VHP Prior Authorization Guidelines

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
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

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

Category of Service	Services Requiring Prior Authorization
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 24 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 • 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)

[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 3 and stage 4 cancer members. Prior authorization is required if the biomarker test is not associated with an FDA-approved cancer therapy for stage 3 and stage 4 cancer. No prior authorization is required for Covid-19 diagnostic, screening, and pre & post exposure or response testing and health care services/treatments approved or granted EUA by the FDA for COVID-19, regardless of whether the services are provided by an in-network or out-of-network provider. No prior authorization is required for all abortion and abortion related services.

Category of Service	Services Requiring Prior Authorization
	➢ 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 24 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
All Medical (Non-Behavioral Health) Specialty Referrals	• Consultation or office visit with any Specialist
Transplants	• All Transplants and Related Services
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.