InterCommunity Health Network CCO

2019 PRIOR APPROVAL LIST

INTERCOMMUNITY HEALTH NETWORK CCO

Some medical services and surgeries require InterCommunity Health Network Coordinated Care Organization's (IHN-CCO) written approval before getting the services. All coverage is limited by Oregon Administrative Rules and the Oregon Health Evidence Review Commission (HERC) Prioritized list – see http://www.oregon.gov/oha/HPA/CSI-HERC/PrioritizedList/1-1-2018%20CPT-4-HCPCS.pdf

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

- Acupuncture
- All non-contracted services
  - **Exception**: labs, x-rays, and dialysis
- 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
- Capsule/wireless endoscopies and motility monitoring studies
- Chemical dependency
  - Inpatient and Residential
  - Medical/Chemical Detoxification
- Contact Lenses
- Elective/planned procedures in the Hospital or Ambulatory Surgery Center
  - **Exception**: colonoscopies and endoscopies
- Genetic Testing
  - **Exception**: standard prenatal testing
- Hyperbaric oxygen therapy
- Infused/injected medications (see attached list)
- Inpatient hospital care*
  - **Exception**: labor & delivery
  - **Exception**: newborn stays less than 5 days
  - **Exception**: respiratory/pulmonary therapies
- Inpatient rehabilitation care
- Mental health services
  - Day treatment
  - Inpatient* and residential
- Neck and back surgery (including in-office procedures)
- Outpatient Rehabilitation services in excess of 30 visits (120 units) per calendar year, including:
  - Occupational Therapy
  - Physical Therapy
  - Speech Language Therapy
  - Cardiac/Pulmonary Rehabilitation
- Potentially cosmetic, experimental, or reconstructive surgery and services, including new and emerging technologies and clinical trials**
- Radiological services (for the following):
  - Magnetic Resonance Imaging (MRI)
  - Nuclear Medicine – PET and CTA coronary
- Skilled Nursing Facility (SNF)
- Skin substitute – tissue engineered
- Transplants
  - Corneal and kidney transplants only require approval if performed out of state

IHN-CCO may review and deny services that are not medically appropriate.

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:

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

*Emergency Services do not require prior approval. Please tell IHN-CCO of any emergency admissions and observation stays that exceed 48 hours (2 days) in order to ensure that all of the member's care is appropriately coordinated.

**Cosmetic, experimental or reconstructive surgery and services, including new and emerging technologies and clinical trials, have the following requirements and considerations:

- Cosmetic and experimental services, which may include new or 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 or emerging technologies is required to ensure that the service meets current accepted standards of care.

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

- Abatacept (Orencia)
- Abobotulinumtoxin A (Dysport)
- Adalimumab (Humira)
- Aflibercept (Eylea)
- Agalsidase Beta (Fabrazyme)
- Albiglutide (Tanzeum)
- Alemtuzumab (Campath, Lemtrada)
- Alglucosidase Alfa (Myozyme)
- Alpha-1 Proteinase Inhibitor (Aralast NP, Glassia, Prolastin-C, Zemaria)
- Antihemophilic Factor (Hemofil M, Koate, Monoclate-P)
- Belatacept (Nulojix)
- Belimumab (Benlysta)
- Bevacizumab (Avastin)
- Bortezomib (Velcade)
- C1 Esterase Inhibitor (Berinert, Cinryze, Haegarda, Ruconest)
- Certolizumab (Cimzia)
- Cetuximab (Erbitux)
- Coagulation Factor IX (Idelvion)
- Coagulation Factor VIIa (NovoSeven RT)
- Collagenase, Injectable (Xiaflex)
- Daratumumab (Darzalex)
- Denosumab (Prolia, Xgeva)
- Eculizumab (Soliris)
- Edetate (EDTA) Chelation
- Elotuzumab (Empliciti)
- Epoetin and Darbepoetin (Epogen, Procrit, Aranesp)
- Epoprostenol (Flolan, Veletri)
- Etanercept (Enbrel)
- Fulvestrant (Faslodex)
- Glatiramer Acetate (Copaxone, Glatopa)
- Golimumab (Simponi, Simponi Aria)
- Granulocyte Colony-Stimulating Factor (G-CSF) (filgrastim, Granix, Neupogen, Zarxio)
- Granulocyte-Macrophage Colony-Stimulating Factor (GM-CSF) (sargramostim, Leukine)
- Hyaluronic Acid, Intra-articular Injection (Durolane, Gel-One)
- Icatibant (Firazyr)
- Idursulfase (Elaprase)
- Imiglucerase
- Immune Globulin Intravenous (IVIG, Bivigam, Carimune, Cuvitru, Gammagard, Octagam, Privigen)
- Infliximab (Remicade, Inflectra, Renflexis)
- Interferon and Peginterferon (Intron A, Avonex, Betaseron, Extavia, Rebif, Pegasys)
- Ipilimumab (Yervoy)
- Lanreotide (Somatuline)
- Laronidase (Aldurazyme)
- Mecasermin (Increlex)
- Mepolizumab (Nucala)
- Natalizumab (Tysabri)
- Nivolumab (Opdivo)
- Octreotide (Sandostatin)
- Ocrelizumab (Ocrevus)
- Omalizumab (Xolair)
- OnabotulinumtoxinA (Botox)
- Oprelvekin (Neumega)
- Palifermin (Kepivance)
- Palivizumab (Synagis)
- Palonosetron (Aloxi)
- Panitumumab (Vectibix)
- Pasireotide (Signifor)
- Pegaptanib (Macugen)
- Pegloticase (Krystexxa)
- Pegvisomant (Somavert)
- Pembrolizumab (Keytruda)
- Pertuzumab (Perjeta)
- Ranibizumab (Lucentis)
- RimabotulinumtoxinB (Myobloc)
- Rituximab (Rituxan)
- Romiplostim (Nplate)
- Secukinumab (Cosentyx)
- Somatropin (Genotropin, Humatrope, Norditropin, Saizen, Omnitrope, Nutropin)
- Taliglucerase (Elelyso)
- Teduglutide (Gattex)
- Teriparatide (Forteo)
- Tocilizumab (Actemra)
- Trastuzumab (Herceptin)
- Ustekinumab (Stelara)
- Vedolizumab (Entyvio)
- Velaglucerase (Vpriv)