AmeriHealth Caritas Pennsylvania

Prior Authorization Tips

To ease administrative burden and make submission review quicker and easier, please review the information requirements listed below.

1. Please use the AmeriHealth Caritas Pennsylvania Prior Authorization form and clearly indicate what device/service you are requesting and the date of service. Fill out the form as completely as possible (including treating and referring doctors).
2. Send clinical information that is directly related to the device or service that you are requesting.
3. Avoid handwritten forms which, when faxed, can be misunderstood or difficult to read.
4. In addition, please use a fax cover sheet stating what you want specifically (such as change date of service, fix price, have wheelchair picked up, etc.).

The information listed below is NOT a comprehensive list and additional information could still be requested.

Requests that are most commonly pended for more information:

Durable medical equipment (DME)

A. Enteral.

B. Oxygen.

C. CPAP/BiPAP.

D. Insulin pump.

E. Wheelchair.

F. Hospital bed.

G. Continuous glucose monitor.

Prior authorization

A. Ambulatory surgery center (ASC) privileges.

B. Outpatient (OP) therapy.
Home care.
Chiropractic.

C. Breast reduction.

D. Gait analysis.

E. Genetic testing.

F. Evoked optoacoustic emissions screening.

G. Wound vac.

H. Injections.

I. Bariatric surgery.

Coverage by AmeriHealth First.

DME information needed for requests

A. Enteral.

1. Letter of medical necessity.
    a. Current height, weight, BMI, relevant lab results.
    b. Details of previous attempts to treat weight loss.
    c. Nutritional reports.
    d. Assessment of response if supplements have been used.

B. Oxygen.

1. Prescription for oxygen.
2. Letter of medical necessity.
    a. Symptoms, complaints related to need for O2.
    b. How many liters being used.
    c. Recent pulse oxymetry reading on room air (at rest, during activity, and/or during sleep).

C. CPAP/BiPAP — initial.

1. Results of complete sleep study performed within the past six months, documenting Apnea Hypopnea Index (AHI).
2. Symptoms of daytime sleepiness or any sleep disorder.

D. CPAP/BiPAP — ongoing.

1. Provide current compliance report covering the past three months, or
2. Letter of medical necessity from prescribing provider stating that the initial clinical indication remains valid; however, no recent compliance report demonstrating that member is currently adherent with therapy.
3. Documentation of the prescribing provider's plan to work with member to improve adherence.

E. Insulin pump.

1. Average of at least three glucose self-tests per day for one month.
2. Documentation of severe changes in blood sugar levels or any emergency situations.

F. Continuous glucose monitor

1. Three recent A1C (average blood sugar) levels.
2. Recent blood glucose logs.
3. Documentation of any severe, recurrent hypoglycemia/hyperglycemia events or recent diabetic emergencies.

G. Wheelchair — initial.

1. Member's height/weight.
2. Expected duration of need.
3. Current ambulatory status and why the use of a walker is not an option.
4. Documentation that member is capable of propelling the wheelchair.
5. Documentation that the wheelchair can be used in the home and community.

Wheelchair — ongoing.

1. Current ambulation status.
2. Ongoing complaints that support the continued need for wheelchair.
3. Progress notes.

H. Hospital bed — initial.

1. Member's height/weight.
2. Functional status.
3. Conditions that support the need for the bed (for example, aspiration risk, breathing problems).
4. Description of the need for frequent/immediate changes in body position.
5. Documentation of medical problems that cannot be improved without a hospital bed.

Hospital bed — ongoing.

1. Update on member's functional status and plan of care.
2. Progress notes.
3. Continuing symptoms or complaints that support the need for the continued use of the bed.

Prior Authorization information needed:

A. Ambulatory surgery center (ASC) privileges

1. Is this procedure going to be performed in a participating ASC?
   - If not, why is this procedure unable to be performed in the ASC setting?

B. OP therapy, chiro, home care.

1. Number of visits needed.
2. Dates of service.
3. Symptoms/diagnoses.
4. Short- and long-term goals.

C. Breast reduction.

1. Member has reached full adult height and legal age of consent.
2. Significant symptoms interfering with activities of daily living (ADLs).
3. Trial of at least six months of conservative treatment without resolution.
   a. Back or shoulder pain — NSAIDs, compresses, massage, bracing or support garments, physical therapy (PT), weight loss.
   b. Arthritic changes in the cervical or upper thoracic spine — activity restriction.
   c. Inframammary intertrigo — topical treatments or derm treatment.
   d. Shoulder grooving and skin irritation — appropriate supporting garment.
4. Amount of breast tissue to be removed using the Schnur nomogram guideline.

D. Gait analysis.

1. Diagnosis (cerebral palsy [CP], myelomeningocele, traumatic brain injury [TBI], incomplete quadriplegia, spastic hemiplegia/diplegia).
2. Child's current functional status.
3. Current interventions or therapies child has received to treat his/her condition.
4. What this test will determine that cannot be or has not been determined with standard tests (observational gait analysis).
5. How results will impact child's current management.

E. Genetic testing

1. Symptoms/conditions that are the reason for the testing.
2. What the testing will determine.
3. How results will impact medical management.
4. If cancer related, family history.

F. Evoked otoacoustic emission screening.

1. Results of most recent audiogram.
2. What this testing will determine that standard testing could not.

G. Wound vac.

1. Type of wound (surgical, traumatic, chronic).
2. Comorbidities (especially those that may impact healing).
3. Description of wound (presence of necrotic tissue, osteomyelitis, cancer, fistula, vasculature or nerves, drainage).
4. Wound measurements/surface area.
5. Care plan details.

H. Injections.

1. Initial injection: Description of symptoms; MRI/imaging results (demonstrating nerve root impingement); pain interfering with ADLs; pain level on visual analog scale; conservative treatments tried and for how long.
2. 2nd through 6th within 12 months: Percentage of pain relief from prior injection; duration of pain relief from prior injection; no evidence of infection at injection site.

I. Bariatric surgery.

1. BMI.
2. Comorbidities.
3. Participation in a supervised weight loss program for six consecutive months and failure to maintain weight loss.
4. Mental health clearance.
5. GI clearance.
6. Endocrine causes of obesity excluded.
7. No ongoing substance abuse issues.

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