Prior Authorization Grid for VHP Members

This Prior Authorization Grid reflects services that **require** prior authorization and is not intended to be a comprehensive list of covered services. Providers should refer to the appropriate Evidence of Coverage (EOC), available online at www.valleyhealthplan.org for a complete list of covered benefits.

Category of Service	Services Requiring Prior Authorization

Behavioral Health	• All Admissions for:
	  ○ Acute Inpatient Psychiatric
	  ○ Partial Hospital Psychiatric
	  ○ Residential Mental Health
	  ○ Substance Use Disorder, including Detoxification
	• Applied Behavior Analysis (ABA) Services
	• Electroconvulsive Therapy (ECT)
	• Intensive Outpatient Program (IOP)
	• Psychological Testing
	• Office-based Opioid Treatment and Withdrawal Management

Durable Medical Equipment (DME)[1]	• Bone stimulators • Breast pump • Baclofen pump, Insulin Pump, Continuous Glucose Monitoring Device (CGM) and supplies • Customized DME (e.g., diabetic shoes, compression sleeves) • DME Repair Services • Formula and Enteral Therapy • Hearing Aids and Hearing Aid Repairs • Hospital Beds and Mattress • Medical Equipment and Supplies (e.g., IV Pole, Syringes, Catheters, Wound Care Supplies, etc.) • Mobility Devices and accessories (e.g., Power Wheelchairs, Scooters, Manual Wheelchairs, Motorized Wheelchairs, Cushion, Foot and Head rests) • Negative Pressure Wound Therapy System or Wound Vac • Other Specialty Devices (e.g., Speech Generating Device) • Prosthetics and Orthotics • Respiratory Equipment and Supplies (e.g., Oxygen, Bilevel Positive Airway Pressure (BiPAP), Continuous Positive Airway Pressure (CPAP), Ventilators, Airway Clearance Vest) • Vision Aids as treatment for Aniridia and Aphakia

[1] No prior authorization is required if VHP is secondary coverage, however, claim must attach the Explanation of Benefit (EOB) for processing based on Coordination of Benefit (COB).

Category of Service	Services Requiring Prior Authorization
Experimental/Investigational Treatment, Procedures and Drugs	• Clinical Trials[2] • Investigational and Experimental Drug Therapies • Investigational and Experimental Procedures • New Technologies non-FDA approved for use (e.g., Robotic surgery) • Non-FDA approved and/or off-label use
Home Health/Hospice	• All Home Health Services (Registered Nurse, Physical, Speech and Occupational Therapists, Home Health Aide, etc.) • Home Intravenous (IV) Infusions • Hospice Services
Inpatient Admissions	• All Elective Inpatient Admissions and Admission via ED to: ➢ Acute Care Hospitals ➢ Long Term Acute Care Hospital (LTACH) • Rehabilitation and Therapy Services: ➢ Acute Inpatient Rehabilitation or Acute Rehabilitation Unit (AIR/ARU) ➢ Skilled Nursing Facilities (SNF) ➢ Subacute Nursing Facilities
Medications	• Infusion Services • Injections (Excluding Immunizations) • Non-Formulary Prescription Drugs
Non-Contracted Providers, Tertiary Providers and/or Quaternary Providers	• All Non-Urgent/Non-Emergent Medical or Behavioral Health Services rendered by Non-Contracted Providers, Tertiary Providers and/or Quaternary Providers such as Lucile Packard Children's Hospital, Stanford Children's Health, Stanford Health Care, and Stanford Hospital & Clinics
Outpatient Services and Procedures[3]	• Acupuncture and Chiropractic Services after the initial 12 visits per calendar year • All Outpatient Procedures (e.g., Amniocentesis, Nerve Conduction Studies, Varicose Vein Treatment, Performed Outside of a Physician's Office, Endoscopy and Colonoscopy) • All Outpatient Surgery (e.g., Cataract surgery, tonsillectomy, Abdominoplasty, Panniculectomy, Breast Reduction and Augmentation Surgery) • Automated External Defibrillator (AED), Holter, Mobile Cardiac Telemetry Monitoring Services • CAR T-cell Therapy • Cardiac and Pulmonary Rehabilitation

[2] Request must include the investigational protocol that sets forth the trial information and medical expenses to be incurred by VHP.

[3] No authorization is required from VHP if routine labs and/or x-rays are performed pursuant to an approved authorization for a consultation within the member's primary network. If routine labs and/or x-rays are required for an authorized 2nd opinion consultation, labs and/or x-rays should be obtained from the physician performing the initial diagnostic evaluation. No authorization is required on Biomarker testing for stage and stage 4 cancer members.

Category of Service	Services Requiring Prior Authorization
	• Chemotherapy and Radiation Treatment (e.g., Brachytherapy, Neutron Beam therapy, proton beam therapy, Intensity-modulated radiation therapy (IMRT), Stereotactic Body Radiation Therapy (SBRT), Stereotactic radiosurgery (SRS), Gamma-ray and CyberKnife) • Dental Surgery, Dental Anesthesiology Service, Jaw Surgery and Orthognathic Procedures • Diagnostic Imaging: ➢ Bone Density (DEXA Scan) ➢ Computerized Tomography Scans (CT) ➢ Magnetic Resonance Angiography (MRA) ➢ Magnetic Resonance Imaging (MRI) ➢ Nuclear Cardiology Procedures (Stress Tests/Treadmill) ➢ Positron-Emission Tomography (PET/PET-CT) ➢ Single-Photon Emission Computerized Tomography (SPECT) • Dialysis: all hemodialysis and peritoneal, continuous ambulatory peritoneal dialysis (CAPD), automated peritoneal dialysis (APD), Continuous cycling peritoneal dialysis (CCPD). • Gender Affirming Therapy and Surgery • Genetic Testing and Counseling • Hyperbaric Oxygen Therapy • Infertility Services • Neuropsychological testing • Non-routine Laboratory, Ultrasound and Radiology Services • Outpatient Therapies (Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST)) after the initial 12 visits per each discipline per calendar year • Pain Management services • Palliative Care Services • Reconstructive Procedures • Second Opinions • Sleep Studies • Spinal Procedures, including all Injections • Surgical Implants (e.g., Pacemaker, Baclofen Pump, Neuro and Spinal Cord Stimulators, Cochlear Auditory Implant) • Temporomandibular Disorder (TMJ) Treatment • Unclassified Procedures • Ventricular Assist Device
Non-Behavioral Health Specialty Referrals	• Consultation or office visit with any Specialist
Transplants	• All Transplants and Related Services

Category of Service	Services Requiring Prior Authorization
Non-Emergency Medical Transportation: Non-Interfacility	• Non-Emergency Medical Transport (NEMT) (including Fixed-Wing Air Transport)[4]
Other	• All non-urgent/non-emergent services performed out-of-area • All non-covered services • All services that are not covered by the member's primary insurance and VHP is secondary coverage • Any services that exceed the benefit limit

[4] NEMT must be billed with the appropriate modifier.