEMOTHER PROLONG INFUSE W/PUMP	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96417	PR CHEMOTHER, IV INFUSE, EACH SEQU INFUS	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96420	PR CHEMOTHER,IA PUSH TECHNIQUE	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96422	PR CHEMOTHER,IA INFUSN TECH,<1 HR	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
96423	PR CHEMOTHER, IA INFUSION, EA HR	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96425	PR CHEMOTHER,IA INFUSN TECH,>8 HR	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96440	PR CHEMOTHER,IN TRACAVITARY, PLEURAL	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96445	PR CHEMOTHER,IN TRACAVITARY, PERITONEAL	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96446	PR ADMINISTRATI ON OF CHEMOTHERAP Y INTO ABDOMINAL CAVITY	NO AUTHORIZATION REQUIRED	PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
96450	PR CHEMOTHER, CNS,W/LUMBAR PUNCTURE	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96520	PR PUMP PORT REFILL,MAINTENANCE	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96521	PR REFILL/MAINT, PORTABLE PUMP	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96522	PR REFILL/MAINT SYSTEMIC PUMP/RESVR	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96523	PR IRRIG IMPLANTED DRUG DELIVERY DEVICE	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
96530	PR REF/MAINT,IMP LAN PUMP/RES DRUG DEL,SYS	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96542	PR CHEMOTHER INJECT,SUBAR ACH/INTRAIVEN T	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96545	PR PROVIDE CHEMOTHERAP Y AGENT	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96547	INTRAOPERATI VE HEATED INTRAPERITON EAL CHEMOTHERAP Y, FIRST 60 MINUTES	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96548	INTRAOPERATI VE HEATED INTRAPERITON EAL CHEMOTHERAP Y, EACH ADDITIONAL 30 MINUTES	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
96549	PR CHEMOTHERAPY, UNSPECIFIED PROCEDURE	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
96999	PR DERMATOLOGICAL PROCEDURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
97010	PR HOT OR COLD PACKS THERAPY	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97010	PR HOT OR COLD PACKS THERAPY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97012	PR MECHANICAL TRACTION THERAPY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97012	PR MECHANICAL TRACTION THERAPY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97014	PR ELECTRIC STIMULATION THERAPY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (CARPAL TUNNEL SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/CA RPAL-TUNNEL-SYNDROME.PDF</p> <p>MD GUIDELINE 2 (LUMBAGO OF PREGNANCY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/LU MBAGO-OF-PREGNANCY.PDF</p> <p>MD GUIDELINE 3 (PATELLOFEMORAL PAIN SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PAT ELOFEMORAL-PAIN-SYNDROME.PDF</p> <p>MD GUIDELINE 4 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 5 (THERAPY REFERRAL REVIEW BY ORDERING PHYSICIAN ATTESTATION FORM.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-REFERRAL-REVIEW-BY-ORDERING-PHYSICIAN-ATTESTATION-FORM.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97014	PR ELECTRIC STIMULATION THERAPY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (CARPAL TUNNEL SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/CA-RPAL-TUNNEL-SYNDROME.PDF MD GUIDELINE 2 (LUMBAGO OF PREGNANCY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/LU-MBAGO-OF-PREGNANCY.PDF MD GUIDELINE 3 (PATELLOFEMORAL PAIN SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PATELLOFEMORAL-PAIN-SYNDROME.PDF MD GUIDELINE 4 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 5 (THERAPY REFERRAL REVIEW BY ORDERING PHYSICIAN ATTESTATION FORM.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/THERAPY-REFERRAL-REVIEW-BY-ORDERING-PHYSICIAN-ATTESTATION-FORM.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97016	PR VASOPNEUMATIC DEVICE THERAPY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97016	PR VASOPNEUMATIC DEVICE THERAPY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97018	PR PARAFFIN BATH THERAPY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97018	PR PARAFFIN BATH THERAPY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97020	PR MICROWAVE THERAPY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021
97020	PR MICROWAVE THERAPY	<p>NO AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97022	PR WHIRLPOOL THERAPY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97022	PR WHIRLPOOL THERAPY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97024	PR DIATHERMY TREATMENT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97024	PR DIATHERMY TREATMENT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97026	PR INFRARED THERAPY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97026	PR INFRARED THERAPY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97028	PR ULTRAVIOLET THERAPY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97028	PR ULTRAVIOLET THERAPY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97032	PR ELECTRICAL STIMULATION	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97032	PR ELECTRICAL STIMULATION	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97033	PR ELECTRIC CURRENT THERAPY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97033	PR ELECTRIC CURRENT THERAPY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97034	PR CONTRAST BATH THERAPY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97034	PR CONTRAST BATH THERAPY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97035	PR ULTRASOUND THERAPY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97035	PR ULTRASOUND THERAPY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97036	PR HYDROTHERAPY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97036	PR HYDROTHERAPY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
97037	LOW-LEVEL LASER THERAPY APPLICATION FOR PAIN MANAGEMENT AFTER SURGERY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97037	LOW-LEVEL LASER THERAPY APPLICATION FOR PAIN MANAGEMENT AFTER SURGERY	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
97039	PR PHYSICAL THERAPY TREATMENT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97039	PR PHYSICAL THERAPY TREATMENT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97110	PR THERAPEUTIC EXERCISES	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (BACK PAIN.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BA CK-PAIN.PDF</p> <p>MD GUIDELINE 2 (BELLS PALSY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BEL LS-PALSY.PDF</p> <p>MD GUIDELINE 3 (CARPAL TUNNEL SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/CA RPAL-TUNNEL-SYNDROME.PDF</p> <p>MD GUIDELINE 4 (LUMBAGO OF PREGNANCY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/LU MBAGO-OF-PREGNANCY.PDF</p> <p>MD GUIDELINE 5 (PATELLOFEMORAL PAIN SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PA TELLOFEMORAL-PAIN-SYNDROME.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97110	PR THERAPEUTIC EXERCISES	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (BACK PAIN.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BA CK-PAIN.PDF MD GUIDELINE 2 (BELLS PALSY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BEL LS-PALSY.PDF MD GUIDELINE 3 (CARPAL TUNNEL SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/CAR PAL-TUNNEL-SYNDROME.PDF MD GUIDELINE 4 (LUMBAGO OF PREGNANCY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/LU MBAGO-OF-PREGNANCY.PDF MD GUIDELINE 5 (PATELLOFEMORAL PAIN SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PATELLOFEMORAL-PAIN-SYNDROME.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97112	PR NEUROMUSC REEDUCAT,1+ AREAS, EA 15 MIN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (BACK PAIN.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BA CK-PAIN.PDF</p> <p>MD GUIDELINE 2 (BELLS PALSY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BEL LS-PALSY.PDF</p> <p>MD GUIDELINE 3 (CARPAL TUNNEL SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/CAR PAL-TUNNEL-SYNDROME.PDF</p> <p>MD GUIDELINE 4 (LUMBAGO OF PREGNANCY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/LU MBAGO-OF-PREGNANCY.PDF</p> <p>MD GUIDELINE 5 (PATELLOFEMORAL PAIN SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PATELLOFEMORAL-PAIN-SYNDROME.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97112	PR NEUROMUSC REEDUCAT,1+ AREAS, EA 15 MIN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (BACK PAIN.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BA CK-PAIN.PDF MD GUIDELINE 2 (BELLS PALSY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BEL LS-PALSY.PDF MD GUIDELINE 3 (CARPAL TUNNEL SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/CAR PAL-TUNNEL-SYNDROME.PDF MD GUIDELINE 4 (LUMBAGO OF PREGNANCY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/LU MBAGO-OF-PREGNANCY.PDF MD GUIDELINE 5 (PATELLOFEMORAL PAIN SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PATELLOFEMORAL-PAIN-SYNDROME.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97113	PR AQUATIC THERAPY/EXERCISES	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (BACK PAIN.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BACK-PAIN.PDF MD GUIDELINE 2 (LUMBAGO OF PREGNANCY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/LUMBAGO-OF-PREGNANCY.PDF MD GUIDELINE 3 (PATELLOFEMORAL PAIN SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PATELLOFEMORAL-PAIN-SYNDROME.PDF MD GUIDELINE 4 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 5 (THERAPY REFERRAL REVIEW BY ORDERING PHYSICIAN ATTESTATION FORM.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/THERAPY-REFERRAL-REVIEW-BY-ORDERING-PHYSICIAN-ATTESTATION-FORM.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97113	PR AQUATIC THERAPY/EXERCISES	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (BACK PAIN.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BACK-PAIN.PDF</p> <p>MD GUIDELINE 2 (LUMBAGO OF PREGNANCY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/LUMBAGO-OF-PREGNANCY.PDF</p> <p>MD GUIDELINE 3 (PATELLOFEMORAL PAIN SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PATELLOFEMORAL-PAIN-SYNDROME.PDF</p> <p>MD GUIDELINE 4 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf</p> <p>MD GUIDELINE 5 (THERAPY REFERRAL REVIEW BY ORDERING PHYSICIAN ATTESTATION FORM.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/THERAPY-REFERRAL-REVIEW-BY-ORDERING-PHYSICIAN-ATTESTATION-FORM.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97116	PR GAIT TRAINING THERAPY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (BACK PAIN.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BA CK-PAIN.PDF</p> <p>MD GUIDELINE 2 (LUMBAGO OF PREGNANCY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/LU MBAGO-OF-PREGNANCY.PDF</p> <p>MD GUIDELINE 3 (PATELLOFEMORAL PAIN SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PAT ELOFEMORAL-PAIN-SYNDROME.PDF</p> <p>MD GUIDELINE 4 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 5 (THERAPY REFERRAL REVIEW BY ORDERING PHYSICIAN ATTESTATION FORM.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-REFERRAL-REVIEW-BY-ORDERING-PHYSICIAN-ATTESTATION-FORM.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97116	PR GAIT TRAINING THERAPY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (BACK PAIN.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BA CK-PAIN.PDF MD GUIDELINE 2 (LUMBAGO OF PREGNANCY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/LU MBAGO-OF-PREGNANCY.PDF MD GUIDELINE 3 (PATELLOFEMORAL PAIN SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PATELLOFEMORAL-PAIN-SYNDROME.PDF MD GUIDELINE 4 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 5 (THERAPY REFERRAL REVIEW BY ORDERING PHYSICIAN ATTESTATION FORM.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/THERAPY-REFERRAL-REVIEW-BY-ORDERING-PHYSICIAN-ATTESTATION-FORM.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97124	PR MASSAGE THERAPY	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (BACK PAIN.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BA CK-PAIN.PDF</p> <p>MD GUIDELINE 2 (BELLS PALSY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BEL LS-PALSY.PDF</p> <p>MD GUIDELINE 3 (CARPAL TUNNEL SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/CA RPAL-TUNNEL-SYNDROME.PDF</p> <p>MD GUIDELINE 4 (LUMBAGO OF PREGNANCY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/LU MBAGO-OF-PREGNANCY.PDF</p> <p>MD GUIDELINE 5 (PATELLOFEMORAL PAIN SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PA TELLOFEMORAL-PAIN-SYNDROME.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97124	PR MASSAGE THERAPY	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (BACK PAIN.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BA CK-PAIN.PDF MD GUIDELINE 2 (BELLS PALSY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BEL LS-PALSY.PDF MD GUIDELINE 3 (CARPAL TUNNEL SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/CAR PAL-TUNNEL-SYNDROME.PDF MD GUIDELINE 4 (LUMBAGO OF PREGNANCY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/LU MBAGO-OF-PREGNANCY.PDF MD GUIDELINE 5 (PATELLOFEMORAL PAIN SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PATELLOFEMORAL-PAIN-SYNDROME.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97127	PR THERAPEUTIC IVNTJ W/FOCUS ON COGNITIVE FUNCTION	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
97127	PR THERAPEUTIC IVNTJ W/FOCUS ON COGNITIVE FUNCTION	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97129	PR THER IVNTJ COG FUNCJ CNTCT 1ST 15 MINUTES	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97129	PR THER IVNTJ COG FUNCJ CNTCT 1ST 15 MINUTES	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97130	PR THER IVNTJ COG FUNCJ CNTCT EA ADDL 15 MINUTES	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97130	PR THER IVNTJ COG FUNCJ CNTCT EA ADDL 15 MINUTES	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97139	PR PHYSICAL MEDICINE PROCEDURE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97139	PR PHYSICAL MEDICINE PROCEDURE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97140	PR MANUAL THER TECH,1+REGIONS,EA 15 MIN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (BACK PAIN.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BA CK-PAIN.PDF</p> <p>MD GUIDELINE 2 (BELLS PALSY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BELLS-PALSY.PDF</p> <p>MD GUIDELINE 3 (CARPAL TUNNEL SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/CARPAL-TUNNEL-SYNDROME.PDF</p> <p>MD GUIDELINE 4 (LUMBAGO OF PREGNANCY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/LUMBAGO-OF-PREGNANCY.PDF</p> <p>MD GUIDELINE 5 (PATELLOFEMORAL PAIN SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PATELLOFEMORAL-PAIN-SYNDROME.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97140	PR MANUAL THER TECH,1+REGIONS,EA 15 MIN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (BACK PAIN.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BACK-PAIN.PDF MD GUIDELINE 2 (BELLS PALSY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BELLS-PALSY.PDF MD GUIDELINE 3 (CARPAL TUNNEL SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/CARPAL-TUNNEL-SYNDROME.PDF MD GUIDELINE 4 (LUMBAGO OF PREGNANCY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/LUMBAGO-OF-PREGNANCY.PDF MD GUIDELINE 5 (PATELLOFEMORAL PAIN SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PATELLOFEMORAL-PAIN-SYNDROME.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97150	PR GROUP THERAPEUTIC PROCEDURES	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97150	PR GROUP THERAPEUTIC PROCEDURES	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97151	PR BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97151	PR BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
97151	PR BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	<p>AUTHORIZATION REQUIRED</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMHP TMPPM CHILDREN SERVICES HANDBOOK, VOLUME 2, SECTION 2.3, MEDICAID AUTISM SERVICES POLICY</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97152	PR BEHAVIOR ID SUPPORT ASSMT BY 1 TECH EA 15 MIN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97152	PR BEHAVIOR ID SUPPORT ASSMT BY 1 TECH EA 15 MIN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97153	PR ADAPTIVE BEHAVIOR TX BY PROTOCOL TECH EA 15 MIN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97153	PR ADAPTIVE BEHAVIOR TX BY PROTOCOL TECH EA 15 MIN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
97153	PR ADAPTIVE BEHAVIOR TX BY PROTOCOL TECH EA 15 MIN	<p>AUTHORIZATION REQUIRED</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMHP TMPPM CHILDREN SERVICES HANDBOOK, VOLUME 2, SECTION 2.3, MEDICAID AUTISM SERVICES POLICY</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97154	PR GROUP ADAPTIVE BHV TX BY PROTOCOL TECH EA 15 MIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMHP TMPPM CHILDREN SERVICES HANDBOOK, VOLUME 2, SECTION 2.3, MEDICAID AUTISM SERVICES POLICY HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	2/1/2022
97154	PR GROUP ADAPTIVE BHV TX BY PROTOCOL TECH EA 15 MIN	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97154	PR GROUP ADAPTIVE BHV TX BY PROTOCOL TECH EA 15 MIN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97155	PR ADAPT BHV TX PRTCL MODIFICAJ PHYS/QHP EA 15 MIN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97155	PR ADAPT BHV TX PRTCL MODIFICA PHYS/QHP EA 15 MIN	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
97155	PR ADAPT BHV TX PRTCL MODIFICA PHYS/QHP EA 15 MIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMHP TMPPM CHILDREN SERVICES HANDBOOK, VOLUME 2, SECTION 2.3, MEDICAID AUTISM SERVICES POLICY HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97156	PR FAMILY ADAPT BHV TX GDN PHYS/QHP EA 15 MIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMHP TMPPM CHILDREN SERVICES HANDBOOK, VOLUME 2, SECTION 2.3, MEDICAID AUTISM SERVICES POLICY HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	2/1/2022
97156	PR FAMILY ADAPT BHV TX GDN PHYS/QHP EA 15 MIN	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/The-rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/The-rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/The-rapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97156	PR FAMILY ADAPT BHV TX GDN PHYS/QHP EA 15 MIN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97157	PR MULTIPLE FAM GROUP BHV TX GDN PHYS/QHP EA 15 MIN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97157	PR MULTIPLE FAM GROUP BHV TX GDN PHYS/QHP EA 15 MIN	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97158	PR GRP ADAPT BHV PRTCL MODIFCAJ PHYS/QHP EA 15 MIN	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97158	PR GRP ADAPT BHV PRTCL MODIFCAJ PHYS/QHP EA 15 MIN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
97158	PR GRP ADAPT BHV PRTCL MODIFCAJ PHYS/QHP EA 15 MIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMHP TMPPM CHILDREN SERVICES HANDBOOK, VOLUME 2, SECTION 2.3, MEDICAID AUTISM SERVICES POLICY HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97161	PR PHYSICAL THERAPY EVALUATION LOW COMPLEX 20 MINS	NO AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97161	PR PHYSICAL THERAPY EVALUATION LOW COMPLEX 20 MINS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97162	PR PHYSICAL THERAPY EVALUATION MOD COMPLEX 30 MINS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97162	PR PHYSICAL THERAPY EVALUATION MOD COMPLEX 30 MINS	NO AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97163	PR PHYSICAL THERAPY EVALUATION HIGH COMPLEX 45 MINS	NO AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97163	PR PHYSICAL THERAPY EVALUATION HIGH COMPLEX 45 MINS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97164	PR PHYSICAL THERAPY RE-EVAL EST PLAN CARE 20 MINS	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL CLINIC	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97164	PR PHYSICAL THERAPY RE-EVAL EST PLAN CARE 20 MINS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A DRISCOLL CHILDREN'S HOSPITAL CLINIC</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97165	PR OCCUPATIONAL THERAPY EVAL LOW COMPLEX 30 MINS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97165	PR OCCUPATIONAL THERAPY EVAL LOW COMPLEX 30 MINS	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97166	PR OCCUPATIONAL THERAPY EVAL MOD COMPLEX 45 MINS	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97166	PR OCCUPATIONAL THERAPY EVAL MOD COMPLEX 45 MINS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97167	PR OCCUPATIONAL THERAPY EVAL HIGH COMPLEX 60 MINS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97167	PR OCCUPATIONAL THERAPY EVAL HIGH COMPLEX 60 MINS	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97168	PR OCCUPATIONAL THER RE-EVAL EST PLAN CARE 30 MINS	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL CLINIC	TMPPM MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97168	PR OCCUPATIONAL THER RE-EVAL EST PLAN CARE 30 MINS	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A DRISCOLL CHILDREN'S HOSPITAL CLINIC EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97530	PR THERAPEUT ACTIVITY DIRECT PT CONTACT EACH 15 MIN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM MD GUIDELINE 1 (BACK PAIN.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BA CK-PAIN.PDF MD GUIDELINE 2 (BELLS PALSYP.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BEL LS-PALSYP.PDF MD GUIDELINE 3 (CARPAL TUNNEL SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/CAR PAL-TUNNEL-SYNDROME.PDF MD GUIDELINE 4 (LUMBAGO OF PREGNANCY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/LU MBAGO-OF-PREGNANCY.PDF MD GUIDELINE 5 (PATELLOFEMORAL PAIN SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PATELLOFEMORAL-PAIN-SYNDROME.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97530	PR THERAPEUT ACTIVITY DIRECT PT CONTACT EACH 15 MIN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (BACK PAIN.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BA CK-PAIN.PDF</p> <p>MD GUIDELINE 2 (BELLS PALSY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BEL LS-PALSY.PDF</p> <p>MD GUIDELINE 3 (CARPAL TUNNEL SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/CAR PAL-TUNNEL-SYNDROME.PDF</p> <p>MD GUIDELINE 4 (LUMBAGO OF PREGNANCY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/LU MBAGO-OF-PREGNANCY.PDF</p> <p>MD GUIDELINE 5 (PATELLOFEMORAL PAIN SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PATELLOFEMORAL-PAIN-SYNDROME.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97532	PR DEVELOPMENT OF COGNITIVE SKILLS EACH 15 MINUTES	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
97532	PR DEVELOPMENT OF COGNITIVE SKILLS EACH 15 MINUTES	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97533	PR SENSORY INTEGRATIVE TECHNIQUES EACH 15 MINUTES	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97533	PR SENSORY INTEGRATIVE TECHNIQUES EACH 15 MINUTES	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97535	PR SELF-CARE/HOME MGMT TRAINING EACH 15 MINUTES	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (BACK PAIN.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BA CK-PAIN.PDF</p> <p>MD GUIDELINE 2 (BELLS PALSY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BEL LS-PALSY.PDF</p> <p>MD GUIDELINE 3 (CARPAL TUNNEL SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/CAR PAL-TUNNEL-SYNDROME.PDF</p> <p>MD GUIDELINE 4 (LUMBAGO OF PREGNANCY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/LU MBAGO-OF-PREGNANCY.PDF</p> <p>MD GUIDELINE 5 (PATELLOFEMORAL PAIN SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PATELLOFEMORAL-PAIN-SYNDROME.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97535	PR SELF-CARE/HOME MGMT TRAINING EACH 15 MINUTES	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (BACK PAIN.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BA CK-PAIN.PDF MD GUIDELINE 2 (BELLS PALSYPDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BELLS-PALSYPDF MD GUIDELINE 3 (CARPAL TUNNEL SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/CARPAL-TUNNEL-SYNDROME.PDF MD GUIDELINE 4 (LUMBAGO OF PREGNANCY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/LUMBAGO-OF-PREGNANCY.PDF MD GUIDELINE 5 (PATELLOFEMORAL PAIN SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PATELLOFEMORAL-PAIN-SYNDROME.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97537	PR COMMUNITY/WORK REINTEGRATION TRAINING EA 15 MIN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (BACK PAIN.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BACK-PAIN.PDF</p> <p>MD GUIDELINE 2 (LUMBAGO OF PREGNANCY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/LUMBAGO-OF-PREGNANCY.PDF</p> <p>MD GUIDELINE 3 (PATELLOFEMORAL PAIN SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PATELLOFEMORAL-PAIN-SYNDROME.PDF</p> <p>MD GUIDELINE 4 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf</p> <p>MD GUIDELINE 5 (THERAPY REFERRAL REVIEW BY ORDERING PHYSICIAN ATTESTATION FORM.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/THERAPY-REFERRAL-REVIEW-BY-ORDERING-PHYSICIAN-ATTESTATION-FORM.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97537	PR COMMUNITY/W ORK REINTEGRATION TRAINJ EA 15 MIN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (BACK PAIN.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/BACK-PAIN.PDF MD GUIDELINE 2 (LUMBAGO OF PREGNANCY.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/LUMBAGO-OF-PREGNANCY.PDF MD GUIDELINE 3 (PATELLOFEMORAL PAIN SYNDROME.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PATELLOFEMORAL-PAIN-SYNDROME.PDF MD GUIDELINE 4 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 5 (THERAPY REFERRAL REVIEW BY ORDERING PHYSICIAN ATTESTATION FORM.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/THERAPY-REFERRAL-REVIEW-BY-ORDERING-PHYSICIAN-ATTESTATION-FORM.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97542	PR WHEELCHAIR MNGEMENT TRAINING, EA 15 MIN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97542	PR WHEELCHAIR MNGEMENT TRAINING, EA 15 MIN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97545	PR WORK HARDENING/C ONDN,0-2 HR	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97545	PR WORK HARDENING/C ONDN,0-2 HR	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97546	PR WORK HARDENING/C ONDN,EA ADDNL HR	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97546	PR WORK HARDENING/C ONDN,EA ADDNL HR	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT DRISCOLL CHILDREN'S HOSPITAL</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97597	PR DEBRIDEMENT OPEN WOUND 20 SQ CM<	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Therapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97598	PR DEBRIDEMENT OPEN WOUND EA ADDL 20 SQ CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
97602	PR RMVL DEVITAL TISS N-SLCTV DBRDMT W/O ANES 1 SESS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
97605	PR NEGATIVE PRESSURE WOUND THERAPY DME </= 50 SQ CM	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97606	PR NEGATIVE PRESSURE WOUND THERAPY DME >50 SQ CM	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
97607	PR NEG PRESSURE WOUND THERAPY NON DME <= 50 SQ CM	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
97608	PR NEG PRESSURE WOUND THERAPY NON DME >50 SQ CM	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
97610	PR LOW FREQUENCY NON-THERMAL ULTRASOUND PER DAY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
97802	PR MED NUTR THER, 1ST, INDIV, EA 15 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
97803	PR MED NUTR THER, SUBSQ, INDIV, EA 15 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
97804	PR MED NUTR THER, GROUP, EA 30 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
97810	PR ACUPUNCT W/O ELEC STIMUL 15 MIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
97811	PR ACUPUNCT W/O ELEC STIMUL ADDL 15M	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
98925	PR OSTEOPATHIC MANIP,1-2 BODY REGN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
98926	PR OSTEOPATHIC MANIP,3-4 BODY REGN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
98927	PR OSTEOPATHIC MANIP,5-6 BODY REGN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
98928	PR OSTEOPATHIC MANIP,7-8 BODY REGN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
98929	PR OSTEOPATHIC MANIP,9-10 BODY REGN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
98940	PR CHIROPRACTIC MANIP,SPINAL, 1-2 REGIONS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
98941	PR CHIROPRACTIC MANIP,SPINAL, 3-4 REGIONS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
98942	PR CHIROPRACTIC MANIP,SPINAL, 5 REGIONS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
98943	PR CHIROPRACTIC MANIPULATION, EXTRAS PINAL, 1+ REGNS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
99000	PR HANDLING/OR CONVEY OF SPEC FOR TR OFFICE TO LAB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
99001	PR HANDLING/OR CONVEY OF SPEC FOR TR FROM PT TO LAB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		5/12/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99050	PR MEDICAL SERVICES AFTER HRS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
99072	PR ADDL SUPL MATRL&STAF TM DRG PHE RES-TR NFCT DS	<p>NO AUTHORIZATION REQUIRED</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99080	PR SPECIAL REPORTS OR FORMS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
99091	PR COLLJ & INTERPJ PHYSIOL DATA MIN 30 MIN EA 30 D	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2021
99151	PR MOD SED SAME PHYS / QHP < 5 YRS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
99152	PR MOD SED SAME PHYSC / QHP 5/> YRS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
99153	PR MOD SED SAME PHYS / QHP ADD 15 MIN EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
99170	PR ANOGENITAL XM MAGNIFY CHILD/SUSPECT TRAUMA W IMG	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A CHILD ABUSE PEDIATRIC EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99170	PR ANOGENITAL XM MAGNIFY CHILD/SUSPECT TRAUMA WITH IMG	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A CHILD ABUSE PEDIATRICS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
99202	PR NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT WITH STRAIGHTFORWARD MEDICAL DECISION MAKING, IF USING TIME, 15 MINUTES OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023
99202	PR NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT WITH STRAIGHTFORWARD MEDICAL DECISION MAKING, IF USING TIME, 15 MINUTES OR MORE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A BEHAVIORAL HEALTH		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99202	PR NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT WITH STRAIGHTFOR WARD MEDICAL DECISION MAKING, IF USING TIME, 15 MINUTES OR MORE	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A FEDERALLY QUALIFIED HEALTH CENTERS (FEDERALLY QUALIFIED HEALTH CENTERS (FQHC))	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023
99202	PR NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT WITH STRAIGHTFOR WARD MEDICAL DECISION MAKING, IF USING TIME, 15 MINUTES OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
99202	PR NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT WITH STRAIGHTFOR WARD MEDICAL DECISION MAKING, IF USING TIME, 15 MINUTES OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99202	PR NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT WITH STRAIGHTFORWARD MEDICAL DECISION MAKING, IF USING TIME, 15 MINUTES OR MORE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99203	PR OFFICE/OUTPATIENT NEW LOW MDM 30 MIN OR MORE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
99203	PR OFFICE/OUTPATIENT NEW LOW MDM 30 MIN OR MORE	<p>NO AUTHORIZATION REQUIRED</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99203	PR OFFICE/OUTPATIENT NEW LOW MDM 30 MIN OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
99203	PR OFFICE/OUTPATIENT NEW LOW MDM 30 MIN OR MORE	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A FEDERALLY QUALIFIED HEALTH CENTERS (FEDERALLY QUALIFIED HEALTH CENTERS (FQHC))	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023
99203	PR OFFICE/OUTPATIENT NEW LOW MDM 30 MIN OR MORE	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A BEHAVIORAL HEALTH	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
99203	PR OFFICE/OUTPATIENT NEW LOW MDM 30 MIN OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023
99204	PR OFFICE/OUTPATIENT NEW MODERATE MDM 45 MIN OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023
99204	PR OFFICE/OUTPATIENT NEW MODERATE MDM 45 MIN OR MORE	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A BEHAVIORAL HEALTH	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99204	PR OFFICE/OUTPATIENT NEW MODERATE MDM 45 MIN OR MORE	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A FEDERALLY QUALIFIED HEALTH CENTERS (FEDERALLY QUALIFIED HEALTH CENTERS (FQHC))	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023
99204	PR OFFICE/OUTPATIENT NEW MODERATE MDM 45 MIN OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
99204	PR OFFICE/OUTPATIENT NEW MODERATE MDM 45 MIN OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99204	PR OFFICE/OUTPATIENT NEW MODERATE MDM 45 MIN OR MORE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99205	PR OFFICE/OUTPATIENT NEW HIGH MDM 60 MIN OR MORE	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
99205	PR OFFICE/OUTPATIENT NEW HIGH MDM 60 MIN OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99205	PR OFFICE/OUTPATIENT NEW HIGH MDM 60 MIN OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
99205	PR OFFICE/OUTPATIENT NEW HIGH MDM 60 MIN OR MORE	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A FEDERALLY QUALIFIED HEALTH CENTERS (FEDERALLY QUALIFIED HEALTH CENTERS (FQHC))	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023
99205	PR OFFICE/OUTPATIENT NEW HIGH MDM 60 MIN OR MORE	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A BEHAVIORAL HEALTH	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
99205	PR OFFICE/OUTPATIENT NEW HIGH MDM 60 MIN OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023
99211	PR OFFICE/OUTPATIENT EST PT MAY NOT REQ PHYS/QHP	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A FEDERALLY QUALIFIED HEALTH CENTERS (FEDERALLY QUALIFIED HEALTH CENTERS (FQHC))	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99211	PR OFFICE/OUTPATIENT EST PT MAY NOT REQ PHYS/QHP	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A BEHAVIORAL HEALTH	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
99211	PR OFFICE/OUTPATIENT EST PT MAY NOT REQ PHYS/QHP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
99211	PR OFFICE/OUTPATIENT EST PT MAY NOT REQ PHYS/QHP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
99211	PR OFFICE/OUTPATIENT EST PT MAY NOT REQ PHYS/QHP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99211	PR OFFICE/OUTPATIENT EST PT MAY NOT REQ PHYS/QHP	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99212	PR OFFICE/OUTPATIENT ESTABLISHED SF MDM 10 MIN OR MORE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
99212	PR OFFICE/OUTPATIENT ESTABLISHED SF MDM 10 MIN OR MORE	<p>NO AUTHORIZATION REQUIRED</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99212	PR OFFICE/OUTPATIENT ESTABLISHED SF MDM 10 MIN OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
99212	PR OFFICE/OUTPATIENT ESTABLISHED SF MDM 10 MIN OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
99212	PR OFFICE/OUTPATIENT ESTABLISHED SF MDM 10 MIN OR MORE	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A BEHAVIORAL HEALTH	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
99212	PR OFFICE/OUTPATIENT ESTABLISHED SF MDM 10 MIN OR MORE	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A FEDERALLY QUALIFIED HEALTH CENTERS (FEDERALLY QUALIFIED HEALTH CENTERS (FQHC))	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023
99213	PR OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20 MIN OR MORE	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A FEDERALLY QUALIFIED HEALTH CENTERS (FEDERALLY QUALIFIED HEALTH CENTERS (FQHC))	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99213	PR OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20 MIN OR MORE	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A BEHAVIORAL HEALTH	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
99213	PR OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20 MIN OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
99213	PR OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20 MIN OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
99213	PR OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20 MIN OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99213	PR OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20 MIN OR MORE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99214	PR OFFICE/OUTPATIENT ESTABLISHED MOD MDM 30 MIN OR MORE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
99214	PR OFFICE/OUTPATIENT ESTABLISHED MOD MDM 30 MIN OR MORE	<p>NO AUTHORIZATION REQUIRED</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99214	PR OFFICE/OUTPATIENT ESTABLISHED MOD MDM 30 MIN OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
99214	PR OFFICE/OUTPATIENT ESTABLISHED MOD MDM 30 MIN OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
99214	PR OFFICE/OUTPATIENT ESTABLISHED MOD MDM 30 MIN OR MORE	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A BEHAVIORAL HEALTH	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
99214	PR OFFICE/OUTPATIENT ESTABLISHED MOD MDM 30 MIN OR MORE	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A FEDERALLY QUALIFIED HEALTH CENTERS (FEDERALLY QUALIFIED HEALTH CENTERS (FQHC))	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023
99215	PR OFFICE/OUTPATIENT ESTABLISHED HIGH MDM 40 MIN OR MORE	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A FEDERALLY QUALIFIED HEALTH CENTERS (FEDERALLY QUALIFIED HEALTH CENTERS (FQHC))	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99215	PR OFFICE/OUTPATIENT ESTABLISHED HIGH MDM 40 MIN OR MORE	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A BEHAVIORAL HEALTH	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
99215	PR OFFICE/OUTPATIENT ESTABLISHED HIGH MDM 40 MIN OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
99215	PR OFFICE/OUTPATIENT ESTABLISHED HIGH MDM 40 MIN OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
99215	PR OFFICE/OUTPATIENT ESTABLISHED HIGH MDM 40 MIN OR MORE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99215	PR OFFICE/OUTPATIENT ESTABLISHED HIGH MDM 40 MIN OR MORE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99217	PR OBSERVATION CARE DISCHARGE MANAGEMENT	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99221	PR INITIAL HOSPITAL INPAT OR OBS PER DAY 40 MINUTES	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99221	PR INITIAL HOSPITAL INPAT OR OBS PER DAY 40 MINUTES	AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
99221	PR INITIAL HOSPITAL INPAT OR OBS PER DAY 40 MINUTES	AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
99221	PR INITIAL HOSPITAL INPAT OR OBS PER DAY 40 MINUTES	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED FOR UP TO 2 DAYS DIAGNOSIS CODES: NO AUTH IS REQUIRED IF OB OBS DX: A34, O00.0, O00.1, O00.2, O00.8, O00.9, O01.9, O02.1, O02.81, O03.0, O03.1, O03.2, O03.30, O03.31, O03.33, O03.34, O03.37, O03.38, O03.39, O03.4, O03.5, O03.6, O03.7, O03.80, O03.81, O03.82, O03.83, O03.84, O03.85, O03.86, O03.87, O03.88, O03.9, O04.5, O04.6, O04.7, O04.80, O04.81, O04.82, O04.83, O04.84, O04.85, O04.86, O04.87, O04.88, O04.89, O07.0, O07.1, O07.2, O07.30, O07.31, O07.32, O07.33, O07.34, O07.35, O07.36, O07.37, O07.38, O07.39, O07.4, O08.0,	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

O08.1, O08.2, O08.3, O08.4, O08.5O
O08.6, O08.7, O08.81, O08.82,
O08.83, O08.89, O09.00, O09.10,
O09.211, O09.291, O09.30, O09.40,
O09.41, O09.42, O09.43, O09.511,
O09.512, O09.513, O09.519,
O09.521, O09.522, O09.523,
O09.529, O09.611, O09.621,
O09.819, O09.821, O09.822,
O09.823, O09.829, O09.891,
O09.892, O09.893, O09.899, O09.90,
O09.91, O09.92, O09.93, O10.011,
O10.012, O10.013, O10.019, O10.02,
O10.03, O10.111, O10.112, O10.113,
O10.119, O10.12, O10.13, O10.20,
O10.211, O10.212, O10.213,
O10.219, O10.22, O10.23O O10.311,
O10.312, O10.313, O10.319, O10.32,
O10.33, O10.411, O10.412, O10.413,
O10.419, O10.42, O10.43, O10.911,
O10.912, O10.913, O10.919, O10.92,
O10.93, O11.1, O11.2, O11.3, O11.9,
O12.0, O12.00, O12.01, O12.02,
O12.03, O12.20, O12.21, O12.22,
O12.23, O13.1, O13.2, O13.3, O13.9,
O14.00, O14.02, O14.03, O14.10,
O14.12, O14.13, O14.20, O14.22,
O14.23, O14.90, O14.92, O14.93,
O15.02, O15.03, O15.1, O15.2,
O15.9, O16.1, O16.2, O16.3, O16.9,
O20.0, O20.8, O20.9, O21.0, O21.1,
O21.2, O21.8, O21.9, O22.00,
O22.01, O22.02, O22.03, O22.10,
O22.11, O22.12, O22.13, O22.20,
O22.21, O22.23, O22.31, O22.32,
O22.33, O22.4, O22.41, O22.42,
O22.43, O22.50, O22.51, O22.52,
O22.53, O22.8X1, O22.8X2,
O22.8X3, O22.91, O22.92, O22.93,
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Prior Authorization Requirements for STAR, STAR Kids, and CHIP

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O98.63, O98.811, O98.812, O98.813,
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O98.912, O98.3913, O98.919,
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 O99.810, O99.814, O99.815,
 O99.834, O99.835, O99.840,
 O99.841, O99.842, O99.843,
 O99.844, O99.845, O99.89, Z33.1,
 Z33.2, Z34.0, Z34.80, Z34.90

99221	PR INITIAL HOSPITAL INPAT OR OBS PER DAY 40 MINUTES	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 2 DAYS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE OB OBS DX: A34, O00.0, O00.1, O00.2, O00.8, O00.9, O01.9, O02.1, O02.81, O03.0, O03.1, O03.2, O03.30, O03.31, O03.33, O03.34, O03.37, O03.38, O03.39, O03.4, O03.5, O03.6, O03.7, O03.80, O03.81, O03.82, O03.83, O03.84, O03.85, O03.86, O03.87, O03.88, O03.9, O04.5, O04.6, O04.7, O04.80, O04.81, O04.82, O04.83, O04.84, O04.85, O04.86, O04.87, O04.88, O04.89, O07.0, O07.1, O07.2, O07.30, O07.31, O07.32, O07.33, O07.34, O07.35, O07.36, O07.37, O07.38, O07.39, O07.4, O08.0, O08.1, O08.2, O08.3, O08.4, O08.5O, O08.6, O08.7, O08.81, O08.82, O08.83, O08.89, O09.00, O09.10, O09.211, O09.291, O09.30, O09.40,</p>	<p>INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	<p>C, S, SK,CP</p>	<p>1/1/2024</p>
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Prior Authorization Requirements for STAR, STAR Kids, and CHIP

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O88.219, O88.22, O88.23, O88.311,
O88.312, O88.313, O88.319, O88.32,
O88.33, O88.811, O88.812, O88.813,
O88.819, O88.82, O88.83, O89.09,
O89.2, O89.8, O89.9, O9A.23, O90.3,
O90.5, O90.6, O90.81, O90.89,
O90.9, O91.011, O91.012, O91.013,
O91.019, O91.02, O91.111, O91.112,
O91.113, O91.119, O91.12, O91.211,
O91.212, O91.213, O91.219, O91.22,
O91.23, O91.8X90, O92.011,
O92.012, O92.013, O92.019, O92.03,
O92.111, O92.112, O92.113,
O92.119, O92.13, O92.20, O92.29,
O92.3, O92.5, O92.6, O92.70,
O92.79, O94, O98.011, O98.012,
O98.013, O98.019, O98.02, O98.03,
O98.111, O98.112, O98.113,
O98.119, O98.12, O98.211, O98.212,
O98.213, O98.219, O98.22, O98.23,
O98.311, O98.312, O98.313,
O98.319, O98.32, O98.33, O98.42,
O98.43, O98.511, O98.512, O98.513,
O98.519, O98.52, O98.53, O98.611,
O98.612, O98.613, O98.619, O98.62,
O98.63, O98.811, O98.812, O98.813,
O98.819, O98.82, O98.83, O98.911,
O98.912, O98.3913, O98.919,
O98.92, O98.93, O99.011, O99.012,
O99.013, O99.019, O99.02, O99.03,
O99.111, O99.112, O99.113, O99.12,
O99.13, O99.19, O99.210, O99.211,
O99.212, O99.213, O99.214,
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O99.322, O99.323, O99.324,

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 O99.332, O99.333, O99.334,
 O99.335, O99.340, O99.341,
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 O99.345, O99.350, O99.351,
 O99.352, O99.353, O99.354,
 O99.355, O99.411, O99.412,
 O99.413, O99.419, O99.42, O99.43,
 O99.511, O99.512, O99.513,
 O99.519, O99.52, O99.53, O99.412,
 O99.413, O99.419, O99.42, O99.43,
 O99.53, O99.61, O99.611, O99.612,
 O99.613, O99.619, O99.62, O99.63,
 O99.810, O99.814, O99.815,
 O99.834, O99.835, O99.840,
 O99.841, O99.842, O99.843,
 O99.844, O99.845, O99.89, Z33.1,
 Z33.2, Z34.0, Z34.80, Z34.90

99222	PR INITIAL HOSPITAL CARE/DAY 55 MINUTES	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 2 DAYS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE OB OBS DX: A34, O00.0, O00.1, O00.2, O00.8, O00.9, O01.9, O02.1, O02.81, O03.0, O03.1, O03.2, O03.30, O03.31, O03.33, O03.34, O03.37, O03.38, O03.39, O03.4, O03.5, O03.6, O03.7, O03.80, O03.81, O03.82, O03.83, O03.84, O03.85, O03.86, O03.87, O03.88, O03.9, O04.5, O04.6, O04.7, O04.80, O04.81, O04.82, O04.83, O04.84, O04.85, O04.86, O04.87, O04.88, O04.89, O07.0, O07.1, O07.2, O07.30, O07.31, O07.32, O07.33, O07.34, O07.35, O07.36, O07.37, O07.38, O07.39, O07.4, O08.0, O08.1, O08.2, O08.3, O08.4, O08.5O, O08.6, O08.7, O08.81, O08.82, O08.83, O08.89, O09.00, O09.10, O09.211, O09.291, O09.30, O09.40, O09.41, O09.42, O09.43, O09.511, O09.512, O09.513, O09.519, O09.521, O09.522, O09.523, O09.529, O09.611, O09.621,</p>	<p>INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	<p>C, S, SK,CP</p>	<p>1/1/2024</p>
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Prior Authorization Requirements for STAR, STAR Kids, and CHIP

O09.819, O09.821, O09.822,
O09.823, O09.829, O09.891,
O09.892, O09.893, O09.899, O09.90,
O09.91, O09.92, O09.93, O10.011,
O10.012, O10.013, O10.019, O10.02,
O10.03, O10.111, O10.112, O10.113,
O10.119, O10.12, O10.13, O10.20,
O10.211, O10.212, O10.213,
O10.219, O10.22, O10.23O O10.311,
O10.312, O10.313, O10.319, O10.32,
O10.33, O10.411, O10.412, O10.413,
O10.419, O10.42, O10.43, O10.911,
O10.912, O10.913, O10.919, O10.92,
O10.93, O11.1, O11.2, O11.3, O11.9,
O12.0, O12.00, O12.01, O12.02,
O12.03, O12.20, O12.21, O12.22,
O12.23, O13.1, O13.2, O13.3, O13.9,
O14.00, O14.02, O14.03, O14.10,
O14.12, O14.13, O14.20, O14.22,
O14.23, O14.90, O14.92, O14.93,
O15.02, O15.03, O15.1, O15.2,
O15.9, O16.1, O16.2, O16.3, O16.9,
O20.0, O20.8, O20.9, O21.0, O21.1,
O21.2, O21.8, O21.9, O22.00,
O22.01, O22.02, O22.03, O22.10,
O22.11, O22.12, O22.13, O22.20,
O22.21, O22.23, O22.31, O22.32,
O22.33, O22.4, O22.41, O22.42,
O22.43, O22.50, O22.51, O22.52,
O22.53, O22.8X1, O22.8X2,
O22.8X3, O22.91, O22.92, O22.93,
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O23.519, O23.529, O23.599, O23.90,
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O24.32, O24.419, O24.429, O24.439,
O24.911, O24.912, O24.913, O24.92,
O24.93, O25.10, O25.11, O25.12,
O25.13, O25.20 O25.3, O26.00,
O26.01, O26.02, O26.03, O26.11,
O26.12, O26.13, O26.20, O26.21,
O26.22, O26.23, O26.41, O26.42,
O26.43, O26.50, O26.51, O26.52,
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O26.812, O26.813, O26.819,
O26.821, O26.822, O26.823,
O26.829, O26.83, O26.831, O26.832,
O26.833, O26.839, O26.841,
O26.842, O26.843, O26.849,

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

O26.851, O26.852, O26.853,
O26.859, O26.891, O26.892,
O26.893, O26.90, O30.001, O30.003,
O30.009, O30.101, O30.102,
O30.103, O30.109, O30.201,
O30.202, O30.203, O30.209,
O30.801, O30.802, O30.803,
O30.809, O30.90, O30.91, O30.92,
O30.93, O31.00X0, O31.01X0,
O31.02X0, O31.03X0, O31.10X0,
O31.30X0, O31.31X0, O31.32X0,
O31.33X0, O31.8X10, O31.8X20,
O31.8X30, O32.0XX0, O32.1XX0,
O32.2XX0, O32.3XX0, O32.4XX0,
O32.6XX0, O32.8XX0, O32.9XX0,
O33.0, O33.1, O33.2, O33.7, O33.8,
O33.9, O33.3XX0, O33.4XX0,
O33.5XX0, O33.6XX0, O34.00,
O34.01, O34.02, O34.03, O34.10,
O34.11, O34.12, O34.13, O34.21,
O34.29, O34.30, O34.31, O34.32,
O34.33, O34.40, O34.41, O34.42,
O34.43, O34.511, O34.512, O34.513,
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O34.523, O34.529, O34.531,
O34.532, O34.533, O34.539,
O34.591, O34.592, O34.593,
O34.599, O34.60, O34.61, O34.62,
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O34.93, O35.0XX0, O35.1XX0,
O35.2XX0, O35.3XX0, O35.4XX0,
O35.5XX0, O35.6XX0, O35.8XX0,
O35.9XX0, O36.0110, O36.0120,
O36.0130, O36.0190, O36.0910,
O36.0920, O36.0930, O36.0990,
O36.1110, O36.1120, O36.1130,
O36.1190, O36.9110, O36.1920,
O36.1930, O36.1990, O36.4XX0,
O36.5110, O36.5120, O36.5130,
O36.5190, O36.5910, O36.5920,
O36.5930, O36.5990, O36.61X0,
O36.62X0, O36.63X0, O36.8120,
O36.8130, O36.8190, O36.91X0,
O36.92X0, O36.93X0, O40.1XX0,
O40.2XX0, O40.3XX0, O40.9XX0,
O41.00X0, O41.01X0, O41.02X0,
O41.03X0, O41.1010, O41.1020,
O41.1030, O41.1090, O41.1210,

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

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O41.1490, O41.8X10, O41.8X20,
O41.8X30, O41.8X90, O41.90X0,
O41.91X0, O41.92X0, O41.93X0,
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O42.02, O42.10, O42.111, O42.112,
O42.113, O43.011, O43.019,
O43.101, O43.102, O43.103, O43.19,
O43.199, O43.211, O43.212,
O43.213, O43.221, O43.222,
O43.223, O43.231, O43.232,
O43.233, O43.239, O43.811,
O43.812, O43.813, O43.819, O43.91,
O43.92, O43.93, O44.00, O44.01,
O44.02, O44.03, O44.10, O44.11,
O44.12, O44.13, O45.001, O45.002,
O45.003, O45.011, O45.012,
O45.013, O45.021, O45.022,
O45.023, O45.091, O45.092,
O45.093, O45.8X1, O45.8X2,
O45.8X3, O45.8X9, O45.91, O45.92,
O45.93, O46.001, O46.002, O46.003,
O46.009, O46.011, O46.012,
O46.013, O46.021, O46.022,
O46.023, O46.029, O46.091,
O46.092, O46.093, O46.099, O46.19,
O46.8X1, O46.8X2, O46.8X3,
O46.8X9, O46.91, O46.92, O46.93,
O47.00, O47.02, O47.03, O47.1,
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O62.2, O62.3, O62.4, O62.9, O63.0,
O63.1, O63.2, O63.9, O64.1XX0,
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O66.5, O66.8, O66.9, O67.0, O67.8,
O67.8X1, O67.8X2, O67.8X3, O68,
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O69.4XX0, O69.5XX0, O69.81X0,
O69.82X0, O69.89X0, O69.9XX0,
O70.0, O70.1, O70.2, O70.3, O70.4,
O70.9, O71.00, O71.02, O71.03,
O71.1, O71.2, O71.3, O71.4, O71.5,
O71.6, O71.7, O71.82, O71.89,
O71.9, O72.0, O72.1, O72.2, O72.3,
O73.0, O73.1, O74.1, O74.2, O74.3,
O74.8, O74.9, O75.0, O75.1, O75.2,
O75.3, O75.4, O75.5, O75.81,

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

O75.89, O75.9, O76, O80, O82, O85,
O86.11, O86.12, O86.13, O86.19,
O86.20, O86.21, O86.22, O86.29,
O86.4, O86.81, O86.89, O87.0,
O87.1, O87.2, O87.3, O87.4, O87.8,
O87.9, O88.011, O88.012, O88.013,
O88.019, O88.02, O88.03, O88.111,
O88.112, O88.113, O88.119, O88.12,
O88.13, O88.211, O88.212, O88.213,
O88.219, O88.22, O88.23, O88.311,
O88.312, O88.313, O88.319, O88.32,
O88.33, O88.811, O88.812, O88.813,
O88.819, O88.82, O88.83, O89.09,
O89.2, O89.8, O89.9, O9A.23, O90.3,
O90.5, O90.6, O90.81, O90.89,
O90.9, O91.011, O91.012, O91.013,
O91.019, O91.02, O91.111, O91.112,
O91.113, O91.119, O91.12, O91.211,
O91.212, O91.213, O91.219, O91.22,
O91.23, O91.8X90, O92.011,
O92.012, O92.013, O92.019, O92.03,
O92.111, O92.112, O92.113,
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O92.79, O94, O98.011, O98.012,
O98.013, O98.019, O98.02, O98.03,
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O98.213, O98.219, O98.22, O98.23,
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O98.319, O98.32, O98.33, O98.42,
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O98.63, O98.811, O98.812, O98.813,
O98.819, O98.82, O98.83, O98.911,
O98.912, O98.3913, O98.919,
O98.92, O98.93, O99.011, O99.012,
O99.013, O99.019, O99.02, O99.03,
O99.111, O99.112, O99.113, O99.12,
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O99.212, O99.213, O99.214,
O99.215, O99.280, O99.281,
O99.282, O99.283, O99.284,
O99.285, O99.320, O99.321,
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O99.332, O99.333, O99.334,
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O99.342, O99.343, O99.344,

O99.345, O99.350, O99.351,
 O99.352, O99.353, O99.354,
 O99.355, O99.411, O99.412,
 O99.413, O99.419, O99.42, O99.43,
 O99.511, O99.512, O99.513,
 O99.519, O99.52, O99.53, O99.412,
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 O99.53, O99.61, O99.611, O99.612,
 O99.613, O99.619, O99.62, O99.63,
 O99.810, O99.814, O99.815,
 O99.834, O99.835, O99.840,
 O99.841, O99.842, O99.843,
 O99.844, O99.845, O99.89, Z33.1,
 Z33.2, Z34.0, Z34.80, Z34.90

99222	PR INITIAL HOSPITAL CARE/DAY 55 MINUTES	<p>NO AUTHORIZATION REQUIRED</p> <p>LIMITS: NO AUTH IS REQUIRED FOR UP TO 2 DAYS</p> <p>DIAGNOSIS CODES: NO AUTH IS REQUIRED IF OB OBS DX: A34, O00.0, O00.1, O00.2, O00.8, O00.9, O01.9, O02.1, O02.81, O03.0, O03.1, O03.2, O03.30, O03.31, O03.33, O03.34, O03.37, O03.38, O03.39, O03.4, O03.5, O03.6, O03.7, O03.80, O03.81, O03.82, O03.83, O03.84, O03.85, O03.86, O03.87, O03.88, O03.9, O04.5, O04.6, O04.7, O04.80, O04.81, O04.82, O04.83, O04.84, O04.85, O04.86, O04.87, O04.88, O04.89, O07.0, O07.1, O07.2, O07.30, O07.31, O07.32, O07.33, O07.34, O07.35, O07.36, O07.37, O07.38, O07.39, O07.4, O08.0, O08.1, O08.2, O08.3, O08.4, O08.5O, O08.6, O08.7, O08.81, O08.82, O08.83, O08.89, O09.00, O09.10, O09.211, O09.291, O09.30, O09.40, O09.41, O09.42, O09.43, O09.511, O09.512, O09.513, O09.519, O09.521, O09.522, O09.523, O09.529, O09.611, O09.621, O09.819, O09.821, O09.822, O09.823, O09.829, O09.891, O09.892, O09.893, O09.899, O09.90, O09.91, O09.92, O09.93, O10.011, O10.012, O10.013, O10.019, O10.02,</p>	<p>INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	<p>C, S, SK,CP</p>	<p>1/1/2024</p>
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Prior Authorization Requirements for STAR, STAR Kids, and CHIP

O10.03, O10.111, O10.112, O10.113,
O10.119, O10.12, O10.13, O10.20,
O10.211, O10.212, O10.213,
O10.219, O10.22, O10.23O O10.311,
O10.312, O10.313, O10.319, O10.32,
O10.33, O10.411, O10.412, O10.413,
O10.419, O10.42, O10.43, O10.911,
O10.912, O10.913, O10.919, O10.92,
O10.93, O11.1, O11.2, O11.3, O11.9,
O12.0, O12.00, O12.01, O12.02,
O12.03, O12.20, O12.21, O12.22,
O12.23, O13.1, O13.2, O13.3, O13.9,
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O14.12, O14.13, O14.20, O14.22,
O14.23, O14.90, O14.92, O14.93,
O15.02, O15.03, O15.1, O15.2,
O15.9, O16.1, O16.2, O16.3, O16.9,
O20.0, O20.8, O20.9, O21.0, O21.1,
O21.2, O21.8, O21.9, O22.00,
O22.01, O22.02, O22.03, O22.10,
O22.11, O22.12, O22.13, O22.20,
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O22.33, O22.4, O22.41, O22.42,
O22.43, O22.50, O22.51, O22.52,
O22.53, O22.8X1, O22.8X2,
O22.8X3, O22.91, O22.92, O22.93,
O23.00, O23.10, O23.20, O23.30,
O23.40, O23.41, O23.42, O23.43,
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O23.91, O23.92, O23.93, O24.319,
O24.32, O24.419, O24.429, O24.439,
O24.911, O24.912, O24.913, O24.92,
O24.93, O25.10, O25.11, O25.12,
O25.13, O25.20 O25.3, O26.00,
O26.01, O26.02, O26.03, O26.11,
O26.12, O26.13, O26.20, O26.21,
O26.22, O26.23, O26.41, O26.42,
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O30.103, O30.109, O30.201,

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

O30.202, O30.203, O30.209,
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O31.30X0, O31.31X0, O31.32X0,
O31.33X0, O31.8X10, O31.8X20,
O31.8X30, O32.0XX0, O32.1XX0,
O32.2XX0, O32.3XX0, O32.4XX0,
O32.6XX0, O32.8XX0, O32.9XX0,
O33.0, O33.1, O33.2, O33.7, O33.8,
O33.9, O33.3XX0, O33.4XX0,
O33.5XX0, O33.6XX0, O34.00,
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O35.2XX0, O35.3XX0, O35.4XX0,
O35.5XX0, O35.6XX0, O35.8XX0,
O35.9XX0, O36.0110, O36.0120,
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O36.1190, O36.9110, O36.1920,
O36.1930, O36.1990, O36.4XX0,
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O36.5190, O36.5910, O36.5920,
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O36.8130, O36.8190, O36.91X0,
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O40.2XX0, O40.3XX0, O40.9XX0,
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O41.03X0, O41.1010, O41.1020,
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O41.8X30, O41.8X90, O41.90X0,
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O43.812, O43.813, O43.819, O43.91,
O43.92, O43.93, O44.00, O44.01,
O44.02, O44.03, O44.10, O44.11,
O44.12, O44.13, O45.001, O45.002,
O45.003, O45.011, O45.012,
O45.013, O45.021, O45.022,
O45.023, O45.091, O45.092,
O45.093, O45.8X1, O45.8X2,
O45.8X3, O45.8X9, O45.91, O45.92,
O45.93, O46.001, O46.002, O46.003,
O46.009, O46.011, O46.012,
O46.013, O46.021, O46.022,
O46.023, O46.029, O46.091,
O46.092, O46.093, O46.099, O46.19,
O46.8X1, O46.8X2, O46.8X3,
O46.8X9, O46.91, O46.92, O46.93,
O47.00, O47.02, O47.03, O47.1,
O47.9, O48.0, O48.1, O60.00,
O60.02, O60.10X0, O60.12X0,
O60.13X0, O60.14X0, O60.03,
O61.0, O61.1, O61.9, O62.0, O62.1,
O62.2, O62.3, O62.4, O62.9, O63.0,
O63.1, O63.2, O63.9, O64.1XX0,
O64.9XX0, O66.0, O66.1, O66.40,
O66.5, O66.8, O66.9, O67.0, O67.8,
O67.8X1, O67.8X2, O67.8X3, O68,
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O69.4XX0, O69.5XX0, O69.81X0,
O69.82X0, O69.89X0, O69.9XX0,
O70.0, O70.1, O70.2, O70.3, O70.4,
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O71.9, O72.0, O72.1, O72.2, O72.3,
O73.0, O73.1, O74.1, O74.2, O74.3,
O74.8, O74.9, O75.0, O75.1, O75.2,
O75.3, O75.4, O75.5, O75.81,
O75.89, O75.9, O76, O80, O82, O85,
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O87.1, O87.2, O87.3, O87.4, O87.8,

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O88.819, O88.82, O88.83, O89.09,
O89.2, O89.8, O89.9, O9A.23, O90.3,
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O91.212, O91.213, O91.219, O91.22,
O91.23, O91.8X90, O92.011,
O92.012, O92.013, O92.019, O92.03,
O92.111, O92.112, O92.113,
O92.119, O92.13, O92.20, O92.29,
O92.3, O92.5, O92.6, O92.70,
O92.79, O94, O98.011, O98.012,
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O98.819, O98.82, O98.83, O98.911,
O98.912, O98.3913, O98.919,
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O99.345, O99.350, O99.351,
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O99.355, O99.411, O99.412,
O99.413, O99.419, O99.42, O99.43,
O99.511, O99.512, O99.513,

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O99.519, O99.52, O99.53, O99.412,
 O99.413, O99.419, O99.42, O99.43,
 O99.53, O99.61, O99.611, O99.612,
 O99.613, O99.619, O99.62, O99.63,
 O99.810, O99.814, O99.815,
 O99.834, O99.835, O99.840,
 O99.841, O99.842, O99.843,
 O99.844, O99.845, O99.89, Z33.1,
 Z33.2, Z34.0, Z34.80, Z34.90

99222	PR INITIAL HOSPITAL CARE/DAY 55 MINUTES	AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
99222	PR INITIAL HOSPITAL CARE/DAY 55 MINUTES	AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99222	PR INITIAL HOSPITAL CARE/DAY 55 MINUTES	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99223	PR INITIAL HOSPITAL CARE/DAY 75 MINUTES	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99223	PR INITIAL HOSPITAL CARE/DAY 75 MINUTES	AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
99223	PR INITIAL HOSPITAL CARE/DAY 75 MINUTES	AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
99223	PR INITIAL HOSPITAL CARE/DAY 75 MINUTES	NO AUTHORIZATION REQUIRED LIMITS: NO AUTH IS REQUIRED FOR UP TO 2 DAYS DIAGNOSIS CODES: NO AUTH IS REQUIRED IF OB OBS DX: A34, O00.0, O00.1, O00.2, O00.8, O00.9, O01.9, O02.1, O02.81, O03.0, O03.1, O03.2, O03.30, O03.31, O03.33, O03.34, O03.37, O03.38, O03.39, O03.4, O03.5, O03.6, O03.7, O03.80, O03.81, O03.82, O03.83, O03.84, O03.85, O03.86, O03.87, O03.88, O03.9, O04.5, O04.6, O04.7, O04.80, O04.81, O04.82, O04.83, O04.84, O04.85, O04.86, O04.87, O04.88, O04.89, O07.0, O07.1, O07.2, O07.30, O07.31, O07.32, O07.33, O07.34, O07.35, O07.36, O07.37, O07.38, O07.39, O07.4, O08.0,	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2024

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O09.892, O09.893, O09.899, O09.90,
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O10.012, O10.013, O10.019, O10.02,
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O26.859, O26.891, O26.892,
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Prior Authorization Requirements for STAR, STAR Kids, and CHIP

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 O99.834, O99.835, O99.840,
 O99.841, O99.842, O99.843,
 O99.844, O99.845, O99.89, Z33.1,
 Z33.2, Z34.0, Z34.80, Z34.90

99223	PR INITIAL HOSPITAL CARE/DAY 75 MINUTES	<p>AUTHORIZATION REQUIRED</p> <p>LIMITS: AUTH IS REQUIRED IF MORE THAN 2 DAYS</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE OB OBS DX: A34, O00.0, O00.1, O00.2, O00.8, O00.9, O01.9, O02.1, O02.81, O03.0, O03.1, O03.2, O03.30, O03.31, O03.33, O03.34, O03.37, O03.38, O03.39, O03.4, O03.5, O03.6, O03.7, O03.80, O03.81, O03.82, O03.83, O03.84, O03.85, O03.86, O03.87, O03.88, O03.9, O04.5, O04.6, O04.7, O04.80, O04.81, O04.82, O04.83, O04.84, O04.85, O04.86, O04.87, O04.88, O04.89, O07.0, O07.1, O07.2, O07.30, O07.31, O07.32, O07.33, O07.34, O07.35, O07.36, O07.37, O07.38, O07.39, O07.4, O08.0, O08.1, O08.2, O08.3, O08.4, O08.5O, O08.6, O08.7, O08.81, O08.82, O08.83, O08.89, O09.00, O09.10, O09.211, O09.291, O09.30, O09.40,</p>	<p>INTERQUAL</p> <p>DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	<p>C, S, SK,CP</p>	<p>1/1/2024</p>
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Prior Authorization Requirements for STAR, STAR Kids, and CHIP

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O99.613, O99.619, O99.62, O99.63,
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O99.834, O99.835, O99.840,
O99.841, O99.842, O99.843,
O99.844, O99.845, O99.89, Z33.1,
Z33.2, Z34.0, Z34.80, Z34.90

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99231	PR SBSQ HOSPITAL CARE/DAY 25 MINUTES	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99232	PR SBSQ HOSPITAL CARE/DAY 35 MINUTES	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99232	PR SBSQ HOSPITAL CARE/DAY 35 MINUTES	<p>NO AUTHORIZATION REQUIRED</p> <p>ALERT: NO AUTH IS REQUIRED IF LESS THAN 35 DAYS PER EPISODE, WITH A MAXIMUM OF 2 EPISODES OF CARE PER ROLLING 6 MONTH PERIOD, AND 4 EPISODES OF CARE PER ROLLING YEAR DOES NOT REQUIRE AN AUTH.</p> <p>DIAGNOSIS CODES: NO AUTH IS REQUIRED IF DX: F12.10, F31.0, F31.10, F31.12, F31.2, F31.4, F31.63, F31.64, F31.9, F32.2, F32.89, F32.9, F33.2, F33.3, F34.81, F34.89, F39, F40.10, F41.1, F41.9, F43.10, F43.12, F43.9, F43.50, F50.9, F60.3, F63.81, F65.0, F65.89, F84.0, F90.0, F90.1, F90.2, F90.8, F90.9, F91.3, F94.1, G40.813, G40.824, G40.919, Z62.810, Z62.820. Z71.3</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	4/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99232	PR SBSQ HOSPITAL CARE/DAY 35 MINUTES	<p>AUTHORIZATION REQUIRED</p> <p>ALERT: AUTH IS REQUIRED IF MORE THAN 35 DAYS PER EPISODE, MORE THAN 2 EPISODES OF CARE PER ROLLING 6 MONTH PERIOD, OR MORE THAN 4 EPISODES OF CARE PER ROLLING YEAR</p> <p>DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DX: F12.10, F31.0, F31.10, F31.12, F31.2, F31.4, F31.63, F31.64, F31.9, F32.2, F32.89, F32.9, F33.2, F33.3, F34.81, F34.89, F39, F40.10, F41.1, F41.9, F43.10, F43.12, F43.9, F43.50, F50.9, F60.3, F63.81, F65.0, F65.89, F84.0, F90.0, F90.1, F90.2, F90.8, F90.9, F91.3, F94.1, G40.813, G40.824, G40.919, Z62.810, Z62.820. Z71.3</p> <p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	4/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99233	PR SBSQ HOSPITAL CARE/DAY 50 MINUTES	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99242	PR OFFICE/OTHER OUTPAT CONSULTATIO N NEW/ESTAB PATIENT 20 MIN	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
99242	PR OFFICE/OTHER OUTPAT CONSULTATIO N NEW/ESTAB PATIENT 20 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99242	PR OFFICE/OTHER OUTPAT CONSULTATION NEW/ESTABLISHED PATIENT 20 MIN	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTHORIZATION REQUIRED IF REFERRED TO PROVIDER IS A BEHAVIORAL HEALTH	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
99242	PR OFFICE/OTHER OUTPAT CONSULTATION NEW/ESTABLISHED PATIENT 20 MIN	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTHORIZATION REQUIRED IF REFERRED TO PROVIDER IS A FEDERALLY QUALIFIED HEALTH CENTERS (FEDERALLY QUALIFIED HEALTH CENTERS (FQHC))	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023
99243	PR OFFICE/OTHER OUTPAT CONSULT NEW/ESTABLISHED PATIENT 30 MIN	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTHORIZATION REQUIRED IF REFERRED TO PROVIDER IS A FEDERALLY QUALIFIED HEALTH CENTERS (FEDERALLY QUALIFIED HEALTH CENTERS (FQHC))	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023
99243	PR OFFICE/OTHER OUTPAT CONSULT NEW/ESTABLISHED PATIENT 30 MIN	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTHORIZATION REQUIRED IF REFERRED TO PROVIDER IS A BEHAVIORAL HEALTH	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
99243	PR OFFICE/OTHER OUTPAT CONSULT NEW/ESTABLISHED PATIENT 30 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99243	PR OFFICE/OTHER OUTPAT CONSULT NEW/ESTAB PATIENT 30 MIN	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99243	PR OFFICE/OTHER OUTPAT CONSULT NEW/ESTAB PATIENT 30 MIN	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99244	PR OFFICE/OTHER OUTPAT CONSULT NEW/ESTAB PATIENT 40 MIN	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
99244	PR OFFICE/OTHER OUTPAT CONSULT NEW/ESTAB PATIENT 40 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99244	PR OFFICE/OTHER OUTPAT CONSULT NEW/ESTAB PATIENT 40 MIN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A BEHAVIORAL HEALTH		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
99244	PR OFFICE/OTHER OUTPAT CONSULT NEW/ESTAB PATIENT 40 MIN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A FEDERALLY QUALIFIED HEALTH CENTERS (FEDERALLY QUALIFIED HEALTH CENTERS (FQHC))		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023
99245	PR OFFICE/OTHER OUTPAT CONSULT NEW/ESTAB PATIENT 55 MIN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A FEDERALLY QUALIFIED HEALTH CENTERS (FEDERALLY QUALIFIED HEALTH CENTERS (FQHC))		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023
99245	PR OFFICE/OTHER OUTPAT CONSULT NEW/ESTAB PATIENT 55 MIN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A BEHAVIORAL HEALTH		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
99245	PR OFFICE/OTHER OUTPAT CONSULT NEW/ESTAB PATIENT 55 MIN	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A BEHAVIORAL HEALTH		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99245	PR OFFICE/OTHER OUTPAT CONSULT NEW/ESTAB PATIENT 55 MIN	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
99252	PR INITL INPATIENT/OBS CONSULT NEW/ESTAB PT 35 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99252	PR INITL INPATIENT/OBS CONSULT NEW/ESTAB PT 35 MIN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99253	PR INITL INPATIENT/OBS CONSULT NEW/ESTAB PT 45 MIN	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
99253	PR INITL INPATIENT/OBS CONSULT NEW/ESTAB PT 45 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99254	PR INITL INPATIENT/OBS CONSULT NEW/ESTAB PT 60 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2023
99254	PR INITL INPATIENT/OBS CONSULT NEW/ESTAB PT 60 MIN	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99255	PR INITIAL INPATIENT/OBS CONSULT NEW/ESTAB PT 80 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2023
99282	PR EMERGENCY DEPARTMENT VISIT STRAIGHTFORWARD MEDICAL DECISION MAKING	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99283	PR EMERGENCY DEPARTMENT VISIT LOW LEVEL OF MEDICAL DECISION	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99284	PR EMERGENCY DEPARTMENT VISIT MODERATE LEVEL OF MEDICAL DECISION	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99285	PR EMERGENCY DEPT VISIT HIGH LEVEL OF MEDICAL DECISION	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99366	PR TEAM CONFERENCE FACE-TO-FACE NONPHYSICIAN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMHP TMPPM CHILDREN SERVICES HANDBOOK, VOLUME 2, SECTION 2.3, MEDICAID AUTISM SERVICES POLICY HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	2/1/2022
99377	PR SUPERVISION HOSPICE PATIENT/MONT H 15-29 MIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
99378	PR SUPERVISION HOSPICE PATIENT/MONT H 30 MINUTES/>	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
99381	PREVENTIVE VISIT,NEW,INFA NT < 1 YR	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		4/28/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99381	PREVENTIVE VISIT,NEW,INFA NT < 1 YR	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		4/28/2021
99382	PREVENTIVE VISIT,NEW,AGE 1-4	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		4/28/2021
99382	PREVENTIVE VISIT,NEW,AGE 1-4	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		4/28/2021
99383	PREVENTIVE VISIT,NEW,AGE 5-11	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		4/28/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99383	PREVENTIVE VISIT,NEW,AGE 5-11	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		4/28/2021
99384	PREVENTIVE VISIT,NEW,12-17	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		4/28/2021
99384	PREVENTIVE VISIT,NEW,12-17	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		4/28/2021
99385	PREVENTIVE VISIT,NEW,18-39	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		4/28/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99385	PREVENTIVE VISIT,NEW,18-39	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		4/28/2021
99391	PREVENTIVE VISIT,EST, INFANT < 1 YR	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		4/28/2021
99391	PREVENTIVE VISIT,EST, INFANT < 1 YR	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		4/28/2021
99392	PREVENTIVE VISIT,EST,AGE 1-4	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		4/28/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99392	PREVENTIVE VISIT,EST,AGE 1-4	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		4/28/2021
99393	PREVENTIVE VISIT,EST,AGE5 -11	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		4/28/2021
99393	PREVENTIVE VISIT,EST,AGE5 -11	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		4/28/2021
99394	PREVENTIVE VISIT,EST,12-17	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		4/28/2021

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99394	PREVENTIVE VISIT,EST,12-17	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		4/28/2021
99395	PREVENTIVE VISIT,EST,18-39	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01 EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		4/28/2021
99395	PREVENTIVE VISIT,EST,18-39	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		4/28/2021
99406	PR TOBACCO USE CESSATION INTERMEDIATE 3-10 MINUTES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99407	PR TOBACCO USE CESSATION INTENSIVE >10 MINUTES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	5/10/2021
99408	PR ALCOHOL/SUBSTANCE SCREEN & INTERVEN 15-30 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
99417	PR PROLONGED OFFICE/OUTPATIENT E/M SVC EA 15 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
99417	PR PROLONGED OFFICE/OUTPATIENT E/M SVC EA 15 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
99417	PR PROLONGED OFFICE/OUTPATIENT E/M SVC EA 15 MIN	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A FEDERALLY QUALIFIED HEALTH CENTERS (FEDERALLY QUALIFIED HEALTH CENTERS (FQHC))	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023
99417	PR PROLONGED OFFICE/OUTPATIENT E/M SVC EA 15 MIN	NO AUTHORIZATION REQUIRED	RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A BEHAVIORAL HEALTH	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99417	PR PROLONGED OFFICE/OUTPATIENT E/M SVC EA 15 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2023
99418	PR PROLONGED INPATIENT/OBSERVATION E/M SVC EA 15 MIN	AUTHORIZATION REQUIRED LIMITS: AUTH IS REQUIRED IF MORE THAN 2 DAYS DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE OB OBS DX: A34, O00.0, O00.1, O00.2, O00.8, O00.9, O01.9, O02.1, O02.81, O03.0, O03.1, O03.2, O03.30, O03.31, O03.33, O03.34, O03.37, O03.38, O03.39, O03.4, O03.5, O03.6, O03.7, O03.80, O03.81, O03.82, O03.83, O03.84, O03.85, O03.86, O03.87, O03.88, O03.9, O04.5, O04.6, O04.7, O04.80, O04.81, O04.82, O04.83, O04.84, O04.85, O04.86, O04.87, O04.88, O04.89, O07.0, O07.1, O07.2, O07.30, O07.31, O07.32, O07.33, O07.34, O07.35, O07.36, O07.37, O07.38, O07.39, O07.4, O08.0, O08.1, O08.2, O08.3, O08.4, O08.50, O08.6, O08.7, O08.81, O08.82, O08.83, O08.89, O09.00, O09.10, O09.211, O09.291, O09.30, O09.40, O09.41, O09.42, O09.43, O09.511, O09.512, O09.513, O09.519, O09.521, O09.522, O09.523, O09.529, O09.611, O09.621, O09.819, O09.821, O09.822, O09.823, O09.829, O09.891, O09.892, O09.893, O09.899, O09.90, O09.91, O09.92, O09.93, O10.011, O10.012, O10.013, O10.019, O10.02, O10.03, O10.111, O10.112, O10.113, O10.119, O10.12, O10.13, O10.20, O10.211, O10.212, O10.213, O10.219, O10.22, O10.230, O10.311, O10.312, O10.313, O10.319, O10.32,	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		1/1/2024

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O10.33, O10.411, O10.412, O10.413,
O10.419, O10.42, O10.43, O10.911,
O10.912, O10.913, O10.919, O10.92,
O10.93, O11.1, O11.2, O11.3, O11.9,
O12.0, O12.00, O12.01, O12.02,
O12.03, O12.20, O12.21, O12.22,
O12.23, O13.1, O13.2, O13.3, O13.9,
O14.00, O14.02, O14.03, O14.10,
O14.12, O14.13, O14.20, O14.22,
O14.23, O14.90, O14.92, O14.93,
O15.02, O15.03, O15.1, O15.2,
O15.9, O16.1, O16.2, O16.3, O16.9,
O20.0, O20.8, O20.9, O21.0, O21.1,
O21.2, O21.8, O21.9, O22.00,
O22.01, O22.02, O22.03, O22.10,
O22.11, O22.12, O22.13, O22.20,
O22.21, O22.23, O22.31, O22.32,
O22.33, O22.4, O22.41, O22.42,
O22.43, O22.50, O22.51, O22.52,
O22.53, O22.8X1, O22.8X2,
O22.8X3, O22.91, O22.92, O22.93,
O23.00, O23.10, O23.20, O23.30,
O23.40, O23.41, O23.42, O23.43,
O23.519, O23.529, O23.599, O23.90,
O23.91, O23.92, O23.93, O24.319,
O24.32, O24.419, O24.429, O24.439,
O24.911, O24.912, O24.913, O24.92,
O24.93, O25.10, O25.11, O25.12,
O25.13, O25.20, O25.3, O26.00,
O26.01, O26.02, O26.03, O26.11,
O26.12, O26.13, O26.20, O26.21,
O26.22, O26.23, O26.41, O26.42,
O26.43, O26.50, O26.51, O26.52,
O26.53, O26.611, O26.612, O26.613,
O26.619, O26.62, O26.63, O26.811,
O26.812, O26.813, O26.819,
O26.821, O26.822, O26.823,
O26.829, O26.83, O26.831, O26.832,
O26.833, O26.839, O26.841,
O26.842, O26.843, O26.849,
O26.851, O26.852, O26.853,
O26.859, O26.891, O26.892,
O26.893, O26.90, O30.001, O30.003,
O30.009, O30.101, O30.102,
O30.103, O30.109, O30.201,
O30.202, O30.203, O30.209,
O30.801, O30.802, O30.803,
O30.809, O30.90, O30.91, O30.92,
O30.93, O31.00X0, O31.01X0,
O31.02X0, O31.03X0, O31.10X0,

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O31.30X0, O31.31X0, O31.32X0,
O31.33X0, O31.8X10, O31.8X20,
O31.8X30, O32.0XX0, O32.1XX0,
O32.2XX0, O32.3XX0, O32.4XX0,
O32.6XX0, O32.8XX0, O32.9XX0,
O33.0, O33.1, O33.2, O33.7, O33.8,
O33.9, O33.3XX0, O33.4XX0,
O33.5XX0, O33.6XX0, O34.00,
O34.01, O34.02, O34.03, O34.10,
O34.11, O34.12, O34.13, O34.21,
O34.29, O34.30, O34.31, O34.32,
O34.33, O34.40, O34.41, O34.42,
O34.43, O34.511, O34.512, O34.513,
O34.519, O34.521, O34.522,
O34.523, O34.529, O34.531,
O34.532, O34.533, O34.539,
O34.591, O34.592, O34.593,
O34.599, O34.60, O34.61, O34.62,
O34.63, O34.70, O34.71, O34.72,
O34.73, O34.80, O34.81, O34.82,
O34.83, O34.90, O34.91, O34.92,
O34.93, O35.0XX0, O35.1XX0,
O35.2XX0, O35.3XX0, O35.4XX0,
O35.5XX0, O35.6XX0, O35.8XX0,
O35.9XX0, O36.0110, O36.0120,
O36.0130, O36.0190, O36.0910,
O36.0920, O36.0930, O36.0990,
O36.1110, O36.1120, O36.1130,
O36.1190, O36.9110, O36.1920,
O36.1930, O36.1990, O36.4XX0,
O36.5110, O36.5120, O36.5130,
O36.5190, O36.5910, O36.5920,
O36.5930, O36.5990, O36.61X0,
O36.62X0, O36.63X0, O36.8120,
O36.8130, O36.8190, O36.91X0,
O36.92X0, O36.93X0, O40.1XX0,
O40.2XX0, O40.3XX0, O40.9XX0,
O41.00X0, O41.01X0, O41.02X0,
O41.03X0, O41.1010, O41.1020,
O41.1030, O41.1090, O41.1210,
O41.1220, O41.1230, O41.1290,
O41.1410, O41.1420, O41.1430,
O41.1490, O41.8X10, O41.8X20,
O41.8X30, O41.8X90, O41.90X0,
O41.91X0, O41.92X0, O41.93X0,
O42.00, O42.011, O42.012, O42.013,
O42.02, O42.10, O42.111, O42.112,
O42.113, O43.011, O43.019,
O43.101, O43.102, O43.103, O43.19,
O43.199, O43.211, O43.212,

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O43.213, O43.221, O43.222,
O43.223, O43.231, O43.232,
O43.233, O43.239, O43.811,
O43.812, O43.813, O43.819, O43.91,
O43.92, O43.93, O44.00, O44.01,
O44.02, O44.03, O44.10, O44.11,
O44.12, O44.13, O45.001, O45.002,
O45.003, O45.011, O45.012,
O45.013, O45.021, O45.022,
O45.023, O45.091, O45.092,
O45.093, O45.8X1, O45.8X2,
O45.8X3, O45.8X9, O45.91, O45.92,
O45.93, O46.001, O46.002, O46.003,
O46.009, O46.011, O46.012,
O46.013, O46.021, O46.022,
O46.023, O46.029, O46.091,
O46.092, O46.093, O46.099, O46.19,
O46.8X1, O46.8X2, O46.8X3,
O46.8X9, O46.91, O46.92, O46.93,
O47.00, O47.02, O47.03, O47.1,
O47.9, O48.0, O48.1, O60.00,
O60.02, O60.10X0, O60.12X0,
O60.13X0, O60.14X0, O60.03,
O61.0, O61.1, O61.9, O62.0, O62.1,
O62.2, O62.3, O62.4, O62.9, O63.0,
O63.1, O63.2, O63.9, O64.1XX0,
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O66.5, O66.8, O66.9, O67.0, O67.8,
O67.8X1, O67.8X2, O67.8X3, O68,
O69.0XX0, O69.1XX0, O69.2XX0,
O69.4XX0, O69.5XX0, O69.81X0,
O69.82X0, O69.89X0, O69.9XX0,
O70.0, O70.1, O70.2, O70.3, O70.4,
O70.9, O71.00, O71.02, O71.03,
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O71.9, O72.0, O72.1, O72.2, O72.3,
O73.0, O73.1, O74.1, O74.2, O74.3,
O74.8, O74.9, O75.0, O75.1, O75.2,
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O75.89, O75.9, O76, O80, O82, O85,
O86.11, O86.12, O86.13, O86.19,
O86.20, O86.21, O86.22, O86.29,
O86.4, O86.81, O86.89, O87.0,
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O87.9, O88.011, O88.012, O88.013,
O88.019, O88.02, O88.03, O88.111,
O88.112, O88.113, O88.119, O88.12,
O88.13, O88.211, O88.212, O88.213,
O88.219, O88.22, O88.23, O88.311,

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

O88.312, O88.313, O88.319, O88.32,
O88.33, O88.811, O88.812, O88.813,
O88.819, O88.82, O88.83, O89.09,
O89.2, O89.8, O89.9, O9A.23, O90.3,
O90.5, O90.6, O90.81, O90.89,
O90.9, O91.011, O91.012, O91.013,
O91.019, O91.02, O91.111, O91.112,
O91.113, O91.119, O91.12, O91.211,
O91.212, O91.213, O91.219, O91.22,
O91.23, O91.8X90, O92.011,
O92.012, O92.013, O92.019, O92.03,
O92.111, O92.112, O92.113,
O92.119, O92.13, O92.20, O92.29,
O92.3, O92.5, O92.6, O92.70,
O92.79, O94, O98.011, O98.012,
O98.013, O98.019, O98.02, O98.03,
O98.111, O98.112, O98.113,
O98.119, O98.12, O98.211, O98.212,
O98.213, O98.219, O98.22, O98.23,
O98.311, O98.312, O98.313,
O98.319, O98.32, O98.33, O98.42,
O98.43, O98.511, O98.512, O98.513,
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O98.612, O98.613, O98.619, O98.62,
O98.63, O98.811, O98.812, O98.813,
O98.819, O98.82, O98.83, O98.911,
O98.912, O98.3913, O98.919,
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O99.335, O99.340, O99.341,
O99.342, O99.343, O99.344,
O99.345, O99.350, O99.351,
O99.352, O99.353, O99.354,
O99.355, O99.411, O99.412,
O99.413, O99.419, O99.42, O99.43,
O99.511, O99.512, O99.513,
O99.519, O99.52, O99.53, O99.412,
O99.413, O99.419, O99.42, O99.43,
O99.53, O99.61, O99.611, O99.612,
O99.613, O99.619, O99.62, O99.63,
O99.810, O99.814, O99.815,

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

O99.834, O99.835, O99.840,
O99.841, O99.842, O99.843,
O99.844, O99.845, O99.89, Z33.1,
Z33.2, Z34.0, Z34.80, Z34.90

99418	PR PROLONGED INPATIENT/OBS ERVATION E/M SVC EA 15 MIN	NO AUTHORIZATION REQUIRED	INTERQUAL	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP	1/1/2024
		<p>LIMITS: NO AUTH IS REQUIRED FOR UP TO 2 DAYS</p> <p>DIAGNOSIS CODES: NO AUTH IS REQUIRED IF OB OBS DX: A34, O00.0, O00.1, O00.2, O00.8, O00.9, O01.9, O02.1, O02.81, O03.0, O03.1, O03.2, O03.30, O03.31, O03.33, O03.34, O03.37, O03.38, O03.39, O03.4, O03.5, O03.6, O03.7, O03.80, O03.81, O03.82, O03.83, O03.84, O03.85, O03.86, O03.87, O03.88, O03.9, O04.5, O04.6, O04.7, O04.80, O04.81, O04.82, O04.83, O04.84, O04.85, O04.86, O04.87, O04.88, O04.89, O07.0, O07.1, O07.2, O07.30, O07.31, O07.32, O07.33, O07.34, O07.35, O07.36, O07.37, O07.38, O07.39, O07.4, O08.0, O08.1, O08.2, O08.3, O08.4, O08.5O O08.6, O08.7, O08.81, O08.82, O08.83, O08.89, O09.00, O09.10, O09.211, O09.291, O09.30, O09.40, O09.41, O09.42, O09.43, O09.511, O09.512, O09.513, O09.519, O09.521, O09.522, O09.523, O09.529, O09.611, O09.621, O09.819, O09.821, O09.822, O09.823, O09.829, O09.891, O09.892, O09.893, O09.899, O09.90, O09.91, O09.92, O09.93, O10.011, O10.012, O10.013, O10.019, O10.02, O10.03, O10.111, O10.112, O10.113, O10.119, O10.12, O10.13, O10.20, O10.211, O10.212, O10.213, O10.219, O10.22, O10.23O O10.311, O10.312, O10.313, O10.319, O10.32, O10.33, O10.411, O10.412, O10.413, O10.419, O10.42, O10.43, O10.911, O10.912, O10.913, O10.919, O10.92, O10.93, O11.1, O11.2, O11.3, O11.9, O12.0, O12.00, O12.01, O12.02,</p>	DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.			

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O12.03, O12.20, O12.21, O12.22,
O12.23, O13.1, O13.2, O13.3, O13.9,
O14.00, O14.02, O14.03, O14.10,
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O14.23, O14.90, O14.92, O14.93,
O15.02, O15.03, O15.1, O15.2,
O15.9, O16.1, O16.2, O16.3, O16.9,
O20.0, O20.8, O20.9, O21.0, O21.1,
O21.2, O21.8, O21.9, O22.00,
O22.01, O22.02, O22.03, O22.10,
O22.11, O22.12, O22.13, O22.20,
O22.21, O22.23, O22.31, O22.32,
O22.33, O22.4, O22.41, O22.42,
O22.43, O22.50, O22.51, O22.52,
O22.53, O22.8X1, O22.8X2,
O22.8X3, O22.91, O22.92, O22.93,
O23.00, O23.10, O23.20, O23.30,
O23.40, O23.41, O23.42, O23.43,
O23.519, O23.529, O23.599, O23.90,
O23.91, O23.92, O23.93, O24.319,
O24.32, O24.419, O24.429, O24.439,
O24.911, O24.912, O24.913, O24.92,
O24.93, O25.10, O25.11, O25.12,
O25.13, O25.20, O25.3, O26.00,
O26.01, O26.02, O26.03, O26.11,
O26.12, O26.13, O26.20, O26.21,
O26.22, O26.23, O26.41, O26.42,
O26.43, O26.50, O26.51, O26.52,
O26.53, O26.611, O26.612, O26.613,
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O26.829, O26.83, O26.831, O26.832,
O26.833, O26.839, O26.841,
O26.842, O26.843, O26.849,
O26.851, O26.852, O26.853,
O26.859, O26.891, O26.892,
O26.893, O26.90, O30.001, O30.003,
O30.009, O30.101, O30.102,
O30.103, O30.109, O30.201,
O30.202, O30.203, O30.209,
O30.801, O30.802, O30.803,
O30.809, O30.90, O30.91, O30.92,
O30.93, O31.00X0, O31.01X0,
O31.02X0, O31.03X0, O31.10X0,
O31.30X0, O31.31X0, O31.32X0,
O31.33X0, O31.8X10, O31.8X20,
O31.8X30, O32.0XX0, O32.1XX0,
O32.2XX0, O32.3XX0, O32.4XX0,
O32.6XX0, O32.8XX0, O32.9XX0,

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O33.5XX0, O33.6XX0, O34.00,
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O34.43, O34.511, O34.512, O34.513,
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O34.523, O34.529, O34.531,
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O34.63, O34.70, O34.71, O34.72,
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O35.5XX0, O35.6XX0, O35.8XX0,
O35.9XX0, O36.0110, O36.0120,
O36.0130, O36.0190, O36.0910,
O36.0920, O36.0930, O36.0990,
O36.1110, O36.1120, O36.1130,
O36.1190, O36.9110, O36.1920,
O36.1930, O36.1990, O36.4XX0,
O36.5110, O36.5120, O36.5130,
O36.5190, O36.5910, O36.5920,
O36.5930, O36.5990, O36.61X0,
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O36.8130, O36.8190, O36.91X0,
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O40.2XX0, O40.3XX0, O40.9XX0,
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O41.03X0, O41.1010, O41.1020,
O41.1030, O41.1090, O41.1210,
O41.1220, O41.1230, O41.1290,
O41.1410, O41.1420, O41.1430,
O41.1490, O41.8X10, O41.8X20,
O41.8X30, O41.8X90, O41.90X0,
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O42.113, O43.011, O43.019,
O43.101, O43.102, O43.103, O43.19,
O43.199, O43.211, O43.212,
O43.213, O43.221, O43.222,
O43.223, O43.231, O43.232,
O43.233, O43.239, O43.811,
O43.812, O43.813, O43.819, O43.91,
O43.92, O43.93, O44.00, O44.01,

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O44.02, O44.03, O44.10, O44.11,
O44.12, O44.13, O45.001, O45.002,
O45.003, O45.011, O45.012,
O45.013, O45.021, O45.022,
O45.023, O45.091, O45.092,
O45.093, O45.8X1, O45.8X2,
O45.8X3, O45.8X9, O45.91, O45.92,
O45.93, O46.001, O46.002, O46.003,
O46.009, O46.011, O46.012,
O46.013, O46.021, O46.022,
O46.023, O46.029, O46.091,
O46.092, O46.093, O46.099, O46.19,
O46.8X1, O46.8X2, O46.8X3,
O46.8X9, O46.91, O46.92, O46.93,
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O60.13X0, O60.14X0, O60.03,
O61.0, O61.1, O61.9, O62.0, O62.1,
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O67.8X1, O67.8X2, O67.8X3, O68,
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O69.82X0, O69.89X0, O69.9XX0,
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O86.4, O86.81, O86.89, O87.0,
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O89.2, O89.8, O89.9, O9A.23, O90.3,
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Prior Authorization Requirements for STAR, STAR Kids, and CHIP

O90.9, O91.011, O91.012, O91.013,
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O91.113, O91.119, O91.12, O91.211,
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O91.23, O91.8X90, O92.011,
O92.012, O92.013, O92.019, O92.03,
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O98.63, O98.811, O98.812, O98.813,
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O98.912, O98.3913, O98.919,
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O99.413, O99.419, O99.42, O99.43,
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O99.413, O99.419, O99.42, O99.43,
O99.53, O99.61, O99.611, O99.612,
O99.613, O99.619, O99.62, O99.63,
O99.810, O99.814, O99.815,
O99.834, O99.835, O99.840,
O99.841, O99.842, O99.843,
O99.844, O99.845, O99.89, Z33.1,
Z33.2, Z34.0, Z34.80, Z34.90

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99418	PR PROLONGED INPATIENT/OBS ERVATION E/M SVC EA 15 MIN	AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
99418	PR PROLONGED INPATIENT/OBS ERVATION E/M SVC EA 15 MIN	AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023

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Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99421	PR ONLINE DIGITAL E/M SVC EST PT <7 D 5-10 MINUTES	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99422	PR ONLINE DIGITAL E/M SVC EST PT <7 D 11-20 MINUTES	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99441	PR PHYS/QHP TELEPHONE EVALUATION 5-10 MIN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99441	PR PHYS/QHP TELEPHONE EVALUATION 5-10 MIN	AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		7/1/2023
99442	PR PHYS/QHP TELEPHONE EVALUATION 11-20 MIN	AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99442	PR PHYS/QHP TELEPHONE EVALUATION 11 -20 MIN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99443	PR PHYS/QHP TELEPHONE EVALUATION 21 -30 MIN	AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		7/1/2023
99468	PR INITIAL HOSP NEONATE 28 DAY OR LESS, CRITICALLY ILL	AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
99469	PR SUBSEQUENT HOSP NEONATE 28 DAY OR LESS, CRITICALLY ILL	AUTHORIZATION REQUIRED	INTERQUAL DRISCOLL HEALTH PLAN UTILIZES PROPRIETARY INTERQUAL REVIEW CRITERIA FOR THE REQUESTED SERVICE AS A GUIDE FOR MEDICAL JUDGMENT OF QUALIFIED HEALTH CARE PROVIDERS/REVIEWERS.	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2023
99473	PR SELF-MEAS BP PT EDUCAJ/TRAIN G & DEV CALIBRATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
99474	PR SELF-MEAS BP 2 READG 1 MIN APART BID 30 DAY PD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
99492	PR 1ST PSYCHIATRIC COLLAB CARE MGMT 1ST 70 MINS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
99493	PR SBSQ PSYCHIATRIC COLLAB CARE MGMT 1ST 60 MINS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
99494	PR 1ST/SBSQ PSYCH COLLAB CARE MGMT EA ADDL 30 MINS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
99499	PR UNLISTED E/M SERVICE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A CHILD ABUSE PEDIATRICS	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
99499	PR UNLISTED E/M SERVICE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A CHILD ABUSE PEDIATRIC EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A0021	PR OUTSIDE STATE AMBULANCE SERV	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A0021	PR OUTSIDE STATE AMBULANCE SERV	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0080	PR NONINTEREST ESCORT IN NON ER	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0080	PR NONINTEREST ESCORT IN NON ER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0090	PR INTEREST ESCORT IN NON ER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0090	PR INTEREST ESCORT IN NON ER	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0100	PR NONEMERGEN CY TRANSPORT TAXI	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A0100	PR NONEMERGEN CY TRANSPORT TAXI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0110	PR NONEMERGEN CY TRANSPORT BUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0110	PR NONEMERGEN CY TRANSPORT BUS	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0120	PR NONER TRANSPORT MINI-BUS	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0120	PR NONER TRANSPORT MINI-BUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A0130	PR NONER TRANSPORT WHEELCH VAN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0130	PR NONER TRANSPORT WHEELCH VAN	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0140	PR NONEMERGEN CY TRANSPORT AIR	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0140	PR NONEMERGEN CY TRANSPORT AIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0160	PR NONER TRANSPORT CASE WORKER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0160	PR NONER TRANSPORT CASE WORKER	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A0170	PR TRANSPORT PARKING FEES/TOLLS	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0170	PR TRANSPORT PARKING FEES/TOLLS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0180	PR NONER TRANSPORT LODGNG RECIP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0180	PR NONER TRANSPORT LODGNG RECIP	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0190	PR NONER TRANSPORT MEALS RECIP	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0190	PR NONER TRANSPORT MEALS RECIP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A0200	PR NONER TRANSPORT LODNG ESCRT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0200	PR NONER TRANSPORT LODNG ESCRT	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0210	PR NONER TRANSPORT MEALS ESCORT	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0210	PR NONER TRANSPORT MEALS ESCORT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0225	PR NEONATAL EMERGENCY TRANSPORT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0225	PR NEONATAL EMERGENCY TRANSPORT	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A0380	PR BASIC LIFE SUPPORT MILEAGE	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0380	PR BASIC LIFE SUPPORT MILEAGE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0382	PR BASIC SUPPORT ROUTINE SUPPLS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0382	PR BASIC SUPPORT ROUTINE SUPPLS	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0384	PR BLS DEFIBRILLATION SUPPLIES	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0384	PR BLS DEFIBRILLATION SUPPLIES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A0390	PR ADVANCED LIFE SUPPORT MILEAG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0390	PR ADVANCED LIFE SUPPORT MILEAG	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0392	PR ALS DEFIBRILLATION SUPPLIES	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0392	PR ALS DEFIBRILLATION SUPPLIES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0394	PR ALS IV DRUG THERAPY SUPPLIES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0394	PR ALS IV DRUG THERAPY SUPPLIES	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A0396	PR ALS ESOPHAGEAL INTUB SUPPLS	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0396	PR ALS ESOPHAGEAL INTUB SUPPLS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0398	PR ALS ROUTINE DISPOSBLE SUPPLS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0398	PR ALS ROUTINE DISPOSBLE SUPPLS	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0420	PR AMBULANCE WAITING 1/2 HR	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0420	PR AMBULANCE WAITING 1/2 HR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A0422	PR AMBULANCE 02 LIFE SUSTAINING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0422	PR AMBULANCE 02 LIFE SUSTAINING	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0424	PR EXTRA AMBULANCE ATTENDANT	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0424	PR EXTRA AMBULANCE ATTENDANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0425	PR GROUND MILEAGE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0425	PR GROUND MILEAGE	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A0426	PR ALS 1	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0426	PR ALS 1	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0427	PR ALS1-EMERGENCY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0427	PR ALS1-EMERGENCY	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0428	PR BLS	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0428	PR BLS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A0429	PR BLS-EMERGENCY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0429	PR BLS-EMERGENCY	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0430	PR FIXED WING AIR TRANSPORT	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0430	PR FIXED WING AIR TRANSPORT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0431	PR ROTARY WING AIR TRANSPORT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0431	PR ROTARY WING AIR TRANSPORT	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A0432	PR PI VOLUNTEER AMBULANCE CO	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0432	PR PI VOLUNTEER AMBULANCE CO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0433	PR ALS 2	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0433	PR ALS 2	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0434	PR SPECIALTY CARE TRANSPORT	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0434	PR SPECIALTY CARE TRANSPORT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A0435	PR FIXED WING AIR MILEAGE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0435	PR FIXED WING AIR MILEAGE	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0436	PR ROTARY WING AIR MILEAGE	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0436	PR ROTARY WING AIR MILEAGE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0888	PR NONCOVERED AMBULANCE MILEAGE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0888	PR NONCOVERED AMBULANCE MILEAGE	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A0998	PR AMBULANCE RESPONSE/TR EATMENT	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0998	PR AMBULANCE RESPONSE/TR EATMENT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0999	PR UNLISTED AMBULANCE SERVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A0999	PR UNLISTED AMBULANCE SERVICE	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
A2022	INNOVABURN OR INNOVAMATRIX XL, PER SQUARE CENTIMETER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A2023	INNOVAMATRIX PD, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
A2024	RESOLVE MATRIX, PER SQUARE CENTIMETER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
A2025	MIRO3D, PER CUBIC CENTIMETER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
A4206	1 CC STERILE SYRINGE&NEE DLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4207	PR 2 CC STERILE SYRINGE&NEE DLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4208	PR 3 CC STERILE SYRINGE&NEE DLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4209	PR 5+ CC STERILE SYRINGE&NEE DLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4211	PR SUPP FOR SELF-ADM INJECTIONS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4212	PR NON CORING NEEDLE OR STYLET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4213	PR 20+ CC SYRINGE ONLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4215	PR STERILE NEEDLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4216	PR STERILE WATER/SALINE, 10 ML	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4217	PR STERILE WATER/SALINE, 500 ML	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4220	PR INFUSION PUMP REFILL KIT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4221	PR MAINT DRUG INFUS CATH PER WK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4222	PR INFUSION SUPPLIES WITH PUMP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4223	PR INFUSION SUPPLIES W/O PUMP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4224	PR SUPPLY INSULIN INF CATH/WK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4225	PR SUP/EXT INSULIN INF PUMP SYR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4230	PR INFUS INSULIN PUMP NON NEEDL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4231	PR INFUSION INSULIN PUMP NEEDLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4232	PR SYRINGE W/NEEDLE INSULIN 3CC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4233	PR ALKALIN BATT FOR GLUCOSE MON	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4234	PR J-CELL BATT FOR GLUCOSE MON	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4235	PR LITHIUM BATT FOR GLUCOSE MON	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4236	PR SILVR OXIDE BATT GLUCOSE MON	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4238	SUPPLY ALLOWANCE FOR ADJUNCTIVE CONTINUOUS GLUCOSE MONITOR (CGM), INCLUDES ALL SUPPLIES AND ACCESSORIES, 1 MONTH SUPPLY = 1 UNIT OF SERVICE	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
A4239	PR SUPPLY ALLOWANCE FOR NON-ADJUNCTIVE, NON-IMPLANTED CONTINUOUS GLUCOSE MONITOR (CGM), INCLUDES ALL SUPPLIES AND ACCESSORIES, 1 MONTH SUPPLY = 1 UNIT OF SERVICE	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
A4244	PR ALCOHOL OR PEROXIDE PER PINT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4245	PR ALCOHOL WIPES PER BOX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4246	PR BETADINE/PHIS OHEX SOLUTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4247	PR BETADINE/IODINE SWABS/WIPES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4248	PR CHLORHEXIDINE ANTISEPT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4250	PR URINE REAGENT STRIPS/TABLETS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4252	BLOOD KETONE TEST OR STRIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4253	PR BLOOD GLUCOSE/REAAGENT STRIPS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4256	PR CALIBRATOR SOLUTION/CHIPS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4258	PR LANCET DEVICE EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4259	PR LANCETS PER BOX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4263	PR PERMANENT TEAR DUCT PLUG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4264	PR INTRATUBAL OCCLUSION DEVICE	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	5/10/2021
A4265	PR PARAFFIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4280	PR BRST PRSTHS ADHSV ATTCHMNT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4281	PR REPLACEMENT BREASTPUMP TUBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4282	PR REPLACEMENT BREASTPUMP ADPT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4283	PR REPLACEMENT BREASTPUMP CAP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4284	PR REPLCMNT BREAST PUMP SHIELD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4285	PR REPLCMNT BREAST PUMP BOTTLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4286	PR REPLCMNT BREASTPUMP LOK RING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4290	PR SACRAL NERVE STIM TEST LEAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4300	PR CATH IMPL VASC ACCESS PORTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4301	PR IMPLANTABLE ACCESS SYST PERC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4305	PR DRUG DELIVERY SYSTEM >=50 ML	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4306	PR DRUG DELIVERY SYSTEM <=50 ML	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4310	PR INSERT TRAY W/O BAG/CATH	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4311	PR CATHETER W/O BAG 2-WAY LATEX	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4312	PR CATH W/O BAG 2-WAY SILICONE	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4313	PR CATHETER W/BAG 3-WAY	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4314	PR CATH W/DRAINAGE 2-WAY LATEX	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4315	PR CATH W/DRAINAGE 2-WAY SILCNE	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4316	PR CATH W/DRAINAGE 3-WAY	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4320	PR IRRIGATION TRAY	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4321	PR CATH THERAPEUTIC IRRIG AGENT	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4322	PR IRRIGATION SYRINGE	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4326	PR MALE EXTERNAL CATHETER	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4327	PR FEM URINARY COLLECT DEV CUP	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4328	PR FEM URINARY COLLECT POUCH	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4330	PR STOOL COLLECTION POUCH	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4331	PR EXTENSION DRAINAGE TUBING	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4332	PR LUBE STERILE PACKET	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4333	PR URINARY CATH ANCHOR DEVICE	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4334	PR URINARY CATH LEG STRAP	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4335	PR INCONTINENCE SUPPLY	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Incontinence Supplies): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Incontinence-Supplies.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4337	PR INCONTINENT RECTAL INSERT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4338	PR INDWELLING CATHETER LATEX	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4340	PR INDWELLING CATHETER SPECIAL	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4344	PR CATH INDW FOLEY 2 WAY SILICN OR POLYURETHAN E	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4346	PR CATH INDW FOLEY 3 WAY	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4349	PR DISPOSABLE MALE EXTERNAL CAT	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4351	PR STRAIGHT TIP URINE CATHETER	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4352	PR COUDE TIP URINARY CATHETER	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4353	PR INTERMITTENT URINARY CATH	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4354	PR CATH INSERTION TRAY W/BAG	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4355	PR BLADDER IRRIGATION TUBING	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4356	PR EXT URETH CLMP OR COMPR DVC	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4357	PR BEDSIDE DRAINAGE BAG	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4358	PR URINARY LEG OR ABDOMEN BAG	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4359	PR URINARY SUSPENSORY W/O LEG B	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4360	PR DISPOSABLE EXT URETHRAL DEV	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4361	PR OSTOMY FACE PLATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4362	PR SOLID SKIN BARRIER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4363	PR OSTOMY CLAMP, REPLACEMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4364	PR ADHESIVE, LIQUID OR EQUAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4365	PR ADHESIVE REMOVER WIPES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4366	PR OSTOMY VENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4367	PR OSTOMY BELT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4368	PR OSTOMY FILTER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4369	PR SKIN BARRIER LIQUID PER OZ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4371	PR SKIN BARRIER POWDER PER OZ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4372	PR SKIN BARRIER SOLID 4X4 EQUIV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4373	PR SKIN BARRIER WITH FLANGE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4375	PR DRAINABLE PLASTIC PCH W FCPL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4376	PR DRAINABLE RUBBER PCH W FCPLT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4377	PR DRAINABLE PLSTIC PCH W/O FP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4378	PR DRAINABLE RUBBER PCH W/O FP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4379	PR URINARY PLASTIC POUCH W FCPL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4380	PR URINARY RUBBER POUCH W FCPLT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4381	PR URINARY PLASTIC POUCH W/O FP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4382	PR URINARY HVY PLSTC PCH W/O FP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4383	PR URINARY RUBBER POUCH W/O FP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4384	PR OSTOMY FACEPLT/SILIC ONE RING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4385	PR OST SKN BARRIER SLD EXT WEAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4387	PR OST CLSD POUCH W ATT ST BARR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4388	PR DRAINABLE PCH W EX WEAR BARR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4389	PR DRAINABLE PCH W ST WEAR BARR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4390	PR DRAINABLE PCH EX WEAR CONVEX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4391	PR URINARY POUCH W EX WEAR BARR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4392	PR URINARY POUCH W ST WEAR BARR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4393	PR URINE PCH W EX WEAR BAR CONV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4394	PR OSTOMY POUCH LIQ DEODORANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4395	PR OSTOMY POUCH SOLID DEODORANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4396	PR PERISTOMAL HERNIA SUPPRT BLT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4398	PR OSTOMY IRRIGATION BAG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4399	PR OSTOMY IRRIG CONE/CATH W BRS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4400	PR OSTOMY IRRIGATION SET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4402	PR LUBRICANT PER OUNCE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4404	PR OSTOMY RING EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4405	PR NONPECTIN BASED OSTOMY PASTE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4406	PR PECTIN BASED OSTOMY PASTE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4407	PR EXT WEAR OST SKN BARR <=4SQ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4408	PR EXT WEAR OST SKN BARR >4SQ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4409	PR OST SKN BARR CONVEX <=4 SQ I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4410	PR OST SKN BARR EXTND >4 SQ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4411	PR OST SKN BARR EXTND =4SQ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4412	PR OST POUCH DRAIN HIGH OUTPUT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4413	PR 2 PC DRAINABLE OST POUCH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4414	PR OST SKNBAR W/O CONV<=4 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4415	PR OST SKN BARR W/O CONV >4 SQI	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4416	PR OST PCH CLSD W BARRIER/FILTR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4417	PR OST PCH W BAR/BLTINCON V/FLTR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4418	PR OST PCH CLSD W/O BAR W FILTR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4419	PR OST PCH FOR BAR W FLANGE/FLT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4420	PR OST PCH CLSD FOR BAR W LK FL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4421	PR OSTOMY SUPPLY MISC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4422	PR OST POUCH ABSORBENT MATERIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4423	PR OST PCH FOR BAR W LK FL/FLTR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4424	PR OST PCH DRAIN W BAR & FILTER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4425	PR OST PCH DRAIN FOR BARRIER FL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4426	PR OST PCH DRAIN 2 PIECE SYSTEM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4427	PR OST PCH DRAIN/BARR LK FLNG/F	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4428	PR URINE OST POUCH W FAUCET/TAP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4429	PR URINE OST POUCH W BLTINCONV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4430	PR OST URINE PCH W B/BLTIN CONV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4431	PR OST PCH URINE W BARRIER/TAPV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4432	PR OS PCH URINE W BAR/FANGE/TAP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4433	PR URINE OST PCH BAR W LOCK FLN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4434	PR OST PCH URINE W LOCK FLNG/FT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4436	PR IRR SUPPLY SLEEV REUS PER MO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4437	PR IRR SUPPLY SLEEV DISP PER MO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4450	PR NON-WATERPROOF TAPE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4452	PR WATERPROOF TAPE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4453	PR REC CATH MAN PUMP ENEMA REPL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4455	PR ADHESIVE REMOVER PER OUNCE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4456	PR ADHESIVE REMOVER, WIPES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4461	PR SURGICL DRESS HOLD NON-REUSE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4465	PR NON-ELASTIC EXTREMITY BINDER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4467	PR BELT STRAP SLEEV GRMNT COVER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4481	PR TRACHEOSTOM A FILTER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4483	PR MOISTURE EXCHANGER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4490	PR ABOVE KNEE SURGICAL STOCKING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4495	PR THIGH LENGTH SURG STOCKING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4500	PR BELOW KNEE SURGICAL STOCKING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4510	PR FULL LENGTH SURG STOCKING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4541	MONTHLY SUPPLIES FOR USE OF DEVICE CODED AT E0733	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4554	PR DISPOSABLE UNDERPADS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Incontinence Supplies): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Incontinence-Supplies.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4556	PR ELECTRODES, PAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4557	PR LEAD WIRES, PAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4558	PR CONDUCTIVE GEL OR PASTE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4560	NEUROMUSCULAR ELECTRICAL STIMULATOR (NMES), DISPOSABLE, REPLACEMENT ONLY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023
A4561	PR PESSARY, REUSABLE, RUBBER, ANY TYPE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4562	PR PESSARY, REUSABLE, NON RUBBER, ANY TYPE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4565	PR SLINGS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4566	PR SHOULD SLING/VEST/AB RESTRAIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4570	PR SPLINT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4595	PR TENS SUPPL 2 LEAD PER MONTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4600	PR SLEEVE, INTER LIMB COMP DEV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4601	PR LITH ION NON PROSTH RECHARGE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4605	PR TRACH SUCTION CATH CLOSE SYS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4606	PR OXYGEN PROBE USED W OXIMETER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4611	PR HEAVY DUTY BATTERY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4612	PR BATTERY CABLES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4613	PR BATTERY CHARGER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4614	PR HAND-HELD PEFR METER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4615	CANNULA NASAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4616	TUBING (OXYGEN) PER FOOT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4617	MOUTH PIECE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4618	PR BREATHING CIRCUITS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4619	PR FACE TENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4620	VARIABLE CONCENTRATION MASK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4623	PR TRACHEOSTOMY INNER CANNULA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4624	PR TRACHEAL SUCTION TUBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4627	PR SPACER BAG/RESERVOIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4628	PR OROPHARYNGEAL SUCTION CATH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A4629	PR TRACHEOSTOMY CARE KIT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4630	PR REPL BAT T.E.N.S. OWN BY PT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4635	PR UNDERARM CRUTCH PAD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4636	PR HANDGRIP FOR CANE ETC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4637	PR REPL TIP CANE/CRUTCH/WALKER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4640	PR ALTERNATING PRESSURE PAD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4649	PR SURGICAL SUPPLIES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4651	PR CALIBRATED MICROCAP TUBE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4652	PR MICROCAPILLARY TUBE SEALANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4657	PR SYRINGE W/WO NEEDLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4660	PR SPHYG/BP APP W CUFF AND STET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4663	PR DIALYSIS BLOOD PRESSURE CUFF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4670	PR AUTOMATIC BP MONITOR, DIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4680	PR ACTIVATED CARBON FILTER, EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4690	PR DIALYZER, EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4706	PR BICARBONATE CONC SOL PER GAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4707	PR BICARBONATE CONC POW PER PAC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4708	PR ACETATE CONC SOL PER GALLON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4709	PR ACID CONC SOL PER GALLON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4714	PR TREATED WATER PER GALLON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4719	PR Y SET TUBING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4720	PR DIALYSAT SOL FLD VOL > 249CC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4721	PR DIALYSAT SOL FLD VOL > 999CC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4722	PR DIALYS SOL FLD VOL > 1999CC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4723	PR DIALYS SOL FLD VOL > 2999CC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4724	PR DIALYS SOL FLD VOL > 3999CC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4725	PR DIALYS SOL FLD VOL > 4999CC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4726	PR DIALYS SOL FLD VOL > 5999CC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4730	PR FISTULA CANNULATION SET, EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4736	PR TOPICAL ANESTHETIC, PER GRAM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4737	PR INJ ANESTHETIC PER 10 ML	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4740	PR SHUNT ACCESSORY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4750	PR ART OR VENOUS BLOOD TUBING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4755	PR COMB ART/VENOUS BLOOD TUBING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4760	PR DIALYSATE SOL TEST KIT, EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4765	PR DIALYSATE CONC POW PER PACK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4766	PR DIALYSATE CONC SOL ADD 10 ML	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4772	PR BLOOD GLUCOSE TEST STRIPS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4773	PR OCCULT BLOOD TEST STRIPS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4774	PR AMMONIA TEST STRIPS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4802	PR PROTAMINE SULFATE PER 50 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4860	PR DISPOSABLE CATHETER TIPS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4911	PR DRAIN BAG/BOTTLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4913	PR MISC DIALYSIS SUPPLIES NOC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4918	PR VENOUS PRESSURE CLAMP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A4927	PR NON-STERILE GLOVES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4928	PR SURGICAL MASK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A4929	PR TOURNIQUET FOR DIALYSIS, EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4930	PR STERILE, GLOVES PER PAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4931	PR REUSABLE ORAL THERMOMETER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A4932	PR REUSABLE RECTAL THERMOMETER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A5051	PR POUCH CLSD W BARR ATTACHED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A5052	PR CLSD OSTOMY POUCH W/O BARR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A5053	PR CLSD OSTOMY POUCH FACEPLATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A5054	PR CLSD OSTOMY POUCH W/FLANGE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A5055	PR STOMA CAP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A5056	PR 1 PC OST POUCH W FILTER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A5057	PR 1 PC OST POU W BUILT-IN CONV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A5061	PR POUCH DRAINABLE W BARRIER AT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A5062	PR DRNBLE OSTOMY POUCH W/O BARR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A5063	PR DRAIN OSTOMY POUCH W/FLANGE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A5071	PR URINARY POUCH W/BARRIER	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A5072	PR URINARY POUCH W/O BARRIER	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A5073	PR URINARY POUCH ON BARR W/FLNG	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A5081	PR CONTINENT STOMA PLUG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A5082	PR CONTINENT STOMA CATHETER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A5083	STOMA ABSORPTIVE COVER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A5093	PR OSTOMY ACCESSORY CONVEX INSE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A5102	PR BEDSIDE DRAIN BTL W/WO TUBE	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A5105	URINARY SUSPENSORY	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A5112	PR URINARY LEG BAG	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A5113	PR LATEX LEG STRAP	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A5114	PR FOAM/FABRIC LEG STRAP	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A5120	PR SKIN BARRIER, WIPE OR SWAB	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A5121	PR SOLID SKIN BARRIER 6X6	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A5122	PR SOLID SKIN BARRIER 8X8	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A5126	PR DISK/FOAM PAD +OR-ADHESIVE	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A5131	PR APPLIANCE CLEANER	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A5200	PR PERCUTANEOUS CATHETER ANCHOR	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A5500	PR DIAB SHOE FOR DENSITY INSERT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A5501	PR DIABETIC CUSTOM MOLDED SHOE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A5503	PR DIABETIC SHOE W/ROLLER/ROCK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A5504	PR DIABETIC SHOE WITH WEDGE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A5505	PR DIAB SHOE W/METATARSA L BAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A5506	PR DIABETIC SHOE W/OFF SET HEEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A5507	PR MODIFICATION DIABETIC SHOE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6010	PR COLLAGEN BASED WOUND FILLER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6011	PR COLLAGEN GEL/PASTE WOUND FIL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6021	PR COLLAGEN DRESSING <=16 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6022	PR COLLAGEN DRSG>6<=48 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6023	PR COLLAGEN DRESSING >48 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6024	PR COLLAGEN DSG WOUND FILLER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A6025	PR SILICONE GEL SHEET, EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6154	PR WOUND POUCH EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6196	PR ALGINATE DRESSING <=16 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6197	PR ALGINATE DRSG >16 <=48 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6198	PR ALGINATE DRESSING > 48 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6199	PR ALGINATE DRSG WOUND FILLER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6203	PR COMPOSITE DRSG <= 16 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6204	PR COMPOSITE DRSG >16<=48 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6205	PR COMPOSITE DRSG > 48 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6206	PR CONTACT LAYER <= 16 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A6207	PR CONTACT LAYER >16<= 48 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6208	PR CONTACT LAYER > 48 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6209	PR FOAM DRSG <=16 SQ IN W/O BDR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6210	PR FOAM DRG >16<=48 SQ IN W/O B	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6211	PR FOAM DRG > 48 SQ IN W/O BRDR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6212	PR FOAM DRG <=16 SQ IN W/BORDER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6213	PR FOAM DRG >16<=48 SQ IN W/BDR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6214	PR FOAM DRG > 48 SQ IN W/BORDER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6215	PR FOAM DRESSING WOUND FILLER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A6216	PR NON-STERILE GAUZE<=16 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6217	PR NON-STERILE GAUZE>16<=48 SQ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6218	PR NON-STERILE GAUZE > 48 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6218	PR NON-STERILE GAUZE > 48 SQ IN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A6219	PR GAUZE <= 16 SQ IN W/BORDER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6220	PR GAUZE >16 <=48 SQ IN W/BORDR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6221	PR GAUZE > 48 SQ IN W/BORDER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6222	PR GAUZE <=16 IN NO W/SAL W/O B	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6223	PR GAUZE >16<=48 NO W/SAL W/O B	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A6224	PR GAUZE > 48 IN NO W/SAL W/O B	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6228	PR GAUZE <= 16 SQ IN WATER/SAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6229	PR GAUZE >16<=48 SQ IN WATR/SAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6230	PR GAUZE > 48 SQ IN WATER/SALNE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6231	PR HYDROGEL DSG<=16 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6232	PR HYDROGEL DSG>16<=48 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6233	PR HYDROGEL DRESSING >48 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6234	PR HYDROCOLLD DRG <=16 W/O BDR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6235	PR HYDROCOLLD DRG >16<=48 W/O B	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6236	PR HYDROCOLLD DRG > 48 IN W/O B	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A6237	PR HYDROCOLLD DRG <=16 IN W/BDR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6238	PR HYDROCOLLD DRG >16<=48 W/BDR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6239	PR HYDROCOLLD DRG > 48 IN W/BDR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6240	PR HYDROCOLLD DRG FILLER PASTE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6241	PR HYDROCOLLOID DRG FILLER DRY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6242	PR HYDROGEL DRG <=16 IN W/O BDR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6243	PR HYDROGEL DRG >16<=48 W/O BDR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6244	PR HYDROGEL DRG >48 IN W/O BDR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6245	PR HYDROGEL DRG <= 16 IN W/BDR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6246	PR HYDROGEL DRG >16<=48 IN W/B	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A6247	PR HYDROGEL DRG > 48 SQ IN W/B	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6248	PR HYDROGEL DRSG GEL FILLER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6250	PR SKIN SEAL PROTECT MOISTURIZR	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
A6251	PR ABSORPT DRG <=16 SQ IN W/O B	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6252	PR ABSORPT DRG >16 <=48 W/O BDR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6253	PR ABSORPT DRG > 48 SQ IN W/O B	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6254	PR ABSORPT DRG <=16 SQ IN W/BDR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6255	PR ABSORPT DRG >16<=48 IN W/BDR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A6256	PR ABSORPT DRG > 48 SQ IN W/BDR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A6257	PR TRANSPARENT FILM <= 16 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6258	PR TRANSPARENT FILM >16<=48 IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6259	PR TRANSPARENT FILM > 48 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6260	PR WOUND CLEANSER ANY TYPE/SIZE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A6261	PR WOUND FILLER GEL/PASTE /OZ	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A6262	PR WOUND FILLER DRY FORM / GRAM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A6266	PR IMPREG GAUZE NO H2O/SAL/YARD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6402	PR STERILE GAUZE <= 16 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6403	PR STERILE GAUZE>16 <= 48 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6404	PR STERILE GAUZE > 48 SQ IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6407	PR PACKING STRIPS, NON-IMPREG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6410	PR STERILE EYE PAD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6411	PR NON-STERILE EYE PAD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6412	PR OCCLUSIVE EYE PATCH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A6441	PR PAD BAND W>=3 <5/YD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6442	PR CONFORM BAND N/S W<3/YD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6443	PR CONFORM BAND N/S W>=3<5/YD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6444	PR CONFORM BAND N/S W>=5/YD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6445	PR CONFORM BAND S W <3/YD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6446	PR CONFORM BAND S W>=3 <5/YD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6447	PR CONFORM BAND S W >=5/YD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6448	PR LT COMPRES BAND <3/YD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6449	PR LT COMPRES BAND >=3 <5/YD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6450	PR LT COMPRES BAND >=5/YD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A6451	PR MOD COMPRES BAND W>=3<5/YD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6452	PR HIGH COMPRES BAND W>=3<5YD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6453	PR SELF-ADHER BAND W <3/YD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6454	PR SELF-ADHER BAND W>=3 <5/YD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6455	PR SELF-ADHER BAND >=5/YD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6456	PR ZINC PASTE BAND W >=3<5/YD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6457	PR TUBULAR DRESSING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6501	PR COMPRES BURNGARMEN T BODYSUIT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A6502	PR COMPRES BURNGARMEN T CHINSTRP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A6503	PR COMPRES BURNGARMEN T FACEHOOD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A6504	PR CMPRSBURNG ARMENT GLOVE-WRIST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A6505	PR CMPRSBURNG ARMENT GLOVE-ELBOW	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A6506	PR CMPRSBURNG RMNT GLOVE-AXILLA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A6507	PR CMPRS BURNGARMEN T FOOT-KNEE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A6508	PR CMPRS BURNGARMEN T FOOT-THIGH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A6509	PR COMPRES BURN GARMENT JACKET	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A6510	PR COMPRES BURN GARMENT LEOTARD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A6511	PR COMPRES BURN GARMENT PANTY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A6512	PR COMPRES BURN GARMENT, NOC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A6513	PR COMPRESS BURN MASK FACE/NECK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A6530	PR COMPRESSION STOCKING BK18-30	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6531	PR COMPRESSION STOCKING BK30-40	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6532	PR COMPRESSION STOCKING BK40-50	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6533	PR GC STOCKING THIGHLNGTH 18-30	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6534	PR GC STOCKING THIGHLNGTH 30-40	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6535	PR GC STOCKING THIGHLNGTH 40-50	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A6536	PR GC STOCKING FULL LNGTH 18-30	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6537	PR GC STOCKING FULL LNGTH 30-40	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6538	PR GC STOCKING FULL LNGTH 40-50	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6539	PR GC STOCKING WAISTLNGTH 18-30	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6540	PR GC STOCKING WAISTLNGTH 30-40	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6541	PR GC STOCKING WAISTLNGTH 40-50	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6542	PR GC STOCKING CUSTOM MADE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6543	PR GC STOCKING LYMPHEDEMA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6544	PR GC STOCKING GARTER BELT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A6545	PR GRAD COM NON-ELASTIC BK SURG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A6549	PR G COMPRESSION STOCKING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A6550	PR NEG PRES WOUND THER DRSG SET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7000	PR DISPOSABLE CANISTER FOR PUMP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7002	PR TUBING USED W SUCTION PUMP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7003	PR NEBULIZER ADMINISTRATI ON SET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7004	PR DISPOSABLE NEBULIZER SML VOL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7005	PR NONDISPOSAB LE NEBULIZER SET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7006	PR FILTERED NEBULIZER ADMIN SET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7007	PR LG VOL NEBULIZER DISPOSABLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A7009	PR NEBULIZER RESERVOIR BOTTLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7010	PR DISPOSABLE CORRUGATED TUBING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7011	PR NONDISPOS CORRUGATED TUBING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7012	PR NEBULIZER WATER COLLEC DEVIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7013	PR DISPOSABLE COMPRESSOR FILTER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7014	PR COMPRESSOR NONDISPOS FILTER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7015	PR AEROSOL MASK USED W NEBULIZE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7016	PR NEBULIZER DOME & MOUTHPIECE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7017	PR NEBULIZER NOT USED W OXYGEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7018	PR WATER DISTILLED W/NEBULIZER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A7025	PR REPLACE CHEST COMPRESS VEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7026	PR REPLACE CHST CMPRSS SYS HOSE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7027	COMBINATION ORAL/NASAL MASK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7028	REPL ORAL CUSHION COMBO MASK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7029	REPL NASAL PILLOW COMB MASK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7030	PR CPAP FULL FACE MASK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7031	PR REPLACEMENT FACEMASK INTERFA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7032	PR REPLACEMENT NASAL CUSHION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7033	PR REPLACEMENT NASAL PILLOWS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7034	PR NASAL APPLICATION DEVICE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A7035	PR POS AIRWAY PRESS HEADGEAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7036	PR POS AIRWAY PRESS CHINSTRAP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7037	PR POS AIRWAY PRESSURE TUBING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7038	PR POS AIRWAY PRESSURE FILTER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7039	PR FILTER, NON DISPOSABLE W PAP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7046	PR REPL WATER CHAMBER, PAP DEV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7520	PR TRACH/LARYN TUBE NON-CUFFED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A7521	PR TRACH/LARYN TUBE CUFFED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A7522	PR TRACH/LARYN TUBE STAINLESS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7523	PR TRACHEOSTOM Y SHOWER PROTECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7525	PR TRACHEOSTOM Y MASK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A7526	PR TRACHEOSTOM Y TUBE COLLAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A8000	PR SOFT PROTECT HELMET PREFAB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A8001	PR HARD PROTECT HELMET PREFAB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A8002	PR SOFT PROTECT HELMET CUSTOM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A8003	PR HARD PROTECT HELMET CUSTOM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A8004	PR REPL SOFT INTERFACE, HELMET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A9268	PROGRAMMER FOR TRANSIENT, ORALLY INGESTED CAPSULE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
A9269	PROGRAMABLE , TRANSIENT, ORALLY INGESTED CAPSULE, FOR USE WITH EXTERNAL PROGRAMMER, PER MONTH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THESE PROCEDURE CODES ARE NOT COVERED SERVICES BUT DHP WILL REVIEW REQUESTS FOR THESE PROCEDURE CODES ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
A9272	PR DISP WOUND SUCT, DRSG/ACCESS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A9273	PR HOT/COLD BOTTLE/CAP/CO LWRAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
A9274	EXT AMB INSULIN DELIVERY SYS	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR 15 OR LESS PER MONTH. AGE: NO AUTH IS REQUIRED IF LESS THAN 21 YEARS OF AGE.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	1/1/2024
A9274	EXT AMB INSULIN DELIVERY SYS	AUTHORIZATION REQUIRED ALERT: PRIOR AUTH IS REQUIRED IF MORE THAN 15 PER MONTH. AGE: PRIOR AUTH IS REQUIRED IF 21 YEARS OF AGE OR OLDER. EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	1/1/2024
A9275	PR DISP HOME GLUCOSE MONITOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A9276	DISPOSABLE SENSOR, CGM SYS	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A9277	PR EXTERNAL TRANSMITTER, CGM	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
A9278	EXTERNAL RECEIVER, CGM SYS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
A9279	PR MONITORING FEATURE/DEVI CENOC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
A9284	PR NON-ELECTRONIC SPIROMETER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
A9292	PRESCRIPTION DIGITAL VISUAL THERAPY, SOFTWARE-ONLY, FDA CLEARED, PER COURSE OF TREATMENT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A9507	PR IN111 CAPROMAB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
A9513	PR LUTETIUM IU 177 DOTATAT THER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
A9542	PR IN111 IBRITUMOMAB, DX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
A9573	INJECTION, GADOPICLENOL, 1 ML	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A9589	PR INSTI HEXAMINOLEV ULINATE HCL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
A9590	PR IODINE I-131 IOBENGUANE 1MCI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
A9600	PR SR89 STRONTIUM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
A9697	INJECTION, CARBOXYDEXT RAN-COATED SUPERPARAMA GNETIC IRON OXIDE, PER STUDY DOSE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
A9900	PR SUPPLY/ACCESSORY/SERVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Beds and Support Surfaces Guideline): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Beds-and-Support-Surfaces-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
B4034	ENTER FEED SUPKIT SYR BY DAY	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4035	PR ENTERAL FEED SUPP PUMP PER D	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
B4036	PR ENTERAL FEED SUP KIT GRAV BY	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4081	PR ENTERAL NG TUBING W/ STYLET	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4082	PR ENTERAL NG TUBING W/O STYLET	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
B4083	PR ENTERAL STOMACH TUBE LEVINE	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4087	GASTRO/JEJUNO TUBE, STD	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4088	GASTRO/JEJUNO TUBE, LOW-PRO	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
B4100	PR FOOD THICKENER ORAL	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4103	PR EF PED FLUID AND ELECTROLYTE	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4104	PR ADDITIVE FOR ENTERAL FORMULA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
B4105	PR ENZYME CARTRIDGE ENTERAL NUT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4105	PR ENZYME CARTRIDGE ENTERAL NUT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
B4148	ENTERAL FEEDING SUPPLY KIT; ELASTOMERIC CONTROL FED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK,CP	1/1/2024
B4149	PR EF BLENDERIZED FOODS	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
B4150	PR EF COMPLET W/INTACT NUTRIENT	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4151	DELETED 2088	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4152	PR EF CALORIE DENSE>/=1.5KC AL	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
B4153	PR EF HYDROLYZED/AMINO ACIDS	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4154	PR EF SPEC METABOLIC NONINHERIT	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4155	PR EF INCOMPLETE/MODULAR	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4156	DELETED 2089	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
B4157	PR EF SPECIAL METABOLIC INHERIT	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4158	PR EF PED COMPLETE INTACT NUT	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4159	PR EF PED COMPLETE SOY BASED	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
B4160	PR EF PED CALORIC DENSE >/=0.7KC	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4161	PR EF PED HYDROLYZED/ AMINO ACID	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4162	PR EF PED SPECMETABOL IC INHERIT	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
B4164	PR PARENTERAL 50% DEXTROSE SOLU	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4168	PR PARENTERAL SOL AMINO ACID 3.	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4172	PR PARENTERAL SOL AMINO ACID 5.	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4176	PR PARENTERAL SOL AMINO ACID 7-	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4178	PR PARENTERAL SOL AMINO ACID >	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
B4180	PR PARENTERAL SOL CARB > 50%	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4185	PR PN SOLN NOS 10 GRAMS LIPIDS	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4189	PR PARENTERAL SOL AMINO ACID &	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4193	PR PARENTERAL SOL 52-73 GM PROT	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4197	PR PARENTERAL SOL 74-100 GM PRO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
B4199	PR PARENTERAL SOL > 100GM PROTE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
B4216	PR PARENTERAL NUTRITION ADDITIV	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4220	PR PARENTERAL SUPPLY KIT PREMIX	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4222	PR PARENTERAL SUPPLY KIT HOMEMI	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B4224	PR PARENTERAL ADMINISTRATI ON KI	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
B5000	PR PARENTERAL SOL RENAL-AMIROSY	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B5100	PR PARENTERAL SOL HEPATIC-FREAM	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B5200	PR PARENTERAL SOL HEPATIC FREAM	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B9002	PR ENTERAL INFUSION PUMP W/ ALA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
B9004	PR PARENTERAL INFUS PUMP PORTAB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B9006	PR PARENTERAL INFUS PUMP STATIO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B9998	PR ENTERAL SUPP NOT OTHERWISE C	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Nutritional-Supplements.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
B9999	PR PARENTERAL SUPP NOT OTHRWS C	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
C1789	PR PROSTHESIS, BREAST, IMP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
C1840	PR TELESCOPIC INTRAOCULAR LENS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
C1883	PR ADAPT/EXT PACING/NEURO LEAD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
C1897	PR LEAD NEUROSTIM TEST KIT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
C7556	BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH BRONCHIAL ALVEOLAR LAVAGE AND TRANSENDOSCOPIC ENDOBRONCHIAL ULTRASOUND (EBUS) DURING BRONCHOSCOPYIC DIAGNOSTIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
C7560	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP) WITH REMOVAL OF FOREIGN BODY(S) OR STENT(S) FROM BILIARY/PANCREATIC DUCT(S) AND ENDOSCOPIC CANNULATION OF PAPANICOLAOU WITH DIRECT VISUALIZATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
C9088	PR INSTILL, BUPIVAC AND MELOXICAM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023
C9145	INJECTION, APREPITANT, (APONVIE), 1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
C9147	INJECTION, TREMELIMUMA B-ACTL, 1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
C9150	XENON XE-129 HYPERPOLARIZED GAS, DIAGNOSTIC, PER STUDY DOSE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
C9152	INJECTION, ARIPIRAZOLE, (ABILIFY ASIMTUFII), 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
C9153	INJECTION, AMISULPRIDE, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
C9154	INJECTION, BUPRENORPHINE EXTENDED-RELEASE (BRIXADI), 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
C9155	INJECTION, EPCORITAMAB-BYSP, 0.16 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
C9156	FLOTUFOLAST AT F 18, DIAGNOSTIC, 1 MILLICURIE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
C9157	INJECTION, TOFERSEN, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
C9158	INJECTION, RISPERIDONE, (UZEDY), 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
C9161	INJ, AFLIBERCEPT HD, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
C9162	INJ, AVACINCAPTAD PEG 0.1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
C9163	INJ TALQUETAMAB -TGVS 0.25 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
C9164	CANTHARIDIN TOP, APPLICATOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
C9165	INJ, ELRANATAMAB -BCMM, 1 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
C9167	INJECTION, APADAMTASE ALFA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
C9250	PR ARTISS FIBRIN SEALANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
C9507	FRESH FROZEN PLASMA, HIGH TITER COVID-19 CONVALESCENT, FROZEN WITHIN 8 HOURS OF COLLECTION, EACH UNIT	NO AUTHORIZATION REQUIRED DIAGOSIS CODES: NO AUTH IS REQUIRED IF ONE OF THESE DIAGNOSIS CODES: U07.1		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		6/1/2022
C9600	PR PERC DRUG-EL COR STENT SING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
C9739	PR CYSTOSCOPY PROSTATIC IMP 1-3	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
C9740	PR CYSTO IMPL 4 OR MORE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
C9772	PR REVASC LITHOTRIP TIBI/PERONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
C9773	PR REVASC LITHOTR-STENT TIB/PER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
C9774	PR REVASC LITHOTR-ATHER TIB/PER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
C9775	PR REVASC LITH-STEN-ATH TIB/PER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
C9784	GASTRIC RESTRICTIVE PROCEDURE, ENDOSCOPIC SLEEVE GASTROPLASTY, WITH ESOPHAGOGASTRODUODENOSCOPY AND INTRALUMINAL TUBE INSERTION, IF PERFORMED, INCLUDING ALL SYSTEM AND TISSUE ANCHORING COMPO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
C9785	ENDOSCOPIC OUTLET REDUCTION, GASTRIC POUCH APPLICATION, WITH ENDOSCOPY AND INTRALUMINAL TUBE INSERTION, IF PERFORMED, INCLUDING ALL SYSTEM AND TISSUE ANCHORING COMPONENTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
C9786	ECHOCARDIOGRAPHY IMAGE POST PROCESSING FOR COMPUTER AIDED DETECTION OF HEART FAILURE WITH PRESERVED EJECTION FRACTION, INCLUDING INTERPRETATION AND REPORT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	9/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
C9787	GASTRIC ELECTROPHYSIOLOGY MAPPING WITH SIMULTANEOUS PATIENT SYMPTOM PROFILING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
C9788	OPTO-ACOUSTIC IMAGING, BREAST (INCLUDING AXILLA WHEN PERFORMED), UNILATERAL, WITH IMAGE DOC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
C9789	INSTILLATION OF ANTI-NEOPLASTIC PHARMACOLOGIC/BIOLOGIC AGENT INTO RENAL PELVIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
C9790	HISTOTRIPSY (IE, NON-THERMAL ABLATION VIA ACOUSTIC ENERGY DELIVERY)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
C9791	MAGNETIC RESONANCE IMAGING WITH INHALED HYPERPOLARIZED XENON-129 CONTRAST AGENT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
C9792	BLINDED OR NONBLINDED PROCEDURE FOR SYMPTOMATIC NEW YORK HEART ASSOCIATION (NYHA) CLASS II, III, IVA HEART FAILURE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
C9800	PR DERMAL FILLER INJ PX/SUPPL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
C9803	PR HOPD COVID-19 SPEC COLLECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		5/12/2023
E0100	PR CANE ADJUST/FIXED WITH TIP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0105	PR CANE ADJUST/FIXED QUAD/3 PRO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0110	PR CRUTCH FOREARM PAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0111	PR CRUTCH FOREARM EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0112	PR CRUTCH UNDERARM PAIR WOOD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0113	PR CRUTCH UNDERARM EACH WOOD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0114	PR CRUTCH UNDERARM PAIR NO WOOD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0116	PR CRUTCH UNDERARM EACH NO WOOD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0117	PR UNDERARM SPRINGASSIST CRUTCH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0118	PR CRUTCH SUBSTITUTE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS A NOT COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	1/1/2024
E0130	PR WALKER RIGID ADJUST/FIXED HT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0135	PR WALKER FOLDING ADJUST/FIXED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0140	PR WALKER W TRUNK SUPPORT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0141	PR RIGID WHEELED WALKER ADJ/FIX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0143	PR WALKER FOLDING WHEELED W/O S	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0144	ENCLOSED WALKER W REAR SEAT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0147	PR WALKER VARIABLE WHEEL RESIST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0148	PR HEAVYDUTY WALKER NO WHEELS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0149	PR HEAVY DUTY WHEELED WALKER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0152	WALKER, BATTERY POWER WHEELS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0153	PR FOREARM CRUTCH PLATFORM ATTA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0154	PR WALKER PLATFORM ATTACHMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0155	PR WALKER WHEEL ATTACHMENT,P AIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0157	PR WALKER CRUTCH ATTACHMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0158	PR WALKER LEG EXTENDERS SET OF4	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0159	PR BRAKE FOR WHEELED WALKER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0160	PR SITZ TYPE BATH OR EQUIPMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0161	PR SITZ BATH/EQUIPMENT W/FAUCET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0162	PR SITZ BATH CHAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0163	PR COMMODE CHAIR WITH FIXED ARM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0163	PR COMMODE CHAIR WITH FIXED ARM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0164	PR COMMODE CHAIR MOBILE FIXED A	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0164	PR COMMODE CHAIR MOBILE FIXED A	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0165	PR COMMODE CHAIR WITH DETACHARM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0165	PR COMMODE CHAIR WITH DETACHARM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0166	PR COMMODE CHAIR MOBILE DETACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0167	PR COMMODE CHAIR PAIL OR PAN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0168	PR HEAVYDUTY/WIDE COMMODE CHAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0168	PR HEAVYDUTY/WI DE COMMODE CHAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0169	DELETED 2272	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0170	PR COMMODE CHAIR ELECTRIC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0171	PR COMMODE CHAIR NON-ELECTRIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0172	PR SEAT LIFT MECHANISM TOILET	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0175	PR COMMODE CHAIR FOOT REST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0181	PR PRESS PAD ALTERNATING W/ PUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0182	PR REPLACE PUMP, ALT PRESS PAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0183	POWERED PRESSURE REDUCING UNDERLAY/PAD, ALTERNATING, WITH PUMP, INCLUDES HEAVY DUTY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0184	PR DRY PRESSURE MATTRESS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0185	PR GEL PRESSURE MATTRESS PAD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0186	PR AIR PRESSURE MATTRESS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0186	PR AIR PRESSURE MATTRESS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0187	PR WATER PRESSURE MATTRESS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0188	PR SYNTHETIC SHEEPSKIN PAD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0189	PR LAMBSWOOL SHEEPSKIN PAD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0190	PR POSITIONING CUSHION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0191	PR PROTECTOR HEEL OR ELBOW	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0193	PR POWERED AIR FLOTATION BED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0194	PR AIR FLUIDIZED BED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0196	PR GEL PRESSURE MATTRESS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0197	PR AIR PRESSURE PAD FOR MATTRES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0198	PR WATER PRESSURE PAD FOR MATTR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0199	PR DRY PRESSURE PAD FOR MATTRES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0202	PR PHOTOTHERAPY LIGHT W/ PHOTOM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0210	PR ELECTRIC HEAT PAD STANDARD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0217	PR WATER CIRC HEAT PAD W PUMP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0218	PR FLUID CIRC COLD PAD W PUMP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0225	PR HYDROCOLLAT OR UNIT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0235	PR PARAFFIN BATH UNIT PORTABLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0236	PR PUMP FOR WATER CIRCULATING P	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0240	PR BATH/SHOWER CHAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0243	PR TOILET RAIL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0244	PR TOILET SEAT RAISED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0245	PR TUB STOOL OR BENCH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0246	PR TRANSFER TUB RAIL ATTACHMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0247	PR TRANS BENCH W/VO COMM OPEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0248	PR HDTRANS BENCH W/VO COMM OPEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0250	PR HOSP BED FIXED HT W/ MATTRES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Beds and Support Surfaces Guideline): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Beds-and-Support-Surfaces-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0255	PR HOSPITAL BED VAR HT W/ MATTR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Beds and Support Surfaces Guideline): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Beds-and-Support-Surfaces-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0260	PR HOSP BED SEMI-ELECTR W/ MATT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Beds and Support Surfaces Guideline): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Beds-and-Support-Surfaces-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0265	PR HOSP BED TOTAL ELECTR W/ MAT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0271	PR MATTRESS INNERSPRING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0275	PR BED PAN STANDARD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0276	PR BED PAN FRACTURE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0277	PR POWERED PRES-REDU AIR MATTRES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0280	PR BED CRADLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0300	PR ENCLOSED PED CRIB HOSP GRADE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0303	PR HOSP BED HVY DTY XTRA WIDE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0304	PR HOSP BED XTRA HVY DTY X WIDE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0305	PR RAILS BED SIDE HALF LENGTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0310	PR RAILS BED SIDE FULL LENGTH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0315	PR BED ACCESSORY BRD/TBL/SUPP RT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0316	PR BED SAFETY ENCLOSURE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Beds and Support Surfaces Guideline): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Beds-and-Support-Surfaces-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0325	PR URINAL MALE JUG-TYPE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0326	PR URINAL FEMALE JUG-TYPE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0328	PR PED HOSPITAL BED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Beds and Support Surfaces Guideline): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Beds-and-Support-Surfaces-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0329	PR PED HOSPITAL BED SEMI/ELECT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Beds and Support Surfaces Guideline): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Beds-and-Support-Surfaces-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0350	PR CONTROL UNIT BOWEL SYSTEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0352	PR DISPOSABLE PACK W/BOWEL SYST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0370	PR AIR ELEVATOR FOR HEEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0371	PR NONPOWER MATTRESS OVERLAY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0372	PR POWERED AIR MATTRESS OVERLAY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0373	PR NONPOWERED PRESSURE MATTRESS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0424	PR STATIONARY COMPRESSED GAS 02	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0431	PR PORTABLE GASEOUS 02	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0433	PR PORTABLE LIQUID OXYGEN SYS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0434	PR PORTABLE LIQUID O2	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0439	PR STATIONARY LIQUID O2	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0441	PR OXYGEN CONTENTS, GASEOUS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0442	PR OXYGEN CONTENTS, LIQUID	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0443	PR PORTABLE O2 CONTENTS, GAS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0444	PR PORTABLE O2 CONTENTS, LIQUID	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0445	PR OXIMETER NON-INVASIVE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0447	PR PORT O2 CONT, LIQ OVER 4 LPM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0457	PR CHEST SHELL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0459	PR CHEST WRAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0465	PR HOME VENT INVASIVE INTERFACE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Backup Ventilator): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Backup-Ventilator.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0466	PR HOME VENT NON-INVASIVE INTER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Backup Ventilator): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Backup-Ventilator.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0467	PR HOME VENT MULTI-FUNCTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Backup Ventilator): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Backup-Ventilator.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0470	PR RAD W/O BACKUP NON-INV INTFC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0471	PR RAD W/BACKUP NON INV INTRFC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0472	PR RAD W BACKUP INVASIVE INTRFC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0480	PR PERCUSSOR ELECT/PNEUM HOME M	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0482	PR COUGH STIMULATING DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0483	PR HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM, WITH FULL ANTERIOR AND/OR POSTERIOR THORACIC REGION RECEIVING SIMULTANEOU S EXTERNAL OSCILLATION, INCLUDES ALL ACCESSORIES AND SUPPLIES, EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0490	POWER SOURCE AND CONTROL ELECTRONICS UNIT FOR ORAL DEVICE/APPLIANCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	1/1/2024
E0491	ORAL DEVICE/APPLIANCE FOR NEUROMUSCULAR ELECTRICAL STIMULATION OF THE TONGUE MUSCLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	1/1/2024
E0500	PR IPPB ALL TYPES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0530	ELECTRONIC POSITIONAL OBSTRUCTIVE SLEEP APNEA TREATMENT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0550	PR HUMIDIF EXTENS SUPPLE W IPPB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0561	PR HUMIDIFIER NONHEATED W PAP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0562	PR HUMIDIFIER HEATED USED W PAP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0565	PR COMPRESSOR AIR POWER SOURCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0570	PR NEBULIZER WITH COMPRESSION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0574	PR ULTRASONIC GENERATOR W SVNEB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0575	PR NEBULIZER ULTRASONIC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0580	PR NEBULIZER FOR USE W/ REGULAT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0585	PR NEBULIZER W/ COMPRESSOR & HE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0600	PR SUCTION PUMP PORTAB HOM MODL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0601	PR CONT AIRWAY PRESSURE DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0602	PR MANUAL BREAST PUMP	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR 1 PER PREGNANCY OR 1 EVERY 3 YEARS		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0602	PR MANUAL BREAST PUMP	AUTHORIZATION REQUIRED ALERT: PRIOR AUTH IS REQUIRED IF MORE THAN 1 PER PREGNANCY OR MORE THAN 1 EVERY 3 YEARS EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
E0603	PR ELECTRIC BREAST PUMP	AUTHORIZATION REQUIRED ALERT: PRIOR AUTH IS REQUIRED IF MORE THAN 1 PER PREGNANCY OR MORE THAN 1 EVERY 3 YEARS EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
E0603	PR ELECTRIC BREAST PUMP	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR 1 PER PREGNANCY OR 1 EVERY 3 YEARS		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
E0604	HOSP GRADE ELEC BREAST PUMP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/10/2021
E0606	PR DRAINAGE BOARD POSTURAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0610	PR PACEMAKER MONITR AUDIBLE/VIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0615	PR PACEMAKER MONITR DIGITAL/VIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0616	PR CARDIAC EVENT RECORDER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0617	PR AUTOMATIC EXT DEFIBRILLATOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0618	PR APNEA MONITOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0619	PR APNEA MONITOR W RECORDER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0621	PR PATIENT LIFT SLING OR SEAT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0625	PR PATIENT LIFT BATHROOM OR TOI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0627	PR SEAT LIFT INCORP LIFT-CHAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0628	PR SEAT LIFT FOR PT FURN-ELECTR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0629	PR SEAT LIFT FOR PT FURN-NON-EL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0630	PATIENT LIFT HYDRAULIC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0635	PR PATIENT LIFT ELECTRIC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0637	PR COMBINATION SIT TO STAND SYS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0638	PR STANDING FRAME SYS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0641	PR MULTI-POSITION STND FRAM SYS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0642	PR DYNAMIC STANDING FRAME	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0650	PR PNEUMA COMPRESOR NON-SEGMENT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0651	PR PNEUM COMPRESSOR SEGMENTAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0652	PR PNEUM COMPRES W/CAL PRESSURE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0655	PR PNEUMATIC APPLIANCE HALF ARM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0660	PR PNEUMATIC APPLIANCE FULL LEG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0665	PR PNEUMATIC APPLIANCE FULL ARM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0666	PR PNEUMATIC APPLIANCE HALF LEG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0667	PR SEG PNEUMATIC APPL FULL LEG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0668	PR SEG PNEUMATIC APPL FULL ARM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0669	PR SEG PNEUMATIC APPLI HALF LEG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0670	PR SEG PNEUM INT LEGS/TRUNK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0671	PR PRESSURE PNEUM APPL FULL LEG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0672	PR PRESSURE PNEUM APPL FULL ARM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0673	PR PRESSURE PNEUM APPL HALF LEG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0676	PR INTER LIMB COMPRESS DEV NOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0700	PR SAFETY EQUIPMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0701	PR HELMET W FACE GUARD PREFAB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0705	TRANSFER DEVICE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0710	PR RESTRAINTS ANY TYPE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0711	UPPER EXTREMITY MEDICAL TUBING/LINES ENCLOSURE OR COVERING DEVICE, RESTRICTS ELBOW RANGE OF MOTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0720	PR TENS TWO LEAD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0730	PR TENS FOUR LEAD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0731	PR CONDUCTIVE GARMENT FOR TENS/	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0733	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR FOR ELECTRICAL STIMULATION OF THE TRIGEMINAL NERVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
E0740	PR NON-IMPLANT PELV FLR E-STIM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGES/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0745	PR NEUROMUSCULAR STIM FOR SHOCK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0747	PR ELEC OSTEOGEN STIM NOT SPINE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0748	PR ELEC OSTEOGEN STIM SPINAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0760	PR OSTEOGEN ULTRASOUND STIMLTOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0762	PR TRANS ELEC JT STIM DEV SYS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0764	PR FUNCTIONAL NEUROMUSCULAR STIM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0776	PR IV POLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0779	PR AMB INFUSION PUMP MECHANICAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0780	PR MECH AMB INFUSION PUMP <8HRS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0781	PR EXTERNAL AMBULATORY INFUS PU	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0782	PR NON-PROGRAMBLE INFUSION PUMP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0783	PR PROGRAMMABLE INFUSION PUMP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0784	PR EXT AMB INFUSION PUMP INSULIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
E0786	PR IMPLANTABLE PUMP REPLACEMENT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0787	PR CGS DOSE ADJ INSULIN INF PMP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0791	PR PARENTERAL INFUSION PUMP STA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0840	PR TRACT FRAME ATTACH HEADBOARD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0850	PR TRACTION STAND FREE STANDING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0855	PR CERVICAL TRACTION EQUIPMENT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0856	PR CERVIC COLLAR W AIR BLADDERS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0860	PR TRACT EQUIP CERVICAL TRACT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0880	PR TRAC STAND FREE STAND EXTREM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0900	PR TRAC STAND FREE STAND PELVIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0910	PR TRAPEZE BAR ATTACHED TO BED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0911	PR HD TRAPEZE BAR ATTACH TO BED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0912	PR HD TRAPEZE BAR FREE STANDING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E0920	PR FRACTURE FRAME ATTACHED TO B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0930	PR FRACTURE FRAME FREE STANDING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0935	PR CONT PAS MOTION EXERCISE DEV	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0940	PR TRAPEZE BAR FREE STANDING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E0941	PR GRAVITY ASSISTED TRACTION DE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0942	PR CERVICAL HEAD HARNESS/HALTER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0945	PR BELT/HARNESS EXTREMITY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0946	PR FRACTURE FRAME DUAL W CROSS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E0950	PR TRAY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0951	PR LOOP HEEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0952	PR TOE LOOP/HOLDER, EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0953	PR W/C LATERAL THIGH/KNEE SUP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0954	PR FOOT BOX, ANY TYPE EACH FOOT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0955	PR CUSHIONED HEADREST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0956	PR W/C LATERAL TRUNK/HIP SUPPOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0957	PR W/C MEDIAL THIGH SUPPORT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0958	PR WHLCHR ATT- CONV 1 ARM DRIVE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0959	PR AMPUTEE ADAPTER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0960	PR W/C SHOULDER HARNESS/STRAPS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0961	PR WHEELCHAIR BRAKE EXTENSION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0967	PR MANUAL WC HAND RIM W PROJECT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0969	PR WHEELCHAIR NARROWING DEVICE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0970	PR WHEELCHAIR NO. 2 FOOTPLATES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0971	PR WHEELCHAIR ANTI-TIPPING DEVI	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0972	DELETED 2294	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0973	PR W/CH ACCESS DET ADJ ARMREST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0974	PR W/CH ACCESS ANTI-ROLLBACK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0977	PR WHEELCHAIR WEDGE CUSHION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0978	PR W/C ACC,SAF BELT PELV STRAP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0980	PR WHEELCHAIR SAFETY VEST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E0981	PR SEAT UPHOLSTERY, REPLACEMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0982	PR BACK UPHOLSTERY, REPLACEMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0986	PR MAN W/C PUSH-RIM POW ASSIST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E0990	PR WHELLCHAIR ELEVATING LEG RES	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0992	PR WHEELCHAIR SOLID SEAT INSERT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0994	PR WHEELCHAIR ARM REST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E0995	PR WHEELCHAIR CALF REST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1002	PR PWR SEAT TILT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1003	PR PWR SEAT RECLINE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1004	PR PWR SEAT RECLINE MECH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1005	PR PWR SEAT RECLINE PWR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1006	PR PWR SEAT COMBO W/O SHEAR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1007	PR PWR SEAT COMBO W/SHEAR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1008	PR PWR SEAT COMBO PWR SHEAR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1009	PR ADD MECH LEG ELEVATION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1010	PR ADD PWR LEG ELEVATION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1011	PR PED WC MODIFY WIDTH ADJUSTM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1012	PR CTR MOUNT PWR ELEV LEG REST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1013	DELETED 2304	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1014	PR RECLINING BACK ADD PED W/C	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1015	PR SHOCK ABSORBER FOR MAN W/C	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1016	PR SHOCK ABSORBER FOR POWER W/C	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1017	PR HD SHCK ABSRBR FOR HD MAN WC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1018	PR HD SHCK ABSRBER FOR HD POWWC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1020	PR RESIDUAL LIMB SUPPORT SYSTEM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1028	PR W/C MANUAL SWINGAWAY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1029	PR W/C VENT TRAY FIXED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1031	PR ROLLABOUT CHAIR WITH CASTERS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1035	PR PATIENT TRANSFER SYSTEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1050	PR WHELCHR FXD FULL LENGTH ARMS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1060	PR WHEELCHAIR DETACHABLE ARMS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1070	PR WHEELCHAIR DETACHABLE FOOT R	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1083	PR HEMI-WHEELCHAIR FIXED ARMS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1084	PR HEMI-WHEELCHAIR DETACHABLE A	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1085	PR HEMI-WHEELCHAIR FIXED ARMS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1086	PR HEMI-WHEELCHAIR DETACHABLE A	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1087	PR WHEELCHAIR LIGHTWT FIXED ARM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1088	PR WHEELCHAIR LIGHTWEIGHT DET A	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1089	PR WHEELCHAIR LIGHTWT FIXED ARM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1090	PR WHEELCHAIR LIGHTWEIGHT DET A	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1092	PR WHEELCHAIR WIDE W/ LEG RESTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1093	PR WHEELCHAIR WIDE W/ FOOT REST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1100	PR WHCHR S-RECL FXD ARM LEG RES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1110	PR WHEELCHAIR SEMI-RECL DETACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1130	PR WHLCHR STAND FXD ARM FT REST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1140	PR WHEELCHAIR STANDARD DETACH A	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1150	PR WHEELCHAIR STANDARD W/ LEG R	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1160	PR WHEELCHAIR FIXED ARMS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1161	PR MANUAL ADULT WC W TILTINSPAC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1170	PR WHLCHR AMPU FXD ARM LEG REST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1171	PR WHEELCHAIR AMPUTEE W/O LEG R	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1172	PR WHEELCHAIR AMPUTEE DETACH AR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1180	PR WHEELCHAIR AMPUTEE W/ FOOT R	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1190	PR WHEELCHAIR AMPUTEE W/ LEG RE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1195	PR WHEELCHAIR AMPUTEE HEAVY DUT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1200	PR WHEELCHAIR AMPUTEE FIXED ARM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1210	DELETED 2314	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1211	DELETED 2315	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1212	DELETED 2316	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1213	DELETED 2317	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1220	PR WHLCHR SPECIAL SIZE/CONSTRC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1225	PR MANUAL SEMI-RECLINING BACK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1226	PR MANUAL FULLY RECLINING BACK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1229	PR PEDIATRIC WHEELCHAIR NOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1230	PR POWER OPERATED VEHICLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1231	PR RIGID PED W/C TILT-IN-SPACE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1232	PR FOLDING PED WC TILT-IN-SPACE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1233	PR RIG PED WC TLTNPC W/O SEAT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1234	PR FLD PED WC TLTNPC W/O SEAT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1235	PR RIGID PED WC ADJUSTABLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1236	PR FOLDING PED WC ADJUSTABLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1237	PR RGD PED WC ADJSTABL W/O SEAT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1238	PR FLD PED WC ADJSTABL W/O SEAT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1239	PR PED POWER WHEELCHAIR NOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1240	PR WHCHR LITWT DET ARM LEG REST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1250	PR WHEELCHAIR LIGHTWT FIXED ARM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1260	PR WHEELCHAIR LIGHTWT FOOT REST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1270	PR WHEELCHAIR LIGHTWEIGHT LEG R	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1280	PR WHCHR H-DUTY DET ARM LEG RES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1285	PR WHEELCHAIR HEAVY DUTY FIXED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1290	PR WHEELCHAIR HVY DUTY DETACH A	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1295	PR WHEELCHAIR HEAVY DUTY FIXED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E1296	PR WHEELCHAIR SPECIAL SEAT HEIG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1297	PR WHEELCHAIR SPECIAL SEAT DEPT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1298	PR WHEELCHAIR SPEC SEAT DEPTH/W	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1300	PR WHIRLPOOL PORTABLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1310	PR WHIRLPOOL NON-PORTABLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E1353	PR OXYGEN SUPPLIES REGULATOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1355	PR OXYGEN SUPPLIES STAND/RACK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1372	PR OXY SUPPL HEATER FOR NEBULIZ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1390	PR OXYGEN CONCENTRATOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E1399	PR DURABLE MEDICAL EQUIPMENT MI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS A NOT COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Beds and Support Surfaces Guideline): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Beds-and-Support-Surfaces-Guideline.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1510	PR KIDNEY DIALYSATE DELIVRY SYS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E1520	PR HEPARIN INFUSION PUMP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E1530	PR REPLACEMENT AIR BUBBLE DETEC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E1540	PR REPLACEMENT PRESSURE ALARM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E1550	PR BATH CONDUCTIVITY METER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E1560	PR REPLACE BLOOD LEAK DETECTOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1570	PR ADJUSTABLE CHAIR FOR ESRD PT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E1575	PR TRANSDUCER PROTECT/FLD BAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E1580	PR UNIPUNCTURE CONTROL SYSTEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E1590	PR HEMODIALYSIS MACHINE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E1592	PR AUTO INTERM PERITONEAL DIALY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1594	PR CYCLER DIALYSIS MACHINE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E1600	PR DELI/INSTALL CHG HEMO EQUIP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E1620	PR REPLACEMENT BLOOD PUMP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E1629	PR TABLO FOR DIALYSIS SERVICE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
E1630	PR RECIPROCATIN G PERITONEAL DIA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1632	PR WEARABLE ARTIFICIAL KIDNEY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E1635	PR COMPACT TRAVEL HEMODIALYZE R	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E1637	PR HEMOSTATS FOR DIALYSIS, EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E1639	PR SCALE EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E1699	PR DIALYSIS EQUIPMENT NOC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E1700	PR JAW MOTION REHAB SYSTEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1701	PR REPL CUSHIONS FOR JAW MOTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E1702	PR REPL MEASR SCALES JAW MOTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E1800	PR ADJUST ELBOW EXT/FLEX DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E1801	SPS ELBOW DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E1802	PR ADJUST FOREARM PRO/SUP DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1805	PR ADJUST WRIST EXT/FLEX DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E1806	SPS WRIST DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E1810	PR ADJUST KNEE EXT/FLEX DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E1811	SPS KNEE DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E1812	PR KNEE EXT/FLEX W ACT RES CTRL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1815	PR ADJUST ANKLE EXT/FLEX DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E1816	SPS ANKLE DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E1818	SPS FOREARM DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E1820	PR SOFT INTERFACE MATERIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E1821	PR REPLACEMENT INTERFACE SPSD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E1825	PR ADJUST FINGER EXT/FLEX DEVC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E1830	PR ADJUST TOE EXT/FLEX DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E1831	PR STATIC STR TOE DEV EXT/FLEX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
E1840	PR ADJ SHOULDER EXT/FLEX DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E1841	STATIC STR SHLDR DEV ROM ADJ	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
E2100	PR BLD GLUCOSE MONITOR W VOICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2101	PR BLD GLUCOSE MONITOR W LANCE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
E2102	ADJUNCTIVE CONTINUOUS GLUCOSE MONITOR OR RECEIVER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
E2103	PR NON-ADJUNCTIVE, NON-IMPLANTED CONTINUOUS GLUCOSE MONITOR OR RECEIVER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2023
E2201	PR MAN W/CH ACC SEAT W>=20<24	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2202	PR SEAT WIDTH 24-27 IN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2203	PR FRAME DEPTH LESS THAN 22 IN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2204	PR FRAME DEPTH 22 TO 25 IN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2205	PR MANUAL WC ACCESSORY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2206	PR MAN WC WHL LOCK COMP REPL EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2207	PR CRUTCH AND CANE HOLDER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2208	PR CYLINDER TANK CARRIER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2209	PR ARM TROUGH EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2210	PR WHEELCHAIR BEARINGS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2211	PR PNEUMATIC PROPULSION TIRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2212	PR PNEUMATIC PROP TIRE TUBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2213	PR PNEUMATIC PROP TIRE INSERT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2214	PR PNEUMATIC CASTER TIRE EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2215	PR PNEUMATIC CASTER TIRE TUBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2216	PR FOAM FILLED PROPULSION TIRE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2217	PR FOAM FILLED CASTER TIRE EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2218	PR FOAM PROPULSION TIRE EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2219	PR FOAM CASTER TIRE ANY SIZE EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2220	PR SOLID PROPULSION TIRE EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2221	PR SOLID CASTER TIRE EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2222	PR SOLID CASTER INTEGRATED WHL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2223	PR VALVE REPLACEMENT ONLY EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2224	PR PROPULSION WHL EXCLUDES TIRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2225	PR CASTER WHEEL EXCLUDES TIRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2226	PR CASTER FORK REPLACEMENT ONLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2227	GEAR REDUCTION DRIVE WHEEL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2228	MWC ACC, WHEELCHAIR BRAKE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2291	PR PLANAR BACK FOR PED SIZE WC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2292	PR PLANAR SEAT FOR PED SIZE WC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2293	PR CONTOUR BACK FOR PED SIZE WC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2294	PR CONTOUR SEAT FOR PED SIZE WC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2300	PR PWR SEAT ELEVATION SYS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2310	PR ELECTRO CONNECT BTW CONTROL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E2311	PR ELECTRO CONNECT BTW 2 SYS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E2312	MINI-PROP REMOTE JOYSTICK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E2313	PWC HARNESS, EXPAND CONTROL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2321	PR HAND INTERFACE JOYSTICK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E2323	PR SPECIAL JOYSTICK HANDLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2324	PR CHIN CUP INTERFACE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2325	PR SIP AND PUFF INTERFACE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E2326	PR BREATH TUBE KIT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2327	PR HEAD CONTROL INTERFACE MECH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2328	PR HEAD/EXTREMITY CONTROL INTER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E2329	PR HEAD CONTROL NONPROPORTIONAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E2330	PR HEAD CONTROL PROXIMITY SWITC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E2340	PR W/C WIDTH 20-23 IN SEAT FRAME	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2341	PR W/C WIDTH 24-27 IN SEAT FRAME	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2342	PR W/C DPTH 20-21 IN SEAT FRAME	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2343	PR W/C DPTH 22-25 IN SEAT FRAME	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2351	PR ELECTRONIC SGD INTERFACE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2359	PR GR34 SEALED LEADACID BATTERY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2361	PR 22NF SEALED LEADACID BATTERY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2363	PR GR24 SEALED LEADACID BATTERY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2366	PR BATTERY CHARGER, SINGLE MODE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2368	PR PWR WC DRIVEWHEEL MOTOR REPL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2369	PR PWR WC DRIVEWHEEL GEAR REPL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2370	PR PWR WC DR WH MOTOR/GEAR COMB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2371	PR GR27 SEALED LEADACID BATTERY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2373	HAND/CHIN CTRL SPEC JOYSTICK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2374	PR HAND/CHIN CTRL STD JOYSTICK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2375	PR NON-EXPANDABLE CONTROLLER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2376	PR EXPANDABLE CONTROLLER, REPL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
E2377	PR EXPANDABLE CONTROLLER, INITL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2378	PR PW ACTUATOR REPLACEMENT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2381	PR PNEUM DRIVE WHEEL TIRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2382	PR TUBE, PNEUM WHEEL DRIVE TIRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2383	PR INSERT, PNEUM WHEEL DRIVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2384	PR PNEUMATIC CASTER TIRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2385	PR TUBE, PNEUMATIC CASTER TIRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2386	PR FOAM FILLED DRIVE WHEEL TIRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2387	PR FOAM FILLED CASTER TIRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2388	PR FOAM DRIVE WHEEL TIRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2389	PR FOAM CASTER TIRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2390	PR SOLID DRIVE WHEEL TIRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2391	PR SOLID CASTER TIRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2392	PR SOLID CASTER TIRE, INTEGRATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2393	PR VALVE, PNEUMATIC TIRE TUBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2394	PR DRIVE WHEEL EXCLUDES TIRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2395	PR CASTER WHEEL EXCLUDES TIRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2396	PR CASTER FORK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2402	PR NEG PRESS WOUND THERAPY PUMP	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2500	PR SGD DIGITIZED PRE- REC <=8MIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (ASSISTIVE COMMUNICATION DEVICES.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/AS SISTIVE-COMMUNICATION- DEVICES.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2502	PR SGD PREREC MSG >8MIN <=20MIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (ASSISTIVE COMMUNICATION DEVICES.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/AS SISTIVE-COMMUNICATION- DEVICES.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2504	PR SGD PRREC MSG>20MIN <=40MIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (ASSISTIVE COMMUNICATION DEVICES.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/ASISTIVE-COMMUNICATION-DEVICES.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2506	PR SGD PRREC MSG > 40 MIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (ASSISTIVE COMMUNICATION DEVICES.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/ASISTIVE-COMMUNICATION-DEVICES.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2508	PR SGD SPELLING PHYS CONTACT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (ASSISTIVE COMMUNICATION DEVICES.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/ASISTIVE-COMMUNICATION-DEVICES.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2510	PR SGD W MULTI METHODS MSG/ACCS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (ASSISTIVE COMMUNICATION DEVICES.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/ASISTIVE-COMMUNICATION-DEVICES.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2511	PR SGD SFTWRE PRGRM FOR PC/PDA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (ASSISTIVE COMMUNICATION DEVICES.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/ASISTIVE-COMMUNICATION-DEVICES.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2512	PR SGD ACCESSORY, MOUNTING SYS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (ASSISTIVE COMMUNICATION DEVICES.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/ASISTIVE-COMMUNICATION-DEVICES.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2599	PR SGD ACCESSORY NOC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (ASSISTIVE COMMUNICATION DEVICES.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/ASSISTIVE-COMMUNICATION-DEVICES.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2601	PR GEN W/C CUSHION WIDTH < 22 IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2602	PR GEN W/C CUSHION WIDTH >=22 IN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2603	PR SKIN PROTECT WC CUS WD <22IN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2604	PR SKIN PROTECT WC CUS WD>=22IN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2605	PR POSITION WC CUSH WIDTH <22 IN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2606	PR POSITION WC CUSH WIDTH >=22 IN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2607	PR SKIN PRO/POS WC CUS WD <22IN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2608	PR SKIN PRO/POS WC CUS WD >=22IN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2609	PR CUSTOM FABRICATE W/C CUSHION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2611	PR GEN USE BACK CUSH WIDTH <22IN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2612	PR GEN USE BACK CUSH WIDTH >=22IN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2613	PR POSITION BACK CUSH WD <22IN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2614	PR POSITION BACK CUSH WD >=22IN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2615	PR POS BACK POST/LAT WIDTH <22IN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2616	PR POS BACK POST/LAT WIDTH>=22IN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2617	PR CUSTOM FAB W/C BACK CUSHION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2619	PR REPLACE COVER W/C SEAT CUSH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2620	PR WC PLANAR BACK CUSH WD <22IN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2621	PR WC PLANAR BACK CUSH WD>=22IN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2622	PR ADJ SKIN PRO W/C CUS WD<22IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2623	PR ADJ SKIN PRO WC CUS WD>=22IN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2624	PR ADJ SKIN PRO/POS CUS<22IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2625	PR ADJ SKIN PRO/POS WC CUS>=22	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2626	PR SEO MOBILE ARM SUP ATT TO WC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2627	PR ARM SUPP ATT TO WC RANCHO TY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E2628	PR MOBILE ARM SUPPORTS RECLININ	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2629	PR FRICTION DAMPENING ARM SUPP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2630	PR MONOSUSPENSION ARM/HAND SUPP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2631	PR ELEVAT PROXIMAL ARM SUPPORT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2632	PR OFFSET/LAT ROCKER ARM W/ELA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
E2633	PR MOBILE ARM SUPPORT SUPINATOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
E8001	PR UPRIGHT GAIT TRAINER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
G0011	HIV PREP COUNSEL, MD 15-30M	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
G0012	INJECTION OF HIV PREP DRUG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
G0013	HIV PREP COUNSEL, CLIN STAFF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
G0104	PR CA SCREEN;FLEXI SIGMOIDSCOP E	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
G0108	PR DIAB MANAGE TRN PER INDIV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2021
G0109	PR DIAB MANAGE TRN IND/GROUP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2021
G0117	PR GLAUCOMA SCR N HGH RISK DIREC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2021
G0118	PR GLAUCOMA SCR N HGH RISK DIREC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
G0121	PR COLON CA SCRN NOT HI RSK IND	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
G0127	PR TRIM NAIL (S)	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
G0127	PR TRIM NAIL (S)	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
G0156	PR HHCP-SVS OF AIDE,EA 15 MIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/PD N-SNV-PPECC-GUIDELINES.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
G0162	PR HHC RN E&M PLAN SVS, 15 MIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PCS-Guidelines.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
G0162	PR HHC RN E&M PLAN SVS, 15 MIN	AUTHORIZATION REQUIRED	USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID_PUBLIC ACTIONS_PROVIDER_MANUAL.A SPX MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PCS-Guidelines.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
G0162	PR HHC RN E&M PLAN SVS, 15 MIN	AUTHORIZATION REQUIRED	<p>USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
G0162	PR HHC RN E&M PLAN SVS, 15 MIN	AUTHORIZATION REQUIRED	<p>USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/MEDICAID/MEDICAID_PUBLICATIONS_PROVIDER_MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
G0162	PR HHC RN E&M PLAN SVS, 15 MIN	AUTHORIZATION REQUIRED	USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS_PROVIDER_MANUAL.A SPX MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PCS-Guidelines.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022
G0182	PR HOSPICE CARE SUPERVISION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
G0245	PR INITIAL FOOT EXAM PT LOPS	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
G0245	PR INITIAL FOOT EXAM PT LOPS	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
G0246	PR FOLLOWUP EVAL OF FOOT PT LOP	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
G0246	PR FOLLOWUP EVAL OF FOOT PT LOP	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
G0247	PR ROUTINE FOOTCARE PT W LOPS	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A PODIATRIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
G0247	PR ROUTINE FOOTCARE PT W LOPS	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A PODIATRIST EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
G0279	PR DIAGNOSTIC DIGITAL BREAST TOMOSYNTHESIS	NO AUTHORIZATION REQUIRED EXCLUSIONS: MOBILE PROVIDERS (R0070-R0076), PORTABLE X-RAY SUPPLIER, RADIOLOGICAL LAB, AND PHYSIOLOGICAL LAB SHOULD PEND, MRI SEDATION NON SPECIALTY(01916-01936), PET SCAN(78459-78707, 78709-78816), SWALLOW STUDIES (92611-92617,74230), SPEECH EVALUATION (70371), VCUG (51600, 51605, 51610, 74455)		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
G0299	PR HHS/HOSPICE OF RN EA 15 MIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/PD N-SNV-PPECC-GUIDELINES.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
G0299	PR HHS/HOSPICE OF RN EA 15 MIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): <a href="https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/PD
N-SNV-PPECC-GUIDELINES.PDF">https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/PD N-SNV-PPECC-GUIDELINES.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
G0300	PR HHS/HOSPICE OF LPN EA 15 MIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): <a href="https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/PD
N-SNV-PPECC-GUIDELINES.PDF">https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/PD N-SNV-PPECC-GUIDELINES.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
G0300	PR HHS/HOSPICE OF LPN EA 15 MIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): <a href="https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/PD
N-SNV-PPECC-GUIDELINES.PDF">https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/PD N-SNV-PPECC-GUIDELINES.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
G0315	IMMUNIZATION COUNSELING BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL FOR COVID-19, AGES UNDER 21, 5-15 MINS TIME (THIS CODE IS USED FOR THE MEDICAID EARLY AND PERIODIC SCREENI	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		5/1/2023
G0328	PR FECAL BLOOD SCRIN IMMUNOASSAY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2022
G0337	PR HOSPICE EVALUATION PREELECTI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
G0398	PR HOME SLEEP TEST/TYPE 2 PORTA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Pediatric Sleep Study): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Pediatric-Sleep-Study.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/6/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
G0399	PR HOME SLEEP TEST/TYPE 3 PORTA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Pediatric Sleep Study): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Pediatric-Sleep-Study.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/6/2021
G0400	PR HOME SLEEP TEST/TYPE 4 PORTA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Pediatric Sleep Study): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Pediatric-Sleep-Study.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/6/2021
G0429	PR DERMAL FILLER INJECTION(S)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
G0466	PR FQHC VISIT NEW PATIENT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A FEDERALLY QUALIFIED HEALTH CENTERS (FQHC).	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/1/2023
G0466	PR FQHC VISIT NEW PATIENT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A FEDERALLY QUALIFIED HEALTH CENTERS (FQHC).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/1/2023
G0467	PR FQHC VISIT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A FEDERALLY QUALIFIED HEALTH CENTERS (FQHC).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/1/2023
G0467	PR FQHC VISIT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A FEDERALLY QUALIFIED HEALTH CENTERS (FQHC).	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
G0468	PR FQHC VISIT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A FEDERALLY QUALIFIED HEALTH CENTERS (FQHC).	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/1/2023
G0468	PR FQHC VISIT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A FEDERALLY QUALIFIED HEALTH CENTERS (FQHC).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/1/2023
G0469	PR FQHC VISIT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A FEDERALLY QUALIFIED HEALTH CENTERS (FQHC).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/1/2023
G0469	PR FQHC VISIT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A FEDERALLY QUALIFIED HEALTH CENTERS (FQHC).	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
G0470	PR FQHC VISIT	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A FEDERALLY QUALIFIED HEALTH CENTERS (FQHC).	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/1/2023
G0470	PR FQHC VISIT	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A FEDERALLY QUALIFIED HEALTH CENTERS (FQHC).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/1/2023
G0495	PR RN CARE TRAIN/EDU IN HH	AUTHORIZATION REQUIRED	USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/PCS-Guidelines.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
G0495	PR RN CARE TRAIN/EDU IN HH	AUTHORIZATION REQUIRED	USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/prior_authcheck/uploads/UMGuides/PCS-Guidelines.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022
G2011	PR ALCOHOL/SUB ABUSE ASSESS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
G2022	PR BENEF REFUSES SERVICE, MOD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
G2022	PR BENEF REFUSES SERVICE, MOD	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
G2214	PR INIT/SUB PSYCH CARE M 1ST 30	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
G3002	PR CHRONIC PAIN MANAGEMENT AND TREATMNT REQD FIRST 30 MIN BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, PER CALENDAR MONTH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023
G3003	PR EA ADDL 15 MIN OF CHRONIC PAIN MANAGEMENT AND TREATMENT BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, PER CALENDAR MONTH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023
G9012	PR OTHER SPECIFIED CASE MGMT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	9/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
H0001	PR ALCOHOL AND/OR DRUG ASSESS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
H0004	PR ALCOHOL AND/OR DRUG SERVICES	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED IF 135 UNITS OR LESS OF GROUP COUNSELING OR 26 HOURS OR LESS OF INDIVIDUAL COUNSELING PER YEAR.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
H0004	PR ALCOHOL AND/OR DRUG SERVICES	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER 135 UNITS OF GROUP COUNSELING OR OVER 26 HOURS OF INDIVIDUAL COUNSELING PER YEAR.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
H0005	PR ALCOHOL AND/OR DRUG SERVICES	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER 135 UNITS OF GROUP COUNSELING OR OVER 26 HOURS OF INDIVIDUAL COUNSELING PER YEAR.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
H0005	PR ALCOHOL AND/OR DRUG SERVICES	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED IF 135 UNITS OR LESS OF GROUP COUNSELING OR 26 HOURS OR LESS OF INDIVIDUAL COUNSELING PER YEAR.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
H0012	PR ALCOHOL AND/OR DRUG SERVICES	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED IF LESS THAN 21 DAYS PER EPISODE, WITH A MAXIMUM OF 2 EPISODES OF CARE PER ROLLING 6 MONTH PERIOD, AND 4 EPISODES OF CARE PER ROLLING YEAR DOES NOT REQUIRE AN AUTH. ADMISSION AND DISCHARGE NOTIFICATION ARE REQUIRED TO BE GIVEN TO DHP.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
H0012	PR ALCOHOL AND/OR DRUG SERVICES	AUTHORIZATION REQUIRED ALERT: AUTH IS REQUIRED IF MORE THAN 21 DAYS PER EPISODE, WITH MORE THAN A MAXIMUM OF 2 EPISODES OF CARE PER ROLLING 6 MONTH PERIOD, AND MORE THAN 4 EPISODES OF CARE PER ROLLING YEAR DOES REQUIRE AN AUTH. EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
H0015	PR ALCOHOL AND/OR DRUG SERVICES	NO AUTHORIZATION REQUIRED EXCLUSIONS: IOP SERVICES ARE NO AUTH REQUIRED FOR IN-NETWORK PROVIDERS CONTRACTED WITH DRISCOLL HEALTH PLAN FOR THESE SERVICES.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
H0016	PR ALCOHOL AND/OR DRUG SERVICES	AUTHORIZATION REQUIRED ALERT: AUTH IS REQUIRED IF MORE THAN 21 DAYS PER EPISODE, WITH MORE THAN A MAXIMUM OF 2 EPISODES OF CARE PER ROLLING 6 MONTH PERIOD, AND MORE THAN 4 EPISODES OF CARE PER ROLLING YEAR DOES REQUIRE AN AUTH. EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
H0016	PR ALCOHOL AND/OR DRUG SERVICES	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED IF LESS THAN 21 DAYS PER EPISODE, WITH A MAXIMUM OF 2 EPISODES OF CARE PER ROLLING 6 MONTH PERIOD, AND 4 EPISODES OF CARE PER ROLLING YEAR DOES NOT REQUIRE AN AUTH. ADMISSION AND DISCHARGE NOTIFICATION ARE REQUIRED TO BE GIVEN TO DHP.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
H0020	PR ALCOHOL AND/OR DRUG SERVICES	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED IF 135 UNITS OR LESS OF GROUP COUNSELING OR 26 HOURS OR LESS OF INDIVIDUAL COUNSELING PER YEAR.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
H0020	PR ALCOHOL AND/OR DRUG SERVICES	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER 135 UNITS OF GROUP COUNSELING OR OVER 26 HOURS OF INDIVIDUAL COUNSELING PER YEAR.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
H0031	PR MH HEALTH ASSESS BY NON-MD	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED IF LESS THAN 21 DAYS PER EPISODE, WITH A MAXIMUM OF 2 EPISODES OF CARE PER ROLLING 6 MONTH PERIOD, AND 4 EPISODES OF CARE PER ROLLING YEAR DOES NOT REQUIRE AN AUTH. ADMISSION AND DISCHARGE NOTIFICATION ARE REQUIRED TO BE GIVEN TO DHP.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
H0031	PR MH HEALTH ASSESS BY NON-MD	AUTHORIZATION REQUIRED ALERT: AUTH IS REQUIRED IF MORE THAN 21 DAYS PER EPISODE, WITH MORE THAN A MAXIMUM OF 2 EPISODES OF CARE PER ROLLING 6 MONTH PERIOD, AND MORE THAN 4 EPISODES OF CARE PER ROLLING YEAR DOES REQUIRE AN AUTH. EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
H0033	PR ORAL MED ADM DIRECT OBSERVE	AUTHORIZATION REQUIRED ALERT: AUTH REQUIRED IF OVER 135 UNITS OF GROUP COUNSELING OR OVER 26 HOURS OF INDIVIDUAL COUNSELING PER YEAR.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
H0033	PR ORAL MED ADM DIRECT OBSERVE	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED IF 135 UNITS OR LESS OF GROUP COUNSELING OR 26 HOURS OR LESS OF INDIVIDUAL COUNSELING PER YEAR.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
H0034	PR MED TRNG & SUPPORT PER 15MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
H0035	PR MH PARTIAL HOSP TX UNDER 24H	NO AUTHORIZATION REQUIRED EXCLUSIONS: PHP SERVICES ARE NO AUTH REQUIRED FOR IN-NETWORK PROVIDERS CONTRACTED WITH DRISCOLL HEALTH PLAN FOR THESE SERVICES.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	5/10/2021
H0038	PR SELF-HELP/PEER SVC PER 15MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
H0047	PR ALCOHOL/DRUG ABUSE SVC NOS	AUTHORIZATION REQUIRED ALERT: AUTH IS REQUIRED IF MORE THAN 21 DAYS PER EPISODE, WITH MORE THAN A MAXIMUM OF 2 EPISODES OF CARE PER ROLLING 6 MONTH PERIOD, AND MORE THAN 4 EPISODES OF CARE PER ROLLING YEAR DOES REQUIRE AN AUTH. EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
H0047	PR ALCOHOL/DRUG ABUSE SVC NOS	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED IF LESS THAN 21 DAYS PER EPISODE, WITH A MAXIMUM OF 2 EPISODES OF CARE PER ROLLING 6 MONTH PERIOD, AND 4 EPISODES OF CARE PER ROLLING YEAR DOES NOT REQUIRE AN AUTH. ADMISSION AND DISCHARGE NOTIFICATION ARE REQUIRED TO BE GIVEN TO DHP.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
H0049	PR ALCOHOL/DRUG SCREENING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
H0050	PR ALCOHOL/DRUG SERVICE 15 MIN	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED IF LESS THAN 21 DAYS PER EPISODE, WITH A MAXIMUM OF 2 EPISODES OF CARE PER ROLLING 6 MONTH PERIOD, AND 4 EPISODES OF CARE PER ROLLING YEAR DOES NOT REQUIRE AN AUTH. ADMISSION AND DISCHARGE NOTIFICATION ARE REQUIRED TO BE GIVEN TO DHP.	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
H0050	PR ALCOHOL/DRUG SERVICE 15 MIN	AUTHORIZATION REQUIRED ALERT: AUTH IS REQUIRED IF MORE THAN 21 DAYS PER EPISODE, WITH MORE THAN A MAXIMUM OF 2 EPISODES OF CARE PER ROLLING 6 MONTH PERIOD, AND MORE THAN 4 EPISODES OF CARE PER ROLLING YEAR DOES REQUIRE AN AUTH. EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
H2011	PR CRISIS INTERVEN SVC, 15 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
H2012	PR BEHAV HLTH DAY TREAT, PER HR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
H2014	PR SKILLS TRAIN AND DEV, 15 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
H2017	PR PSYSOC REHAB SVC, PER 15 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
H2023	PR SUPPORTED EMPLOY, PER 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS - REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
H2023	PR SUPPORTED EMPLOY, PER 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS - REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
H2023	PR SUPPORTED EMPLOY, PER 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
H2025	PR SUPP MAINT EMPLOY, 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
H2025	PR SUPP MAINT EMPLOY, 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS - REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
H2025	PR SUPP MAINT EMPLOY, 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS - REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
H2035	PR A/D TX PROGRAM, PER HOUR	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED IF LESS THAN 35 DAYS PER EPISODE, WITH A MAXIMUM OF 2 EPISODES OF CARE PER ROLLING 6 MONTH PERIOD, AND 4 EPISODES OF CARE PER ROLLING YEAR DOES NOT REQUIRE AN AUTH.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
H2035	PR A/D TX PROGRAM, PER HOUR	AUTHORIZATION REQUIRED ALERT: AUTH IS REQUIRED IF MORE THAN 35 DAYS PER EPISODE, MORE THAN 2 EPISODES OF CARE PER ROLLING 6 MONTH PERIOD, OR MORE THAN 4 EPISODES OF CARE PER ROLLING YEAR EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
H2040	COORDINATED SPECIALTY CARE, TEAM-BASED, FOR FIRST EPISODE PSYCHOSIS, PER MONTH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
H2041	COORDINATED SPECIALTY CARE, TEAM-BASED, FOR FIRST EPISODE PSYCHOSIS, PER ENCOUNTER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	1/1/2024
J0121	PR INJ., OMADACYCLIN E, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0122	PR INJ., ERAVACYCLINE , 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0129	PR ABATACEPT INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0130	PR ABCIXIMAB INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0135	PR ADALIMUMAB INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0137	INJECTION, ACETAMINOPH EN (HIKMA) NOT THERAPEUTICALLY EQUIVALENT TO J0131, 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J0172	PR INJ, ADUCANUMAB-AVWA, 2 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J0174	INJECTION, LECANEMAB-IRMB, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0178	PR AFLIBERCEPT INJECTION	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0179	PR INJ, BROLUCIZUMA B-DBLL, 1 MG	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0179	PR INJ, BROLUCIZUMA B-DBLL, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0180	PR AGALSIDASE BETA INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0184	INJECTION, AMISULPRIDE, 1 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
J0184	INJECTION, AMISULPRIDE, 1 MG	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
J0185	PR INJ., APREPITANT, 1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
J0206	INJECTION, ALLOPURINOL SODIUM, 1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0208	INJECTION, SODIUM THIOSULFATE (PEDMARK), 100 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J0216	INJECTION, ALFENTANIL HYDROCHLORIDE, 500 MICROGRAMS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	2/1/2024
J0217	INJ VELMANASE ALFA-TYCV 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J0218	INJECTION, OLIPUDASE ALFA-RPCP, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0219	INJECTION, AVALGLUCOSIDASE ALFANGPT, 4 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0221	PR LUMIZYME INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0222	PR INJ., PATISIRAN, 0.1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0223	PR INJ GIVOSIRAN 0.5 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0224	PR INJ. LUMASIRAN, 0.5 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0225	PR INJECTION, VUTRISIRAN, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0248	INJECTION, REMDESIVIR, 1 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2022
J0291	PR INJ., PLAZOMICIN, 5 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0349	INJECTION, REZAFUNGIN, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	2/1/2024
J0402	INJECTION, ARIPIRAZOLE (ABILIFY ASIMTUFI), 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0457	INJECTION, AZTREONAM, 100 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0480	PR BASILIXIMAB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0490	PR BELIMUMAB INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0491	INJECTION, ANIFROLUMAB-FNIA, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0517	PR INJ., BENRALIZUMA B, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0567	PR INJ., CERLIPONASE ALFA 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0570	PR BUPRENORPHINE IMPLANT 74.2MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0584	PR INJECTION, BUROSUMAB-TWZA 1M	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J0585	PR INJECTION, ONABOTULINUM TOXINA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0586	PR ABOBOTULINUM TOXINA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0587	PR INJ RIMABOTULINUM TOXINB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0588	PR INCOBOTULINU MTOXIN A	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0593	PR INJ., LANADELUMAB -FLYO, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0596	PR INJECTION RUCONEST	NO AUTHORIZATION REQUIRED DX CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: D84.1 AGE: NO AUTH IS REQUIRED IF 13 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2022
J0596	PR INJECTION RUCONEST	AUTHORIZATION REQUIRED DX CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: D84.1 AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 13 YEARS OLD EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0597	PR C-1 ESTERASE, BERINERT	NO AUTHORIZATION REQUIRED DX CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: D84.1 AGE: NO AUTH IS REQUIRED IF 5 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2023
J0597	PR C-1 ESTERASE, BERINERT	AUTHORIZATION REQUIRED DX CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: D84.1 AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 5 YEARS OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2023
J0598	PR C-1 ESTERASE CINRYZE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0599	PR INJ., HAEGARDA 10 UNITS	NO AUTHORIZATION REQUIRED DX CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: D84.1 AGE: NO AUTH IS REQUIRED IF 6 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0599	PR INJ., HAEGARDA 10 UNITS	AUTHORIZATION REQUIRED DX CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: D84.1 AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 6 YEARS OLD EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2022
J0600	PR EDETATE CALCIUM DISODIUM INJ	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0606	PR INJ, ETELCALCETID E, 0.1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0612	INJECTION, CALCIUM GLUCONATE, NOT OTHERWISE SPECIFIED, 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0613	INJECTION, CALCIUM GLUCONATE (WG CRITICAL CARE), NOT THERAPEUTICALLY EQUIVALENT TO J0612, 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J0665	INJECTION, BUPIVICAINE, NOT OTHERWISE SPECIFIED, 0.5 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
J0665	INJECTION, BUPIVICAINE, NOT OTHERWISE SPECIFIED, 0.5 MG	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
J0691	PR INJ LEFAMULIN 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0699	PR INJ, CEFIDEROCOL, 10 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0699	PR INJ, CEFIDEROCOL, 10 MG	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
J0706	PR CAFFEINE CITRATE INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0713	PR INJ CEFTAZIDIME PER 500 MG	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0716	PR CENTRUROIDE S IMMUNE F (AB)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0735	PR CLONIDINE HYDROCHLORIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J0736	INJECTION, CLINDAMYCIN PHOSPHATE, 300 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J0737	INJECTION, CLINDAMYCIN PHOSPHATE (BAXTER), NOT THERAPEUTICALLY EQUIVALENT TO J0736, 300 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J0739	INJECTION, CABOTEGRAVIR, 1 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
J0741	PR INJ, CABOTE RILPIVIR 2MG 3MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 12 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0741	PR INJ, CABOTE RILPIVIR 2MG 3MG	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 12 YEARS OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
J0742	PR INJ IMIP 4 CILAS 4 RELEB 2MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0791	PR INJ CRIZANLIZUMA B-TMCA 5MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0801	INJECTION, CORTICOTROPIN (ACTHAR GEL), UP TO 40 UNITS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0802	INJECTION, CORTICOTROPIN (ANI), UP TO 40 UNITS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0841	PR INJ CROTALIDAE IM F(AB')2 EQ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2022
J0850	PR CYTOMEGALOVIRUS IMM IV /VIAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0874	INJECTION, DAPTOMYCIN (BAXTER), NOT THERAPEUTICALLY EQUIVALENT TO J0878, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	2/1/2024
J0877	PR INJECTION, DAPTOMYCIN (HOSPIRA), NOT THERAPEUTICALLY EQUIVALENT TO J0878, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J0878	PR DAPTOMYCIN INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0881	PR DARBEPOETIN ALFA, NON- ESRD	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: C90.00, C90.01, C90.02, D46.0, D46.1, D46.21, D46.A, D46.B, D61.1, D61.2, D61.3, D61.89, D61.9, D63.0, D63.1, D64.4, D64.81, D64.89, D64.9, N18.1, N18.2, N18.30, N18.31, N18.32, N18.4, N18.5, N18.6, N18.9, N19, Z51.11, Z51.12	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
J0881	PR DARBEPOETIN ALFA, NON- ESRD	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: C90.00, C90.01, C90.02, D46.0, D46.1, D46.21, D46.A, D46.B, D61.1, D61.2, D61.3, D61.89, D61.9, D63.0, D63.1, D64.4, D64.81, D64.89, D64.9, N18.1, N18.2, N18.30, N18.31, N18.32, N18.4, N18.5, N18.6, N18.9, N19, Z51.11, Z51.12 EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
J0882	PR DARBEPOETIN ALFA, ESRD USE	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: D63.1, N18.1, N18.2, N18.30, N18.31, N18.32, N18.4, N18.5, N18.6, N18.9, N19		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0882	PR DARBEPOETIN ALFA, ESRD USE	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: D63.1, N18.1, N18.2, N18.30, N18.31, N18.32, N18.4, N18.5, N18.6, N18.9, N19 EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J0885	PR EPOETIN ALFA, NON-ESRD	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: B20, C90.00-C90.02, D46.0, D46.1, D46.21, D46.22, D46.4, D46.9, D46.A-D46.C, D46.Z, D47.1, D47.9, D47.Z9, D61.1-D61.3, D61.89, D61.9, D63.0, D63.1, D64.4, D64.81, D64.89, D64.9, N18.1-N18.6, N18.9, N19, P61.2	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
J0885	PR EPOETIN ALFA, NON-ESRD	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: B20, C90.00-C90.02, D46.0, D46.1, D46.21, D46.22, D46.4, D46.9, D46.A-D46.C, D46.Z, D47.1, D47.9, D47.Z9, D61.1-D61.3, D61.89, D61.9, D63.0, D63.1, D64.4, D64.81, D64.89, D64.9, N18.1-N18.6, N18.9, N19, P61.2 EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0888	PR EPOETIN BETA NON ESRD	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: D63.1, I12.0, I12.9, I13.0, I13.11, I13.2, N18.1-N18.6	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
J0888	PR EPOETIN BETA NON ESRD	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: D63.1, I12.0, I12.9, I13.0, I13.11, I13.2, N18.1-N18.6 EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
J0889	DAPRODUSTAT , ORAL, 1 MG, (FOR ESRD ON DIALYSIS)	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	2/1/2024
J0895	PR DEFEROXAMIN E MESYLATE INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J0896	PR INJ LUSPATERCEP T-AAMT 0.25MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1000	PR DEPO- ESTRADIOL CYPIONATE INJ	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1050	PR MEDROXYPRO GESTERONE ACETATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	
J1071	PR INJ TESTOSTERON E CYPIONATE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1095	PR INJECTION, DEXAMETHASO NE 9%	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
J1096	PR DEXAMETHA OPHTH INSERT 0.1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J1100	PR DEXAMETHASONE SODIUM PHOS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
J1105	INJ, DAPTOMYCIN (XELLIA)	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
J1105	INJ, DAPTOMYCIN (XELLIA)	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
J1200	PR DIPHENHYDRAMINE HCL INJECTIO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
J1201	PR INJ. CETIRIZINE HCL 0.5MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1203	INJ, CIPAGLUCOSID ASE, 5 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J1290	PR ECALLANTIDE INJECTION	NO AUTHORIZATION REQUIRED DX CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: D84.1 AGE: NO AUTH IS REQUIRED IF 12 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2023
J1290	PR ECALLANTIDE INJECTION	AUTHORIZATION REQUIRED DX CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: D84.1 AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 12 YEARS OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2023
J1300	ECULIZUMAB INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1302	INJECTION, SUTIMLIMAB-JOME, 10 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J1303	PR INJ., RAVULIZUMAB- CWVZ 10 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1305	PR INJ, EVINACUMAB- DGNB, 5MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1306	INJECTION, INCLISIRAN, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
J1322	PR ELOSULFASE ALFA INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1380	PR ESTRADIOL VALERATE 10 MG INJ	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J1411	INJECTION, ETRANACOGEN E DEZAPARVOVE C-DRLB, PER THERAPEUTIC DOSE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J1412	INJ, DINUTUXIMAB, 0.1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J1413	INJ ROCTAVIAN ML 2X10^13VC G	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J1426	PR INJECTION, CASIMERSEN, 10 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J1427	PR INJ. VILTOLARSEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J1428	PR INJ, ETEPLIRSEN, 10 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J1429	INJ DELANDISTRO GENE MOX ROKL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J1437	PR INJ. FE DERISOMALTO SE 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		7/1/2021
J1439	PR INJ FERRIC CARBOXYMALT OS 1MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		7/1/2021
J1440	PR FILGRASTIM 300 MCG INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1442	PR INJ FILGRASTIM EXCL BIOSIMIL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J1448	PR INJECTION, TRILACICLIB, 1MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
J1448	PR INJECTION, TRILACICLIB, 1MG	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
J1449	INJECTION, EFLAPEGRASTI M-XNST, 0.1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1453	PR FOSAPREPITAN T INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
J1455	PR FOSCARNET SODIUM INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J1458	PR GALSULFASE INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1459	PR INJ IVIG PRIVIGEN 500 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1551	INJECTION, IMMUNE GLOBULIN (CUTAQUIG), 100 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
J1554	PR INJ. ASCENIV	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1558	PR INJ. XEMBIFY, 100 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J1569	GAMMAGARD LIQUID INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1571	HEPAGAM B IM INJECTION	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
J1573	HEPAGAM B INTRAVENOUS, INJ	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		3/1/2024
J1574	PR INJECTION, GANCICLOVIR SODIUM (EXELA) NOT THERAPEUTICALLY EQUIVALENT TO J1570, 500 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J1576	INJECTION, IMMUNE GLOBULIN (PANZYGA), INTRAVENOUS, NON-LYOPHILIZED (E.G., LIQUID), 500 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J1602	PR GOLIMUMAB FOR IV USE 1MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1632	PR INJ., BREXANOLONE , 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1640	PR HEMIN, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1642	PR INJ HEPARIN SODIUM PER 10 U	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J1720	PR HYDROCORTIS ONE SODIUM SUCC I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J1726	PR MAKENA, 10 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J1729	PR INJ HYDROXYPRO GST CAPOAT NOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1738	PR INJ. MELOXICAM 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1743	IDURSULFASE INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1744	PR ICATIBANT INJECTION	NO AUTHORIZATION REQUIRED DX CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: D84.1 AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J1744	PR ICATIBANT INJECTION	AUTHORIZATION REQUIRED DX CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: D84.1 AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2023
J1745	PR INFLIXIMAB INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1747	INJECTION, SPESOLIMAB-SBZO, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1750	PR INJECTION, IRON DEXTRAN, 50 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		7/1/2021
J1756	PR IRON SUCROSE INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		7/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J1786	PR IMUGLUCERAS E INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1805	INJECTION, ESMOLOL HYDROCHLORIDE, 10 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
J1805	INJECTION, ESMOLOL HYDROCHLORIDE, 10 MG	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
J1806	INJECTION, ESMOLOL HYDROCHLORIDE (WG CRITICAL CARE) NOT THERAPEUTICALLY EQUIVALENT TO J1805, 10 MG	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J1806	INJECTION, ESMOLOL HYDROCHLORIDE (WG CRITICAL CARE) NOT THERAPEUTICALLY EQUIVALENT TO J1805, 10 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
J1811	INSULIN (FIASP) FOR ADMINISTRATION THROUGH DME (I.E., INSULIN PUMP) PER 50 UNITS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	2/1/2024
J1812	INSULIN (FIASP), PER 5 UNITS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J1813	INSULIN (LYUMJEV) FOR ADMINISTRATI ON THROUGH DME (I.E., INSULIN PUMP) PER 50 UNITS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	2/1/2024
J1814	INSULIN (LYUMJEV), PER 5 UNITS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1815	PR INSULIN INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		5/10/2021
J1817	PR INSULIN FOR INSULIN PUMP USE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		5/10/2021
J1823	PR INJ. INEBILIZUMAB-CDON, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J1826	PR INTERFERON BETA-1A INJ	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1836	INJECTION, METRONIDAZOLE, 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J1920	INJECTION, LABETALOL HYDROCHLORIDE, 5 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 1 YEAR OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2023
J1920	INJECTION, LABETALOL HYDROCHLORIDE, 5 MG	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 1 YEAR OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2023
J1921	INJECTION, LABETALOL HYDROCHLORIDE (HIKMA) NOT THERAPEUTICALLY EQUIVALENT TO J1820, 5 MG	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 1 YEAR OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J1921	INJECTION, LABETALOL HYDROCHLORIDE (HIKMA) NOT THERAPEUTICALLY EQUIVALENT TO J1820, 5 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 1 YEAR OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2023
J1931	PR LARONIDASE INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1932	INJECTION, LANREOTIDE, (CIPLA), 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1941	INJECTION, FUROSEMIDE (FUROSCIX), 20 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1943	PR INJ., ARISTADA INITIO, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J1944	PR ARIPRAZOLE LAUROXIL 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1950	PR LEUPROLIDE ACETATE /3.75 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1951	PR INJ FENSOLVI 0.25 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1952	PR LEUPROLIDE INJ, CAMCEVI, 1MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J1954	PR INJECTION, LEUPROLIDE ACETATE FOR DEPOT SUSPENSION (CIPLA), 7.5 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J1961	INJECTION, LENACAPAVIR, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J2020	PR LINEZOLID INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2022
J2182	PR INJECTION MEPOLIZUMAB 1MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J2249	INJECTION, REMIMAZOLAM, 1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J2250	PR INJ MIDAZOLAM HYDROCHLORIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J2260	PR INJ MILRINONE LACTATE / 5 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J2305	INJECTION, NITROGLYCERIN, 5 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J2315	PR NALTREXONE, DEPOT FORM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J2326	PR INJ, NUSINERSEN, 0.1MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J2329	INJECTION, UBLITUXIMAB-XIYY, 1MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J2356	INJECTION, TEZEPELUMAB-EKKO, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J2357	PR OMALIZUMAB INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J2359	INJECTION, OLANZAPINE, 0.5 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J2371	INJECTION, PHENYLEPHRINE HYDROCHLORIDE, 20 MICROGRAMS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J2372	INJECTION, PHENYLEPHRINE HYDROCHLORIDE (BIORPHEN), 20 MICROGRAMS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J2405	PR ONDANSETRON HCL INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
J2406	PR INJECTION, ORITAVANCIN 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J2427	INJECTION, PALIPERIDONE PALMITATE EXTENDED RELEASE (INVEGA HAFYERA, OR INVEGA TRINZA), 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J2469	PR PALONOSETRON HCL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J2503	PR PEGAPTANIB SODIUM INJECTION	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J2506	PR INJ PEGFILGRAST EX BIO 0.5MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J2507	PR PEGLOTICASE INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J2508	INJ, NICARDIPINE 0.1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J2561	INJECTION, PHENOBARBIT AL SODIUM (SEZABY), 1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J2597	PR INJ DESMOPRESSI N ACETATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J2598	INJECTION, VASOPRESSIN, 1 UNIT	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J2598	INJECTION, VASOPRESSIN, 1 UNIT	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
J2599	INJECTION, VASOPRESSIN (AMERICAN REGENT) NOT THERAPEUTICALLY EQUIVALENT TO J2598, 1 UNIT	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
J2599	INJECTION, VASOPRESSIN (AMERICAN REGENT) NOT THERAPEUTICALLY EQUIVALENT TO J2598, 1 UNIT	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
J2724	PROTEIN C CONCENTRATE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J2777	INJECTION, FARICIMAB-SVOA, 0.1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J2778	RANIBIZUMAB INJECTION	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J2779	INJECTION, RANIBIZUMAB, VIA INTRAVITREAL IMPLANT (SUSVIMO), 0.1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J2781	INJECTION, PEGCETACOPLAN, INTRAVITREAL, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J2786	PR INJECTION RESLIZUMAB 1MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J2788	PR RHO D IMMUNE GLOBULIN 50 MCG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		5/10/2021
J2790	PR RHO D IMMUNE GLOBULIN INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		5/10/2021
J2791	RHOPHYLAC INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		5/10/2021
J2792	PR RHO(D) IMMUNE GLOBULIN H, SD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J2793	PR RILONACEPT INJECTION	NO AUTHORIZATION REQUIRED DX CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: M04.2 AGE: NO AUTH IS REQUIRED IF 12 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2022
J2793	PR RILONACEPT INJECTION	AUTHORIZATION REQUIRED DX CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: M04.2 AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 12 YEARS OLD EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2022
J2798	PR INJ., PERSERIS, 0.5 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J2799	INJECTION, RISPERIDONE (UZEDY), 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J2806	INJECTION, SINCALIDE (MAIA) NOT THERAPEUTICALLY EQUIVALENT TO J2805, 5 MICROGRAMS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	2/1/2024
J2820	PR SARGRAMOSTIM INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J2840	PR INJ SEBELIPASE ALFA 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J2916	PR NA FERRIC GLUCONATE COMPLEX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		7/1/2021
J2997	PR ALTEPLASE RECOMBINANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J2998	INJECTION, PLASMINOGEN, HUMAN-TVMH, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
J3010	PR FENTANYL CITRATE INJECITON	NO AUTHORIZATION REQUIRED REQUESTING PROVIDER: NO AUTH REQUIRED IF REFERRED BY PROVIDER IS AN ONCOLOGIST, HEMATOLOGIST/ONCOLOGIST		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2023
J3010	PR FENTANYL CITRATE INJECITON	AUTHORIZATION REQUIRED REQUESTING PROVIDER: AUTH IS REQUIRED IF REFERRED BY PROVIDER IS NOT AN ONCOLOGIST, HEMATOLOGIST/ONCOLOGIST EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2023
J3031	PR INJ., FREMANEZUMA B-VFRM 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J3032	PR INJ. EPTINEZUMAB-JJMR 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J3060	PR INJ TALIGLUCERAS E ALFA 10 U	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J3111	PR INJ. ROMOSOZUMA B-AQQG 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J3121	PR INJ TESTOSTERO ENANTHATE 1MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J3145	PR TESTOSTERON E UNDECANOATE 1MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J3240	PR THYROTROPIN INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J3241	PR INJ. TEPROTUMUM AB-TRBW 10 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J3245	PR INJ., TILDRAKIZUMA B, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J3262	PR TOCILIZUMAB INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J3299	INJECTION, TRIAMCINOLONE ACETONIDE, SUPRACHOROIDAL (XIPERE), 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J3300	PR TRIAMCINOLON E A INJ PRS- FREE	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J3301	PR TRIAMCINOLON E ACETONIDE INJ	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J3315	PR TRIPTORELIN PAMOATE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J3316	PR INJ., TRIPTORELIN XR 3.75 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J3370	PR VANCOMYCIN HCL INJECTION	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J3380	PR INJECTION, VEDOLIZUMAB, INTRAVENOUS, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J3385	PR VELAGLUCERA SE ALFA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J3396	PR VERTEPORFIN INJECTION	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J3398	PR INJ LUXTURNA 1 BILLION VEC G	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX . ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J3398	PR INJ LUXTURNA 1 BILLION VEC G	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	3/1/2024
J3399	PR INJ ONASE ABEPAR-XIOI TREAT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J3401	VYJUVEK 5X10^9PFU/ML, 0.1 ML	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J3490	PR DRUGS UNCLASSIFIED INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J3590	PR UNCLASSIFIED BIOLOGICS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7100	PR DEXTRAN 40 INFUSION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		7/1/2021
J7110	PR DEXTRAN 75 INFUSION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		7/1/2021
J7168	PR PROTHROMBIN COMPLEX KCENTRA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7169	PR INJ ANDEXXA, 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7170	PR INJ., EMICIZUMAB-KXWH 0.5 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7175	PR INJ FACTOR X (HUMAN) 1IU	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7179	PR VONVENDI INJ 1 IU VWF:RCO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7180	PR FACTOR XIII ANTI-HEM FACTOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J7181	PR FACTOR XIII RECOMB A-SUBUNIT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7182	PR FACTOR VIII RECOMB NOVOEIGHT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7183	PR WILATE INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7185	PR XYNTHA INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7186	PR ANTIHEMOPHILIC VIII/VWF COMP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7187	HUMATE-P, INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7188	PR FACTOR VIII RECOMB OBIZUR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7189	PR FACTOR VIIA RECOMB NOVOSEVEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7190	PR FACTOR VIII	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7192	PR FACTOR VIII RECOMBINANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J7193	PR FACTOR IX NON-RECOMBINANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7194	PR FACTOR IX COMPLEX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7195	PR FACTOR IX RECOMBINANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7198	PR ANTI-INHIBITOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7200	PR FACTOR IX RECOMBINAN RIXUBIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7201	PR FACTOR IX ALPROLIX RECOMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7202	PR FACTOR IX IDELVION INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7203	PR FACTOR IX RECOMB GLY REBINYN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7204	PR INJ RECOMBIN ESPEROCT PER IU	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7205	PR FACTOR VIII FC FUSION RECOMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J7207	PR FACTOR VIII PEGYLATED RECOMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7208	PR INJ. JIVI 1 IU	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7209	PR FACTOR VIII NUWIQ RECOMB 1IU	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7210	PR INJ, AFSTYLA, 1 I.U.	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7211	PR INJ, KOVALTRY, 1 I.U.	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7212	PR FACTOR VIIA RECOMB SEVENFACT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7212	PR FACTOR VIIA RECOMB SEVENFACT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J7213	INJECTION, COAGULATION FACTOR IX (RECOMBINANT), IXINITY, 1 I.U.	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 12 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J7213	INJECTION, COAGULATION FACTOR IX (RECOMBINANT), IXINITY, 1 I.U.	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 12 YEARS OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2023
J7214	INJECTION, FACTOR VIII/VON WILLEBRAND FACTOR COMPLEX, RECOMBINANT (ALTUVIIIIO), PER FACTOR VIII I.U.	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J7294	PR SEG ACET AND ETH ESTR YEARLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	1/1/2022
J7295	PR ETH ESTR AND ETON MONTHLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	1/1/2022
J7296	PR KYLEENA, 19.5 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	
J7297	PR LILETTA 52 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	
J7298	PR MIRENA 52 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J7300	PR INTRAUT COPPER CONTRACEPTI VE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	
J7301	PR SKYLA 13.5 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	
J7304	PR CONTRACEPTI VE HORMONE PATCH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	
J7307	ETONOGESTRE L IMPLANT SYSTEM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK	C, CP	
J7311	PR INJ., RETISERT, 0.01 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J7312	PR DEXAMETHASO NE INTRA IMPLANT	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J7314	PR INJ., YUTIQ, 0.01 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J7316	PR INJ OCRIPLASMIN 0.125 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J7351	PR INJ BIMATOPROST ITC IMP1MCG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J7352	PR AFAMELANOTI DE IMPLANT, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J7353	ANACAULASE-BCDB, 8.8% GEL, 1 GRAM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	2/1/2024
J7402	PR MOMETASONE SINUS SINUVA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J7504	PR LYMPHOCYTE IMMUNE GLOBULIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J7519	INJECTION, MYCOPHENOLATE MOFETIL, 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J8501	PR ORAL APREPITANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
J9000	PR DOXORUBIC HCL 10 MG VL CHEMO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9015	PR ALDESLEUKIN/ SINGLE USE VIAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9017	PR ARSENIC TRIOXIDE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9019	PR ERWINAZE INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9020	PR ASPARAGINAS E INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9021	PR INJ, ASPARA, RYLAZE, 0.1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9022	PR INJ, ATEZOLIZUMAB ,10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9023	PR INJECTION, AVELUMAB, 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9025	PR AZACITIDINE INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J9027	PR CLOFARABINE INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J9029	INTRAVESICAL INSTILLATION, NADOFARAGEN E FIRADENOVEC-VNCG, PER THERAPEUTIC DOSE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J9030	PR BCG LIVE INTRAVESICAL 1MG	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: C67.0-C67.9, C79.11, D09.0		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9030	PR BCG LIVE INTRAVESICAL 1MG	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: C67.0-C67.9, C79.11, D09.0 EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
J9031	PR BCG LIVE INTRAVESICAL VAC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9035	PR BEVACIZUMAB INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9035	PR BEVACIZUMAB INJECTION	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
J9036	PR INJ. BELRAPZO/BEN DAMUSTINE	<p>NO AUTHORIZATION REQUIRED</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9036	PR INJ. BELRAPZO/BEN DAMUSTINE	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
J9037	PR INJ BELANTAMAB MAFODOT BLMF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J9039	PR INJECTION BLINATUMOMA B	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9040	PR BLEOMYCIN SULFATE INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9041	PR INJ., VELCADE 0.1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9042	PR BRENTUXIMAB VEDOTIN INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9043	PR CABAZITAXEL INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9044	PR INJ, BORTEZOMIB, NOS, 0.1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9045	PR CARBOPLATIN INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9046	PR INJECTION, BORTEZOMIB, (DR. REDDY'S), NOT THERAPEUTICALLY EQUIVALENT TO J9041, 0.1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9047	PR INJECTION CARFILZOMIB 1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9050	PR CARMUS BISCHL NITRO INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9051	INJECTION, BORTEZOMIB (MAIA), NOT THERAPEUTICALLY EQUIVALENT TO J9041, 0.1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9055	PR CETUXIMAB INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9056	INJECTION, BENDAMUSTINE HYDROCHLORIDE (VIVIMUSTA), 1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9057	PR INJ., COPANLISIB, 1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9058	INJECTION, BENDAMUSTINE HYDROCHLORIDE (APOTEX), 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	2/1/2024
J9059	INJECTION, BENDAMUSTINE HYDROCHLORIDE (BAXTER), 1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9060	PR CISPLATIN 10 MG INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9061	PR INJ, AMIVANTAMAB-VMJW	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
J9061	PR INJ, AMIVANTAMAB-VMJW	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9063	INJECTION, MIRVETUXIMAB SORAVTANSIN E-GYNX, 1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9064	INJECTION, CABAZITAXEL (SANDOZ), NOT THERAPEUTICALLY EQUIVALENT TO J9043, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	2/1/2024
J9065	PR INJ CLADRIBINE PER 1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9070	PR CYCLOPHOSPHAMIDE 100 MG INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9071	INJECTION, CYCLOPHOSPHAMIDE, (AUROMEDICS), 5 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9072	INJ CYCLOPHOS DR.REDDY'S 5MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9073	INJ CYCLOPHOSPHAMIDE (INGENUS)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9074	INJ, CYCLOPHOSPHAMIDE, SANDOZ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9075	INJ, CYCLOPHOSPH AMIDE, NOS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9080	PR CYCLOPHOSPH AMIDE 200 MG INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9090	PR CYCLOPHOSPH AMIDE 500 MG INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9091	PR CYCLOPHOSPH AMIDE 1.0 GRM INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9092	PR CYCLOPHOSPH AMIDE 2.0 GRM INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9093	PR CYCLOPHOSPH AMIDE LYOPHILIZED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9094	PR CYCLOPHOSPH AMIDE LYOPHILIZED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9095	PR CYCLOPHOSPH AMIDE LYOPHILIZED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9096	PR CYCLOPHOSPH AMIDE LYOPHILIZED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9097	PR CYCLOPHOSPH AMIDE LYOPHILIZED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9098	PR CYTARABINE LIPOSOME	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9100	PR CYTARABINE HCL 100 MG INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9118	PR INJ. CALASPARGAS E PEGOL-MKNL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9119	PR INJ., CEMIPLIMAB- RWLC, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J9120	PR DACTINOMYCIN ACTINOMYCIN D	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J9130	PR DACARBAZINE 100 MG INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9144	PR DARATUMUMA B, HYALURONIDA SE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9145	PR INJECTION DARATUMUMA B 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9150	PR DAUNORUBICIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9151	PR DAUNORUBICIN CITRATE LIPOSOM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9153	PR INJ DAUNORUBICIN , CYTARABINE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9155	PR DEGARELIX INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9155	PR DEGARELIX INJECTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J9160	PR DENILEUKIN DIFTITOX, 300 MCG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9165	PR DIETHYLSTILBE STROL INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9170	PR DOCETAXEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9171	PR DOCETAXEL INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

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J9172	DOCETAXEL (INGENUS), 1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9173	PR INJ., DURVALUMAB, 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9175	PR ELLIOTTS B SOLUTION PER ML	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9176	PR INJECTION ELOTUZUMAB 1MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9177	PR INJ ENFORT VEDO-EJFV 0.25MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J9178	PR INJ, EPIRUBICIN HCL, 2 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9179	PR ERIBULIN MESYLATE INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9181	PR ETOPOSIDE 10 MG INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9182	PR ETOPOSIDE 100 MG INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9185	PR FLUDARABINE PHOSPHATE INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9190	PR FLUOROURACIL INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9196	INJECTION, GEMCITABINE HYDROCHLORIDE (ACCORD)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9198	PR INJ. INFUGEM, 100 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9199	PR INJECTION, INFUGEM, 200 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9200	PR FLOXURIDINE INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9201	PR IN GEMCITABINE HCL NOS 200MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9202	PR GOSERELIN ACETATE IMPLANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9204	PR INJ MOGAMULIZUM AB-KPKC, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9205	PR INJ IRINOTECAN LIPOSOME 1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9206	PR IRINOTECAN INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9207	PR IXABEPILONE INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9208	PR IFOSFOMIDE INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9209	PR MESNA INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9210	PR INJ., EMAPALUMAB-LZSG, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J9211	PR IDARUBICIN HCL INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9214	PR INTERFERON ALFA-2B INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9216	PR INTERFERON GAMMA 1-B INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9217	PR LEUPROLIDE ACETATE SUSPNSION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J9218	PR LEUPROLIDE ACETATE INJECITON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J9218	PR LEUPROLIDE ACETATE INJECITON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J9223	PR INJ. LURBINECTEDI N, 0.1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9225	VANTAS IMPLANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9226	SUPPRELIN LA IMPLANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9227	PR INJ. ISATUXIMAB- IRFC 10 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J9228	PR IPILIMUMAB INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9229	PR INJ INOTUZUMAB OZOGAM 0.1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9230	PR MECHLORETHA MINE HCL INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9245	PR INJ MELPHALAN HYDROCHL 50 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9246	PR INJ., EVOMELA, 1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9247	PR INJ, MELPHALAN FLUFENAMI 1MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9247	PR INJ, MELPHALAN FLUFENAMI 1MG	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2022
J9250	PR METHOTREXATE SODIUM INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9255	INJ, METHOTREXATE (ACCORD)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9258	PACLITAXEL (TEVA)	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9259	INJECTION, PACLITAXEL PROTEIN-BOUND PARTICLES (AMERICAN REGENT) NOT THERAPEUTICALLY EQUIVALENT TO J9264, 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	2/1/2024
J9260	INJECTION, METHOTREXATE SODIUM, 50 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9261	PR NELARABINE INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9262	PR INJ OMACETAXINE MEP 0.01MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9263	PR OXALIPLATIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9264	PR PACLITAXEL PROTEIN BOUND	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9266	PR PEGASPARGAS E/SINGL DOSE VIAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J9267	PR PACLITAXEL INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9268	PR PENTOSTATIN INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9269	PR INJ. TAGRAXOFUSP -ERZS 10 MCG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9270	PR PLICAMYCIN (MITHRAMYCIN) INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9271	PR INJ PEMBROLIZUM AB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9272	PR INJ, DOSTARLIMAB-GXLY, 10 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
J9272	PR INJ, DOSTARLIMAB-GXLY, 10 MG	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
J9273	INJECTION, TISOTUMAB VEDOTIN-TFTV, 1 MG	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2022
J9273	INJECTION, TISOTUMAB VEDOTIN-TFTV, 1 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2022
J9274	INJECTION, TEBENTAFUSP-TEBN, 1 MCG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9280	PR MITOMYCIN 5 MG INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9281	PR MITOMYCIN INSTILLATION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9285	PR INJ, OLARATUMAB, 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9286	INJ GLOFITAMAB GXBM, 2.5 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9286	INJ GLOFITAMAB GXBM, 2.5 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
J9290	PR MITOMYCIN 20 MG INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9291	PR MITOMYCIN 40 MG INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9293	PR MITOXANTRON E HYDROCHL / 5 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9294	INJECTION, PEMETREXED (HOSPIRA) NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9295	PR INJECTION NECITUMUMAB 1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9296	INJECTION, PEMETREXED (ACCORD) NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9297	INJECTION, PEMETREXED (SANDOZ), NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9298	INJECTION, NIVOLUMAB AND RELATLIMAB-RMBW, 3 MG/1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9298	INJECTION, NIVOLUMAB AND RELATLIMAB-RMBW, 3 MG/1 MG	NO AUTHORIZATION REQUIRED	AGE: NO AUTH IS REQUIRED IF 12 YEARS OF AGE AND OLDER	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9298	INJECTION, NIVOLUMAB AND RELATLIMAB-RMBW, 3 MG/1 MG	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 12 YEARS OLD	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
J9299	PR INJECTION NIVOLUMAB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9300	PR GEMTUZUMAB OZOGAMICIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9301	PR OBINUTUZUMAB INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9302	PR OFATUMUMAB INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9303	PANITUMUMAB INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9304	PR INJ. PEMETREXED, 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9305	PR PEMETREXED INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9306	PR INJECTION PERTUZUMAB 1 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9307	PR PRALATREXAT E INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9308	PR INJECTION RAMUCIRUMAB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9309	PR INJ, POLATUZUMAB VEDOTIN 1MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9310	PR RITUXIMAB INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9311	PR INJ RITUXIMAB, HYALURONIDA SE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J9312	PR INJ., RITUXIMAB, 10 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J9313	PR INJ., LUMOXITI, 0.01 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9314	PR INJECTION, PEMETREXED (TEVA) NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9316	PR PERTUZU, TRASTUZU, 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9317	PR SACITUZUMAB GOVITECAN-HZIY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9318	PR INJ ROMIDEPSIN NON-LYO 0.1MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9319	PR INJ ROMIDEPSIN LYOPHIL 0.1MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9320	PR STREPTOZOICIN INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9321	INJECTION, EPCORITAMAB-BYSP, 0.16 MG	NO AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9322	INJECTION, PEMETREXED (BLUEPOINT) NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
J9323	INJECTION, PEMETREXED DITROMETHAMINE, 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9324	INJ, PEMRYDINTRU, 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9325	PR INJ TALIMOGENE LAHERPAREPV EC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9328	PR TEMOZOLOMIDE INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9330	PR TEMSIROLIMUS INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9331	INJECTION, SIROLIMUS PROTEIN-BOUND PARTICLES, 1 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9332	INJECTION, EFGARTIGIMOD ALFA-FCAB, 2MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
J9333	INJ RONZANOLIXIZ UM-NOLI 1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J9334	INJ EFGART-ALFA 2MG HYA-QVFC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J9340	PR THIOTEPA INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9345	INJECTION, RETIFANLIMAB-DLWR, 1 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9347	INJECTION, TREMELIMUMA B-ACTL, 1 MG	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
J9347	INJECTION, TREMELIMUMA B-ACTL, 1 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
J9348	PR INJ. NAXITAMAB-GQGK, 1 MG	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: C74.00-C74.02, C74.10-C74.12, C74.90-C74.92 AGE: NO AUTH IS REQUIRED IF 1 YEARS OF AGE AND OLDER	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021
J9348	PR INJ. NAXITAMAB-GQGK, 1 MG	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES:C74.00-C74.02, C74.10-C74.12, C74.90-C74.92 AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 1 YEARS OLD EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9349	PR INJ., TAFASITAMAB-CXIX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9350	PR TOPOTECAN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9351	PR TOPOTECAN INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9352	PR INJECTION TRABECTEDIN 0.1MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9353	PR INJ. MARGETUXIMA B-CMKB, 5 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
J9353	PR INJ. MARGETUXIMA B-CMKB, 5 MG	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
J9354	PR INJ ADO-TRASTUZUMAB EMT 1MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9355	PR INJ TRASTUZUMAB EXCL BIOSIMI	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9356	PR INJ. HERCEPTIN HYLECTA, 10MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9357	PR VALRUBICIN, 200 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J9358	INJ FAM-TRASTU DERU-NXKI 1MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
J9359	INJECTION, LONCASTUXIM AB TESIRINE-LPYL, 0.075 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
J9359	INJECTION, LONCASTUXIM AB TESIRINE-LPYL, 0.075 MG	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
J9360	PR VINBLASTINE SULFATE INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9370	PR VINCRISTINE SULFATE 1 MG INJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9371	PR INJ VINCRISTINE SUL LIP 1MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9380	INJECTION, TECLISTAMAB-CQYV, 0.5 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
J9381	INJECTION, TEPLIZUMAB-MZWV, 5 MCG	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
J9381	INJECTION, TEPLIZUMAB-MZWV, 5 MCG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9390	PR VINOELBINE TARTRATE/10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
J9393	PR INJECTION, FULVESTRANT (TEVA) NOT THERAPEUTICALLY EQUIVALENT TO J9395, 25 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9394	PR INJECTION, FULVESTRANT (FRESENIUS KABI) NOT THERAPEUTICALLY EQUIVALENT TO J9395, 25 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9395	PR INJECTION, FULVESTRANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9400	PR INJ ZIV-AFLIBERCEPT 1MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9600	PR PORFIMER SODIUM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
J9999	PR CHEMOTHERAPY DRUG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
K0001	PR STANDARD WHEELCHAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0002	PR STND HEMI (LOW SEAT) WHLCHR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0003	PR LIGHTWEIGHT WHEELCHAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0004	PR HIGH STRENGTH LTWT WHLCHR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0005	PR ULTRALIGHTW EIGHT WHEELCHAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0006	PR HEAVY DUTY WHEELCHAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0007	PR EXTRA HEAVY DUTY WHEELCHAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0008	PR CSTM MANUAL WHEELCHAIR/B ASE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0009	PR OTHER MANUAL WHEELCHAIR/B ASE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0010	PR STND WT FRAME POWER WHLCHR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0011	PR STND WT PWR WHLCHR W CONTROL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0012	PR LTWT PORTBL POWER WHLCHR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0013	PR CUSTOM POWER WHLCHR BASE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0015	PR DETACH NON-ADJUS HGHT ARMREST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0017	PR DETACH ADJUST ARMREST BASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0018	PR DETACH ADJUST ARMREST UPPER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0019	PR ARM PAD EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0020	PR FIXED ADJUST ARMREST PAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0023	DELETED 2474	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0024	DELETED 2475	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0037	PR HI MOUNT FLIP-UP FOOTREST EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0038	PR LEG STRAP EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0039	PR LEG STRAP H STYLE EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0040	PR ADJUSTABLE ANGLE FOOTPLATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0041	PR LARGE SIZE FOOTPLATE EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0042	PR STANDARD SIZE FOOTPLATE EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0043	PR FTRST LOWER EXTENSION TUBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0044	PR FTRST UPPER HANGER BRACKET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0045	PR FOOTREST COMPLETE ASSEMBLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0046	PR ELEVAT LEGRST LOW EXTENSION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0047	PR ELEVAT LEGRST UP HANGR BRACK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0050	PR RATCHET ASSEMBLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0051	PR CAM RELESE ASSEM FTRST/LGRST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0052	PR SWINGAWAY DETACH FOOTREST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0053	PR ELEVATE FOOTREST ARTICULATE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0056	PR SEAT HT <17 OR >=21 LTWT WC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0059	DELETED 2494	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0060	DELETED 2495	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0061	DELETED 2496	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0064	DELETED 2499	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0065	PR SPOKE PROTECTORS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0066	DELETED 2500	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0067	DELETED 2501	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0068	DELETED 2502	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0069	PR REAR WHL COMPLETE SOLID TIRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0070	PR REAR WHL COMPL PNEUM TIRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0071	PR FRONT CASTR COMPL PNEUM TIRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0072	PR FRNT CSTR CMPL SEM-PNEUM TIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0073	PR CASTER PIN LOCK EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0074	DELETED 2503	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0075	DELETED 2504	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0076	DELETED 2505	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0077	PR FRONT CASTER ASSEM COMPLETE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0078	DELETED 2506	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0081	DELETED 2509	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0090	PR REAR TIRE POWER WHEELCHAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0091	PR REAR TIRE TUBE POWER WHLCHR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0092	PR REAR ASSEM CMPLT POWR WHLCHR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0093	PR REAR ZERO PRESSURE TIRE TUBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0094	PR WHEEL TIRE FOR POWER BASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0095	PR WHEEL TIRE TUBE EACH BASE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0096	PR WHEEL ASSEM POWR BASE COMPLT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0097	PR WHEEL ZERO PRESURE TIRE TUBE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0098	PR DRIVE BELT POWER WHEELCHAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0099	PR PWR WHEELCHAIR FRONT CASTER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0108	PR W/C COMPONENT-ACCESSORY NOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0108	PR W/C COMPONENT-ACCESSORY NOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0195	PR ELEVATING WHLCHAIR LEG RESTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0455	PR PUMP UNINTERRUPTED INFUSION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2022
K0462	PR TEMPORARY REPLACEMENT EQPMNT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
K0552	PR SUPPLY/EXT INF PUMP SYR TYPE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
K0601	PR REPL BATT SILVER OXIDE 1.5 V	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
K0602	PR REPL BATT SILVER OXIDE 3 V	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
K0603	PR REPL BATT ALKALINE 1.5 V	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
K0604	PR REPL BATT LITHIUM 3.6 V	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0605	PR REPL BATT LITHIUM 4.5 V	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
K0606	PR AED GARMENT W ELEC ANALYSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
K0607	PR REPL BATT FOR AED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
K0609	PR REPL ELECTRODE FOR AED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
K0672	PR REMOVABLE SOFT INTERFACE LE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
K0730	PR CTRL DOSE INH DRUG DELIV SYS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0738	PR PORTABLE GAS OXYGEN SYSTEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0739	PR REPAIR/SVC DME NON-OXYGEN EQ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0800	PR POV GROUP 1 STD UP TO 300LBS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0801	PR POV GROUP 1 HD 301-450 LBS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0802	PR POV GROUP 1 VHD 451-600 LBS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0813	PR PWC GP 1 STD PORT SEAT/BACK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0814	PR PWC GP 1 STD PORT CAP CHAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0815	PR PWC GP 1 STD SEAT/BACK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0816	PR PWC GP 1 STD CAP CHAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0820	PR PWC GP 2 STD PORT SEAT/BACK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0821	PR PWC GP 2 STD PORT CAP CHAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0822	PR PWC GP 2 STD SEAT/BACK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0823	PR PWC GP 2 STD CAP CHAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0824	PR PWC GP 2 HD SEAT/BACK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0825	PR PWC GP 2 HD CAP CHAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0826	PR PWC GP 2 VHD SEAT/BACK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0827	PR PWC GP VHD CAP CHAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0828	PR PWC GP 2 XTRA HD SEAT/BACK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0829	PR PWC GP 2 XTRA HD CAP CHAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0835	PR PWC GP2 STD SING POW OPT S/B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0836	PR PWC GP2 STD SING POW OPT CAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0837	PR PWC GP 2 HD SING POW OPT S/B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0838	PR PWC GP 2 HD SING POW OPT CAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0839	PR PWC GP2 VHD SING POW OPT S/B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0840	PR PWC GP2 XHD SING POW OPT S/B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0841	PR PWC GP2 STD MULT POW OPT S/B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0842	PR PWC GP2 STD MULT POW OPT CAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0843	PR PWC GP2 HD MULT POW OPT S/B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0848	PR PWC GP 3 STD SEAT/BACK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0849	PR PWC GP 3 STD CAP CHAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0850	PR PWC GP 3 HD SEAT/BACK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0851	PR PWC GP 3 HD CAP CHAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0852	PR PWC GP 3 VHD SEAT/BACK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0853	PR PWC GP 3 VHD CAP CHAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0854	PR PWC GP 3 XHD SEAT/BACK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0855	PR PWC GP 3 XHD CAP CHAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0856	PR PWC GP3 STD SING POW OPT S/B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0857	PR PWC GP3 STD SING POW OPT CAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0858	PR PWC GP3 HD SING POW OPT S/B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0859	PR PWC GP3 HD SING POW OPT CAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0860	PR PWC GP3 VHD SING POW OPT S/B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0861	PR PWC GP3 STD MULT POW OPT S/B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0862	PR PWC GP3 HD MULT POW OPT S/B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0863	PR PWC GP3 VHD MULT POW OPT S/B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0864	PR PWC GP3 XHD MULT POW OPT S/B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0868	PR PWC GP 4 STD SEAT/BACK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0869	PR PWC GP 4 STD CAP CHAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0870	PR PWC GP 4 HD SEAT/BACK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0871	PR PWC GP 4 VHD SEAT/BACK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0877	PR PWC GP4 STD SING POW OPT S/B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0878	PR PWC GP4 STD SING POW OPT CAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0879	PR PWC GP4 HD SING POW OPT S/B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0880	PR PWC GP4 VHD SING POW OPT S/B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0884	PR PWC GP4 STD MULT POW OPT S/B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0885	PR PWC GP4 STD MULT POW OPT CAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0886	PR PWC GP4 HD MULT POW S/B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0890	PR PWC GP5 PED SING POW OPT S/B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0891	PR PWC GP5 PED MULT POW OPT S/B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2022
K0898	PR POWER WHEELCHAIR NOC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
K0899	PR POW MOBIL DEV NO SADMERC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
K0900	PR CSTM DME OTHER THAN WHEELCHR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
K1022	PR ENDOSKEL POSIT ROTAT UNIT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
K1030	EXTERNAL RECHARGING SYSTEM FOR BATTERY (INTERNAL) FOR USE WITH IMPLANTED CARDIAC CONTRACTILITY MODULATION GENERATOR, REPLACEMENT ONLY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	10/1/2022
K1036	SUPPLIES AND ACCESSORIES (E.G., TRANSDUCER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS A NOT COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L0112	PR CRANIAL CERVICAL ORTHOSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L0113	PR CRANIAL CERVICAL TORTICOLLIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L0120	PR CERV FLEXIBLE NON-ADJUSTABLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L0130	PR FLEX THERMOPLASTIC COLLAR MO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L0140	PR CERVICAL SEMI-RIGID ADJUSTAB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L0150	PR CERV SEMI-RIG ADJ MOLDED CHN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L0160	PR CERV SEMI-RIG WIRE OCC/MAND	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L0170	PR CERVICAL COLLAR MOLDED TO PT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L0172	PR CERV COL SR FOAM 2PC PRE OTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L0174	PR CERV SR 2PC THOR EXT PRE OTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L0180	PR CER POST COL OCC/MAN SUP ADJ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L0190	PR CERV COLLAR SUPP ADJ CERV BA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L0200	PR CERV COL SUPP ADJ BAR & THOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L0220	PR THOR RIB BELT CUSTOM FABRICA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L0450	PR TLSSO FLEX TRUNK/THOR PRE OTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0452	PR TLSSO FLEX CUSTOM FAB THORACI	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L0454	PR TLSO TRNK SJ-T9 PRE CST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0456	PR TLSO FLEX TRNK SJ-SS PRE CST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0458	PR TLSO 2MOD SYMPHIS-XIPHO PRE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0460	PR TLSO 2 SHL SYMPHYS-STERN CST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0462	PR TLSO 3MOD SACRO-SCAP PRE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L0464	PR TLSO 4MOD SACRO-SCAP PRE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0466	PR TLSO R FRAM SOFT ANT PRE CST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0468	PR TLSO RIGID FRAME PREFAB PELV	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0470	PR TLSO RIGID FRAME PRE SUBCLAV	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0472	PR TLSO RIGID FRAME HYPEREX PRE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L0480	PR TLSO RIGID PLASTIC CUSTOM FA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L0482	PR TLSO RIGID LINED CUSTOM FAB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L0484	PR TLSO RIGID PLASTIC CUST FAB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L0486	PR TLSO RIGIDLINED CUST FAB TWO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L0488	PR TLSO RIGID LINED PRE ONE PIE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L0490	PR TLSO RIGID PLASTIC PRE ONE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0491	PR TLSO 2 PIECE RIGID SHELL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0492	PR TLSO 3 PIECE RIGID SHELL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0621	PR SIO FLEX PELVIC/SACR PRE OTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0622	PR SIO FLEX PELVISACRAL CUSTOM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0623	PR SIO PANEL PREFAB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0624	PR SIO PANEL CUSTOM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L0625	PR LO FLEXIBL L1-BELOW L5 PRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0626	PR LO SAG STAYS/PANELS PRE-FAB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0627	PR LO SAGITT RIGID PANEL PREFAB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0628	PR LO FLEX W/O RIGID STAYS PRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0629	PR LSO FLEX W/RIGID STAYS CUST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0630	PR LSO POST RIGID PANEL PRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0631	PR LSO SAG-CORO RIGID FRAME PRE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L0632	PR LSO SAG RIGID FRAME CUST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0633	PR LSO FLEXION CONTROL PREFAB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0634	PR LSO FLEXION CONTROL CUSTOM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0635	PR LSO SAGIT RIGID PANEL PREFAB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0636	PR LSO SAGITTAL RIGID PANEL CUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L0637	PR LSO SAG-CORONAL PANEL PREFAB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0638	PR LSO SAG-CORONAL PANEL CUSTOM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L0639	PR LSO S/C SHELL/PANEL PREFAB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0640	PR LSO S/C SHELL/PANEL CUSTOM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L0700	PR CTLSO A-P-L MOLDED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L0710	PR CTLSO A-P-L CONTROL W/ INTER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L0810	PR HALO CERVICAL INTO JCKT VEST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L0820	PR HALO CERVICAL INTO BODY JACK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L0830	PR HALO CERV INTO MILWAUKEE TYP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L0859	PR MRI COMPATIBLE SYSTEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L0861	PR HALO REPL LINER/INTERFACE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L0970	PR TLSO CORSET FRONT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L0972	PR LSO CORSET FRONT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L0974	PR TLSO FULL CORSET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L0976	PR LSO FULL CORSET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L0978	PR AXILLARY CRUTCH EXTENSION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L0980	PR PERONEAL STRAPS PAIR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L0982	PR STOCKING SUPP GRIPS SET OF F	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L0984	PR PROTECTIVE BODY SOCK EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L0999	PR ADD TO SPINAL ORTHOSIS NOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1000	PR CTLSO MILWAUKE INITIAL MODEL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L1001	PR CTLSO INFANT IMMOBILIZER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1005	PR TENSION BASED SCOLIOSIS ORTH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L1010	PR CTLSO AXILLA SLING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L1020	PR KYPHOSIS PAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1025	PR KYPHOSIS PAD FLOATING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1030	PR LUMBAR BOLSTER PAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1040	PR LUMBAR OR LUMBAR RIB PAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1050	PR STERNAL PAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L1060	PR THORACIC PAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1070	PR TRAPEZIUS SLING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1080	PR OUTRIGGER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1085	PR OUTRIGGER BIL W/ VERT EXTENS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1090	PR LUMBAR SLING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L1100	PR RING FLANGE PLASTIC/LEATHER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1110	PR RING FLANGE PLAS/LEATHER MOL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1120	PR COVERS FOR UPRIGHT EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1200	PR FURNISH INITIAL ORTHOSIS ONLY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L1210	PR LATERAL THORACIC EXTENSION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L1220	PR ANTERIOR THORACIC EXTENSION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1230	PR MILWAUKEE TYPE SUPERSTRUCTUR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1240	PR LUMBAR DEROTATION PAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1250	PR ANTERIOR ASIS PAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1260	PR ANTERIOR THORACIC DEROTATION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L1270	PR ABDOMINAL PAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1280	PR RIB GUSSET (ELASTIC) EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1290	PR LATERAL TROCHANTERIC PAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1300	PR BODY JACKET MOLD TO PATIENT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L1310	PR POST-OPERATIVE BODY JACKET	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L1499	PR SPINAL ORTHOSIS NOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1600	PR ABDUCT HIP FLEX FREJKA W CVR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L1610	PR ABDUCT HIP FLEX FREJKA COVR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L1620	PR ABDUCT HIP FLEX PAVLIK HARNE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L1630	PR ABDUCT CONTROL HIP SEMI-FLEX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L1640	PR PELV BAND/SPREAD BAR THIGH C	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1650	PR HO ABDUCTION HIP ADJUSTABLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L1652	PR HO BI THIGHCUFFS W SPRDR BAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L1660	PR HO ABDUCTION STATIC PLASTIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L1680	PR PELVIC & HIP CONTROL THIGH C	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1681	HIP ORTHOSIS, BILATERAL HIP JOINTS AND THIGH CUFFS, ADJUSTABLE FLEXION, EXTENSION, ABDUCTION CONTROL OF HIP JOIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	C, S, SK, CP	1/1/2024
L1685	PR POST-OP HIP ABDUCT CUSTOM FA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L1686	PR HO POST-OP HIP ABDUCTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L1690	PR COMBINATION BILATERAL HO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L1700	PR LEG PERTHES ORTH TORONTO TYP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L1710	PR LEGG PERTHES ORTH NEWINGTON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L1720	PR LEGG PERTHES ORTHOSIS TRILAT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L1730	PR LEGG PERTHES ORTH SCOTTISH R	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L1755	PR LEGG PERTHES PATTEN BOTTOM T	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L1810	PR KO ELASTIC WITH JOINTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1812	PR KO ELASTIC W/JOINTS PRE OTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1820	PR KO ELAS W/ CONDYLE PADS & JO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1830	PR KO IMMOBILIZER CANVAS LONGIT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1831	PR KNEE ORTH POS LOCKING JOINT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1832	PR KO ADJ JNT POS RIGID SUPPORT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L1834	PR KO W/O JOINT RIGID MOLDED TO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1836	PR RIGID KO WO JOINTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1840	PR KO DEROT ANT CRUCIATE CUSTOM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1843	PR KO SINGLE UPRIGHT CUSTOM FIT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1844	PR KO W/ADJ JT ROT CNTRL MOLDED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

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L1845	PR KO DOUBLE UPRIGHT PRE CST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1846	PR KO W ADJ FLEX/EXT ROTAT MOLD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1847	PR KO DBL UPRIGHT W/AIR PRE CST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1850	PR KO SWEDISH TYPE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1851	PR KO SINGLE UPRIGHT PREFAB OTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L1852	PR KO DOUBLE UPRIGHT PREFAB OTS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1860	PR KO SUPRACONDYL AR SOCKET MOLD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1900	PR AFO SPRNG WIR DRSFLX CALF BD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1901	PR PREFAB ANKLE ORTHOSIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1902	PR AFO ANKLE GAUNTLET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1904	PR AFO MOLDED ANKLE GAUNTLET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1906	PR AFO MULTILIGAMEN TUS ANKLE SU	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L1907	PR AFO SUPRAMALLEO LAR CUSTOM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (Flat Feet and Orthotics): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Flat-Feet-and-Orthotics.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1910	PR AFO SING BAR CLASP ATTACH SH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1920	PR AFO SING UPRIGHT W/ ADJUST S	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1930	PR AFO PLASTIC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1932	PR AFO RIG ANT TIB PREFAB TCF/=	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1940	PR AFO MOLDED TO PATIENT PLASTI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L1945	PR AFO MOLDED PLAS RIG ANT TIB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1950	PR AFO SPIRAL MOLDED TO PT PLAS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1951	PR AFO SPIRAL PREFABRICATE D	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1960	PR AFO POS SOLID ANK PLASTIC MO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1970	PR AFO PLASTIC MOLDED W/ANKLE J	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L1971	PR AFO W/ANKLE JOINT, PREFAB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1980	PR AFO SING SOLID STIRRUP CALF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L1990	PR AFO DOUB SOLID STIRRUP CALF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2000	PR KAFO SING FRE STIRR THI/CALF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2005	PR KAFO SNG/DBL MECHANICAL ACT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2010	PR KAFO SNG SOLID STIRRUP W/O J	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2020	PR KAFO DBL SOLID STIRRUP BAND/	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2030	PR KAFO DBL SOLID STIRRUP W/O J	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2034	PR KAFO PLA SIN UP W/WO K/A CUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L2035	PR KAFO PLASTIC PEDIATRIC SIZE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2036	PR KAFO PLAS DOUB FREE KNEE MOL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L2037	PR KAFO PLAS SING FREE KNEE MOL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2038	PR KAFO W/O JOINT MULTI-AXIS AN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2040	PR HKAFO TORSION BIL ROT STRAPS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L2050	PR HKAFO TORSION CABLE HIP PELV	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2060	PR HKAFO TORSION BALL BEARING J	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L2070	PR HKAFO TORSION UNILAT ROT STR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L2080	PR HKAFO UNILAT TORSION CABLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L2090	PR HKAFO UNILAT TORSION BALL BR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L2106	PR AFO TIB FX CAST PLASTER MOLD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2108	PR AFO TIB FX CAST MOLDED TO PT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2112	PR AFO TIBIAL FRACTURE SOFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2114	PR AFO TIB FX SEMI-RIGID	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2116	PR AFO TIBIAL FRACTURE RIGID	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2126	PR KAFO FEM FX CAST THERMOPLAS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2128	PR KAFO FEM FX CAST MOLDED TO P	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2132	PR KAFO FEMORAL FX CAST SOFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2134	PR KAFO FEM FX CAST SEMI-RIGID	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2136	PR KAFO FEMORAL FX CAST RIGID	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2180	PR PLAS SHOE INSERT W ANK JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2182	PR DROP LOCK KNEE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2184	PR LIMITED MOTION KNEE JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2186	PR ADJ MOTION KNEE JNT LERMAN T	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2188	PR QUADRILATERAL BRIM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2190	PR WAIST BELT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2192	PR PELVIC BAND & BELT THIGH FLA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2200	PR LIMITED ANKLE MOTION EA JNT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2210	PR DORSIFLEXION ASSIST EACH JOI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2220	PR DORSI & PLANTAR FLEX ASS/RES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2230	PR SPLIT FLAT CALIPER STIRR & P	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2232	PR ROCKER BOTTOM, CONTACT AFO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2240	PR ROUND CALIPER AND PLATE ATTA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2250	PR FOOT PLATE MOLDED STIRRUP AT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2260	PR REINFORCED SOLID STIRRUP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2265	PR LONG TONGUE STIRRUP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2270	PR VARUS/VALGUS STRAP PADDED/LI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2275	PR PLASTIC MOD LOW EXT PAD/LINE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2280	PR MOLDED INNER BOOT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2300	PR ABDUCTION BAR JOINTED ADJUST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2310	PR ABDUCTION BAR-STRAIGHT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2320	PR NON-MOLDED LACER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2330	PR LACER MOLDED TO PATIENT MODE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2335	PR ANTERIOR SWING BAND	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2340	PR PRE-TIBIAL SHELL MOLDED TO P	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2350	PR PROSTHETIC TYPE SOCKET MOLDE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2360	PR EXTENDED STEEL SHANK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2370	PR PATTEN BOTTOM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2375	PR TORSION ANK & HALF SOLID STI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2380	PR TORSION STRAIGHT KNEE JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2385	PR STRAIGHT KNEE JOINT HEAVY DU	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2387	PR ADD LE POLY KNEE CUSTOM KAFO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2390	PR OFFSET KNEE JOINT EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2395	PR OFFSET KNEE JOINT HEAVY DUTY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2397	PR SUSPENSION SLEEVE LOWER EXT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2405	PR KNEE JOINT DROP LOCK EA JNT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2415	PR KNEE JOINT CAM LOCK EACH JOI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2425	PR KNEE DISC/DIAL LOCK/ADJ FLEX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2430	PR KNEE JNT RATCHET LOCK EA JNT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2435	DELETED 2716	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2492	PR KNEE LIFT LOOP DROP LOCK RIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2500	PR THI/GLUT/ISCHI A WGT BEARING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2510	PR TH/WGHT BEAR QUAD-LAT BRIM M	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2520	PR TH/WGHT BEAR QUAD-LAT BRIM C	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2525	PR TH/WGHT BEAR NAR M-L BRIM MO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2526	PR TH/WGHT BEAR NAR M-L BRIM CU	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2530	PR THIGH/WGHT BEAR LACER NON-MO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2540	PR THIGH/WGHT BEAR LACER MOLDED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2550	PR THIGH/WGHT BEAR HIGH ROLL CU	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2570	PR HIP CLEVIS TYPE 2 POSIT JNT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L2580	PR PELVIC CONTROL PELVIC SLING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L2600	PR HIP CLEVIS/THRUS T BEARING FR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2610	PR HIP CLEVIS/THRUS T BEARING LO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L2620	PR PELVIC CONTROL HIP HEAVY DUT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L2622	PR HIP JOINT ADJUSTABLE FLEXION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L2624	PR HIP ADJ FLEX EXT ABDUCT CONT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L2627	PR PLASTIC MOLD RECIPRO HIP & C	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2628	PR METAL FRAME RECIPRO HIP & CA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L2630	PR PELVIC CONTROL BAND & BELT U	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L2640	PR PELVIC CONTROL BAND & BELT B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L2650	PR PELV & THOR CONTROL GLUTEAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L2660	PR THORACIC CONTROL THORACIC BA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2670	PR THORAC CONT PARASPINAL UPRIG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L2680	PR THORAC CONT LAT SUPPORT UPRI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L2750	PR PLATING CHROME/NICK EL PR BAR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2755	PR CARBON GRAPHITE LAMINATION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2760	PR EXTENSION PER EXTENSION PER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2768	PR ORTHO SIDEBAR DISCONNECT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2770	PR LOW EXT ORTHOSIS PER BAR/JNT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2780	PR NON-CORROSIVE FINISH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2785	PR DROP LOCK RETAINER EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2795	PR KNEE CONTROL FULL KNEECAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2800	PR KNEE CAP MEDIAL OR LATERAL P	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2810	PR KNEE CONTROL CONDYLAR PAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2820	PR SOFT INTERFACE BELOW KNEE SE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2830	PR SOFT INTERFACE ABOVE KNEE SE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2840	PR TIBIAL LENGTH SOCK FX OR EQU	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L2850	PR FEMORAL LGTH SOCK FX OR EQUA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L2861	PR TORSION MECHANISM KNEE/ANKLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L2999	PR LOWER EXTREMITY ORTHOSIS NOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L3000	PR FT INSERT UCB BERKELEY SHELL	NO AUTHORIZATION REQUIRED	MD GUIDELINE 1 (Flat Feet and Orthotics): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Flat-Feet-and-Orthotics.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L3001	PR FOOT INSERT REMOV MOLDED SPE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3002	PR FOOT INSERT PLASTAZOTE OR EQ	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3003	PR FOOT INSERT SILICONE GEL EAC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3010	PR FOOT LONGITUDINAL ARCH SUPPO	NO AUTHORIZATION REQUIRED	MD GUIDELINE 1 (Flat Feet and Orthotics): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Flat-Feet-and-Orthotics.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3020	PR FOOT LONGITUD/MET ATARSAL SUP	NO AUTHORIZATION REQUIRED	MD GUIDELINE 1 (Flat Feet and Orthotics): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Flat-Feet-and-Orthotics.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L3030	PR FOOT ARCH SUPPORT REMOV PREM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3031	PR FOOT LAMIN/PREPREG COMPOSITE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3040	PR FT ARCH SUPRT PREMOLD LONGIT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3050	PR FOOT ARCH SUPP PREMOLD METAT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3060	PR FOOT ARCH SUPP LONGITUD/MET A	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3070	PR ARCH SUPRT ATT TO SHO LONGIT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3080	PR ARCH SUPP ATT TO SHOE METATA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3090	PR ARCH SUPP ATT TO SHOE LONG/M	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3100	PR HALLUS-VALGUS NGHT DYNAMIC S	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3140	PR ABDUCTION ROTATION BAR SHOE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3150	PR ABDUCT ROTATION BAR W/O SHOE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3160	PR SHOE STYLED POSITIONING DEV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3161	FOOT, ADDUCTUS POSITIONING DEVICE, ADJUSTABLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3161	FOOT, ADDUCTUS POSITIONING DEVICE, ADJUSTABLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L3170	PR FOOT PLASTIC HEEL STABILIZER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3201	PR OXFORD W SUPINAT/PRON AT INF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3202	PR OXFORD W/ SUPINAT/PRONATOR C	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3203	PR OXFORD W/ SUPINATOR/PRONATOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3204	PR HIGHTOP W/ SUPP/PRONATOR OR INF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3206	PR HIGHTOP W/ SUPP/PRONATOR OR CHI	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3207	PR HIGHTOP W/ SUPP/PRONATOR OR JUN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3208	PR SURGICAL BOOT EACH INFANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3209	PR SURGICAL BOOT EACH CHILD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3211	PR SURGICAL BOOT EACH JUNIOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3212	PR BENESCH BOOT PAIR INFANT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3213	PR BENESCH BOOT PAIR CHILD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3214	PR BENESCH BOOT PAIR JUNIOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3215	PR ORTHOPEDIC FTWEAR LADIES OXF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3216	PR ORTHOPED LADIES SHOES DPTH I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3217	PR LADIES SHOES HIGHTOP DEPTH I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3219	PR ORTHOPEDIC MENS SHOES OXFORD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3221	PR ORTHOPEDIC MENS SHOES DPTH I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3222	PR MENS SHOES HIGHTOP DEPTH INL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3224	PR WOMAN'S SHOE OXFORD BRACE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3225	PR MAN'S SHOE OXFORD BRACE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3230	PR CUSTOM SHOES DEPTH INLAY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3250	PR CUSTOM MOLD SHOE REMOV PROST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3251	PR SHOE MOLDED TO PT SILICONE S	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3252	PR SHOE MOLDED PLASTAZOTE CUST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3253	PR SHOE MOLDED PLASTAZOTE CUST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3254	PR ORTH FOOT NON-STANDARD SIZE/W	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3255	PR ORTH FOOT NON-STANDARD SIZE/	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3257	PR ORTH FOOT ADD CHARGE SPLIT S	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3260	PR AMBULATORY SURGICAL BOOT EAC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3265	PR PLASTAZOTE SANDAL EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3300	PR SHO LIFT TAPER TO METATARSAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3310	PR SHOE LIFT ELEV HEEL/SOLE NEO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3320	PR SHOE LIFT ELEV HEEL/SOLE COR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3330	PR LIFTS ELEVATION METAL EXTENS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3332	PR SHOE LIFTS TAPERED TO ONE-HA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3334	PR SHOE LIFTS ELEVATION HEEL /I	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3340	PR SHOE WEDGE SACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3360	PR SHOE SOLE WEDGE OUTSIDE SOLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3370	PR SHOE SOLE WEDGE BETWEEN SOLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3380	PR SHOE CLUBFOOT WEDGE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3390	PR SHOE OUTFLARE WEDGE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3400	PR SHOE METATARSAL BAR WEDGE RO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3410	PR SHOE METATARSAL BAR BETWEEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3420	PR FULL SOLE/HEEL WEDGE BTWEEN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3430	PR SHO HEEL COUNT PLAST REINFOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3440	PR HEEL LEATHER REINFORCED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3450	PR SHOE HEEL SACH CUSHION TYPE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3455	PR SHOE HEEL NEW LEATHER STANDA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3460	PR SHOE HEEL NEW RUBBER STANDAR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3465	PR SHOE HEEL THOMAS WITH WEDGE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3470	PR SHOE HEEL THOMAS EXTEND TO B	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3480	PR SHOE HEEL PAD & DEPRESS FOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3485	PR SHOE HEEL PAD REMOVABLE FOR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3500	PR ORTHO SHOE ADD LEATHER INSOL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3510	PR ORTHOPEDIC SHOE ADD RUB INSL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3520	PR O SHOE ADD FELT W LEATH INSL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3530	PR ORTHO SHOE ADD HALF SOLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3540	PR ORTHO SHOE ADD FULL SOLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3550	PR O SHOE ADD STANDARD TOE TAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3560	PR O SHOE ADD HORSESHOE TOE TAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3570	PR O SHOE ADD INSTEP EXTENSION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3580	PR O SHOE ADD INSTEP VELCRO CLO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3590	PR O SHOE CONVERT TO SOF COUNT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3595	PR ORTHO SHOE ADD MARCH BAR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3600	PR TRANS SHOE CALIP PLATE EXIST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3610	PR TRANS SHOE CALIPER PLATE NEW	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3620	PR TRANS SHOE SOLID STIRRUP EXI	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3630	PR TRANS SHOE SOLID STIRRUP NEW	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3640	PR SHOE DENNIS BROWNE SPLINT BO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3649	PR ORTHOPEDIC SHOE MODIFICA NOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3650	PR SO 8 ABD RESTRAINT PRE OTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3651	PR PREFAB SHOULDER ORTHOSIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3652	PR PREFAB DBL SHOULDER ORTHOSIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3660	PR SO 8 AB RSTR CAN/WEB PRE OTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3670	PR SO ACRO/CLAV CAN WEB PRE OTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3671	PR SO CAP DESIGN W/O JNTS CF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3672	PR SO AIRPLANE W/O JNTS CF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3673	PR SO AIRPLANE W/JOINT CF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3674	PR SO AIRPLANE W/WO JOINT CF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3675	PR SO VEST CANVAS/WEB PRE OTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3677	PR SO HARD PLASTIC STABILIZER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3702	PR EO W/O JOINTS CF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3710	PR ELBOW ELASTIC WITH METAL JOI	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3720	PR FOREARM/ARM CUFFS FREE MOTIO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3730	PR FOREARM/ARM CUFFS EXT/FLEX A	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3740	PR CUFFS ADJ LOCK W/ ACTIVE CON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3760	PR EO ADJ JT PREFAB CUSTOM FIT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3761	PR EO, ADJ LOCK JOINT PREFAB OT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3762	PR RIGID EO WO JOINTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3763	PR EWHO RIGID W/O JNTS CF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3764	PR EWHO W/JOINT(S) CF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3765	PR EWHFO RIGID W/O JNTS CF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3766	PR EWHFO W/JOINT(S) CF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3806	WHFO W/JOINT (S) CUSTOM FAB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3807	PR WHFO,NO JOINT, PREFABRICATED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3808	PR WHFO, RIGID W/O JOINTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3891	PR TORSION MECHANISM WRIST/ELBO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3900	PR HINGE EXTENSION/FL EX WRIST/F	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3901	PR HINGE EXT/FLEX WRIST FINGER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3904	PR WHFO ELECTRIC CUSTOM FITTED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L3905	PR WHO W/NONTORSION JNT(S) CF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3906	PR WHO W/O JOINTS CF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3907	PR WHFO WRST GAUNTLT THMB SPICA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3908	PR WRIST COCK-UP NON-MOLDED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3909	PR PREFAB WRIST ORTHOSIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3910	PR WHFO SWANSON DESIGN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3911	PR PREFAB HAND FINGER ORTHOSIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3912	PR FLEX GLOVE W/ELASTIC FINGER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3913	PR HFO W/O JOINTS CF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3915	PR WHO W NONTOR JNT (S) PREFAB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3917	PR PREFAB METACARPL FX ORTHOSIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3919	PR HO W/O JOINTS CF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3921	PR HFO W/JOINT(S) CF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3922	PR KNUCKLE BEND 2 SEG TO FLEX J	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3923	PR HFO W/O JOINTS PF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3925	FO PIP/DIP WITH JOINT/SPRING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3926	PR THOMAS SUSPENSION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3927	FO PIP/DIP W/O JOINT/SPRING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3928	PR FINGER EXTENSION W/ CLOCK SP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3929	HFO NONTORSION JOINT, PREFAB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3931	WHFO NONTORSION JOINT PREFAB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3932	PR SAFETY PIN SPRING WIRE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3933	PR FO W/O JOINTS CF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3934	PR SAFETY PIN MODIFIED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3935	PR FO NONTORSION JOINT CF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3956	PR ADD JOINT UPPER EXT ORTHOSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3960	PR SEWHO AIRPLAN DESIG ABDU POS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3961	PR SEWHO CAP DESIGN W/O JNTS CF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3962	PR SEWHO ERBS PALSEY DESIGN ABD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3963	DELETED 2719	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3964	PR SEO MOBILE ARM SUP ATT TO WC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3965	PR ARM SUPP ATT TO WC RANCHO TY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3966	PR MOBILE ARM SUPPORTS RECLININ	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3967	PR SEWHO AIRPLANE W/O JNTS CF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3968	PR FRICTION DAMPENING ARM SUPP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3969	PR MONOSUSPENSION ARM/HAND SUPP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3970	PR ELEVAT PROXIMAL ARM SUPPORT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3971	PR SEWHO CAP DESIGN W/JNT(S) CF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3972	PR OFFSET/LAT ROCKER ARM W/ ELA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3973	PR SEWHO AIRPLANE W/JNT(S) CF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3974	PR MOBILE ARM SUPPORT SUPINATOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3975	PR SEWHFO CAP DESIGN W/O JNT CF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3976	PR SEWHFO AIRPLANE W/O JNTS CF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3977	PR SEWHFO CAP DESGN W/JNT(S) CF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3978	PR SEWHFO AIRPLANE W/JNT(S) CF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L3980	PR UPP EXT FX ORTHOSIS HUMERAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3981	PR UE FX ORTH SHOUL CAP FOREARM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3982	PR UPPER EXT FX ORTHOSIS RAD/UL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3984	PR UPPER EXT FX ORTHOSIS WRIST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3985	PR FOREARM HAND FX ORTH W/ WR H	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3986	PR HUMERAL RAD/ULNA WRIST FX OR	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L3995	PR SOCK FRACTURE OR EQUAL EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L3999	PR UPPER LIMB ORTHOSIS NOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L4000	PR REPL GIRDLE MILWAUKEE ORTH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L4002	PR REPLACE STRAP, ANY ORTHOSIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L4010	PR REPLACE TRILATERAL SOCKET BR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L4020	PR REPLACE QUADLAT SOCKET BRIM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L4030	PR REPLACE SOCKET BRIM CUST FIT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L4040	PR REPLACE MOLDED THIGH LACER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L4045	PR REPLACE NON-MOLDED THIGH LAC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L4050	PR REPLACE MOLDED CALF LACER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L4055	PR REPLACE NON-MOLDED CALF LACE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L4060	PR REPLACE HIGH ROLL CUFF	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L4070	PR REPLACE PROX & DIST UPRIGHT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L4080	PR REPL MET BAND KAFO-AFO PROX	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L4090	PR REPL MET BAND KAFO-AFO CALF/	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L4100	PR REPL LEATH CUFF KAFO PROX TH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L4110	PR REPL LEATH CUFF KAFO-AFO CAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L4130	PR REPLACE PRETIBIAL SHELL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L4205	PR ORTHO DVC REPAIR PER 15 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L4210	PR ORTH DEV REPAIR/REPL MINOR P	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L4350	PR ANKLE CONTROL ORTHOSI PREFAB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L4360	PR PNEUMATI WALKING BOOT PREFAB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L4361	PR PNEUMA/VAC WALK BOOT PRE OTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L4370	PR PNEUMATIC FULL LEG SPLINT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L4380	PR PNEUMATIC KNEE SPLINT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L4386	PR NON-PNEUM WALK BOOT PREFAB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L4387	PR NON-PNEUM WALK BOOT PRE OTS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L4392	PR REPLACE AFO SOFT INTERFACE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L4394	PR REPLACE FOOT DROP SPINT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L4396	PR STATIC AFO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L4398	PR FOOT DROP SPLINT RECUMBENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L4631	PR AFO, WALK BOOT TYPE, CUS FAB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L5000	PR SHO INSERT W ARCH TOE FILLER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5010	PR MOLD SOCKET ANK HGT W/ TOE F	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5020	PR TIBIAL TUBERCLE HGT W/ TOE F	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5050	PR ANK SYMES MOLD SCKT SACH FT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5060	PR SYMES MET FR LEATH SOCKET AR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5100	PR MOLDED SOCKET SHIN SACH FOOT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5105	PR PLAST SOCKET JTS/THGH LACER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5150	PR MOLD SCKT EXT KNEE SHIN SACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5160	PR MOLD SOCKET BENT KNEE SHIN S	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5200	PR KNE SING AXIS FRIC SHIN SACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5210	PR NO KNEE/ANKLE JOINTS W/ FT B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5220	PR NO KNEE JOINT WITH ARTIC ALI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5230	PR FEM FOCAL DEFIC CONSTANT FRI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5250	PR HIP CANAD SING AXI CONS FRIC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5270	PR TILT TABLE LOCKING HIP SING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5280	PR HEMIPELVECT CANAD SING AXIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5301	PR BK MOLD SOCKET SACH FT ENDO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5311	PR KNEE DISART, SACH FT, ENDO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5312	PR KNEE DISART, SACH FT, ENDO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5321	PR AK OPEN END SACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5331	PR HIP DISART CANADIAN SACH FT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5341	PR HEMIPELVECT OMY CANADIAN SACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5400	PR POSTOP DRESS & 1 CAST CHG BK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5410	PR POSTOP DSG BK EA ADD CAST CH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5420	PR POSTOP DSG & 1 CAST CHG AK/D	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5430	PR POSTOP DSG AK EA ADD CAST CH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5450	PR POSTOP APP NON-WGT BEAR DSG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5460	PR POSTOP APP NON-WGT BEAR DSG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5500	PR INIT BK PTB PLASTER DIRECT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5505	PR INIT AK ISCHAL PLSTR DIRECT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5510	PR PREP BK PTB PLASTER MOLDED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5520	PR PERP BK PTB THERMOPLS DIRECT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5530	PR PREP BK PTB THERMOPLS MOLDED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5535	PR PREP BK PTB OPEN END SOCKET	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5540	PR PREP BK PTB LAMINATED SOCKET	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5560	PR PREP AK ISCHIAL PLAST MOLDED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5570	PR PREP AK ISCHIAL DIRECT FORM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5580	PR PREP AK ISCHIAL THERMO MOLD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5585	PR PREP AK ISCHIAL OPEN END	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5590	PR PREP AK ISCHIAL LAMINATED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5595	PR HIP DISARTIC SACH THERMOPLS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5600	PR HIP DISART SACH LAMINAT MOLD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5610	PR ABOVE KNEE HYDRACADENCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5611	PR AK 4 BAR LINK W/FRIC SWING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5613	PR AK 4 BAR LING W/HYDRAUL SWIG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5614	PR 4-BAR LINK ABOVE KNEE W/SWNG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5615	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, 4 BAR LINKAGE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5616	PR AK UNIV MULTIPLEX SYS FRICT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5617	PR AK/BK SELF-ALIGNING UNIT EA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5618	PR TEST SOCKET SYMES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5620	PR TEST SOCKET BELOW KNEE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5622	PR TEST SOCKET KNEE DISARTICULA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5624	PR TEST SOCKET ABOVE KNEE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5626	PR TEST SOCKET HIP DISARTICULAT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5628	PR TEST SOCKET HEMIPELVECT OMY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5629	PR BELOW KNEE ACRYLIC SOCKET	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5630	PR SYME TYP EXPANDABL WALL SCKT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5631	PR AK/KNEE DISARTIC ACRYLIC SOC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5632	PR SYMES TYPE PTB BRIM DESIGN S	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5634	PR SYMES TYPE POSTER OPENING SO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5636	PR SYMES TYPE MEDIAL OPENING SO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5637	PR BELOW KNEE TOTAL CONTACT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5638	PR BELOW KNEE LEATHER SOCKET	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5639	PR BELOW KNEE WOOD SOCKET	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5640	PR KNEE DISARTICULAT LEATHER SO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5642	PR ABOVE KNEE LEATHER SOCKET	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5643	PR HIP FLEX INNER SOCKET EXT FR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5644	PR ABOVE KNEE WOOD SOCKET	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5645	PR BK FLEX INNER SOCKET EXT FRA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5646	PR BELOW KNEE CUSHION SOCKET	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5647	PR BELOW KNEE SUCTION SOCKET	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5648	PR ABOVE KNEE CUSHION SOCKET	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5649	PR ISCH CONTAINMT/NA RROW M-L SO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5650	PR TOT CONTACT AK/KNEE DISART S	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5651	PR AK FLEX INNER SOCKET EXT FRA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5652	PR SUCTION SUSP AK/KNEE DISART	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

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L5653	PR KNEE DISART EXPAND WALL SOCK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5654	PR SOCKET INSERT SYMES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5655	PR SOCKET INSERT BELOW KNEE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5656	PR SOCKET INSERT KNEE ARTICULAT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5658	PR SOCKET INSERT ABOVE KNEE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5661	PR MULTI-DUROMETER SYMES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5665	PR MULTI-DUROMETER BELOW KNEE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5666	PR BELOW KNEE CUFF SUSPENSION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5668	PR BK MOLDED DISTAL CUSHION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5670	PR BK MOLDED SUPRACONDYL AR SUSP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5671	PR BK/AK LOCKING MECHANISM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5672	PR BK REMOVABLE MEDIAL BRIM SUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5673	PR SOCKET INSERT W LOCK MECH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5676	PR BK KNEE JOINTS SINGLE AXIS P	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5677	PR BK KNEE JOINTS POLYCENTRIC P	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

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L5678	PR BK JOINT COVERS PAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5679	PR SOCKET INSERT W/O LOCK MECH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5680	PR BK THIGH LACER NON-MOLDED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5681	PR INTL CUSTM CONG/LATYP INSERT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5682	PR BK THIGH LACER GLUT/ISCHIA M	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5683	PR INITIAL CUSTOM SOCKET INSERT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5684	PR BK FORK STRAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5685	PR BELOW KNEE SUS/SEAL SLEEVE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5686	PR BK BACK CHECK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5688	PR BK WAIST BELT WEBBING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5690	PR BK WAIST BELT PADDED AND LIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5692	PR AK PELVIC CONTROL BELT LIGHT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5694	PR AK PELVIC CONTROL BELT PAD/L	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5695	PR AK SLEEVE SUSP NEOPRENE/EQ UA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5696	PR AK/KNEE DISARTIC PELVIC JOIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5697	PR AK/KNEE DISARTIC PELVIC BAND	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5698	PR AK/KNEE DISARTIC SILESIA BA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5699	PR SHOULDER HARNESS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5700	PR REPLACE SOCKET BELOW KNEE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5701	PR REPLACE SOCKET ABOVE KNEE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5702	PR REPLACE SOCKET HIP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5703	PR SYMES ANKLE W/O (SACH) FOOT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5704	PR CUSTOM SHAPE COVER BK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5705	PR CUSTOM SHAPE COVER AK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5706	PR CUSTOM SHAPE CVR KNEE DISART	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5707	PR CUSTOM SHAPE CVR HIP DISART	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5710	PR KNEE-SHIN EXO SNG AXI MNL LOC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5711	PR KNEE-SHIN EXO MNL LOCK ULTRA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5712	PR KNEE-SHIN EXO FRICT SWG & ST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5714	PR KNEE-SHIN EXO VARIABLE FRICT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5716	PR KNEE-SHIN EXO MECH STANCE PH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5718	PR KNEE-SHIN EXO FRCT SWG & STA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5722	PR KNEE-SHIN PNEUM SWG FRCT EXO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5724	PR KNEE-SHIN EXO FLUID SWING PH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5726	PR KNEE-SHIN EXT JNTS FLD SWG E	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5728	PR KNEE-SHIN FLUID SWG & STANCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5780	PR KNEE-SHIN PNEUM/HYDRA PNEUM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5785	PR EXOSKELETAL BK ULTRALT MATER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5790	PR EXOSKELETAL AK ULTRA-LIGHT M	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5795	PR EXOSKEL HIP ULTRA-LIGHT MATE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5810	PR ENDOSKEL KNEE-SHIN MNL LOCK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5811	PR ENDO KNEE-SHIN MNL LCK ULTRA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5812	PR ENDO KNEE-SHIN FRCT SWG & ST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5814	PR ENDO KNEE-SHIN HYDRAL SWG PH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5816	PR ENDO KNEE-SHIN POLYC MCH STA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5818	PR ENDO KNEE-SHIN FRCT SWG & ST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5822	PR ENDO KNEE-SHIN PNEUM SWG FRC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5824	PR ENDO KNEE-SHIN FLUID SWING P	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5826	PR MINIATURE KNEE JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5828	PR ENDO KNEE-SHIN FLUID SWG/STA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5830	PR ENDO KNEE-SHIN PNEUM/SWG PHA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5840	PR MULTI-AXIAL KNEE/SHIN SYSTEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5841	ADDITION ENDOSKLETL KNEE-SHI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5845	PR KNEE-SHIN SYS STANCE FLEXION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5848	PR KNEE-SHIN SYS HYDRAUL STANCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5850	PR ENDO AK/HIP KNEE EXTENS ASSI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5855	PR MECH HIP EXTENSION ASSIST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5856	PR ELEC KNEE-SHIN SWING/STANCE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5857	PR ELEC KNEE-SHIN SWING ONLY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5858	PR STANCE PHASE ONLY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5910	PR ENDO BELOW KNEE ALIGNABLE SY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5920	PR ENDO AK/HIP ALIGNABLE SYSTEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5925	PR ABOVE KNEE MANUAL LOCK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5926	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL, KNEE DISARTICULATION, ABOVE KNEE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L5930	PR HIGH ACTIVITY KNEE FRAME	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5940	PR ENDO BK ULTRA-LIGHT MATERIAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5950	PR ENDO AK ULTRA-LIGHT MATERIAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5960	PR ENDO HIP ULTRA-LIGHT MATERIA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5961	PR ENDO POLY HIP, PNEU/HYD/ROT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5962	PR BELOW KNEE FLEX COVER SYSTEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5964	PR ABOVE KNEE FLEX COVER SYSTEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5966	PR HIP FLEXIBLE COVER SYSTEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5968	PR MULTIAXIAL ANKLE W DORSIFLEX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5970	PR FOOT EXTERNAL KEEL SACH FOOT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L5971	PR SACH FOOT, REPLACEMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L5972	PR FLEXIBLE KEEL FOOT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5973	PR ANK-FOOT SYS DORS- PLANT FLEX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5974	PR FOOT SINGLE AXIS ANKLE/FOOT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L5975	PR COMBO ANKLE/FOOT PROSTHESIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5976	PR ENERGY STORING FOOT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5978	PR FT PROSTH MULTIAXIAL ANKL/FT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L5979	PR MULTI- AXIAL ANKLE/FT PROSTH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5980	PR FLEX FOOT SYSTEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5981	PR FLEX-WALK SYS LOW EXT PROSTH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5982	PR EXOSKELETAL AXIAL ROTATION U	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5984	PR ENDOSKELETAL AXIAL ROTATION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5985	PR LWR EXT DYNAMIC PROSTH PYLON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5985	PR LWR EXT DYNAMIC PROSTH PYLON	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L5986	PR MULTI-AXIAL ROTATION UNIT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L5987	PR SHANK FT W VERT LOAD PYLON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5988	PR VERTICAL SHOCK REDUCING PYLO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5989	DELETED 2728	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L5990	PR USER ADJUSTABLE HEEL HEIGHT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L5991	ADDITION TO LOWER EXTREMITY PROSTHESES, OSSEOINTEGRATED EXTERNAL PROSTHETIC CONNECTOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	C, S, SK, CP	1/1/2024
L5999	PR LOWR EXTREMITY PROSTHES NOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6000	PR PAR HAND ROBIN-AIDS THUM REM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6010	PR HAND ROBIN-AIDS LITTLE/RING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6020	PR PART HAND ROBIN-AIDS NO FING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6050	PR WRST MLD SCK FLX HNG TRI PAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6055	PR WRST MOLD SOCK W/EXP INTERFA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6100	PR ELB MOLD SOCK FLEX HINGE PAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6110	PR ELBOW MOLD SOCK SUSPENSION T	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6120	PR ELBOW MOLD DOUB SPLT SOC STE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6130	PR ELBOW STUMP ACTIVATED LOCK H	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6200	PR ELBOW MOLD OUTSID LOCK HINGE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6205	PR ELBOW MOLDED W/ EXPAND INTER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6250	PR ELBOW INTER LOC ELBOW FORARM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6300	PR SHLDER DISART INT LOCK ELBOW	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6310	PR SHOULDER PASSIVE RESTOR COMP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6320	PR SHOULDER PASSIVE RESTOR CAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6350	PR THORACIC INTERN LOCK ELBOW	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6360	PR THORACIC PASSIVE RESTOR COMP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6370	PR THORACIC PASSIVE RESTOR CAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6380	PR POSTOP DSG CAST CHG WRST/ELB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6382	PR POSTOP DSG CAST CHG ELB DIS/	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6384	PR POSTOP DSG CAST CHG SHLDER/T	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6386	PR POSTOP EA CAST CHG & REALIGN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L6388	PR POSTOP APPLICAT RIGID DSG ON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6400	PR BELOW ELBOW PROSTH TISS SHAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6450	PR ELB DISART PROSTH TISS SHAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6500	PR ABOVE ELBOW PROSTH TISS SHAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6550	PR SHLDR DISAR PROSTH TISS SHAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6570	PR SCAP THORAC PROSTH TISS SHAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6580	PR WRIST/ELBOW BOWDEN CABLE MOL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6582	PR WRIST/ELBOW BOWDEN CBL DIR F	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6584	PR ELBOW FAIR LEAD CABLE MOLDED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6586	PR ELBOW FAIR LEAD CABLE DIR FO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6588	PR SHDR FAIR LEAD CABLE MOLDED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6590	PR SHDR FAIR LEAD CABLE DIRECT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6600	PR POLYCENTRIC HINGE PAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6605	PR SINGLE PIVOT HINGE PAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6610	PR FLEXIBLE METAL HINGE PAIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6611	PR ADDITIONAL SWITCH, EXT POWER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6615	PR DISCONNECT LOCKING WRIST UNI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6616	PR DISCONNECT INSERT LOCKING WR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6620	PR FLEXION/EXTENSION WRIST UNIT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6621	PR FLEX/EXT WRIST W/WO FRICTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6623	PR SPRING-ASS ROT WRST W/ LATCH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6624	PR FLEX/EXT/ROTATION WRIST UNIT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6625	PR ROTATION WRST W/ CABLE LOCK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6628	PR QUICK DISCONN HOOK ADAPTER O	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6629	PR LAMINATION COLLAR W/ COUPLIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6630	PR STAINLESS STEEL ANY WRIST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6632	PR LATEX SUSPENSION SLEEVE EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6635	PR LIFT ASSIST FOR ELBOW	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6637	PR NUDGE CONTROL ELBOW LOCK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6638	PR ELEC LOCK ON MANUAL PW ELBOW	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6640	PR SHOULDER ABDUCTION JOINT PAI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6641	PR EXCURSION AMPLIFIER PULLEY T	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6642	PR EXCURSION AMPLIFIER LEVER TY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6645	PR SHOULDER FLEXION- ABDUCTION J	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6646	PR MULTIPO LOCKING SHOULDER JNT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6647	PR SHOULDER LOCK ACTUATOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6648	PR EXT PWRD SHLDER LOCK/UNLOCK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6650	PR SHOULDER UNIVERSAL JOINT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6655	PR STANDARD CONTROL CABLE EXTRA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6660	PR HEAVY DUTY CONTROL CABLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6665	PR TEFLON OR EQUAL CABLE LINING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6670	PR HOOK TO HAND CABLE ADAPTER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6672	PR HARNESS CHEST/SHLDER SADDLE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6675	PR HARNESS FIGURE OF 8 SING CON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6676	PR HARNESS FIGURE OF 8 DUAL CON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6677	PR UE TRIPLE CONTROL HARNESS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6680	PR TEST SOCK WRIST DISART/BEL E	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6682	PR TEST SOCK ELBW DISART/ABOVE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6684	PR TEST SOCKET SHLDR DISART/THO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6686	PR SUCTION SOCKET	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6687	PR FRAME TYP SOCKET BEL ELBOW/W	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6688	PR FRAME TYP SOCK ABOVE ELB/DIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6689	PR FRAME TYP SOCKET SHOULDER DI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6690	PR FRAME TYP SOCK INTERSCAP-THO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6691	PR REMOVABLE INSERT EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6692	PR SILICONE GEL INSERT OR EQUAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6693	PR LOCKINGELBO W FOREARM CNTRBAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6694	PR ELBOW SOCKET INS USE W/LOCK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6695	PR ELBOW SOCKET INS USE W/O LCK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6696	PR CUS ELBO SKT IN FOR CON/ATYP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6697	PR CUS ELBO SKT IN NOT CON/ATYP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6698	PR BELOW/ABOVE ELBOW LOCK MECH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6703	PR TERM DEV, PASSIVE HAND MITT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6704	PR TERM DEV, SPORT/REC/W ORK ATT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6705	PR TERMINAL DEVICE MODEL #5	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6706	PR TERM DEV MECH HOOK VOL OPEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6707	PR TERM DEV MECH HOOK VOL CLOSE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6708	PR TERM DEV MECH HAND VOL OPEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6709	PR TERM DEV MECH HAND VOL CLOSE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6711	PR PED TERM DEV, HOOK, VOL OPEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6712	PR PED TERM DEV, HOOK, VOL CLOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6713	PR PED TERM DEV, HAND, VOL OPEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6714	PR PED TERM DEV, HAND, VOL CLOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6715	PR TERM DEVICE MULTI ART DIGIT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6720	PR TERMINAL DEVICE MODEL #6	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6721	PR HOOK/HAND, HVY DTY, VOL OPEN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6722	PR HOOK/HAND, HVY DTY, VOL CLOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6805	PR TERM DEV MODIFIER WRIST UNIT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6806	PR TRS GRIP VC OR EQUAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6807	PR TERM DEVICE GRIP1/2 OR EQUAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6808	PR TERM DEVICE INFANT OR CHILD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6809	PR TRS SUPER SPORT PASSIVE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6810	PR TERM DEV PRECISION PINCH DEV	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6880	PR ELEC HAND IND ART DIGITS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6881	PR TERM DEV AUTO GRASP FEATURE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6882	PR MICROPROCESSOR CONTROL UPLMB	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6883	PR REPLC SOCKT BELOW E/W DISA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6884	PR REPLC SOCKT ABOVE ELBOW DISA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6885	PR REPLC SOCKT SHLDR DIS/INTERC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6890	PR PREFAB GLOVE FOR TERM DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6895	PR CUSTOM GLOVE FOR TERM DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6900	PR HAND RESTORAT THUMB/1 FINGER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6905	PR HAND RESTORATION MULTIPLE FI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6910	PR HAND RESTORATION NO FINGERS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6915	PR HAND RESTORATION REPLACMNT G	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L6920	PR WRIST DISARTICUL SWITCH CTRL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6925	PR WRIST DISART MYOELECTRON IC C	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6930	PR BELOW ELBOW SWITCH CONTROL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6935	PR BELOW ELBOW MYOELECTRON IC CT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6940	PR ELBOW DISARTICULATION SWITCH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6945	PR ELBOW DISARTICULATION MYOELECTRONIC C	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6950	PR ABOVE ELBOW SWITCH CONTROL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6955	PR ABOVE ELBOW MYOELECTRONIC CT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6960	PR SHLDR DISARTICULATION SWITCH CONTROL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L6965	PR SHLDR DISARTIC MYOELECTRON IC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6970	PR INTERSCAPULA R-THOR SWITCH CT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L6975	PR INTERSCAP- THOR MYOELECTRON IC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L7007	PR ADULT ELECTRIC HAND	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L7008	PR PEDIATRIC ELECTRIC HAND	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L7009	PR ADULT ELECTRIC HOOK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L7010	PR HAND OTTO BACK STEEPER/EQ SW	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L7015	PR HAND SYS TEKNIK VILLAGE SWIT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L7020	PR ELECTRONIC GREIFER SWITCH CT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L7025	PR ELECTRON HAND MYOELECTRON IC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L7030	PR HAND SYS TEKNIK VILL MYOELEC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L7035	PR ELECTRON GREIFER MYOELECTRO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L7040	PR PREHENSILE ACTUATOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L7045	PR PEDIATRIC ELECTRIC HOOK	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L7170	PR ELECTRONIC ELBOW HOSMER SWIT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L7180	PR ELECTRONIC ELBOW SEQUENTIAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L7181	PR ELECTRONIC ELBO SIMULTANEOUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L7185	PR ELECTRON ELBOW ADOLESCENT SW	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L7186	PR ELECTRON ELBOW CHILD SWITCH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L7190	PR ELBOW ADOLESCENT MYOELECTRON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L7191	PR ELBOW CHILD MYOELECTRON IC CT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L7360	SIX VOLT BAT OTTO BOCK/EQ EA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L7362	BATTERY CHRGR SIX VOLT OTTO	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L7364	TWELVE VOLT BATTERY UTAH/EQU	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L7366	BATTERY CHRGR 12 VOLT UTAH/E	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L7367	PR REPLACEMNT LITHIUM IONBATTER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L7368	PR LITHIUM ION BATTERY CHARGER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L7400	PR ADD UE PROST BE/WD, UTLITE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L7401	PR ADD UE PROST A/E UTLITE MAT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L7402	PR ADD UE PROST S/D UTLITE MAT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L7403	PR ADD UE PROST B/E ACRYLIC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L7404	PR ADD UE PROST A/E ACRYLIC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L7405	PR ADD UE PROST S/D ACRYLIC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L7499	PR UPPER EXTREMITY PROSTHES NOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L7510	PR PROSTHETIC DEVICE REPAIR REP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L7520	PR REPAIR PROSTHESIS PER 15 MIN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L7520	PR REPAIR PROSTHESIS PER 15 MIN	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
L7600	PR PROSTHETIC DONNING SLEEVE	<p>NO AUTHORIZATION REQUIRED</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L7700	PR PROS SOC INSERT GASKET/SEAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8000	PR MASTECTOMY BRA	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8001	PR BREAST PROSTHESIS BRA & FORM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8002	PR BRST PRSTH BRA & BILAT FORM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8010	PR MASTECTOMY SLEEVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8015	PR EXT BREASTPROSTHESIS GARMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8020	PR MASTECTOMY FORM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8030	PR BREAST PROSTHESIS SILICONE/E	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8031	PR BREAST PROSTHESIS W ADHESIVE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L8032	PR REUSABLE NIPPLE PROSTHESIS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8035	PR CUSTOM BREAST PROSTHESIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L8039	PR BREAST PROSTHESIS NOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L8040	PR NASAL PROSTHESIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L8041	PR MIDFACIAL PROSTHESIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L8042	PR ORBITAL PROSTHESIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L8043	PR UPPER FACIAL PROSTHESIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L8044	PR HEMI-FACIAL PROSTHESIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L8045	PR AURICULAR PROSTHESIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L8046	PR PARTIAL FACIAL PROSTHESIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L8047	PR NASAL SEPTAL PROSTHESIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
L8300	PR TRUSS SINGLE W/ STANDARD PAD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8310	PR TRUSS DOUBLE W/ STANDARD PAD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8320	PR TRUSS ADDITION TO STD PAD WA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L8330	PR TRUSS ADD TO STD PAD SCROTAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8400	PR SHEATH BELOW KNEE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8410	PR SHEATH ABOVE KNEE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8415	PR SHEATH UPPER LIMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L8417	PR PROS SHEATH/SOCK W GEL CUSHN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8420	PR PROSTHETIC SOCK MULTI PLY BK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8430	PR PROSTHETIC SOCK MULTI PLY AK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8435	PR PROS SOCK MULTI PLY UPPER LM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8440	PR SHRINKER BELOW KNEE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8460	PR SHRINKER ABOVE KNEE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8465	PR SHRINKER UPPER LIMB	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8470	PR PROS SOCK SINGLE PLY BK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8480	PR PROS SOCK SINGLE PLY AK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8485	PR PROS SOCK SINGLE PLY UPPER L	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L8499	PR UNLISTED MISC PROSTHETIC SER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L8500	PR ARTIFICIAL LARYNX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L8501	PR TRACHEOSTOMY SPEAKING VALVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8507	PR TRACH-ESOPH VOICE PROS PT IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8509	PR TRACH-ESOPH VOICE PROS MD IN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8510	PR VOICE AMPLIFIER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L8600	PR IMPLANT BREAST SILICONE/EQ	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
L8603	PR COLLAGEN IMP URINARY 2.5 ML	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L8604	PR DEXTRANOMER /HYALURONIC ACID	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8606	PR SYNTHETIC IMPLNT URINARY 1ML	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
L8610	PR OCULAR IMPLANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L8614	PR COCHLEAR DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L8615	PR COCH IMPLANT HEADSET REPLACE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L8616	PR COCH IMPLANT MICROPHONE REPL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L8617	PR COCH IMPLANT TRANS COIL REPL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L8618	PR COCH IMPLANT TRAN CABLE REPL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L8619	PR REPLACE COCHLEAR PROCESSOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L8621	PR REPL ZINC AIR BATTERY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L8622	PR REPL ALKALINE BATTERY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L8623	PR LITH ION BATT CID, NON-EARLVL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L8624	PR LITH ION BATT CID EAR LEVEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L8625	PR CHARGER COCH IMPL/AOI BATTERY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L8627	PR CID EXT SPEECH PROCESS REPL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L8628	PR CID EXT CONTROLLER REPL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L8629	PR CID TRANSMIT COIL AND CABLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L8680	PR IMPLT NEUROSTIM ELCTR EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023
L8680	PR IMPLT NEUROSTIM ELCTR EACH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
L8681	PR PT PRGRM FOR IMPLT NEUROSTIM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
L8682	PR IMPLT NEUROSTIM RADIOFQ REC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023
L8683	PR RADIOFQ TRSMTR FOR IMPLT NEU	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023
L8684	PR RADIOF TRSMTR IMPLT SCRL NEU	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L8685	PR IMPLT NROSTM PLS GEN SNG REC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023
L8686	PR IMPLT NROSTM PLS GEN SNG NON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023
L8687	PR IMPLT NROSTM PLS GEN DUA REC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023
L8688	PR IMPLT NROSTM PLS GEN DUA NON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023
L8689	PR EXTERNAL RECHARG SYS INTERN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	7/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L8690	PR AUD OSSEO DEV, INT/EXT COMP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L8691	PR AOI SND PROC REPL EXCL ACTUA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L8692	PR NON-OSSEOINTEGRATED SND PROC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L8693	PR AUD OSSEO DEV ABUTMENT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
L8694	PR AOI TRANSDUCER/ACTUATOR REPL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
L8695	PR EXTERNAL RECHARG SYS EXTERN	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
M0201	PR ADMIN OF PNU, FLU, HEB B, COVID INSIDE PATIENS HOME	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN HOME SETTING (12). AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		6/8/2021
M0220	PR ASTRAZENICAS 'S EVUSHELD ADMINISTRATI ON IN HEALTH-CARE SETTING	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		6/1/2022
M0221	PR ASTRAZENECA' S EVUSHELD ADMINISTRATI ON IN HOME OR RESIDENCE	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		6/1/2022
M0222	INTRAVENOUS INJECTION, BEBTELOVIMAB , INCLUDES INJECTION AND POST ADMINISTRATI ON MONITORING	AUTHORIZATION REQUIRED DX CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: U07.1 AGE: AUTH IS REQUIRED IF NOT AN AGE APPROPRIATE MEMBER. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		4/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
M0222	INTRAVENOUS INJECTION, BEBTELOVIMAB , INCLUDES INJECTION AND POST ADMINISTRATI ON MONITORING	NO AUTHORIZATION REQUIRED DX CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: U07.1, AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		4/1/2023
M0223	BEBTELOVIMAB INJECTION HOME	NO AUTHORIZATION REQUIRED DX CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: U07.1, AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		4/1/2023
M0223	BEBTELOVIMAB INJECTION HOME	AUTHORIZATION REQUIRED DX CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: U07.1 AGE: AUTH IS REQUIRED IF NOT AN AGE APPROPRIATE MEMBER. EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		4/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
M0239	PR BAMLANIVIMAB -XXXX INFUSION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	4/30/2021
M0240	PR CASIRI AND IMDEV REPEAT	AUTHORIZATION REQUIRED DX CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: U07.1, Z20.822 AGES: PRIOR AUTH IS REQUIRED IF LESS THAN 12 YEARS OF AGE EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2022
M0240	PR CASIRI AND IMDEV REPEAT	NO AUTHORIZATION REQUIRED DX CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: U07.1, Z20.822 AGE: NO AUTH IS REQUIRED IF 12 YEARS OF AGE AND OLDER	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
M0241	PR CASIRI AND IMDEV REPEAT HM	NO AUTHORIZATION REQUIRED DX CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: U07.1, Z20.822 AGE: NO AUTH IS REQUIRED IF 12 YEARS OF AGE AND OLDER	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2022
M0241	PR CASIRI AND IMDEV REPEAT HM	AUTHORIZATION REQUIRED DX CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: U07.1, Z20.822 AGES: PRIOR AUTH IS REQUIRED IF LESS THAN 12 YEARS OF AGE EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2022
M0243	PR CASIRIVI AND IMDEVI INFUSION	AUTHORIZATION REQUIRED DX CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: U07.1, Z20.822 AGES: PRIOR AUTH IS REQUIRED IF LESS THAN 12 YEARS OF AGE EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
M0243	PR CASIRIVI AND IMDEVI INFUSION	NO AUTHORIZATION REQUIRED DX CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: U07.1, Z20.822 AGE: NO AUTH IS REQUIRED IF 12 YEARS OF AGE AND OLDER	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2022
M0244	PR CASIRIVI AND IMDEVI INJ HM	NO AUTHORIZATION REQUIRED DX CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: U07.1, Z20.822 AGE: NO AUTH IS REQUIRED IF 12 YEARS OF AGE AND OLDER	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2022
M0244	PR CASIRIVI AND IMDEVI INJ HM	AUTHORIZATION REQUIRED DX CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: U07.1, Z20.822 AGES: PRIOR AUTH IS REQUIRED IF LESS THAN 12 YEARS OF AGE EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2022
M0245	PR BAMLAN AND ETESEV INFUSION	NO AUTHORIZATION REQUIRED DX CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: U07.1, Z20.822		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		2/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
M0245	PR BAMLAN AND ETESEV INFUSION	AUTHORIZATION REQUIRED DX CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: U07.1, Z20.822 EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		2/1/2022
M0246	PR BAMLAN AND ETESEV INFUS HOME	AUTHORIZATION REQUIRED DX CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: U07.1, Z20.822 EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		2/1/2022
M0246	PR BAMLAN AND ETESEV INFUS HOME	NO AUTHORIZATION REQUIRED DX CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: U07.1, Z20.822		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		2/1/2022
M0247	PR SOTROVIMAB INFUSION	AUTHORIZATION REQUIRED DX CODES: PRIOR AUTH IS REQUIRED IF NOT THIS DIAGNOSIS CODE: U07.1 AGES: PRIOR AUTH IS REQUIRED IF LESS THAN 12 YEARS OF AGE EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
M0247	PR SOTROVIMAB INFUSION	NO AUTHORIZATION REQUIRED DX CODES: NO AUTH IS REQUIRED FOR THIS DIAGNOSIS CODE: U07.1 AGE: NO AUTH IS REQUIRED IF 12 YEARS OF AGE AND OLDER	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2022
M0248	PR SOTROVIMAB INF, HOME ADMIN	NO AUTHORIZATION REQUIRED DX CODES: NO AUTH IS REQUIRED FOR THIS DIAGNOSIS CODE: U07.1 AGE: NO AUTH IS REQUIRED IF 12 YEARS OF AGE AND OLDER	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2022
M0248	PR SOTROVIMAB INF, HOME ADMIN	AUTHORIZATION REQUIRED DX CODES: PRIOR AUTH IS REQUIRED IF NOT THIS DIAGNOSIS CODE: U07.1 AGES: PRIOR AUTH IS REQUIRED IF LESS THAN 12 YEARS OF AGE EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2022
P9025	PR PLASMA CRYO REDU PATH EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2022
P9026	PR CRYO FIB COMP PATH REDU EACH	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q0138	PR FERUMOXYTOL NON-ESRD	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		7/1/2021
Q0163	PR DIPHENHYDRA MINE HCL 50MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
Q0167	PR DRONABINOL 2.5MG ORAL	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2022
Q0167	PR DRONABINOL 2.5MG ORAL	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2022
Q0169	PR PROMETHAZIN E HCL 12.5MG ORAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
Q0175	PR PERPHENAZINE 4MG ORAL	AUTHORIZATION REQUIRED AGE: PRIOR AUTH IS REQUIRED IF LESS THAN 18 YEARS OLD EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q0175	PR PERPHENAZINE 4MG ORAL	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED IF 18 YEARS OF AGE AND OLDER	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2022
Q0220	PR EVUSHELD MONOCLONAL ANTIBODY THERAPY	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		6/1/2022
Q0221	TIXAGEV AND CILGAV, 600MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		6/1/2022
Q0222	BEBTELOVIMAB 175 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR.	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		4/1/2023
Q0239	PR BAMLANIVIMAB -XXXX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	4/30/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q0243	PR CASIRIVIMAB AND IMDEVIMAB	AUTHORIZATION REQUIRED DX CODES: PRIOR AUTH IS REQUIRED IF NOT THIS DIAGNOSIS CODE: U07.1 AGES: PRIOR AUTH IS REQUIRED IF LESS THAN 12 YEARS OF AGE EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2022
Q0243	PR CASIRIVIMAB AND IMDEVIMAB	NO AUTHORIZATION REQUIRED DX CODES: NO AUTH IS REQUIRED FOR THIS DIAGNOSIS CODE: U07.1 AGE: NO AUTH IS REQUIRED IF 12 YEARS OF AGE AND OLDER	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2022
Q0244	PR CASIRIVI AND IMDEVI 1200 MG	NO AUTHORIZATION REQUIRED DX CODES: NO AUTH IS REQUIRED FOR THIS DIAGNOSIS CODE: U07.1 AGE: NO AUTH IS REQUIRED IF 12 YEARS OF AGE AND OLDER	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q0244	PR CASIRIVI AND IMDEVI 1200 MG	AUTHORIZATION REQUIRED DX CODES: PRIOR AUTH IS REQUIRED IF NOT THIS DIAGNOSIS CODE: U07.1 AGES: PRIOR AUTH IS REQUIRED IF LESS THAN 12 YEARS OF AGE EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2022
Q0245	PR BAMLANIVIMAB AND ETESEVIMA	AUTHORIZATION REQUIRED DX CODES: PRIOR AUTH IS REQUIRED IF NOT THIS DIAGNOSIS CODE: U07.1 AGES: PRIOR AUTH IS REQUIRED IF LESS THAN 12 YEARS OF AGE EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2022
Q0245	PR BAMLANIVIMAB AND ETESEVIMA	NO AUTHORIZATION REQUIRED DX CODES: NO AUTH IS REQUIRED FOR THIS DIAGNOSIS CODE: U07.1 AGE: NO AUTH IS REQUIRED IF 12 YEARS OF AGE AND OLDER	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q0247	PR SOTROVIMAB	NO AUTHORIZATION REQUIRED DX CODES: NO AUTH IS REQUIRED FOR THIS DIAGNOSIS CODE: U07.1 AGE: NO AUTH IS REQUIRED IF 12 YEARS OF AGE AND OLDER	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2022
Q0247	PR SOTROVIMAB	AUTHORIZATION REQUIRED DX CODES: PRIOR AUTH IS REQUIRED IF NOT THIS DIAGNOSIS CODE: U07.1 AGES: PRIOR AUTH IS REQUIRED IF LESS THAN 12 YEARS OF AGE EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		1/1/2022
Q0477	PR PWR MODULE PT CABLE LVAD RPL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
Q0480	PR DRIVER PNEUMATIC VAD, REP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q0481	PR MICROPRCSR CU ELEC VAD, REP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
Q0482	PR MICROPRCSR CU COMBO VAD, REP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
Q0483	PR MONITOR ELEC VAD, REP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
Q0484	PR MONITOR ELEC OR COMB VAD REP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
Q0485	PR MONITOR CABLE ELEC VAD, REP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q0486	PR MON CABLE ELEC/PNEUM VAD REP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
Q0487	PR LEADS ANY TYPE VAD, REP ONLY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
Q0488	PR PWR PACK BASE ELEC VAD, REP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
Q0489	PR PWR PCK BASE COMBO VAD, REP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
Q0490	PR EMR PWR SOURCE ELEC VAD, REP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q0491	PR EMR PWR SOURCE COMBO VAD REP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
Q0492	PR EMR PWR CBL ELEC VAD, REP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
Q0493	PR EMR PWR CBL COMBO VAD, REP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
Q0494	PR EMR HD PMP ELEC/COMBO, REP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
Q0495	PR CHARGER ELEC/COMBO VAD, REP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
Q0496	PR BATTERY ELEC/COMBO VAD, REP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q0497	PR BAT CLPS ELEC/COMB VAD, REP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
Q0498	PR HOLSTER ELEC/COMBO VAD, REP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
Q0499	PR BELT/VEST ELEC/COMBO VAD REP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
Q0500	PR FILTERS ELEC/COMBO VAD, REP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
Q0501	PR SHWR COV ELEC/COMBO VAD, REP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
Q0502	PR MOBILITY CART PNEUM VAD, REP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q0503	PR BATTERY PNEUM VAD REPLACEMNT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
Q0504	PR PWR ADPT PNEUM VAD, REP VEH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
Q0505	PR MISCL SUPPLY/ACCESSORY VAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
Q0506	PR LITH-ION BATT ELEC/PNEUM VAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
Q0507	PR MISC SUP/ACC EXT VAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q0508	PR MISC SUP/ACC IMP VAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
Q2017	PR TENIPOSIDE, 50 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
Q2026	PR RADIESSE INJECTION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
Q2028	PR INJ, SCULPTRA, 0.5MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
Q2040	PR TISAGENLECLE UCEL, UP TO 250 MILLION CAR-POSITIVE VIABLE T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER INFUSION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q2041	PR AXICABTAGENE CILOLEUCEL CAR+	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
Q2042	PR TISAGENLECLE UCEL CAR-POS T	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
Q2043	PR SIPULEUCEL - T AUTO CD 54+	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
Q2053	PR BREXUCABTAG ENE CAR POS T	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
Q2054	PR LISOCABTAG NE MARA CAR POS T	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q2055	PR IDECABTAGEN E VICLEUCEL CAR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
Q2056	CILTACABTAGE NE AUTOLEUCEL, UP TO 100 MILLION AUTOLOGOUS B-CELL MATURATION ANTIGEN (BCMA) DIRECTED CAR-POSITIVE T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEU	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q2056	CILTACABTAGE NE AUTOLEUCEL, UP TO 100 MILLION AUTOLOGOUS B-CELL MATURATION ANTIGEN (BCMA) DIRECTED CAR-POSITIVE T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEU	AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
Q3014	PR TELEHEALTH FACILITY FEE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A RURAL HEALTH CLINIC OR FEDERALLY QUALIFIED HEALTH CENTER.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		12/1/2023
Q3014	PR TELEHEALTH FACILITY FEE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022
Q3014	PR TELEHEALTH FACILITY FEE	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED FOR EMERGENCIES.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	9/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q4081	PR EPOETIN ALFA, 100 UNITS ESRD	NO AUTHORIZATION REQUIRED DIAGNOSIS CODES: NO AUTH IS REQUIRED FOR THESE DIAGNOSIS CODES: D63.1, N18.1, N18.2, N18.30, N18.31, N18.32, N18.4, N18.5, N18.6, N18.9, N19		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
Q4081	PR EPOETIN ALFA, 100 UNITS ESRD	AUTHORIZATION REQUIRED DIAGNOSIS CODES: AUTH IS REQUIRED IF NOT ONE OF THESE DIAGNOSIS CODES: D63.1, N18.1, N18.2, N18.30, N18.31, N18.32, N18.4, N18.5, N18.6, N18.9, N19 EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
Q4101	PR APLIGRAF	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023
Q4102	PR OASIS WOUND MATRIX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q4106	PR DERMAGRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023
Q4110	PR PRIMATRIX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023
Q4111	PR GAMMAGRAFT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023
Q4114	PR INTEGRA FLOWABLE WOUND MATRI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q4115	PR ALLOSKIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
Q4121	PR THERASKIN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023
Q4132	PR GRAFIX CORE GRAFIXPL CORE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
Q4133	PR GRAFIX STRAVIX PRIME PL SQCM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q4137	PR AMNIOEXCEL BIODEXCEL 1SQ CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023
Q4145	PR EPIFIX, INJ, 1MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
Q4151	PR AMNIOBAND, GUARDIAN 1 SQ CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023
Q4154	PR BIOVANCE 1 SQUARE CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q4159	PR AFFINITY1 SQUARE CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023
Q4160	PR NUSHIELD 1 SQUARE CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023
Q4163	PR WOUNDEX BIOSKIN PER SQ CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023
Q4173	PR PALINGEN OR PALINGEN XPLUS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023
Q4174	PR PALINGEN OR PROMATRX	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q4186	PR EPIFIX 1 SQ CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023
Q4187	PR EPICORD 1 SQ CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
Q4195	PR PURAPLY 1 SQ CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023
Q4196	PR PURAPLY AM 1 SQ CM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q4272	ESANO A, PER SQUARE CENTIMETER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
Q4273	ESANO AAA, PER SQUARE CENTIMETER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
Q4274	ESANO AC, PER SQUARE CENTIMETER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q4275	ESANO AC, PER SQUARE CENTIMETER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
Q4276	ORION, PER SQUARE CENTIMETER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
Q4277	WOUNDPLUS MEMBRANE OR E-GRAFT, PER SQUARE CENTIMETER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q4278	EPIEFFECT, PER SQUARE CENTIMETER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
Q4280	XCELL AMNIO MATRIX, PER SQUARE CENTIMETER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
Q4281	BARRERA SL OR BARRERA DL, PER SQUARE CENTIMETER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q4282	CYGNUS DUAL, PER SQUARE CENTIMETER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
Q4283	BIOVANCE TRI-LAYER OR BIOVANCE 3L, PER SQUARE CENTIMETER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
Q4284	DERMABIND SL, PER SQUARE CENTIMETER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q4285	NUDYN DL OR NUDYN DL MESH, PER SQUARE CENTIMETER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
Q4286	NUDYN SL OR NUDYN SLW, PER SQUARE CENTIMETER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		S, SK, C, CP	1/1/2024
Q5101	PR INJECTION, ZARXIO	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
Q5103	PR INJECTION, INFLECTRA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q5104	PR INJECTION, RENFLEXIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
Q5105	PR INJ RETACRIT ESRD ON DIALYSI	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	4/1/2023
Q5107	PR INJ MVASI 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
Q5108	PR INJECTION, BIOSIMILAR FULPHILA	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
Q5110	PR NIVESTYM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
Q5111	PR INJECTION, UDENYCA BIOSIMILAR 0.5 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q5111	PR INJECTION, UDENYCA BIOSIMILAR 0.5 MG	NO AUTHORIZATION REQUIRED PLACE OF SERVICE: PRIOR AUTH IS NOT REQUIRED IF PERFORMED IN OFFICE/OUTPATIENT SETTING (11, 22, 24).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
Q5112	PR INJ ONTRUZANT 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
Q5113	PR INJ HERZUMA 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
Q5114	PR INJ OGIVRI 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
Q5116	PR INJ., TRAZIMERA, 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
Q5117	PR INJ., KANJINTI, 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
Q5118	PR INJ., ZIRABEV, 10 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q5119	PR INJ RUXIENCE, 10 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
Q5120	PR INJ PEGFILGRASTI M-BMEZ 0.5MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
Q5121	PR INJ. AVSOLA, 10 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
Q5122	PR INJ, NYVEPRIA,BIOS IMILAR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
Q5123	PR INJ. RIABNI, 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q5124	INJECTION, RANIBIZUMAB-NUNA, BIOSIMILAR, (BYOOVIZ), 0.1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
Q5125	INJECTION, FILGRASTIM-AYOW, BIOSIMILAR, (RELEUKO), 1 MCG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
Q5126	PR INJECTION, BEVACIZUMAB-MALY, BIOSIMILAR, (ALYMSYS), 10 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
Q5127	INJECTION, PEGFILGRASTI M-FPGK (STIMUFEND), BIOSIMILAR, 0.5 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
Q5128	INJECTION, RANIBIZUMAB-EQRN (CIMERLI), BIOSIMILAR, 0.1 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
Q5129	INJECTION, BEVACIZUMAB-ADCD (VEGZELMA), BIOSIMILAR, 10 MG	NO AUTHORIZATION REQUIRED AGE: NO AUTH IS REQUIRED FOR AGE APPROPRIATE MEMBERS.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
Q5130	INJECTION, PEGFILGRASTI M-PBBK (FYLNETRA), BIOSIMILAR, 0.5 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
Q5131	INJECTION, ADALIMUMAB-AACF (IDACIO), BIOSIMILAR, 20 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
Q9991	PR BUPRENORPH XR 100 MG OR LESS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
Q9992	PR BUPRENORPHI NE XR OVER 100 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
R0070	PR TRANSPORT PORTABLE X-RAY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
R0075	PR TRANSPORT PORT X-RAY MULTIPL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
S0013	PR ESKETAMINE, NASAL SPRAY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTPS://WWW.TMHP.COM/	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,	CP	5/10/2021
S0028	PR INJECTION, FAMOTIDINE, 20 MG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2024
S0189	PR TESTOSTERON E PELLETT 75 MG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S0201	PR PARTIAL HOSPITALIZATION SERV	NO AUTHORIZATION REQUIRED EXCLUSIONS: PHP SERVICES ARE NO AUTH REQUIRED FOR IN-NETWORK PROVIDERS CONTRACTED WITH DRISCOLL HEALTH PLAN FOR THESE SERVICES.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK, CP		5/10/2021
S0255	PR HOSPICE REFER VISIT NONMD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S0265	PR GENETIC COUNSEL 15 MINS	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S0271	HOME HOSPICE CASE 30 DAYS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S0515	PR SCLERAL LENS LIQUID BANDAGE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S0620	PR ROUTINE OPHTHALMOLOGICAL EXA	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S0621	PR ROUTINE OPHTHALMOLOGICAL EXA	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
S1015	PR IV TUBING EXTENSION SET	<p>NO AUTHORIZATION REQUIRED</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S1040	PR CRANIAL REMOLDING ORTHOSIS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM MD GUIDELINE 1 (Cranial Molding): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/Cranial-Molding.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022
S1091	PR STENT NON-CORONARY PROPEL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/1/2024
S2066	BREAST GAP FLAP RECONST	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
S2067	BREAST ""STACKED"" DIEP/GAP	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S2068	BREAST DIEP OR SIEA FLAP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	6/1/2023
S2202	PR ECHOSCLEROT HERAPY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	10/1/2023
S5101	PR ADULT DAY CARE PER HALF DAY	AUTHORIZATION REQUIRED	USE OF DAHS IS IDENTIFIED DURING THE STAR KIDS SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS - REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S5101	PR ADULT DAY CARE PER HALF DAY	AUTHORIZATION REQUIRED	USE OF DAHS IS IDENTIFIED DURING THE STAR KIDS SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
S5101	PR ADULT DAY CARE PER HALF DAY	AUTHORIZATION REQUIRED	USE OF DAHS IS IDENTIFIED DURING THE STAR KIDS SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S5101	PR ADULT DAY CARE PER HALF DAY	AUTHORIZATION REQUIRED	<p>USE OF DAHS IS IDENTIFIED DURING THE STAR KIDS SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES.</p> <p>HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
S5151	PR UNSKILLED RESPITECARE /DIEM	AUTHORIZATION REQUIRED	<p>USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES.</p> <p>HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S5151	PR UNSKILLED RESPITECARE /DIEM	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
S5151	PR UNSKILLED RESPITECARE /DIEM	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S5151	PR UNSKILLED RESPITECARE /DIEM	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
S5161	PR EMER RSPNS SYS SERV PERMONTH	AUTHORIZATION REQUIRED	USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID_PUBLIC ATIONS_PROVIDER_MANUAL.A SPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S5161	PR EMER RSPNS SYS SERV PERMONTH	AUTHORIZATION REQUIRED	USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
S5165	PR HOME MODIFICATION S PER SERV	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS - REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S5165	PR HOME MODIFICATION S PER SERV	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
S5165	PR HOME MODIFICATION S PER SERV	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S5165	PR HOME MODIFICATION S PER SERV	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
S5165	PR HOME MODIFICATION S PER SERV	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S5165	PR HOME MODIFICATION S PER SERV	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
S5165	PR HOME MODIFICATION S PER SERV	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S5165	PR HOME MODIFICATION S PER SERV	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS - REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
S8101	PR SPACER WITH MASK	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
S8185	PR FLUTTER DEVICE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
S8189	PR TRACH SUPPLY NOC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
S8265	PR HABERMAN FEEDER	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
S8270	PR ENURESIS ALARM	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S8301	PR INFECT CONTROL SUPPLIES NOS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR. THIS PROCEDURE CODE IS NOT A COVERED SERVICE BUT DHP WILL REVIEW REQUESTS FOR THIS PROCEDURE CODE ON A CASE-BY-CASE BASIS TO DETERMINE MEDICAL NECESSITY.	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK,CP	5/10/2021
S8415	PR SUPPLIES FOR HOME DELIVERY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
S8420	PR CUSTOM GRADIENT SLEEV/GLOV	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
S8421	PR READY GRADIENT SLEEV/GLOV	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
S8422	PR CUSTOM GRAD SLEEVE MED	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
S8423	PR CUSTOM GRAD SLEEVE HEAVY	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
S8424	PR READY GRADIENT SLEEVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S8425	PR CUSTOM GRAD GLOVE MED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
S8426	PR CUSTOM GRAD GLOVE HEAVY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	1/1/2024
S8427	PR READY GRADIENT GLOVE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
S8428	PR READY GRADIENT GAUNTLET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
S8429	PR GRADIENT PRESSURE WRAP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
S8450	PR SPLINT DIGIT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
S8451	PR SPLINT WRIST OR ANKLE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
S8452	PR SPLINT ELBOW	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S8999	PR RESUSCITATION BAG	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	2/1/2024
S9110	PR TELEMONITORING/HOME PER MONTH	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	3/1/2021
S9123	PR NURSING CARE IN HOME RN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/PDN-SNV-PPECC-GUIDELINES.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S9123	PR NURSING CARE IN HOME RN	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/PDN-SNV-PPECC-GUIDELINES.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S9124	PR NURSING CARE, IN THE HOME; B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/PD N-SNV-PPECC-GUIDELINES.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S9126	PR HOSPICE CARE, IN THE HOME, P	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S9140	PR DIABETIC MANAGEMENT PROGRAM,	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S9140	PR DIABETIC MANAGEMENT PROGRAM,	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S9152	SPEECH THERAPY, RE-EVAL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A DRISCOLL CHILDREN'S HOSPITAL CLINIC</p> <p>EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR</p>	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf</p> <p>MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf</p> <p>MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF</p> <p>MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF</p>	<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	8/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S9152	SPEECH THERAPY, RE-EVAL	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS DRISCOLL CHILDREN'S HOSPITAL CLINIC	TMPPM MD GUIDELINE 1 (Therapy Guide): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Guide.pdf MD GUIDELINE 2 (Therapy Referral Review by Ordering Physician Attestation Form): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Referral-Review-by-Ordering-Physician-Attestation-Form.pdf MD GUIDELINE 3 (Therapy Request Checklist.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/The rapy-Request-Checklist.PDF MD GUIDELINE 4 (THERAPY TELEHEALTH.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/TH ERAPY-TELEHEALTH.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	8/1/2021
S9208	PR HOME MGMT PRETERM LABOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S9208	PR HOME MGMT PRETERM LABOR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S9209	PR HOME MGMT PPRM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S9209	PR HOME MGMT PPRM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S9211	PR HOME MGMT GEST HYPERTENSION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S9211	PR HOME MGMT GEST HYPERTENSION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S9212	PR HM POSTPAR HYPER PER DIEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S9212	PR HM POSTPAR HYPER PER DIEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S9213	PR HM PREECLAMP PER DIEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S9213	PR HM PREECLAMP PER DIEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S9214	PR HM GEST DM PER DIEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S9214	PR HM GEST DM PER DIEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S9214	PR HM GEST DM PER DIEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S9351	PR HIT CONT ANTIEMETIC DIEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S9351	PR HIT CONT ANTIEMETIC DIEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S9379	PR HIT NOC PER DIEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S9379	PR HIT NOC PER DIEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S9435	PR MEDICAL FOODS FOR INBORN ERR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK,CP	6/1/2021
S9445	PR PT EDUCATION NOC INDIVID	AUTHORIZATION REQUIRED ALERT: AUTH IS REQUIRED IF MORE THAN 21 DAYS PER EPISODE, WITH MORE THAN A MAXIMUM OF 2 EPISODES OF CARE PER ROLLING 6 MONTH PERIOD, AND MORE THAN 4 EPISODES OF CARE PER ROLLING YEAR DOES REQUIRE AN AUTH. EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S9445	PR PT EDUCATION NOC INDIVID	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED IF LESS THAN 21 DAYS PER EPISODE, WITH A MAXIMUM OF 2 EPISODES OF CARE PER ROLLING 6 MONTH PERIOD, AND 4 EPISODES OF CARE PER ROLLING YEAR DOES NOT REQUIRE AN AUTH. ADMISSION AND DISCHARGE NOTIFICATION ARE REQUIRED TO BE GIVEN TO DHP.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S9470	PR NUTRITIONAL COUNSELING, DIET	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
S9480	PR INTENSIVE OUTPATIENT PSYCHIA	NO AUTHORIZATION REQUIRED EXCLUSIONS: IOP SERVICES ARE NO AUTH REQUIRED FOR IN-NETWORK PROVIDERS CONTRACTED WITH DRISCOLL HEALTH PLAN FOR THESE SERVICES.	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S9482	PR FAMILY STABILIZATION 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
S9482	PR FAMILY STABILIZATION 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S9482	PR FAMILY STABILIZATION 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
S9482	PR FAMILY STABILIZATION 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S9482	PR FAMILY STABILIZATION 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
S9482	PR FAMILY STABILIZATION 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S9482	PR FAMILY STABILIZATION 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
S9482	PR FAMILY STABILIZATION 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S9482	PR FAMILY STABILIZATION 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
S9482	PR FAMILY STABILIZATION 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S9482	PR FAMILY STABILIZATION 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
S9482	PR FAMILY STABILIZATION 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S9482	PR FAMILY STABILIZATION 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
S9482	PR FAMILY STABILIZATION 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S9482	PR FAMILY STABILIZATION 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
S9482	PR FAMILY STABILIZATION 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S9482	PR FAMILY STABILIZATION 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS - REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
S9482	PR FAMILY STABILIZATION 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS - REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
S9560	PR HT INJ HORMONE DIEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
S9560	PR HT INJ HORMONE DIEM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
T1000	PR PRIVATE DUTY/INDEPENDENT NSG	AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/MEDICAID/MEDICAID_PUBLICATIONS_PROVIDER_MANUAL.ASPX MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PDN-SNV-PPECC-GUIDELINES.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, S, C	CP	12/1/2022
T1000	PR PRIVATE DUTY/INDEPENDENT NSG	AUTHORIZATION REQUIRED	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/MEDICAID/MEDICAID_PUBLICATIONS_PROVIDER_MANUAL.ASPX MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PDN-SNV-PPECC-GUIDELINES.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, S, C	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1000	PR PRIVATE DUTY/INDEPENDENT NSG	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/MEDICAID/MEDICAID_PUBLICATIONS_PROVIDER_MANUAL.ASPX</p> <p>MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PDN-SNV-PPECC-GUIDELINES.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, S, C	CP	12/1/2022
T1000	PR PRIVATE DUTY/INDEPENDENT NSG	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/MEDICAID/MEDICAID_PUBLICATIONS_PROVIDER_MANUAL.ASPX</p> <p>MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PDN-SNV-PPECC-GUIDELINES.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, S, C	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1000	PR PRIVATE DUTY/INDEPENDENT NSG	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/MEDICAID/MEDICAID_PUBLICATIONS_PROVIDER_MANUAL.ASPX</p> <p>MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PDN-SNV-PPECC-GUIDELINES.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, S, C	CP	12/1/2022
T1000	PR PRIVATE DUTY/INDEPENDENT NSG	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/MEDICAID/MEDICAID_PUBLICATIONS_PROVIDER_MANUAL.ASPX</p> <p>MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PDN-SNV-PPECC-GUIDELINES.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, S, C	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1000	PR PRIVATE DUTY/INDEPENDENT NSG	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/MEDICAID/MEDICAID_PUBLICATIONS_PROVIDER_MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/prior_authcheck/uploads/UMGuides/PDN-SNV-PPECC-GUIDELINES.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, S, C	CP	12/1/2022
T1000	PR PRIVATE DUTY/INDEPENDENT NSG	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/MEDICAID/MEDICAID_PUBLICATIONS_PROVIDER_MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/prior_authcheck/uploads/UMGuides/PDN-SNV-PPECC-GUIDELINES.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, S, C	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1000	PR PRIVATE DUTY/INDEPENDENT NSG	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/MEDICAID/MEDICAID_PUBLIC_ACTIONS_PROVIDER_MANUAL.ASPX</p> <p>MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PDN-SNV-PPECC-GUIDELINES.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, S, C	CP	12/1/2022
T1000	PR PRIVATE DUTY/INDEPENDENT NSG	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/MEDICAID/MEDICAID_PUBLIC_ACTIONS_PROVIDER_MANUAL.ASPX</p> <p>MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PDN-SNV-PPECC-GUIDELINES.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, S, C	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1000	PR PRIVATE DUTY/INDEPENDENT NSG	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/MEDICAID/MEDICAID_PUBLICATIONS_PROVIDER_MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/prior_authcheck/uploads/UMGuides/PDN-SNV-PPECC-GUIDELINES.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, S, C	CP	12/1/2022
T1000	PR PRIVATE DUTY/INDEPENDENT NSG	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/MEDICAID/MEDICAID_PUBLICATIONS_PROVIDER_MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/prior_authcheck/uploads/UMGuides/PDN-SNV-PPECC-GUIDELINES.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, S, C	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1000	PR PRIVATE DUTY/INDEPENDENT NSG	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/MEDICAID/MEDICAID_PUBLICATIONS_PROVIDER_MANUAL.ASPX</p> <p>MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PDN-SNV-PPECC-GUIDELINES.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, S, C	CP	12/1/2022
T1000	PR PRIVATE DUTY/INDEPENDENT NSG	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/MEDICAID/MEDICAID_PUBLICATIONS_PROVIDER_MANUAL.ASPX</p> <p>MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PDN-SNV-PPECC-GUIDELINES.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, S, C	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1000	PR PRIVATE DUTY/INDEPENDENT NSG	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/MEDICAID/MEDICAID_PUBLICATIONS_PROVIDER_MANUAL.ASPX</p> <p>MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PDN-SNV-PPECC-GUIDELINES.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, S, C	CP	12/1/2022
T1000	PR PRIVATE DUTY/INDEPENDENT NSG	AUTHORIZATION REQUIRED	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/MEDICAID/MEDICAID_PUBLICATIONS_PROVIDER_MANUAL.ASPX</p> <p>MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PDN-SNV-PPECC-GUIDELINES.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, S, C	CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1005	PR RESPITE CARE SERVICE 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
T1005	PR RESPITE CARE SERVICE 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1005	PR RESPITE CARE SERVICE 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
T1005	PR RESPITE CARE SERVICE 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1005	PR RESPITE CARE SERVICE 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
T1005	PR RESPITE CARE SERVICE 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1005	PR RESPITE CARE SERVICE 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
T1005	PR RESPITE CARE SERVICE 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1005	PR RESPITE CARE SERVICE 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
T1005	PR RESPITE CARE SERVICE 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1005	PR RESPITE CARE SERVICE 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
T1005	PR RESPITE CARE SERVICE 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1005	PR RESPITE CARE SERVICE 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
T1005	PR RESPITE CARE SERVICE 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1005	PR RESPITE CARE SERVICE 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
T1005	PR RESPITE CARE SERVICE 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1005	PR RESPITE CARE SERVICE 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
T1005	PR RESPITE CARE SERVICE 15 MIN	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1007	PR TREATMENT PLAN DEVELOPMENT	NO AUTHORIZATION REQUIRED ALERT: NO AUTH IS REQUIRED IF LESS THAN 21 DAYS PER EPISODE, WITH A MAXIMUM OF 2 EPISODES OF CARE PER ROLLING 6 MONTH PERIOD, AND 4 EPISODES OF CARE PER ROLLING YEAR DOES NOT REQUIRE AN AUTH. ADMISSION AND DISCHARGE NOTIFICATION ARE REQUIRED TO BE GIVEN TO DHP.	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
T1007	PR TREATMENT PLAN DEVELOPMENT	AUTHORIZATION REQUIRED ALERT: AUTH IS REQUIRED IF MORE THAN 21 DAYS PER EPISODE, WITH MORE THAN A MAXIMUM OF 2 EPISODES OF CARE PER ROLLING 6 MONTH PERIOD, AND MORE THAN 4 EPISODES OF CARE PER ROLLING YEAR DOES REQUIRE AN AUTH. EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
T1015	PR CLINIC SERVICE	NO AUTHORIZATION REQUIRED RENDERING PROVIDER: NO AUTH REQUIRED IF REFERRED TO PROVIDER IS A FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) OR INDIAN HEALTH SERVICES (IHS)/INDIAN HEALTH CARE PROVIDER (IHCP).		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/1/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1015	PR CLINIC SERVICE	AUTHORIZATION REQUIRED RENDERING PROVIDER: AUTH IS REQUIRED IF REFERRED TO PROVIDER IS NOT A FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) OR INDIAN HEALTH SERVICES (IHS)/INDIAN HEALTH CARE PROVIDER (IHCP).	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK,CP		5/1/2023
T1017	PR TARGETED CASE MANAGEMENT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2023
T1019	PR PERSONAL CARE SER PER 15 MIN	AUTHORIZATION REQUIRED	USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM HTTP://WWW.TMHP.COM/PAGE/S/MEDICAID/MEDICAID_PUBLICATIONS_PROVIDER_MANUAL.ASPX MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/PCS-Guidelines.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1019	PR PERSONAL CARE SER PER 15 MIN	AUTHORIZATION REQUIRED	<p>USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1019	PR PERSONAL CARE SER PER 15 MIN	AUTHORIZATION REQUIRED	<p>USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1019	PR PERSONAL CARE SER PER 15 MIN	AUTHORIZATION REQUIRED	<p>USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1019	PR PERSONAL CARE SER PER 15 MIN	AUTHORIZATION REQUIRED	<p>USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1019	PR PERSONAL CARE SER PER 15 MIN	AUTHORIZATION REQUIRED	<p>USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1019	PR PERSONAL CARE SER PER 15 MIN	AUTHORIZATION REQUIRED	<p>USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1019	PR PERSONAL CARE SER PER 15 MIN	AUTHORIZATION REQUIRED	<p>USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1019	PR PERSONAL CARE SER PER 15 MIN	AUTHORIZATION REQUIRED	<p>USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID_PUBLIC ATIONS_PROVIDER_MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1019	PR PERSONAL CARE SER PER 15 MIN	AUTHORIZATION REQUIRED	<p>USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

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Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1019	PR PERSONAL CARE SER PER 15 MIN	AUTHORIZATION REQUIRED	<p>USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1019	PR PERSONAL CARE SER PER 15 MIN	AUTHORIZATION REQUIRED	<p>USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

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T1019	PR PERSONAL CARE SER PER 15 MIN	AUTHORIZATION REQUIRED	<p>USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

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T1019	PR PERSONAL CARE SER PER 15 MIN	AUTHORIZATION REQUIRED	<p>USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1019	PR PERSONAL CARE SER PER 15 MIN	AUTHORIZATION REQUIRED	<p>USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1019	PR PERSONAL CARE SER PER 15 MIN	AUTHORIZATION REQUIRED	<p>USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

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T1019	PR PERSONAL CARE SER PER 15 MIN	AUTHORIZATION REQUIRED	<p>USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID_PUBLIC ATIONS_PROVIDER_MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK, STAR BENEFIT VIA DSHS	C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1025	PR PED COMPR CARE PKG, PER DIEM	AUTHORIZATION REQUIRED	<p>USE OF PPECC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND DHP PDN GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/prior_authcheck/uploads/UMGuides/PD N-SNV-PPECC-GUIDELINES.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1025	PR PED COMPR CARE PKG, PER DIEM	AUTHORIZATION REQUIRED	<p>USE OF PPECC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND DHP PDN GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/prior_authcheck/uploads/UMGuides/PD N-SNV-PPECC-GUIDELINES.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1026	PR PED COMPR CARE PKG, PER HOUR	AUTHORIZATION REQUIRED	<p>USE OF PPECC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND DHP PDN GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/prior_authcheck/uploads/UMGuides/PD N-SNV-PPECC-GUIDELINES.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T1026	PR PED COMPR CARE PKG, PER HOUR	AUTHORIZATION REQUIRED	<p>USE OF PPECC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND DHP PDN GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PDN-SNV-PPECC-GUIDELINES.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
T1999	PR NOC RETAIL ITEMS ANDSUPPLIES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	<p>TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p> <p>MD GUIDELINE 1 (Nutritional Supplements): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Nutritional-Supplements.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T2002	PR N-ET; PER DIEM	AUTHORIZATION REQUIRED	<p>USE OF PPECC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND DHP PDN GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/prior_authcheck/uploads/UMGuides/PD N-SNV-PPECC-GUIDELINES.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T2002	PR N-ET; PER DIEM	AUTHORIZATION REQUIRED	<p>USE OF PPECC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND DHP PDN GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE/S/MEDICAID/MEDICAID_PUBLICATIONS_PROVIDER_MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PDN SNV PPECC GUIDELINES.PDF): https://driscollhealthplan.com/prior_authcheck/uploads/UMGuides/PD N-SNV-PPECC-GUIDELINES.PDF</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
T2027	PR SPEC CHILDCARE WAIVER 15 MIN	AUTHORIZATION REQUIRED	<p>USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES.</p> <p>HTTPS://HHS.TEXAS.GOV/LAWS - REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T2028	PR SPECIAL SUPPLY, NOS WAIVER	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
T2028	PR SPECIAL SUPPLY, NOS WAIVER	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T2029	PR SPECIAL MED EQUIP, NOSWAIVER	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
T2029	PR SPECIAL MED EQUIP, NOSWAIVER	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S,C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T2038	PR COMM TRANS WAIVER/SERVICE	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS - REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
T2039	PR VEHICLE MOD WAIVER/SERVICE	AUTHORIZATION REQUIRED	USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. HTTPS://HHS.TEXAS.GOV/LAWS - REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S,C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T2039	PR VEHICLE MOD WAIVER/SERVICE	AUTHORIZATION REQUIRED	<p>USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES.</p> <p>HTTPS://HHS.TEXAS.GOV/LAWS - REGULATIONS/HANDBOOKS/SKH/STAR-KIDS-HANDBOOK</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S,C, CP	12/1/2022
T2040	PR FINANCIAL MGT WAIVER/15MIN	AUTHORIZATION REQUIRED	<p>USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGES/MEDICAID/MEDICAID_PUBLICATIONS_PROVIDER_MANUAL.ASPX</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T2040	PR FINANCIAL MGT WAIVER/15MIN	AUTHORIZATION REQUIRED	<p>USE OF PCS AND CFC IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES. AND TMPPM</p> <p>HTTP://WWW.TMHP.COM/PAGE S/MEDICAID/MEDICAID PUBLIC ATIONS PROVIDER MANUAL.A SPX</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T2040	PR FINANCIAL MGT WAIVER/15MIN	AUTHORIZATION REQUIRED	<p>USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES.</p> <p>HTTPS://HHS.TEXAS.GOV/LAWS = REGULATIONS/HANDBOOKS/SK H/STAR-KIDS-HANDBOOK</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T2040	PR FINANCIAL MGT WAIVER/15MIN	AUTHORIZATION REQUIRED	<p>USE OF LTSS IS IDENTIFIED DURING THE STAR KIDS - SCREENING AND ASSESSMENT INSTRUMENT. AS SUCH, THE NEED FOR THE BENEFIT IS DETERMINED THROUGH THE NEEDS OF THE MEMBERS AND THE FAMILY RATHER THAN THROUGH GUIDELINES.</p> <p>HTTPS://HHS.TEXAS.GOV/LAWS-REGULATIONS/HANDBOOKS/SKH/STAR-KIDS-HANDBOOK</p> <p>MD GUIDELINE 1 (PCS Guidelines): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/PCS-Guidelines.pdf</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	SK	S, C, CP	12/1/2022
T2042	PR HOSPICE ROUTINE HOME CARE	AUTHORIZATION REQUIRED	<p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
T2043	PR HOSPICE CONTINUOUS HOME CARE	AUTHORIZATION REQUIRED	<p>EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR</p> <p>HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T2044	PR HOSPICE RESPITE CARE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
T2045	PR HOSPICE GENERAL CARE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
T2046	PR HOSPICE LONG TERM CARE, R&B	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
T2101	PR BREAST MILK PROC/STORE/DIST	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	12/1/2021
T4521	PR ADULT SIZE BRIEF/DIAPER SM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T4522	PR ADULT SIZE BRIEF/DIAPER MED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (Incontinence Supplies): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Incontinence-Supplies.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
T4523	PR ADULT SIZE BRIEF/DIAPER LG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (Incontinence Supplies): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Incontinence-Supplies.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
T4524	PR ADULT SIZE BRIEF/DIAPER X1	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/S/DEFAULT.ASPX MD GUIDELINE 1 (Incontinence Supplies): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Incontinence-Supplies.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T4525	PR ADULT ZISE PULL-ON SM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Incontinence Supplies): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Incontinence-Supplies.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
T4526	PR ADULT ZIDE PULL-ON MED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Incontinence Supplies): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Incontinence-Supplies.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
T4527	PR ADULT ZIDE PULL-ON LG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Incontinence Supplies): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Incontinence-Supplies.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T4528	PR ADULT ZIDE PULL-ON X1	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Incontinence Supplies): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Incontinence-Supplies.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
T4529	PR PED SIZE BRIEF/DIAPER SM/MED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Incontinence Supplies): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Incontinence-Supplies.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
T4530	PR PED SIZE BRIEF/DIAPER LG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX MD GUIDELINE 1 (Incontinence Supplies): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Incontinence-Supplies.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T4531	PR PED SIZE PULL-ON SM/MED	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Incontinence Supplies): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Incontinence-Supplies.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
T4532	PR PED SIZE PULL-ON LG	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Incontinence Supplies): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Incontinence-Supplies.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
T4533	PR YOUTH SIZE BRIEF/DIAPER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Incontinence Supplies): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Incontinence-Supplies.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T4534	PR YOUTH SIZE PULL-ON	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Incontinence Supplies): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Incontinence-Supplies.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
T4535	PR DISPOSABLE LINER/SHIELD/PAD	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Incontinence Supplies): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Incontinence-Supplies.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
T4543	PR DISP BARIATRIC BRIEF/DIAPER	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Incontinence Supplies): https://driscollhealthplan.com/priorauthcheck/uploads/UMGuides/Incontinence-Supplies.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
T4544	PR ADLT DISP UND/PULL ON ABV X1	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED UNLESS DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (Incontinence Supplies): https://driscollhealthplan.com/prior authcheck/uploads/UMGuides/Inc ontinence-Supplies.pdf	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
U0001	PR 2019-NCOV DIAGNOSTIC P	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		5/12/2023
U0002	PR COVID-19 LAB TEST NON- CDC	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	S, SK, C, CP		5/12/2023

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2020	PR VISION SVCS FRAMES PURCHASES	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2025	PR EYEGLASSES DELUX FRAMES	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2100	PR LENS SPHER SINGLE PLANO 4.00	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2101	PR SINGLE VISN SPHERE 4.12-7.00	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2102	PR SINGL VISN SPHERE 7.12-20.00	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2103	PR SPHEROCYLIN DR 4.00D/12- 2.00D	AUTHORIZATION REQUIRED RENDERING PROVIDER: OPHTHALMOLOGY ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLV EHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2104	PR SPHEROCYLIN DR 4.00D/2.12-4D	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2105	PR SPHEROCYLINDER 4.00D/4.25-6D	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2106	PR SPHEROCYLINDER 4.00D/>6.00D	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2107	PR SPHEROCYLINDER 4.25D/12-2D	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2108	PR SPHEROCYLINDER 4.25D/2.12-4D	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2109	PR SPHEROCYLINDER 4.25D/4.25-6D	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2110	PR SPHEROCYLIN DER 4.25D/OVER 6D	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2111	PR SPHEROCYLIN DR 7.25D/.25-2.25	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2112	PR SPHEROCYLIN DR 7.25D/2.25-4D	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2113	PR SPHEROCYLIN DR 7.25D/4.25-6D	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2114	PR SPHEROCYLINDER OVER 12.00D	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2199	PR LENS SINGLE VISION NOT OTH C	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2200	PR LENS SPHER BIFOC PLANO 4.00D	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2201	PR LENS SPHERE BIFOCAL 4.12-7.0	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2202	PR LENS SPHERE BIFOCAL 7.12-20.	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2203	PR LENS SPHCYL BIFOCAL 4.00D/1	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2204	PR LENS SPHCY BIFOCAL 4.00D/2.1	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2205	PR LENS SPHCY BIFOCAL 4.00D/4.2	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2206	PR LENS SPHCY BIFOCAL 4.00D/OVE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2207	PR LENS SPHCY BIFOCAL 4.25-7D/.	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2208	PR LENS SPHCY BIFOCAL 4.25-7/2.	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2209	PR LENS SPHCY BIFOCAL 4.25-7/4.	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2211	PR LENS SPHCY BIFO 7.25-12/.25-	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2212	PR LENS SPHCYL BIFO 7.25-12/2.2	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2213	PR LENS SPHCYL BIFO 7.25-12/4.2	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2214	PR LENS SPHCYL BIFOCAL OVER 12.	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2300	PR LENS SPHERE TRIFOCAL 4.00D	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2303	PR LENS SPHCY TRIFOCAL 4.0/.12-	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2304	PR LENS SPHCY TRIFOCAL 4.0/2.25	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2307	PR LENS SPHCY TRIFOCAL 4.25-7/.	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2500	PR CONTACT LENS PMMA SPHERICAL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2510	PR CNTCT GAS PERMEABLE SPHERICL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2511	PR CNTCT TORIC PRISM BALLAST	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2520	PR CONTACT LENS HYDROPHILIC	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2521	PR CNTCT LENS HYDROPHILIC TORIC	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2523	PR CNTCT LENS HYDROPHIL EXTEND	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2526	CONTACT LENS, HYDROPHILIC, WITH BLUE-VIOLET FILTER, PER LENS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGES/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY		C, S, SK, CP	1/1/2024

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2531	PR CONTACT LENS GAS PERMEABLE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2599	PR CONTACT LENS/ES OTHER TYPE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2623	PR PLASTIC EYE PROSTH CUSTOM	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2623	PR PLASTIC EYE PROSTH CUSTOM	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2022

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2624	PR POLISHING ARTIFICIAL EYE	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		<p>CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY</p>	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2625	PR ENLARGEMNT OF EYE PROSTHESIS	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2627	PR SCLERAL COVER SHELL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2628	PR FABRICATION & FITTING	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2784	PR LENS POLYCARB OR EQUAL	<p>AUTHORIZATION REQUIRED</p> <p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V2799	PR MISCELLANEOUS VISION SERVICE	AUTHORIZATION REQUIRED	<p>RENDERING PROVIDER: OPHTHALMOLOGY</p> <p>ROUTINE VISION AND MEDICAL EYE CARE SERVICES FOR DRISCOLL HEALTH PLAN ARE ADMINISTERED BY ENVOLVE VISION OF TEXAS. ALL OPHTHALMOLOGY SERVICES REQUESTS SHOULD BE SUBMITTED TO ENVOLVE VISION OF TEXAS AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX OR VIA FAX AT 1-877-865-1077. IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY AUTHORIZATION REQUIREMENTS THROUGH ENVOLVE VISION OF TEXAS. PLAN SPECIFICS OUTLINING BENEFIT INFORMATION FOR DHP MEMBERS ARE LOCATED THROUGH THE ENVOLVE VISION OF TEXAS 24/7 PROVIDER PORTAL AT HTTPS://VISIONBENEFITS.ENVOLVEHEALTH.COM/LOGON.ASPX. ENVOLVE VISION OF TEXAS PROVIDER SERVICES CAN BE REACHED AT 1-800-531-2818. CLAIMS FOR ROUTINE AND MEDICAL EYE CARE SERVICES PERFORMED MUST BE SUBMITTED TO ENVOLVE VISION OF TEXAS.</p>	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	11/1/2021
V5010	PR ASSESSMENT FOR HEARING AID	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V5011	PR HEARING AID FITTING/CHECKING	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5014	PR HEARING AID REPAIR/MODIFYING	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5020	PR CONFORMITY EVALUATION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5030	PR BODY-WORN HEARING AID AIR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5040	PR BODY-WORN HEARING AID BONE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V5050	PR HEARING AID MONAURAL IN EAR	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5060	PR BEHIND EAR HEARING AID	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5070	PR GLASSES AIR CONDUCTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5080	PR GLASSES BONE CONDUCTION	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5090	PR HEARING AID DISPENSING FEE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V5095	PR IMPLANT MID EAR HEARING PROS	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5100	PR BODY-WORN BILAT HEARING AID	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5110	PR HEARING AID DISPENSING FEE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5120	PR BODY-WORN BINAURAL HEARING AID	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5130	PR IN EAR BINAURAL HEARING AID	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V5140	PR BEHIND EAR BINAURAL HEARING AI	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5150	PR GLASSES BINAURAL HEARING AID	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5160	PR DISPENSING FEE BINAURAL	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5171	PR HEARING AID MONAURAL ITE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V5172	PR HEARING AID MONAURAL ITC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5181	PR HEARING AID MONAURAL BTE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5190	PR HEARING AID MONAURAL GLASSES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5200	PR DISP FEE CONTRALATERAL MONAU	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5211	PR HEARING AID BINAURAL ITE/ITE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V5212	PR HEARING AID BINAURAL ITE/ITC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5213	PR HEARING AID BINAURAL ITE/BTE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5214	PR HEARING AID BINAURAL ITC/ITC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5215	PR HEARING AID BINAURAL ITC/BTE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V5221	PR HEARING AID BINAURAL BTE/BTE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5230	PR HEARING AID BINAURAL GLASSES	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5240	PR DISP FEE CONTRALATERAL BINAURAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5241	PR DISPENSING FEE, MONAURAL	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5242	PR HEARING AID, MONAURAL, CIC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V5243	PR HEARING AID, MONAURAL, ITC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5244	PR HEARING AID, PROG, MON, CIC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5245	PR HEARING AID, PROG, MON, ITC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5246	PR HEARING AID, PROG, MON, ITE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V5247	PR HEARING AID, PROG, MON, BTE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5248	PR HEARING AID, BINAURAL, CIC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5249	PR HEARING AID, BINAURAL, ITC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5250	PR HEARING AID, PROG, BIN, CIC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V5251	PR HEARING AID, PROG, BIN, ITC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5252	PR HEARING AID, PROG, BIN, ITE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5253	PR HEARING AID, PROG, BIN, BTE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5254	PR HEARING ID, DIGIT, MON, CIC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V5256	PR HEARING AID, DIGIT, MON, ITE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5257	PR HEARING AID, DIGIT, MON, BTE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5258	PR HEARING AID, DIGIT, BIN, CIC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5259	PR HEARING AID, DIGIT, BIN, ITC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V5260	PR HEARING AID, DIGIT, BIN, ITE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5261	PR HEARING AID, DIGIT, BIN, BTE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5264	PR EAR MOLD/INSERT	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5265	PR EAR MOLD/INSERT, DISP	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5266	PR BATTERY FOR HEARING DEVICE	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5267	PR HEARING AID SUPPLY/ACCESSORY	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021

Prior Authorization Requirements for STAR, STAR Kids, and CHIP

Procedure Code	Procedure Code Description	Prior Authorization Requirements	Review Criteria	Documentation Requirement	Covered Benefits	Non-Covered Benefits	Prior Authorization Effective Date
V5273	PR ALD FOR COCHLEAR IMPLANT	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5275	PR EAR IMPRESSION	NO AUTHORIZATION REQUIRED		CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5298	PR HEARING AID NOC	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021
V5336	PR REPAIR COMMUNICATI ON DEVICE	AUTHORIZATION REQUIRED EXCLUSIONS: AUTH REQUIRED REGARDLESS IF DHP IS A SECONDARY PAYOR	TMPPM PRORPRIETARY DISCLAIMER HTTP://WWW.TMHP.COM/PAGE S/DEFAULT.ASPX MD GUIDELINE 1 (ASSISTIVE COMMUNICATION DEVICES.PDF): https://driscollhealthplan.com/prior-authcheck/uploads/UMGuides/ASSISTIVE-COMMUNICATION-DEVICES.PDF	CLINICAL INFORMATION AND DOCUMENTS TO SUPPORT MEDICAL NECESSITY	C, S, SK	CP	5/10/2021