University of Arkansas
Services requiring pre-authorization effective 1-1-2015

All pre-authorizations will apply to In and Out of Network Providers unless otherwise noted. Emergency services do not require a pre-authorization.

- In-Patient Hospitalizations
  - Maternity stays over 48 hours for normal delivery, 96 hours for a C-section
  - Transplant and related services
  - In-patient behavioral health including Residential Treatment Center
  - Skilled nursing facilities
  - Long term acute care and acute rehab
  - Inpatient admissions
    *(urgent or emergent admissions including those directly from the physicians’ office require notification within 72 hours of admission)*
  - Home Health Care

- Durable Medical Equipment
  - Purchases over $1500
  - Rentals over $500 per month
  - Prosthetics over $1000

- Nutritional Counseling over 1 visit (Must have BMI of 27 or greater for up to 3 additional visits) *Provider is to use the weight management physician attestation form to authorize level II.*

- Non-surgical weight loss, All Physician Supervised, (Must have BMI of 30 or greater) *Provider is to use the weight management physician attestation form to authorize level III.*

- Genetic Testing

- Special Radiation therapy/Radiotherapy, such as:
  - Stereotactic radiosurgery (Gamma Knife, CyberKnife)
  - Intensity Modulated Radiation Therapy (IMRT)
  - Brachytherapy
  - Proton Beam Therapy

- Sleep apnea surgery and/or treatment of snoring; such as:
  - Uvulopalatopharyngoplasty (UPPP)
  - Laser-assisted uvulopalatopharyngoplasty (LAUP)

- Implantable stimulators including but not limited to:
  - Neuromuscular stimulators
  - Bone growth stimulators
  - Dorsal column stimulators

- OP spinal procedures/OP Back procedures (including but not limited to):
  - Vertebroplasty
  - Kyphoplasty
  - Total Disk Arthroplasty – cervical or lumbar
  - Intervertebral disk prosthesis
  - Radio Frequency Ablation Codes
• Intrathecal pain pumps

• Special oral formula/Enteral feedings infant formula is covered for PKU only; enteral feedings are covered only if administered through a tube as the sole source of nutrition.

• Outpatient Hyperbaric Oxygen Treatment

• Clinical Trials

• Non-emergent outpatient diagnostic imaging services:
  o MRI
  o MRA
  o PET
  o CT
  o CTA
  o EBCT
  o Nuclear Studies

• Any surgery that could be considered potentially cosmetic including but not limited to:
  o Reconstructive surgery
  o Eyelid Surgery
  o Varicose vein surgery

• The following injectibles:
  o Synagis
  o Growth Hormone
  o IVIG
  o ESA (Erythropoesis Stimulating Agents): Epogen, Procrit, and Aranesp

• Specific Outpatient Surgeries
  o Abortions
  o Accidental dental services/oral surgery/ Anesthesia and Facility Fees (when covered)
  o TMJ – Services for the diagnosis and/or treatment –covered under Point of Service Plans only

• Dialysis

• UMR to approve MRI Bone Marrow:
  o 1) Must have a diagnosis for which BMT is being considered;
  o 2) Must be performed at the Bone Marrow Center at UAMS;
  o 3) Must be done in relation to a BMT/stem cell transplant workup. Refer to CM.