

## 2020 PRIOR APPROVAL LIST

### INTERCOMMUNITY HEALTH NETWORK CCO

Some medical services, procedures, supplies and equipment require InterCommunity Health Network Coordinated Care Organization's (IHN-CCO) written approval before being performed or supplied. All coverage is limited by Oregon Administrative Rules and the Oregon Health Evidence Review Commission (HERC) Prioritized list – see <https://www.oregon.gov/oha/hpa/dsi-herc/Pages/index.aspx>. IHN-CCO may review and deny services that are not medically appropriate<sup>4</sup>.

**Prior approval by IHN-CCO is required for the following medical services and surgical procedures:**

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| <ul style="list-style-type: none"> <li>• Acupuncture in excess of 30 visits per calendar year</li> <li>• All non-contracted services             <ul style="list-style-type: none"> <li>○ <b>Exception:</b> labs, x-rays, and dialysis</li> </ul> </li> <li>• Capsule/wireless endoscopies and motility monitoring studies</li> <li>• Chemical dependency             <ul style="list-style-type: none"> <li>○ Inpatient and residential</li> <li>○ Medical/chemical detoxification</li> </ul> </li> <li>• Contact lenses</li> <li>• Durable Medical Equipment (DME) and supplies, prosthetics and orthotics with billed amount greater than \$300 for purchase. Rental items with rental fee greater than \$300 per month or rental length greater than 3 months.</li> <li>• Elective coronary angioplasty</li> <li>• Elective/planned surgeries/procedures in outpatient hospital or Ambulatory Surgery Center (ASC)<sup>1</sup> <ul style="list-style-type: none"> <li>○ <b>Exception:</b> colonoscopies</li> <li>○ <b>Exception:</b> gastrointestinal (GI) and ear, nose, and throat (ENT) endoscopies</li> </ul> </li> <li>• Genetic testing             <ul style="list-style-type: none"> <li>○ <b>Exception:</b> standard prenatal testing</li> </ul> </li> <li>• Hyaluronic acid or viscosupplementation, intra-articular injection (i.e. Orthovisc, Synvisc, etc.)</li> <li>• Hyperbaric oxygen therapy</li> <li>• Infused/injected drugs (see list below)</li> <li>• Inpatient hospital care<sup>2</sup> <ul style="list-style-type: none"> <li>○ <b>Exception:</b> labor and delivery stays less than 96 hours</li> <li>○ <b>Exception:</b> newborn stays less than 5 days</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>• Inpatient rehabilitation care</li> <li>• Mental health services             <ul style="list-style-type: none"> <li>○ Day treatment</li> <li>○ Inpatient<sup>2</sup> and residential</li> </ul> </li> <li>• Outpatient rehabilitation services in excess of 30 visits (120 units) per calendar year, per service, including:             <ul style="list-style-type: none"> <li>○ Occupational therapy</li> <li>○ Physical therapy</li> <li>○ Speech language therapy</li> <li>○ Cardiac/pulmonary rehabilitation</li> </ul> </li> <li>• Parenteral nutrition</li> <li>• Potentially cosmetic, experimental, or reconstructive surgery and services, including new and emerging technologies and infused/injected drugs, and clinical trials<sup>3</sup></li> <li>• Radiological services for the following:             <ul style="list-style-type: none"> <li>○ Magnetic Resonance Imaging (MRI)</li> <li>○ Nuclear Medicine – PET and CTA coronary</li> </ul> </li> <li>• Skilled Nursing Facility (SNF) stays greater than 7 days</li> <li>• Skin substitute – tissue engineered</li> <li>• Spinal surgeries and spinal injections (including in-office procedures)</li> <li>• Transplants             <ul style="list-style-type: none"> <li>○ Corneal and kidney transplants only require approval if performed out of state</li> </ul> </li> <li>• Urine drug tests (prior approval required after 12 units per year)</li> </ul> |
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<sup>1</sup> Infused/injected drugs given in an outpatient hospital or ASC will not require prior authorization unless they are on the list below.

<sup>2</sup> Emergency services do not require prior approval. Please tell IHN-CCO of all emergency admissions and post-emergency observation stays that exceed 48 hours (2 days) to ensure that all the member's care is appropriately coordinated.

<sup>3</sup> Potentially cosmetic, experimental, or reconstructive surgery and services, including new and emerging technologies and infused/injected drugs, and clinical trials have the following requirements and considerations:

- Cosmetic and experimental services, which may include new and emerging technologies, often do not meet medical necessity and are generally not covered.
- Services which may be considered reconstructive will require prior approval to show medical necessity regardless of dollar amounts or codes billed.

- Prior approval for new and emerging technologies is required to ensure that the service meets current accepted standard of care.
- Potentially experimental, new and emerging infused/injected drugs include those which are not approved by the Food and Drug Administration (FDA), or have been FDA approved within the last 3 years.

**4 Medically appropriate:** Services and medical supplies that are required for prevention, diagnosis or treatment of a medical or mental health condition or injury, and which are:

- Consistent with the symptoms of a health condition or treatment of a health condition;
- Meet standards of good health practice, are generally accepted by the medical community, use evidence-based medicine and are considered effective;
- Not only for the convenience of the member or a provider of the service or medical supplies;
- The most effective of the medical services or medical supplies that can be safely provided to the member; and
- In IHN-CCO's determination as based on available information and documentation, according to the terms of the Plan.

**Prior approval by IHN-CCO is required for the following drugs when paid under the medical plan. Any other brand name equivalents of the drugs below also require prior approval.**

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| • Alemtuzumab (Campath, Lemtrada)                    | • Lanreotide (Somatuline)    | • Pertuzumab (Perjeta)                     |
| • Belimumab (Benlysta)                               | • Laronidase (Aldurazyme)    | • Ranibizumab (Lucentis)                   |
| • Bevacizumab (Avastin)                              | • Mecasermin (Increlex)      | • RimabotulinumtoxinB (Myobloc)            |
| • Certolizumab (Cimzia)                              | • Mepolizumab (Nucala)       | • Rituximab (Rituxan)                      |
| • Cetuximab (Erbix)                                  | • Natalizumab (Tysabri)      | • Rituximab/hyaluronidase (Rituxan Hycela) |
| • Daratumumab (Darzalex)                             | • Nivolumab (Opdivo)         | • Secukinumab (Cosentyx)                   |
| • Denosumab (Prolia, Xgeva)                          | • Nusinersen (Spinraza)      | • Tocilizumab (Actemra)                    |
| • Eculizumab (Soliris)                               | • Octreotide (Sandostatin)   | • Voretigene Neparvovec-rzyl (Luxturna)    |
| • Edaravone (Radicava)                               | • Ocrelizumab (Ocrevus)      |  |
| • Elotuzumab (Empliciti)                             | • Omalizumab (Xolair)        |  |
| • Epoetin and Darbepoetin (Epogen, Procrit, Aranesp) | • OnabotulinumtoxinA (Botox) |  |
| • Golimumab (Simponi, Simponi Aria)                  | • Palivizumab (Synagis)      |  |
| • Infliximab (Remicade, Inflectra, Renflexis)        | • Panitumumab (Vectibix)     |  |
| • Ipilimumab (Yervoy)                                | • Pegfilgrastim (Neulasta)   |  |
|  | • Pembrolizumab (Keytruda)   |  |
|  | • Pemetrexed (Alimta)        |  |

Questions? Contact Customer Service at 541-768-4550 | 800-832-4580 | TTY 800-735-2900 | 8 a.m. to 8 p.m., daily.