2024

Western Health Advantage

COMMERCIAL
Prior Authorization & DME Benefits Matrix

This matrix applies to WHA's Commercial line of business only and has been designed to be as user-friendly as possible. Annual updated versions will be posted on WHA's website (www.westernhealth.com) in the Provider sign-in section, drop down box titled: *WHA Group Medical Admin*, which requires a password. Notices will be sent via e-mail to key group provider UM staff notifying them of new Web postings and when any significant changes are made throughout the year.

DISCLAIMER: This matrix is a quick reference guide and is not to be used as the primary source for making decisions re: covered benefits. Please refer to the member's specific Combined Evidence of Coverage & Disclosure Form and Copayment Summary, inclusive of plan exclusions and limitations for a complete reference. This is an internal

document to be used in conjunction with applicable policies and procedures by reviewers as a general guideline only. It should not be shared with members, employers or the public.

Note: WHA does not create WHA-specific customized Medical Policies for making medical necessity decisions. Instead, WHA's contracted Medical Groups are advised to use their own medical necessity guidelines such as MCG, InterQual, etc., taking into consideration the member's own benefit plan design and limitations/exclusions (refer to the member's appropriate EOC for specifics).

WHA does base some coverage decisions on current Medicare benefits. For Medicare benefits refer to Medicare Coverage Guidelines located on the Medicare & Medicaid Services website: https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/index.html

Decisions regarding experimental requests are processed at the Plan level using Hayes' *New Technology Assessment* Criteria or they are sent to WHA's contracted vendors, IMEDECS, for independent medical review by board-certified specialists in their specific field of expertise or InformedDNA for genetic testing reviews.

Matrix Information

This matrix allows a quick reference as to:

- whether the care/service is a benefit
- category for applicable co-payments
- whether the care/services requires a prior authorization; (authorization determinations are based on medical necessity & appropriateness of care clinical criteria – InterQual and/or MCG Guidelines)
- who should be notified for review (Group Medical Director and/or WHA's Medical Director) and should case management be involved
- if the subject is addressed in Hayes' experimental criteria
- relevant comments

Symbols:

WHA uses some symbols/codes to assist reviewers in the use of the matrix; these include *case-by-case review. (We use this code to denote those cases where it could be a benefit for only specific conditions). A double asterisk ** means service may be covered, but is handled through a "carve-out" entity such as Landmark for chiropractic/acupuncture services.

While we may have added an asterisk or a "Y" in the PA or Medical Director Notification columns in the matrix, each Group retains the right to review a request based on its own internal policies - our denotations are only WHA recommendations.

Coverage for services is based on a Member's Eligibility and Medical Necessity, except for those services that are excluded or limited per the EOC. Medical Necessity means services that WHA or the delegated group determines are:

- appropriate and necessary for the diagnosis or treatment of the Member's medical condition, in accordance with professionally recognized standards of care;
- not mainly for the convenience of Member or Member's Physician or other provider; and
- the most appropriate Supply or level of service for the injury or illness.

For hospital admissions, this means that acute care as an inpatient is necessary due to the kind of services the Member is receiving, and that safe and adequate care cannot be received as an outpatient or in a less intensive setting.
Clinical Guidelines (InterQual and/or MCG Care & Treatment Guidelines) are used to determine Medical Necessity.

For specific member information such as eligibility status or co-pays, please contact the Western Health Advantage Member Services department at 1-888-563-2250, M-F 8am-5pm, or check WHA's website for individual member eligibility/benefits. If approved for additional access, you may also view all current co-payment summaries and EOCs in WHA's password protected *WHA Med Group Admin* web pages in the Provider section.

General information

The determination of whether a service is inpatient or outpatient is established by the member's condition, attending physician and Medical Management department of the respective Medical Group based on medical appropriateness. The appropriate co-payment is applied based on this determination. Observation status in an acute care hospital is considered an inpatient admission by WHA.

DME – see "DME" for general coverage guidelines and see individual items for specific product guidelines. If no specific guideline exists for an item, WHA utilizes Medicare Guidelines in reviewing covered DME items.

Since co-payment amounts are unique to individual benefit plans and may change, please refer to the member's current Combined Evidence of Coverage & Disclosure Form and Copayment Summaries for specific co-payment dollar amounts. These are located on WHA's website or call Member Services.

Experimental & New Technology Requests

WHA contracts with IMEDECS (also known as Kepro) for Independent Medical Reviews (IMR) and uses criteria developed by its affiliate, Hayes, Inc., for experimental & new technology requests.

HAYES' *New Technology Assessment and Experimental Guidelines* and IMR case reviews are available through Western Health Advantage. ***Even though a service request is rated "C" or "D", it may be considered as a benefit in rare cases (e.g., when there is no other recourse to possibly save a life)**. Discuss with a WHA Assistant Medical Director.

Hayes ratings for clinical criteria are included in the review materials – Ratings are described by Hayes as follows:

A rating: Standard of Care (consider a benefit; med necessity criteria must be met)
B rating: Evolving standard of care; accepted medical practice as evidenced by the medical literature reviewed, with some proven benefits (consider a benefit; med necessity criteria must be met)
***C rating**: Investigational/experimental; while data is promising, it is inconclusive regarding safety and/or efficacy
***D rating**: Investigational/experimental; not efficacious and/or safe

WHA is contracted with InformedDNA (IDNA) for Independent Medical Review of genetic testing requests and uses guidelines created by IDNA to assist with reviews. WHA also uses IDNA's InformedRx program to review genetic driven therapies.

Abbreviations for Co-Pay Categories

Note: The place of service (e.g. inpatient, outpatient, home health) indicates the category for co-pay that should be applied.

Note: The applicable co-pay is based on the member's benefit plan. Please refer to the member's plan for any questions about co-pay amounts
Medical Supplies:

- Purchased through DME Company – DME co-pay
- Purchased through MD office – Office Visit co-pay
- Purchased at Retail Pharmacy with Pharmacy benefit – Brand Name co-pay.
- Purchased at Retail Pharmacy without Pharmacy benefit - applicable co-pay.

Usually if a service isn't listed, it defaults to the office co-pay amount. It is most consistent with other categories.

Category	Abbreviation
Routine office visits	OV
Allergy Testing & / Therapeutic injections including allergy shots	TInj
Pediatric & adult immunizations	IMM
Well baby care visits; up to age 2	WBvs
Hospital outpatient services	HOP
Outpatient surgical procedures	OPS
Outpatient lab & radiology	OPlab & OPrad
All other diagnostic tests (e.g. EKG, EMG)	test
Skilled nursing care, up to 100 days per calendar year	SNF
Hospital inpatient services	HIP
Emergency room	ER
Urgent care facility	UC
Ambulance services	Amb
Supplies	Sply
Durable medical equipment Prosthetics Orthotics	DME Pros Orth
Behavioral Health (BH) Outpatient-combined benefit	BHOP
(BH) Outpatient services - evaluation and short-term care	BHOP
(BH Inpatient services	BHIP
(BH) Inpatient chemical dependency-detox	BHIP
(BH) Outpatient services	BHOP
Mental Health Inpatient services, unlimited days	BHIP
Home health services - medically necessary	HH
Chiropractic care	Chiro
Acupuncture care	Acup
Annual eye and hearing exams	OPeye & OPhear
Family Planning	FP
Rehabilitation Services (PT, ST, RP)	IPreh or OPreh
Pharmacy	Pharm

PRIOR AUTHORIZATION & DME BENEFIT GUIDELINES

ALPHABETICAL (WITH CROSS REFERENCES) **Note: When in doubt about DME/Supply category for co-pay, refer to HCPCS codes**

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Abdominal binder	Y	Sply	N					Supply
Abdominoplasty								*See - PANNICULECTOMY*
Ablation - Cardiac (of aberrant conducting pathways of the Heart) Also called: Radio-frequency catheter ablation	Y	HIP	Y		Y			For the treatment of arrhythmias associated with Wolff-Parkinson-White syndrome, atrioventricular nodal reentry tachycardia, atrial fibrillation, atrial flutter, and paroxysmal atrial fibrillation. Certain types of treatment for other conditions may be considered Investigational/Experimental by Hayes.
Ablation/Alcohol for Hypertrophic Obstructive Cardiomyopathy (HOCM)	Y	HIP	Y		Y			For patients diagnosed with symptomatic HOCM-Hypertrophic Obstructive Cardiomyopathy who have at least one septal branch suitable for intervention and severe illness, i.e.: NYHA class III or IV, with drug-refractory symptoms. OR In patients with NYHA class II risk factors for sudden cardiac death.
Ablation Varicose Veins								*See - ENDOVENOUS LASER*
Abortions – Elective (non-life threatening-or anomalies) Abortion Counseling (pre abortion)- see also Sterilization Abortion Pill – RU 486 (Mifeprex / Mifepristone)	Y Y	OPS OV	Y					May be covered up to 20 weeks gestation; >20 weeks requires medical necessity review (ex: mother's health jeopardized or life in danger if pregnancy continues, non-viable fetus, etc.). Administered in MD office or pregnancy clinic.
Abortions – Spontaneous	Y	OPS	N					Miscarriage
Acupressure	N	N/A	N/A					Benefit Exclusion (unless provided under Landmark acupuncture benefit)
Accucheck and Supplies	Y	DME Sply	Y					Approve for insulin dependent and non-insulin dependent diabetics
Ace bandages	Y	Sply	N					Supply - Covered when used in conjunction with home health care or when issued in doctor's office. Not covered if over-the-counter (OTC).
Accutane (13 cisretinoic acid)	Y	Pharm	Y					Pharmacy benefit
Acupuncture	Y**	Acup	Y					**Carve-out benefits through Landmark. Members may self-refer to Landmark providers. Covered when medically necessary. Note: *check specific member benefits – not all members have chiro/acu benefits*
Admission – Elective (Med/Surg/OB)	Y	HIP	Y					Review against InterQual and/or MCG guidelines/other nationally recognized guidelines.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Admission – Elective (Mental Health and CD detox/rehab)	Y	BHIP	Y					Mental Health –OptumHealth Behavioral Solutions of California Severe mental health services are treated like any other medical illness (no specific limitations if MH necessity criteria met) Conditions include: Serious Emotional Disturbance of Children (SED) Schizophrenia Schizoaffective Disorder Pervasive Developmental Disorder or Autism Obsessive-Compulsive Disorder Panic Disorder Major Depressive Disorder Bipolar Disorder Anorexia Nervosa Bulimia nervosa Alcoholism & Drug Abuse: Refer to OptumHealth Behavioral Solutions of California or OptumHealth. *See - DETOX*
Admission – Emergency (Mental Health and CD detox)	Y	BHIP	N					Same as above, including coverage under 5150 situations. Notification needed within 1 business day for concurrent review - review against nationally recognized guidelines (i.e., InterQual or MCG).
Admission – Emergency (Med/Surg/OB)	Y	HIP	N					Notification needed within 1 business day for concurrent review; review against InterQual and/or MCG guidelines/other nationally recognized guidelines. ER co-pay is waived if patient admitted directly from ER. Admissions Out-of-the-Country - covered if medically necessary. (Call Assist America if indicated for transfer assistance)
Admission - diagnostic procedures	Y	HIP	Y					Review on a case-by-case basis for inpatient medical necessity.
Admissions- long-term custodial care								*See - CUSTODIAL CARE*
Admission- pre-operative day	*	HIP	Y					*Review on a case-by-case basis for inpatient need. Not generally covered due to lack of medical necessity.
Adult Day Care	N	N/A	N/A					Benefit Exclusion
Adverse Childhood Experience Screening	Y	test	N					Providers can become certified through State's ACEs Training Program.
Aero-chamber	Y	DME	Y					With mask for babies or children under 13 years of age in-lieu of Pulmonaide.
AFP (Alpha-Feto Protein Screen)	Y	OPlab	N					State mandated test
Agile Patency System (AKA Capsule Endoscopy)								*See - CAPSULE ENDOSCOPY*
AIDS Testing (HIV)	Y	OPlab	N					
AIDS treatment	Y	OV	Y			Y		Full scope of treatment modalities, including FDA compassionate programs and research trials.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Air Ambulance								*See AMBULANCE*
Air Conditioners, Humidifiers, Dehumidifiers and Purifiers	N*	N/A	N/A					Personal comfort or convenience items not a covered benefit. *<u>*Exception*</u>: Humidifiers may be covered when ordered in conjunction with a CPAP machine. See HUMIDIFIERS
Air Beds - fluidized and other specialty beds for home use	Y*	DME	Y		Y	Y		*Case-by-case review. May be approved if alternative is long-term hospitalization or coverage will prevent unnecessary admissions for certain categories of patients (e.g., severe decubitus of bed confined person, etc.). Due to weight of some beds, home inspection may be needed – this inspection and related costs are not payable by WHA. If approved, case should be under case management.
Airline travel – non-medical (commercial flight)	N	N/A	N/A					Benefit Exclusion. Non-medical transport is not a covered benefit.
Alarms for equipment	Y	DME	N					
Alcohol Detox - Inpatient								*See - DETOX*
Alcohol Rehabilitation Using Aversion Therapy	N	N/A	N/A					Benefit Exclusion; not an acceptable method of treatment.
Alcoholism treatment – inpt/outpatient Services								*See – CHEMICAL DEPENDENCY and DETOX*
Allergy injections (and serum/antigens)	Y	TInj	Y					Considered Therapeutic Injections If Advantage Referral, transfer pricing applies <u>Note:</u> injection co-pay only applies; no separate/additional co-pay should be charged for serum/antigen.
Allergy testing - in-vitro, PRIST, RAST & FAST	Y	OV	Y		Y			Based on medical necessity criteria
Allogeneic Bone Marrow Transplant	Y	HIP	Y	Y	Y	Y		Must meet medical necessity criteria for diagnosis
Alpha-Feto Protein Screen (AFP)								See AFP
Alternating pressure pads, mattress, lamb wool pads and pump (Decubitus Care Equipment)	Y	DME	Y					Establish medical necessity
Ambulance Service - Emergency	Y	Amb	N		Y*			Land or air emergency transport is covered for emergencies without prior auth.
Ambulance Service – Medical, Non-Emergent	Y	Amb	Y					Must be ordered by a participating provider and prior authorized. Covered for **medical** transportation inside the service area from a member's residence to the location of a covered service or from the location of a covered service to a member's home when the use of other means of transport would endanger the member's health. Medical transport may also be covered when repatriating a member from an out of area/out of network facility to a network facility.
Ambulance Service – Non-Medical transport	N	N/A	N/A					Benefit exclusion – non-medical transport includes gurney vans, wheelchair vans, car/taxi services. Only medical transport (ambulance) is covered under criteria above.
Ambulatory Surgery – OP	Y	OPS	Y					Review against InterQual and/or MCG criteria.
Amino Acid Modified Products for Inborn Errors of Amino Acid Metabolism	Y*	Sply	Y		Y			Supply - *Special amino acid modified nutrient preparations may be covered (on the same basis as insulin for DM), if the product is accepted as essential for the management of the patient's condition.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Amniocentesis	Y	OV	Y					Not a benefit if used solely to determine sex of fetus.
Amniotic membrane ocular surface graft	Y	OV OP	Y					For conjunctival defects
Anesthesia – Administered during In- or Out-patient Surgery	Y	HIP or OPS	N					No separate prior authorization needed if procedure authorized.
Anesthesia for Pain Management	*	HOP	Y		Y			*Case-by-case review
Anesthesia for dental care								*See - DENTAL CARE ,ANESTHESIA*
Angiography/Angiogram	Y	test	Y					Diagnostic procedure
Angioplasty	Y	HIP	Y					
Ankle/foot orthosis								*See - ORTHOTICS*
Ankle Replacement (Total Ankle Arthroplasty)	Y	HIP	Y		Y			Total ankle replacement is medically necessary for skeletally mature individual for treatment of severe inflammatory arthritis, severe osteoarthritis, or post-traumatic arthritis of ankle, as an alternative to ankle arthrodesis, when criteria are met.
Ankyloglossia, total or complete (Frenulectomy, tongue-tie)	Y	OPS	Y		Y			Authorize only if medically necessary; if surgery covered, post-surgical speech therapy is a benefit.
Anti-Gastroesophageal reflux device Implantation	N*	N/A	Y	Y	Y		Y	*May be considered Investigational/Experimental by Hayes. Case-by-Case review by WHA if no other options available to member.
Antigen allergy extract-serum	Y	OV	N					*See - ALLERGY INJECTIONS*
Apheresis, therapeutic (Plasmapheresis)	Y	HIP	Y		Y			Requests beyond 10 exchanges should be evaluated by MD to determine continuing need.
Apnea Monitor, high risk infants	Y	DME	Y					Covered for short-term use in newborns if determined medically necessary. Ongoing use requires MD review/justification.
Apnea sleep studies	Y	OV or test	Y					Must meet medical necessity criteria, i.e. excessive snoring, daytime somnolence, morning headaches, dry mouth, frequent episodes of observed apnea, etc. Sometimes approved for children without severe symptoms; check w/WHA.
Applied Behavioral Analysis-ABA (for Pervasive Development Disorder/Autism)	Y**	*	Y					**Refer to OptumHealth Behavioral Solutions of California. Effective 7/1/12 CA law requires ABA coverage for patients who meet criteria w/autism diagnosis. ABA services provided through member's Behavioral Health provider. Speech therapy, with definitive diagnosis of Autism/Asperger's covered under medical insurance when deemed necessary. *CROSS REFERENCE – AUTISM DIAGNOSIS/TREATMENTS, SPEECH THERAPY, SENSORY INTEGRATION DISORDER*
Aquatic Therapy	*	OPreh	Y					*Case-by-Case basis. Services MUST be medically necessary, short-term (varies by patient) but is typically 8 weeks in length, and may ONLY be provided by a licensed, qualified physical therapist as part of a specific PT treatment plan
Arthroscopy of Temporomandibular Joint (TMJ)	Y	OPS	Y					Benefit based on Medical Necessity
Artificial eye								*See - EYE PROSTHESIS*

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Artificial Disc Replacement – Single or Multi Level								*See - DISC REPLACEMENT*
Artificial Insemination (Infertility Treatment)	*	OPS	Y		Y			Intrauterine Insemination (IUI) - the injection of sperm into the uterus by means of a catheter directed through the cervix. *Always verify specific Infertility Benefits for each member as they vary by plan. Infertility benefits may be included in the plan or as a separate rider or not covered at all. If there no infertility benefits, infertility drugs are not covered either. If infertility covered, Member usually has 50% co-payment. One treatment of up to 3 cycles per lifetime. Lifetime for all infertility riders refers to services obtained during the member's life, including services provided under any other health insurance. CalPERS maintains an exception as noted below For CalPERS IUI ***only***: "Lifetime" refers to any attempts, treatments or services rendered during the member's coverage under a Western Health Advantage plan and at any time during coverage. Procurement/storage of semen/sperm and maintenance costs for storage of eggs or embryos are not covered. *CROSS REFERENCE – INFERTILITY TESTING AND RELATED SERVICES*
Artificial larynx or electronic speech aids	Y	Pros	Y		Y			Electronic speech aids are covered as prosthetic devices when the patient has had a laryngectomy or his larynx is permanently inoperative. There are two (2) types of speech aids: one operates by placing a vibrating head against the throat. The other amplifies sound waves through a tube that is inserted into the user's mouth. A patient who has had radical neck surgery and/or extensive radiation to the anterior part of the neck would generally be able to use only the "oral tube" model or one of the more sensitive and more expense "throat contact" devices. Disposable artificial larynx or artificial speech aids are not covered as they cannot withstand repeated use.
Artificial limbs								*See - PROSTHETIC DEVICES*
Assistant Surgeon	Y*	HIP or OPS	Y					Dependent upon procedure – review against CMS/Medicare guidelines.
Attention Deficit Disorders (ADD) or Attention Deficit Hyperactive Disorders (ADHD) – diagnosis	Y*	OV	Y		Y			*Case-by-case review. Tests to diagnose ADD or ADHD are a covered benefit if indicated.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Attention Deficit Disorders (ADD) or Attention Deficit Hyperactive Disorders (ADHD) – treatment	Y**	OV	Y					**Refer to OptumHealth Behavioral Solutions of California, however, group may be responsible for most/some of the services under medical benefits depending on individual case and needs. Case-by-case review based on necessity. Sensory Integration therapy – is experimental and not covered Must meet criteria: a child suffering from a "serious emotional disturbance" that has one or more mental disorders identified in the latest psychiatric criteria, other than a primary substance abuse or developmental disorder, that result in behavior inappropriate to the child's expected developmental norms. Note: Office visits for medication management are covered.
Audiological Services	Y	OV	Y					Limited to hearing testing
Aural rehabilitation	Y	OV	Y					Follows cochlear implantation and may be used for small children.
Autism diagnosis / treatments (includes Asperger's, a type of Autism), pervasive development disorder	Y*	OV	Y			Y		*Case-by-case. Coverage is allowed to determine diagnosis and treatment needs. Diagnosis may involve genetic testing - Microarray and Fragile X genetic testing is covered if recommended by a genetic counselor. See specific services/treatments for coverage and criteria. *CROSS REFERENCE - APPLIED BEHAVIORAL ANALYSIS, SENSORY INTEGRATION DISORDER, SPEECH THERAPY*
Auto lift, Auto-tilt Chair	N	N/A	N/A					Benefit Exclusion
Autologous Blood Transfusion (Patient's own blood)	Y	HIP	Y					Coverage also includes storage fees. Group risk. Typically 1 – 2 units. Storage for blood donated by another person on the member's behalf is not covered.
Autologous Bone Marrow Transplant								See specific diagnoses listed under high dose chemotherapy.
Autologous Chondrocyte Transplant	Y* limited	HIP	Y	Y	Y	Y	Y	May be appropriate for treatment of disabling knee pain due to full thickness, focal chondral defect in patients who have failed conservative therapy and first line surgical interventions. *All other uses including patellar or talar lesions and lesions of other joints are considered experimental / investigational Involves 3 separate stages including harvest of the patient's healthy cartilage cells, preparation and growth of cells in culture and then re-implantation.
Autolymphocyte Therapy for Treatment of Metastatic Renal Cell Carcinoma	Y*	HIP	Y	Y	Y	Y		*Case-by-case review.
Automatic defibrillators, implanted or Automatic implant cardioverter Defibrillator (AICD)	Y	HIP	Y		Y			Covered when meets medical necessity criteria
AZT	Y	Pharm	N					Pharmacy benefit – drug used for treatment of patients diagnosed with HIV and/or AIDS
Bags: weight	Y	DME	Y					Covered if used in conjunction with traction.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Bandages	Y	Sply	Y					Supply covered if used in conjunction with home health; NOT covered if OTC
Balloon angioplasty	Y	HIP	Y					Cardiac treatment / procedure
Balloon dilation of the Eustachian tube	Y	OPS	Y					Dx Eustachian tube dysfunction, deemed non-experimental as of 5/2020
Balloon Dilation of Prostate or Balloon Urethroplasty	Y	HIP	Y					
Balloon Valvuloplasty (BVP)	Y	HIP	Y					
Barbells	N	N/A	N/A					Personal comfort & convenience item not covered.
Bariatric Surgery (Gastric Bypass, vertical band, lap band, sleeve, Roux-en-y, etc.)	Y*	HIP	Y		Y			*Case-by-case. Must meet medical necessity and coverage criteria for morbid obesity. See examples of type of surgeries covered in far left column. Duodenal switch is typically NOT covered as it is too risky.
BART® – (BRACAnalysis Large Rearrangement Test)								See - *BRACAnalysis®*
Bathroom Equipment	N	N/A	N/A					Includes – handrails, raised toilet seats (except after hip/lower extremity surgery to prevent injury), stools, shower benches, handheld hoses and accessories.
Bathtub lifts (all brands)	Y	DME	Y		Y	Y		Medical necessity must be substantiated; requires medical review.
Bedding (i.e., pillows, sheets, etc.) Bedboard and Bed Cradle	N	N/A	N/A					Personal comfort or convenience items not a covered benefit.
Bed pan	Y	Sply	N					Supply covered if patient is bed confined.
Beds, specialty	Y	DME	Y		Y			Review on a case-by-case determination for medical necessity and possibility of reducing inpatient admissions or prolonged hospital stays – follow DME guidelines.
Bee-sting kit (other anaphylactic shock prevention kits)	Y	Pharm	Y					Pharmacy benefit
Behavioral Health Services Mental Health	Y**	BHIP/ BHOP	Y					**Refer to OptumHealth Behavioral Solutions of California <u>Covered – Severe Mental Health Services</u> Diagnoses include: SED, Schizophrenia, Schizoaffective Disorder, Pervasive Development Disorder or Autism Spectrum Disorders, Obsessive-Compulsive Disorder, Panic Disorder, Major Depression Disorder, Bipolar Disorder, Anorexia Nervosa and Bulimia Nervosa. May require authorization & must use a participating facility or provider. - Subject to co-pay. - Inpatient – unlimited days - Outpatient – unlimited visits

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Behavioral Health Services Drug & Alcohol Abuse Chemical Dependency	Y**	BHIP BHOP	Y					**Refer to OptumHealth Behavioral Solutions of California. Inpatient Benefit – detoxification requiring medical intervention covered under inpt medical benefits. - Must use a WHA acute care facility - Requires coordination by Member's PCP Inpatient/outpatient alcohol & chemical dependency rehabilitation services may not be a benefit; check EOC coverage language. Lab Work required for Behavioral Health treatment must be obtained at a participating lab. If OptumHealth Behavioral Solutions of California's or OptumHealth's specialist sends member to a non-participating lab, OptumHealth Behavioral Solutions of California or OptumHealth is responsible for payment.
Behavioral Health (Mental Health / Substance Abuse)	Y**	BHOP	Y					**Refer to OptumHealth Behavioral Solutions of California
Beta-Interferon for emerging technologies	Y	Tinj	Y	Y	Y			
Bicycles – standard or stationary	N	N/A	N/A					Benefit Exclusion
Bili-lights phototherapy								*See - PHOTOTHERAPY*
Biliopancreatic bypass	Y	HIP	NY					
Biochemical markers of bone mass For postmenopausal women	Y	HIP	Y	Y	Y			
Biofeedback	N*	N/A	N/A					Benefit Exclusion for all plans except CalPERS. Biofeedback is covered for CalPERS members for muscle reeducation of specific muscle groups or treatment of pathological muscle abnormalities of spasticity, incapacitating muscle spasm or weakness, when more conventional treatments have not been successful. Not covered for treatment of ordinary muscle tension states or psychosomatic conditions. OV or MH visit co-pay applies.
Bioidentical Hormones	N	N/A	N/A				Y	Investigational – Not FDA approved, therefore not a covered benefit.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Biomarker Testing	Y		Y					Effective 7/1/2024, WHA covers medically necessary biomarker testing for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment decisions when *any* of the following are met: • A labeled indication for a test that has been approved *or* cleared by the FDA or is an indicated test for an FDA-approved drug. • A national coverage determination made by the Centers for Medicare and Medicaid Services. • A local coverage determination made by a Medicare Administrative Contractor for California. • Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff. This includes standards set by the National Academy of Medicine. *See – BART, BRACAnalysis, DECIPHER, ONCO-TYPE TESTING, ONCOTYPE DX*
BIPAP (Bi-level Positive Airway Pressure)								*See – CPAP*
Birth Control Methods								*See – CONTRACEPTIVES,*
Birthing Centers	Y	HIP	Y					Covered when available within the WHA network and approved by the Medical Group. Network Midwife is allowed, but no home births.
Bladder Stimulators	N*	N/A	Y	Y	Y		Y	*Case-by-Case, but generally considered experimental. Electrical stimulation is used to modify bladder and sphincter behavior to decrease or eliminate urge stress and mixed forms of urinary incontinence. Case-by-Case review by WHA if no other options available to member. Most are considered experimental/investigational by Hayes.
Blepharoplasty	*	OPS	Y		Y			*Case-by-Case. Only covered if medically necessary. Not a benefit if strictly for cosmetic purposes.
Blood (Includes Blood Components – i.e.: cryoprecipitates, fresh-frozen plasma, whole blood, packed cells, etc.)	Y	HIP	N					Includes all blood administration charges.
Blood glucose control devices, closed loop	Y	HIP	Y					Used only in hospital settings with specially trained personnel.
Blood glucose monitors, home use including devices used for the visually impaired	Y	DME	Y					Covered for both Type I and Type II DM, regardless of insulin dependency. Obtain from Group's contracted Supplier.
Blood pressure cuff and supplies	N	N/A	N/A					Benefit Exclusion. Over the counter is not covered.
Blood Transfusion, Autologous (Patient's own blood)								*See – AUTOLOGOUS BLOOD TRANSFUSION*
Blood/Tissue Typing	Y*	Oplab	Y					*Not covered if related to community bone marrow donor drives or large scale donor searches – once potential matches/candidates found coverage is allowed.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Bone anchored hearing "aid" – BAHA (osseointegrated hearing device)	Y*	OPS	Y					*BAHA is not experimental and is **not** considered a hearing aid. Also, is different from cochlear implant. Indications: • Congenital atresia of the ear canal such that it does not exist or cannot accommodate a standard hearing aid • Chronic infection of the middle or outer ear that is exacerbated by a standard hearing aid • Allergic reactions to standard hearing aids • Single-sided deafness as may occur after removal of an acoustic neuroma, from trauma, or from a viral or vascular insult *CROSS REFERENCE – HEARING AID and COCHLEAR IMPLANT*
Bone Density Study, bone biopsy	Y	Oprad	Y					
Bone density study, dual-energy X-ray Absorptiometry (DEXA)								*See - DEXA SCAN*
Bone Graft, Mandibular	Y	HIP	Y		Y			If for medical and not dental reasons
Bone Growth Stimulation -Electrical & Ultrasound Invasive & Non-invasive	Y*	DME	Y		Y		Y	*Case-by-case review – many stimulators are FDA approved. May be appropriate in conditions where there is delayed healing of bones (for delays beyond normal healing time). May be appropriate for patients with risk factors for poor or prolonged healing. Use MCG Guidelines. If in doubt, refer to WHA. Some types for certain conditions may be experimental.
Bone Marrow Transplantation (Autologous or Allogeneic))	Y	HIP	Y	Y	Y	Y		Use current medical necessity criteria Donor drives and searches are not a covered benefit.
Bottles –Baby (Haberman feeders)	Y	DME	Y					Case-by-case review – allow for cleft palate (approx. 4/month x 6 months duration).
Botulinum Toxin	Y	OV, HIP	Y					Used for a variety of conditions. Must meet medical necessity criteria and not be experimental for the specific condition being treated. Use for Migraines – There is no evidence to support safety of Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonist (ie Aimovig, Ajovy, Emgality) in combo with Botox. Review med list prior to approving Botox for migraines.
Bra - Mastectomy								*See – MASTECTOMY BRA*
Bra Inserts								*See - MASTECTOMY PROSTHESIS*
BRACAnalysis® Large Rearrangement Test (BART) – (new technology genetic test to detect rare breast CA)	Y*	test	Y				Y	Covered if meets criteria BART and BRCA are two different tests and must be ordered separately.
Braces – back	Y	DME	Y		Y			
- Boston	Y	DME	Y		Y			Approved for scoliosis
- Jewelt	Y	DME	Y		Y			Approved for lumbar fracture
- Milwaukee	Y	DME	Y		Y			Grade 1 spondylolisthesis confirmed with x-ray review with Medical Director
- Williams	Y	DME	Y		Y			
Braces – leg	Y	DME	Y					Can include shoe(s) if integral part of brace(s)

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
- Adjustabrace	Y	DME						Knee hinge. Brace universally fits the right or left leg. Adjustable even while on the patient. The brace has a bi-pivotal motion that allows patellar tracking and sets varus and valgus thrust. Indication: for acute primary ligament repair and associated conditions
- Aircast –infrapatella band	Y	DME	Y					Adjustable, non-slip form-lined Velcro strip pre-inflated air cell focuses compression
- Aircast patella	Y	DME	Y					Indication: patella femoral pain chondromalacia, subluxation, and patellalgia. Review required. Indication: jumper's knee: patella tendonitis. Review required. Material – inflatable air cell, semi-rigid stays to stabilize the patella. Velcro and veliform attachment.
- Bledsol	Y	DME	Y					Covered – temporary post-surgery in lieu of cast – pay in full
- CTI standard	Y	DME	Y					Material – graphite frame and titanium for strong light weight construction Indication: functional knee orthosis designed to provide medial, lateral, anterior, posterior and combined ligament protection. Review required
- CTI Super light	Y	DME	Y					Material – graphite frame and titanium hinge for light weight (less than 15 ox.) and high strength. Indication: provides excellent protection for rotary and straight knee instabilities
- Donjoy Device System (pain control) - 3-D Orthopedic	Y	DME	Y					Combination of double upright crossing strut and rigid soft tissue containment, abduction and external rotation. (ski injury) The plastic half-shells firmly grips the thigh and calf to maintain the proper tibia/femur relationship. Muscular contractions are enhanced because of the firm encasement by the plastic half-shell. Rotational control is available with use of an optional anti-rotation foot piece indication. Post-operative management of knee ligament repairs or reconstructions and acute management of knee injuries.
- Function knee brace	Y	DME	Y					Rotation/de-rotation control
- Knee hinge	Y	DME	Y					Material – cast aluminum hinge with stainless steel locking components. Indication: for fracture, ligament repair, cast bracing.
- Lenox hill-derotation - Lenox hill-lightweight	Y Y	DME	Y Y					Material – surgical tubing, dural aluminum stainless steel, brass bushings, Teflon washers, Velcro fasteners, latex rubber cadmium and stainless steel rivets. Indication: adjustable through complete range of motion with "limited motion". Material – surgical tubing dural aluminum stainless steel, brass bushings, Teflon washings, Velcro fasteners, latex rubber elasticized webbing, Kemblo sponge rubber cadmium and stainless steel rivets. Lenox Hill is custom made- the new brace is formed by hand using a plaster model of the patient's knee. The brace comes with a neoprene under-sleeve at no extra charge.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
- Lerman (soft)	Y	DME	Y					Knee control orthosis. Material – laminated velour/foam with stainless steel polycentric knee hinges. Indications – postoperative immobilization with controlled range-of-motion adjustments. Super low rehabilitative brace. Covered – temporary. Requires medical review
- Lernond Universal (3-D)	Y		Y					Material – stainless steel uprights on polycentric hinges. Indications: symptomatic ligament instability
- Multi-ligament	Y		Y					
- Omni Anderson	Y	DME	Y					Not covered for sports
- Option – 4	Y	DME	Y					Material – neoprene with polycarbonate upright. Indications: functional knee brace provides anterior/posterior and medial/lateral stability.
- P.C.	Y	DME	Y					Material – polycarbonate upright. Indication: protective knee brace designed to prevent or reduce the severity of knee injury. Review required
- Poli axial knee cage	Y	DME	Y					Material – Ortholen and high carbon steel. Indication: ligament deficient knees. Review required
- Toronto	Y		Y					Approved for leg Perthes disease. Criteria: newly diagnosed 4-10 years old – otherwise review
- Townsend	Y		Y					Material – titanium knee joint, graphite and epoxy shells equaling 20 ounces. Townsend knee brace control rotation instabilities without elastic webbing. It restores the axis of rotation and has non-yielding structural design to stabilize the injured knee.
- TS-T	Y	DME	Y					Approve for ligament(s) weakness in a symptomatic person who wants to be active
- Whitman brace	N	N/A	N/A					Arch Support – also referred to as a Whitman foot plate
- Zinco (knee stabilizer)	Y	DME	Y					Material – stainless steel upright and polycentric hinges. Indication: functional knee brace provides anterior/posterior and medial/lateral stability.
Brachytherapy	Y*	HIP	Y		Y		Y	*Brachytherapy is a form of radiotherapy involving implantation of radioactive sources within the tumor bed, which allows delivery of high radiation doses directly to the tumor site with relative sparing of adjacent normal tissue. May be investigational for some conditions – review per MCG guidelines
Braille readers, devices	N	N/A	N/A					Benefit Exclusion. Personal comfort or convenience items are not a covered benefit. Refer to community resources (Society for the Blind)
Brain stem evoked response Audiometry (BER)	Y	test	Y		Y			
Braille teaching text	N	N/A	N/A					Personal comfort or convenience items not a covered benefit
Bravo pH Monitoring								*See - ESOPHAGEAL PH MONITORING*
Breast Biopsy	Y	OPS	N					

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Breast feeding, support, supplies and counseling	Y*	Varies	Y*					Womens' Preventive Health Services mandate, effective 8/1/12. Covered at no charge to member (no co-pay). Provided in conjunction with each birth (during pregnancy and postpartum period). May require prior auth per Group requirements. Comprehensive prenatal and postpartum breastfeeding counseling, education & support covered at no cost sharing for the member, if provided by an experienced RN lactation specialist, other trained provider or certified lactation consultant (ex: IBLCE certification from Internat'l Board Lactation Consultant Examiners). *CROSS REFERENCE - BREAST PUMP*
Breast Implants (silicone/gel), Implantation or removal of	Y*	OPS	Y		Y			*Case-by-case review. Removal limited to medical necessity reasons only. (i.e., leakage, infection or puncture); Implant covered as part of post mastectomy reconstruction otherwise cosmetic. Requires review by WHA for medical necessity for transgender male to female with no breast development with hormone treatment. *CROSS REFERENCE – RECONSTRUCTIVE SURGERY*
Breast mass/tumor excision	Y	HIP	Y					
Breast prosthesis (External) - Bra pad/insert								*See – MASTECTOMY PROSTHESIS*
Breast pump	Y*	DME	Y*					*Breast pumps/supplies are covered under the New Women's Preventive Health Services mandate, effective 8/1/12. Standard or Manual Breast Pumps: *Purchase* or Rental of a manual or standard electric breast pump is considered medically necessary during pregnancy or at any time following delivery for breastfeeding, with no cost sharing for member. If member is using a pump from previous pregnancy, new pump supplies are covered for each subsequent pregnancy. Replacement pumps for subsequent pregnancies are also covered if needed (ex: broken, pump over 3 yrs old/past warranty). Pumps (rented or purchased) must have a prescription and be provided through a contracted DME provider. Retail grade breastfeeding pumps & supplies purchased by the member over-the-counter (OTC) are not covered/not reimbursable (ex: OTC breast pumps, bottles, breast shields, infant feeding pillows, etc.). *CROSS REFERENCE - BREAST FEEDING SUPPORT, SUPPLIES & COUNSELING*
Breast reconstruction - post Mastectomy, Lumpectomy, etc.	Y	HIP	Y		Y			Surgery for the other / uninvolved breast is also covered when needed to achieve symmetry; must meet criteria.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Breast reconstruction for congenital Anomaly	Y	HIP	Y		Y			Reconstructive Surgery – covered to improve function or to create a normal appearance/symmetry, to the extent possible or repair "abnormal structures" of the body that are caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. *CROSS REFERENCE – RECONSTRUCTIVE SURGERY*
Breast reduction								*See – REDUCTION MAMMOPLASTY*
Button Infuser	Y	OPS	Y		Y			When medically necessary; used to minimize the number of needle insertions when four (4) times per day insulin is required for better control of blood glucose levels.
Calcimar injections for osteoporosis	Y	TInj	N					For post-menopausal osteoporosis and Pagets Disease of the bone.
Cages, knee	Y	DME	Y					
Canaloplasty (Open angle glaucoma refractory procedure)	Y	OPS	Y					Not experimental
Canes, and replacement parts	Y	DME	N					Approved if patient's condition impairs ambulation. White cane for use by a blind person not a covered benefit.
Capsule Endoscopy (video capsule-GI diagnostic tool; small bowel)	Y*	OPS	Y		Y		Y	Video capsules covered when medically necessary. *SmartPill® (no camera) requested prior to capsule endoscopy is experimental and therefore, not covered. *CROSS REFERENCE - SMARTPILL®*
Cardiac Ablation	Y	OPS or HIP	Y					*See – ABLATION, CARDIAC,*
Cardiac Catheterization	Y	HIP or HOP	Y					
Cardiac Event monitoring, trans-telephonic monitoring	Y	N/A	Y					
Cardiac Pacemakers, single or dual chamber	Y	HIP	Y					Approved if medical necessity criteria is met.
Cardiac Rehabilitation Program	Y	HOP	Y					Based on Medical Necessity guidelines.
Cardio beeper pacemaker monitor	Y	DME	Y					
Carotid body de-nervation	Y	HIP	Y					Approved when medical therapy fails and when deterioration in the patient's condition continues.
Carotid duplex scan	Y	OPrad	Y					
Carotid function, non-invasive tests	Y	OPrad	N					
Carpal tunnel release	Y	OPS	Y					Follow InterQual and/or MCG, and check for Worker's Comp.
Cast boot	Y	Sply	Y					Also covered for charcot foot and foot drop
Cast - fiberglass	Y	Sply	N					
CAT Scan (Computed Axial Tomography)	Y	OPrad	Y					Based on medical necessity guidelines
Cataract Extraction with Intraocular Lens Implantation								*See - INTRAOCULAR LENS*
Cataract Surgery, general anesthesia	Y	OPS	Y					General anesthesia is used primarily for cataract surgery that also involves surgery on the face. In general, most cataracts are extracted using local anesthesia.
Cataract Surgery – Laser Assisted	N	N/A						Laser assisted cataract surgery has not been found to be more beneficial than traditional cataract surgery

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Catheters - intravenous (i.e., Broviac, Hickman, etc.)	Y	Sply	Y					Initial PA not required, but Home Health may require PA for ongoing Supplies. This is a medical supply benefit, not pharmacy.
Catheters – urinary (i.e., foley, intermittent, etc.)	Y	Sply	Y					Initial insertion usually does not require PA, but ongoing Supplies do require PA. This is a medical supply, not pharmacy.
CCS eligible services (California Children Services)	Y	N/A	Y					Refer parents to CCS for possible assistance, as appropriate.
CCTA / CTA Coronary Computed Tomographic Angiography	Y	OPlab OPrad	Y					CCTA: non-invasive alternative to traditional angiography. Indicated for suspected acute coronary syndrome and cardiac morphology studies. Not to be used as a routine screening procedure in asymptomatic patients. Review for medical necessity (MCG Care Guidelines, InterQual, etc.)
Central Nervous System Stimulation (Brain and Spinal Cord), H-Wave stimulators	Y	DME	Y					Used for chronic intractable pain - excludes transcutaneous, percutaneous, and functional dorsal column electrical stimulation. H-Wave stimulators are a covered benefit under DME if criteria are met.
Centrifuge readacrit	Y	DME	N					Possible Medicare coordination of benefits when prescribed by a physician for use by patient with home hemodialysis
Cervical cerclage	Y	OPS	Y					If documented gestational history of incompetent cervix and performed at 14-18 weeks gestation.
Cervical collars and pillows	Y	Sply	Y					
Cervical Traction - Saunders								See - *TRACTION DEVICES*
Cesarean sections (C-Section)	Y	HIP	Y					When medically necessary
Chelation Therapy for Overload Conditions	Y	HIP	Y		Y			For treatment of chronic iron overload in patients with transfusion-dependent anemias. For treatment of lead overload in children with blood lead levels > 45 µg/dL.
Chelation Therapy for non-Overload Conditions	Y	HIP	Y					For anthracycline-associated cardiac damage in women with breast cancer
Chemical Dependency – outpatient	Y**	BHOP	Y					**Refer to OptumHealth Behavioral Solutions of California Case-by-Case Services for the treatment of alcoholism and chemical dependency by a participating provider per EOC benefits and BH entity**.**
Chemical Dependency – detox	Y	BHIP	Y					*See - DETOX*
Chemical Peeling for Facial Wrinkles	N	N/A	N/A					Benefit Exclusion. Cosmetic services and Supplies are excluded.
Chemonucleolysis	Y	HIP	Y		Y			
Chemotherapy	Y	HOP or HIP	Y			Y		
Chest percussors (Oscillation/high freq vibration vests)	Y	DME	Y		Y			Used primarily for treatment of patients with cystic fibrosis.
Chest physiotherapy	Y	HIP or HH	Y					If in hospital, no separate auth needed if hospitalization is authorized; authorization required for all other settings.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Chest wall compression- high frequency (HFCC) - Oscillation vest								*See - CHEST PERCUSSORS*
Chronic Fatigue Syndrome, Diagnosis	Y	OV OPlab	Y					For laboratory tests that measure energy metabolism dysfunction. For psychometric testing & measurement, including measures of fatigue & disability.
Chiropractor/Naturopathic Services	Y**	Chiro	Y					Verify Benefits –not included in all plans. For full disclosure of benefit coverage see the Landmark EOC. **Chiropractic/acupuncture services covered under medical benefits but provided through Landmark. Members may self-refer. Homeopathic/naturopathic treatments not covered Covered services are those within the scope of chiropractic care which are supportive or which are necessary to help members achieve the physical state enjoyed before an injury or illness, and which are determined to be medically necessary. Services include: Examinations, Manipulation, Conjunctive Physiotherapy, and X-rays.
Chorionic Villus Sampling	Y	OV	Y				Y	For transcervical or transabdominal testing – used as an alternative to amniocentesis to detect genetic and chromosomal defects.
Circumcision	Y*	HIP or OPS	Y					Covered for newborns (less than one month old). If not done while newborn is in the hospital, there will be a co-payment for the outpatient procedure –it is not included in routine well-baby care. *Adults and children must have medical necessity. Must have PA if done in an ASC.
Clavicle strap	Y	Sply	N					
Cleft palate repair	Y	HIP	Y		Y			
Clinical Trials (i.e. cancer)	Y	HIP	Y	Y		Y		Some covered per state law (cancer trials if criteria met or if no other recourse available for terminal members) – see WHA policy for specifics; Refer to WHA for review.
Clinitron bed (type of air bed)	Y	DME	Y		Y			Normally institutional equipment. Rental approved if Medical Director reviews and concurs bed is medically necessary. Structural assessment/reconstruction of the residence to accommodate bed is not covered.
Cochlear Implantation and programming	Y	OPS	Y		Y	Y		For adults and children with postlingual, profound, bilateral deafness who receive limited or no benefit from hearing aids. This is not the same as an osseointegrated or bone anchored hearing device. Batteries covered at 100% as Medical Supply. Case Management almost always needed as these patients often need counseling, education and speech therapy to properly serve the implant patient. Many of these patients will be on SSDI and Medicare due to their sensorineural deafness – coordinate benefits with Medicare/ACRC.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Cochleostomy with neurovascular transplant for Meniere's Disease	Y	HIP	Y					These procedures are reserved for patients with disabling Meniere's disease.
Cognitive rehabilitation following head injury or cerebrovascular event	Y	HIP	Y		*	Y		These patients must be followed under Case Management to monitor progress in rehabilitation. *Many of the units used for this type of rehab are not Hospital based and will require review by Group's Medical Director for coverage determination. If facility is licensed as a SNF, the SNF benefit is utilized.
Cognitive Rehabilitation –other than Traumatic Brain Injury or cerebrovascular disorders	Y	HIP	Y		*			Cognitive Rehab should be considered if it is going to be effective in decreasing cognitive defects, improving functional skills and increasing independence for pts with Dementia, mental retardation or Parkinson's Disease.
Collagen Implantation/injections	N	N/A	N/A					Benefit Exclusion. Cosmetic services and Supplies are excluded
Cologuard	Y	OPLab	Y		Y			Option for Colon Cancer screening; each group may decide preferred method, No longer Exp/Inv
Colon cancer tumor markers	Y	HIP	Y		Y			Used to diagnose and stage the disease and follow-up of patient's progress.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Colonoscopy	Y	OPS	Y					Preventive screening test after age 50 for non-symptomatic members every 10 years. No co-pay for preventive exams even if polyps found or biopsy is done during screening exam. Exam done following positive stool or DNA screening test (ie FIT or Cologuard) is considered screening (AB342 1/1/22). Exams done due to symptoms are considered diagnostic. After polyp found, all future exams are diagnostic. Frequency of diagnostic exams based on findings. Routine colorectal screening for members 85 years and older is not considered medically necessary unless life expectancy is greater than or equal to 10 years. **High Risk Testing.** Testing with colonoscopy as frequently as every 2 years for members with the following risk factors: • A first-degree relative (sibling, parent, child) who has had colorectal cancer or adenomatous polyps (screening is considered medically necessary beginning at age 40 years, or 10 years younger than the earliest diagnosis in their family, whichever comes first); or • Family history of familial adenomatous polyposis (screening is considered medically necessary beginning at puberty); or • Family history of hereditary non-polyposis colorectal cancer (HNPCC) (screening is considered medically necessary beginning at age 20 years); or • Family history of MYH-associated polyposis in siblings (screening is considered medically necessary beginning at age 25 years); *or* • Diagnosis of Cowden syndrome (screening is considered medically necessary beginning at age 35 years).
Colostomy bags and accessories	Y	Sply	N					Supplies are covered including irrigation and flushing equipment and other needed items and supplies directly related to ostomy care.
Colposcopy	Y	OPS	Y					For emergency care after rape, see also court/law enforcement ordered care. For other than rape allow when deemed medically necessary.
ColoVantage® Blood Test (or other current DNA blood tests to screen for colon cancer)	N	Lab	N	Y	Y		Y	Experimental for screening. Rated D2 by Hayes, UpToDate guidelines concur. Current serum markers are not sufficiently sensitive or specific to be used for screening.
Commercial Airline Travel	N	N/A	N/A					Benefit Exclusion. Non-medical transport – Not a covered benefit
Commode: bedside/3-1 elevated toilet seat	Y	DME	Y					Only covered for those confined to bed or room
Communication Device	Y*	DME	Y		Y			*Case-by-case review to determine necessity.
Compounded Medications	Y	Pharm	Y		Y			Pharmacy; compounded medications are not FDA approved and therefore generally not a covered benefit

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Compression garments/hose or stockings	Y*	DME or Sply	Y		Y			*Case-by-case review for the condition; Must have MD/NP prescription (medical condition to justify need). Covered benefit for compression garments or elastic hose/stockings that need to be fitted (measured for length/size, effectiveness) by a vendor rep or custom ordered. OTC items such as support hose purchased at a drug, medical supply store or dept store by the member without a prescription are not covered. Compression garments may be needed for lymphedema of the arm after mastectomy/lymph node resection due to cancer and chemotherapy, or for symptomatic varicose veins requiring specified amount of pressure needed are covered, usually under DME (refer to HCPCS codes)
Contact lens	*	N/A	N/A					*Usually a Benefit Exclusion, ***except*** when deemed medically necessary by Medical Director for keratoconus. Also covered if diagnosis is aniridia (missing iris) or for aphakia (missing lens). Hydrophilic CL may be medically necessary for severe dry eyes. For other reasons, check for eyewear rider (Supplemental vision insurance would cover the glasses, not medical). Contact lens fitting is only covered if the contact lens is a medically necessary as noted above. Standard intraocular lenses (IOL) are covered for all cataract removal patients, however premium IOLs (such as toric lenses--Crystalens or ReStor lens) are not a covered benefit since they are not medically necessary—(convenience item). *CROSS REFERENCE – EYEGLASSES or INTRAOCULAR LENS, HYDROPHILIC CONTACT LENS*
Continuous Glucose Monitoring	Y*	DME	Y					*Case-by-case basis. Not experimental, but must meet medical necessity criteria. *CROSS REFERENCE - GLUCOSE MONITOR*
Continuous Passive Motion Devices (CPM)	Y*	DME	Y					*Case-by-Case. Equipment rental used post joint surgery to improve outcome compared to physical therapy.
Continuous Positive Airway Pressure (CPAP)								*See - CPAP*
Contraceptives	*	*	*					Birth control pills, patches, injections, IUDs, implants, sponge, spermicide, vaginal ring, and tubal ligations are covered at no charge to member for birth control purposes. OTC “Morning After” pill (Plan B One Step, etc.) for girls/women is covered at no charge. Providers may provide script for 12 month supply of contraceptives. Some employers do not cover contraceptives due to religious directives. Subdermal implants (ex: *Implanon*, *Nexplanon*) are considered experimental if ordered for purposes other than for birth control (ex: to control dyspareunia, menorrhagia).
Contraction stress test -OB	Y	test	N					
Convalescent hospital – Skilled Nursing Facility (Custodial Care)								*See - CUSTODIAL CARE*

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Cooling Cap	Y	Sply	Y					Covered for adults with breast cancer and solid tumors only when member is undergoing chemotherapy with a high risk of complete alopecia. Not indicated for continuous infusion chemotherapy of 1 day or longer.
Cord blood banking	N	N/A	N/A					Benefit Exclusion
Corneal Cross Linking	Y	OPS	Y		Y			Only Epithelium-off Cross-Linking (C-CXL – Conventional Cross-Linking) techniques are considered not experimental for treatment of progressive keratoconus and corneal ectasis after laser refractive surgery. Other techniques or for other indications are still considered experimental/investigational
Corneal endothelial cell photography	Y	OV	Y					
Corneal modeling	Y*	OV	Y		Y			Used to measure the surface contours and thickness of the cornea for corneal diseases such as keratoconus. *LASIK surgery is NOT a covered benefit. Not a benefit if used for radial keratotomy. No PRK.
Corneal Transplants (Keratoplasty)	Y	HIP	Y		Y	Y		
Coronary Angiogram/Heart Catheterization	Y	test	Y					
Coronary Atherectomy	Y	HIP	Y					
Coronary Artery Bypass Graft (CABG)	Y	HIP	Y					Follow InterQual and/or MCG criteria
Coronary Computed Tomographic Angiography [CCTA]								*See - CCTA / CTA*
Coronary Stent Implantation	Y	HIP	Y		Y			For elective stent implantation for a new stenotic lesion in a single native coronary artery. For stent implantation using antiplatelet but not anticoagulation therapy. For elective stent implantation for a new stenotic lesion in a saphenous vein graft. For elective stent implantation for acute myocardial infarction. For elective stent implantation in a single chronically occluded coronary artery. For stent implantation with maximized stent expansion (via intravascular ultrasound or other methods) and elimination of extended anticoagulation therapy.
Corsets, l-s, dorsa-lumbar	Y	Sply	Y					Approved for lumbosacral sprain and disc herniation. Over the counter type not covered.
Cosmetic Surgery	N							Cosmetic surgery is a benefit exclusion *CROSS REFERENCE - BREAST RECONSTRUCTION, RECONSTRUCTIVE SURGERY*

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Counterpulsation, External	Y	HIP or HH	Y					Involves sequential pneumatic compression of the legs that is coordinated with cardiac contractions, and is designed to increase diastolic aortic blood pressure, improve venous blood return, and decrease afterload on the left ventricle. Approve only for patients with severe chronic stable angina who are not considered suitable candidates for angioplasty or revascularization or who have continuing angina despite surgical intervention.
Court/law enforcement Ordered Care	N	N/A	N/A					Benefit Exclusion
CPAP (Continuous Positive Airway Pressure) BiPAP (Bi-level Positive Airway Pessure)	Y	DME	Y		Y			Must meet medical necessity guidelines. Review for purchase after appropriate rental period if proven effective per Group criteria. Humidifier - Covered in conjunction with CPAP/BiPAP. May cover heated humidifier if criteria met. See HUMIDIFIERS for details/criteria.
Crisis Intervention – Mental Health	Y**	BHIP Or BHOP	Y					**Refer to OptumHealth Behavioral Solutions of California
Crutches, and replacement parts	Y	DME	N					Approved if patient's condition impairs ambulation.
Cryoablation for Prostate Cancer	Y	HIP	Y				Y	Cryoablation for prostate cancer is a minimally invasive surgical technique that uses percutaneously inserted cryoprobes to freeze, and thereby destroy, cancerous prostate tissue. Cryoablation is being investigated as a primary treatment alternative to surgery or radiotherapy for clinically localized prostatic carcinoma and as a second line or salvage treatment for patients with residual or recurrent cancer following radical prostatectomy or irradiation. As a primary therapy alternative to surgery or irradiation in patients with clinically localized disease, i.e., T1 or T2 (organ-confined), or T3 (locally advanced). As salvage therapy for recurrent cancer following failure of radiation therapy.
Cryosurgery for Primary and Metastatic cancers of the liver	Y	HIP	Y	*	Y	*		Used alone or in combination with standard resection of primary or secondary liver cancers in patients whose underlying medical condition precludes standard surgery or when the tumor is anatomically unsuitable for standard resection
Cryosurgery for prostatic cancer								*See - CRYOABLATION FOR PROSTATE CANCER*
CT/CAT scans	Y	Oprad	Y					Follow InterQual and/or MCG or radiology guidelines
Custodial care	N	N/A	N/A					Benefit Exclusion. Not a covered benefit. Use Medicare definition (no skilled needs).
Cushions- special chair	Y	DME	Y					Based on medical necessity- usually used for patients confined to wheelchair and/or with stage III or IV decubiti.
Cystometry	Y	test	N					
Cystoscopy	Y	OPS	Y					No PA if done in MD office
Cytogenetic studies	Y	Oplab	Y		Y			May be approved for genetic disorders of the fetus, failure of sexual development or chronic myelogenous leukemia.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Cytoxan Therapy for Systemic Lupus Erythematosus (SLE)	Y	Tinj	Y		Y			
Dance Therapy	N	N/A	N/A					Benefit Exclusion
Decipher	Y	OPlab	Y					Screening test for prostate cancer – not experimental *CROSS REFERENCE – ONCOTYPE DX*
Decubitus ulcer debridement	Y	HIP Or OPS	Y			*		Case-by-case review for CM and plan of care development.
Deep Brain Stimulation (DBS) for Parkinson's Disease (PD) and Essential Tremor (ET)	Y	HIP	Y				Y	Only for DBS as a treatment for severe, medically intractable PD or ET. Use for other diagnoses may be experimental.
Denis-Brown Splint	Y	DME	Y					Shoes must be attached to the brace.
Dental care associated with medical condition	Y*	HIP	Y		Y			Coverage Includes: Non-dental surgical and hospitalization procedures incidental to facial fractures, tumors or congenital defects, *such as cleft lip or cleft palate, or surgery on the maxilla or mandible that is medically necessary to correct temporomandibular joint disease (TMJ) or other medical conditions, when medically necessary. See also anesthesia, dental. *Dental services are covered under medical plan if integral to reconstructive surgery for cleft palate. *Exclusions*: - Items or services in connection with the care, treatment, fillings, removal, replacement, or artificial restoration of the teeth or structures directly supporting the teeth. - Treatment of dental abscesses, braces, bridges, dental plates, dental prostheses or dental orthoses, including anesthetic agents or drugs used for the purpose of dental care.
Dental care - head/neck radiation	Y	HIP	Y					Based on Medical Necessity
Dental Care – routine	N	N/A	N/A					Refers to fillings, crowns, etc. – dental care not covered – Benefit Exclusion Some WHA plans include pediatric dental care or a dental rider through Delta Dental *CROSS REFERENCE - ORTHODONTIA*
Dental care prior to transplant	N	N/A	N/A					Benefit Exclusion
Dental prosthesis	Y	Pros	Y		Y			Prosthetic - This may include palate expanders in preparation for future cleft palate repair, appliances in relation to oral surgery for repair of congenital or traumatic injuries/defects.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Dental care, anesthesia	Y*	HIP or HOP	Y		Y			*Case-by-Case review. Must be provided in a WHA network ASC or OP Center – used for certain DX where person will not allow exam (i.e., mental retardation, etc.) Does not include dental anesthetic administered in dental office. Necessary repair for mouth and tooth injuries that result from accidental injury are covered. General anesthesia is a covered benefit in a hospital or surgery center if child under 7 y/o, developmentally disabled (regardless of age), when health is compromised & general anesthesia is medically necessary. Note - only the anesthesia and associated facility charges are covered, *not* the dental procedure. WHA has Plan level policy posted on website protected pages.
"Dependent" coverage	Y*	OV	Y					*Children, including stepchildren or legally adopted children under the age of 26 yrs are covered under new 2010 HC Reform Act (do not have to be dependents or living in the same household; can be married). Students who reside outside of the service area covered only for urgent or emergent services, not for routine care or ER follow-up.
Depo-Provera Injections for Birth Control	Y	OV	N					This is a medical benefit, not pharmacy. *See - CONTRACEPTIVES*
Dermabrasion	*	HIP	Y					*Requires case-by-case review to determine medical necessity (following accidental injury, revision of a disfiguring scar or extensive scars following neoplastic surgery) versus cosmetic.
Detox – drug or alcohol	Y	BHIP	Y					Generally 3-day inpatient stay under medical benefits – number of detoxification admissions unlimited per calendar year. Refer to OptumHealth Behavioral Solutions of California. *See – CHEMICAL DEPENDENCY*
Developmental Disorders- services	Y*	OV	Y					*Case-by-case basis for medically necessary services. Effective 8/1/12 for most plans, some services may be provided through OptumHealth Behavioral Solutions of California or OptumHealth depending on condition. Coordinate care with Community Resources such as schools and Regional Centers as appropriate *CROSS REFERENCE - AUTISM TREATMENTS & APPLIED BEHAVIORAL ANALYSIS (ABA)*
DEXA Scan for Body Composition (Obesity)	Y	Oprad	Y					Medical Necessity (reviewed by Hayes). Okay to diagnose metabolic syndrome related obesity.
DEXA Scan for Osteoporosis (Bone Density Study)	Y	Oprad	Y					Medical Necessity based on MCG or InterQual For diagnosing osteoporosis in high-risk patients & for predicting fracture risk.
Dextrometer and stix	Y	Sply	Y					Supply - Diagnostic equipment; not considered durable medical equipment
Diabetic shoes	Y	Orth	Y					Orthotic

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Diabetic Supplies - (and insulin)	Y	Pharm	N					Insulin covered under pharmacy benefit with appropriate co-pay. Syringes, monitor strips, other test strips, lancets, etc. also covered under pharmacy benefit; Rx needed, but no prior auth necessary. Diabetic training and classes are a covered benefit – Group risk. Blood glucose monitoring devices (e.g., Accucheck, glucometer) are DME and need prior auth from Group and obtained from Group's contracted supplier.
- Blood meter/testing device	Y	DME	Y					
Diagnostic Sleep Studies (Polysomnography)	Y	test	Y					*See - SLEEP STUDIES*
Dialysis (Renal & Peritoneal)	Y	HOP HIP	Y			Y		Outpatient service All types of dialysis are covered. No facility co-pay for dialysis provided in center. Group responsible for OON non-emergency dialysis treatments (e.g. when member goes out of area for vacation, etc.) Inpatient dialysis covered under inpatient authorization. Authorizations may be issued in blocks of 12 months, once eligibility date for conversion to Medicare primary coverage is established. Medicare coverage generally begins after the 3rd month of dialysis (there are some exceptions to this rule). Also, in most cases WHA remains primary for the first 30 months of dialysis and then becomes secondary after that period of time (see SS's/Medicare's ESRD Handbook for full current details on this program).
Dialysis, home kit	Y*	DME	Y					*Case-by-Case basis
Dialysis Supplies	Y	Sply	Y					All types of dialysis are covered. Supplies are DME benefit under medical portion of coverage, not pharmacy. Authorizations may be issued in blocks of 12 months (standing referral), once eligibility date for conversion to Medicare primary coverage is established.
Dialysis water purification system	Y	DME	Y					Home care
Diapers	N	N/A	N/A					Benefit Exclusion based on OTC Item.
Diaphragms								*See - CONTRACEPTIVES*
Diathermy, pulsed electromagnetic Energy and pulsed ultrasound therapy	Y	test	Y	Y	Y			This is a physical therapy modality that provides deep penetrating heat to reduce pain or swelling caused by inflammation associated with injury or degenerative disease.
Dietary counseling	Y	OV	Y					Covered for diabetes (incl. gestational), hyperlipidemia, heart disease, malnutrition, obesity as appropriate.
Digital subtraction angiography (computed digital radiography)	Y	HIP	Y					This procedure may be covered when performed in clinical conditions when standard angiography would have been needed. Case-by-case approval.
Dilation and Curettage (D&C) (diagnostic or therapeutic)	Y	OPS	Y					Follow InterQual and/or MCG guidelines. Indicated for postpartum bleeding, spontaneous abortion/miscarriage, voluntary termination of pregnancy (first/second trimester), gestational trophoblastic disease by ultrasound, dysfunctional uterine bleeding in women < 35 y/o.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Dilation and curettage (D&C) (Emergent)	Y	OPS	N					
Direct access services	Y	OV	N					Direct access for routine OB-Gyn services (including annual PAP & breast exam), and Ophthalmology appt for annual dilated retinal/eye exam (if covered). ER Ambulance and ER screening exam- No Prior Auth needed.
Disc Replacement (cervical) – 1-2 levels	Y	HIP	Y					Up-date: Cervical disc replacements of 2 contiguous levels are no longer considered experimental.
Disc replacement – cervical 3 or more levels, and All lumbar and thoracic	N	N/A	N/A	Y			Y	Replacement of more than two contiguous cervical discs is experimental. Replacement of lumbar or thoracic discs is experimental.
Discharge medications from Inpatient Hospitalization	Y	HIP	N					Short-term supply only; usually 3 days (until prescription can be filled)
DME - General Guidelines (Durable Medical Equipment)	Y*	DME	Y					See Member's summary of benefits for co-pays (usually percentage of cost). *Case-by-Case Where two or more alternative covered devices are appropriate to treat the Member's condition, the most cost-effective device will be covered. Use Medicare Criteria if other criteria not specified for a specific item. Wheelchairs provided as a benefit under the WHA plan are standard models except in extenuating circumstances when electric chairs are needed to meet basic medical needs. A standard wheelchair is one that meets the minimum functional requirements of the Member. The allowable cost of a covered device cannot be applied towards similar devices that are not covered (e.g., cannot apply the price of basic wheelchair to the price of an electric model and allow member to pay the difference if basic model is all that was deemed medically necessary).
DME - Non-medical	N	N/A	N/A					Benefit Exclusion This may include, but is not limited to: Spas, whirlpools, exercise equipment, computers, equipment that is for convenience, blenders for puree diets, etc.
DME - pre-discharge - Medical	Y	DME	Y					Charges should not start until day of discharge, even when equipment delivered early for patient/caregiver teaching.
DME- Repair Replacement Rental-vs-purchase	Y* Y* Y*	DME DME DME	Y Y Y					*Case-by-Case basis. Not covered if replacement is for misuse or abuse. For example, wheelchair repairs are covered for replacement parts for normal wear and tear, but not from misuse or abuse. If it is more cost effective to replace rather than repair, that is WHA's recommendation. Rental cost cannot exceed purchase cost – equipment limited to most utilitarian version; if long-term need anticipated, outright purchase may be considered, if applicable. Review monthly service contract.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
DME Service contracts	Y	DME	Y					Group's choice; generally more cost effective to purchase equipment for long-term use and allow coverage for monthly service contract than to continue monthly rental.
DMSO treatment for cystitis (Dimethyl Sulfoxide)	Y	Tinj	N					
DNA Typing (Deoxyribonucleic Acid)	*	Oplab	Y			Y		*Case-by Case. Only for medical necessity. Not covered if used to determine paternity.
Dnase, recombinant human deoxyribonclease (Dornase Alfa) Treatment for Cystic Fibrosis	Y	Tinj	Y		Y	*		
Donor Charges for organ transplant (actual donation of organ)	Y	HOP	N					Services and supplies that are in connection with the donation of organs where the recipient is not a member of WHA are excluded. However, medically necessary services for the treatment of organ transplants where the member is the organ recipient are covered.
Donor Searches/Drives	N	N/A	N/A					Benefit Exclusion
Donor Testing	Y	Oplab	Y			Y		Donor testing limited to potential donors and billed on the recipient's charges (i.e., family members). See Donor Charges for organ transplantation, above. See WHA's Organ Transplant policy on website protected pages for details.
Doppler ultrasound	Y	Oprad	N					
Dressings	Y*	HH Sply	N					*Only covered in conjunction with home health care; not covered for OTC items.
Drug/alcohol abuse treatment HIP, OP and freestanding clinics								*See - CHEMICAL DEPENDENCY*
Drugs and Medicines (oral)	Y	Pharm	Y					Pharmacy Benefit - Per preferred drug listing/formulary. WHA risk: self injectables except for diabetic meds.
Drugs and Medicines – Off label or orphan use	*	Pharm	Y	Y	Y			*Use is for other than FDA approved. Check with WHA if necessary
Drugs and Medicines – Investigational New drugs (IND) or experimental	*	Pharm	Y	Y	Y			*As these drugs are still in clinical trials must be approved by both the Group's and WHA's Medical Directors. *See - EXPERIMENTAL / INVESTIGATIONAL*
Dyslexia treatment	*	OV	*			Y		*Case-by-Case. Medically necessary services covered as needed. Primarily a reading disorder. If the person is school age, coordinate services with local school district and regional center as applicable.
Dynamic posturography	Y	test	Y	Y	Y			Used to assess sensory motor and postural control in patients.
Ear molds	Y	Sply	Y					Covered for chronic otitis media or post-op ear surgery. Standard model subject to review. May also be needed as filter for tinnitus.
Eating Disorders – treatment of	Y**	HIP	Y		Y	Y		Authorize certain under medical benefits when appropriate (i.e., stabilization of electrolytes), and coordinate f/u treatment/care with Behavioral Health entity. Bulimia and anorexia nervosa treatment are covered.
ECMO (Extracororeal Membrane Oxygenation)	Y	HIP	Y			Y		Extracorporeal Membrane Oxygenation – An external device that oxygenates blood delivered to it from the body and then returns it to the patient.
Elastic joint Supports - OTC	N*	N/A	N/A					*Benefit Exclusion For example; OTC Ace wraps, elastic wrist/knee supports, braces and splints (no Rx or fitting needed).

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Elastic stockings								*See - COMPRESSION GARMENTS-HOSE*
Electric Stimulation of Bone								*See - BONE GROWTH STIMULATION*
Electrical Stimulation (E-stim)	N	N/A	N/A					Considered Experimental/Investigational for treatment of pain and inflammation and for urinary incontinence. May be seen ordered as part of a physical therapy plan.
Electric Stimulation of the Peripheral Nerve	Y*	test	Y	Y	Y			*Case-by-Case.
Electric wheelchairs								*See - WHEELCHAIRS*
Electrocardiogram (EKG)	Y	Test	N					
Electrocardiographic services, Computer-analyzed	Y	test	N					Non-invasive test to measure cardiac function.
Electrocardiographic services, Trans-telephonic transmissions	Y	test	Y		*			
Electrocardiographic services, long term ECG monitoring	Y	test	Y					
Electrocardiographic services, patient Activated recorders	Y	test	Y					
Electrocardiography, signal-average (SAECG)	Y	test	Y		Y			
Electroconvulsive Therapy (ECT) -Electroshock - creating induced seizures	Y**	BHIP	Y		Y			**Refer to OptumHealth Behavioral Solutions of California.
Electrocorticography (Intraoperative and extra-operative)	Y	HIP	Y		Y			
Electroencephalogram (EEG)	Y	test	N					
Electroencephalographic (EEG) Video Recording/Monitoring (24-hour ambulatory electroencephalographic monitoring)	Y	HIP	Y					
Electroencephalographic monitoring, surgical procedures, cerebral vasculature	Y	test	Y		Y			May be approved for carotid endarterectomies and other neurological procedures where cerebral perfusion could be reduced such as aneurysm surgery where hypotensive anesthesia is used; and/or other cerebral vascular procedures where cerebral blood flow may be interrupted.
Electromyelography (EMG) - nerve conduction study	Y	test	N					Diagnostic test
Electron beam computed tomography (EBCT)	Y*	Oprad	Y	Y	Y			*Case-by-Case. This is a useful tool if conventional cardiac testing has yielded an unexpected negative result or cannot be adequately performed due to physical disability or abnormalities in the resting EKG, which prohibit interpretation of an ischemic change. Also, if there is atypical chest pain present, no other evidence of cardiac disease, and EBTC results would be used to R/O the need for additional cardiac testing or hospitalization.
Electron microscopic services	Y	HOP or HIP	Y		Y			May be approved when additional expense of this technique over standard techniques is warranted, as in: - Distinguishing different types of nephritis based on tissues from renal needle biopsy, and when there is an uncertain diagnosis from the pathologist.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Electronic Environmental Control Device (i.e. Air Purifier)								*See - AIR CONDITIONER*
Electronic nebulizers	Y	DME	Y					Covered if patient's ability to breathe is severely impaired or if there have been multiple ER visits.
Electronic nerve stimulator (E.G., TENS unit, H-Wave, PENS)	Y	DME	Y					Recommend three (3) month rental, then consider purchase if medically necessary.
Electronic speech aid treatment	Y	Pros	Y		Y			Prosthetic - Case-by-case review. Generally needed following laryngectomy. Speech therapy is allowed to teach patient how to use device.
Electrophysiology Study (EPS)	Y	test	Y		Y			Done only at select sites.
Elevated toilet seat	Y*	DME	Y					*Case-by-Case. Covered for post lower extremity joint replacement patients (e.g., hip, knee) where coverage may prevent further injury/dislocation. OTC not covered for others.
Embolization, therapeutic	Y	HIP	Y		Y			See MCG or InterQual for criteria
EMG - Electromyelography (nerve conduction study)								*See - ELECTROMYELOGRAPHY*
Employment Physicals & Immunizations	*	OV	N					*Case-by-Case. Exam covered if it is time for the member's yearly physical examination anyway, otherwise, not a covered benefit. Immunizations – may be covered: depends on type, reason, necessity.
End Stage Renal Disease (ESRD)- treatment	Y	HIP	Y		Y	Y		Refer to Social Security if Medicare eligible *CROSS REFERENCE - DIALYSIS*
Endocardial biopsy	Y	HIP	Y					Frequently required after heart transplant and will be at the frequency ordered by transplant team as prime test used to determine rejection. Also used to confirm myocarditis diagnosis.
Endocardial electrical stimulation (EES), diagnostic	Y	HIP	Y		Y			Used to study arrhythmias and abnormalities of the heart's conduction system.
Endocardial mapping	Y	HIP	Y		Y			Used to identify the anatomical location of sources of abnormal cardiac rhythms for treatment (pharmacological, surgical, electrical, chemical or radiofrequency ablation; use of defibrillation and cardioversion devices).
Endometrial Laser Ablation	Y	HIP	Y				Y	May be used in the treatment of menorrhagia in premenopausal patients who have failed or are unwilling to continue medical treatment, are otherwise candidates for hysterectomy, have no evidence of endometrial or cervical cancer or pre-cancer and no longer childbearing. See MCG™ criteria for further details.
Endometriosis – drug treatment								*See - LUPRON DEPOT INJECTIONS*
Endoscopic Sympathectomy Treatment of Hyperhidrosis	Y	HIP	Y		Y			Endoscopic surgical resection or ablation of the dorsal thoracic sympathetic ganglia is performed to alleviate the excessive palmar, axillary, or craniofacial sweating associated with hyperhidrosis. Covered for treatment for patients with severe primary palmar hyperchidrosis who have failed appropriate non-surgical therapies and for whom the condition causes significant social, psychological, or employment-related disability.
Endoscopic Therapy for GERD (Also called: Antireflux surgery, Bard EndoCinch, & Streeta system)	*	N/A	N/A		Y		Y	*Considered Investigational/Experimental by Hayes. Case-by-Case review by WHA if no other options available to member. *CROSS REFERENCE - BOTULISM TOXIN FOR GI DISORDERS*

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Endoscopy								See specific procedure
Endoscopy /Capsule								*See - CAPSULE ENDOSCOPY*
Endovascular Therapy for Intracranial Aneurysms	Y	HIP	Y		Y		Y	May be used for endovascular therapy for saccular intracranial aneurysms of the posterior cerebral circulation, and for other intracranial aneurysms whose surgical ligation and clipping would pose great technical difficulty or be medically contraindicated
Endovenous Laser for varicose veins [EVLT] - Radiofrequency ablation	Y	HIP	Y					Current literature shows this is an effective and safe alternative to conventional surgical management i.e. (stripping).
Enteral solutions and supplies	Y*	HH Sply	Y					*Enteral solutions and supplies must be reviewed on a case-by-case basis for medical necessity. If approved, solutions and supplies are covered in full under medical Supplies. Pump covered under DME. Enteral solutions cannot be an "OTC" item, a food or dietary supplement (such as Ensure), a breast milk extender or a food modifier. ALSO…PKU (phenylketonuria) patients specially formulated foods and special formulas are a covered benefit
Epidural blood graft, autologous	Y	HOP HIP	Y		Y			Used to remedy headaches that may occur after spinal anesthesia, spinal tap or myelogram.
Epidural medication during labor	Y	HIP	N					No separate auth required; included in hospital auth.
Epidural narcotics	Y	HIP	Y					Epidurals administered during labor and delivery are covered benefits.
Epidural steroids for treatment of back pain	Y	HOP	Y		Y			Generally limited to 3 injections in 6 months.
Erectaid (for erectile dysfunction)	Y	Sply	Y		Y			Supply
Erythropoietin	Y	HIP or Tinj	Y		Y			Approved for anemia associated with specific conditions. See WHA Pharmacy Prior Auth Criteria
Esophageal pH monitoring (Tuttle Test, Bravo)	Y	test	Y					
Esophagogastroduodenoscopy (EGD)	Y	OPS	Y					
Essure Device - birth control	Y	OPS	Y		Y			ESSURE device used as a method to provide permanent birth control. No cost to member for birth control.
ESWT [Extracorporeal Shock Wave Therapy]	*	OPS	Y		Y		Y	*Lithotripsy for kidney stone covered. *See - SHOCK WAVE THERAPY FOR PLANTAR FASCIITIS*
Eustachian Tube Dilation	Y	OPS	Y		Y			Up-date: No longer considered experimental for treatment of Eustachian tube dysfunction
Event monitor (Cardiac Monitor)	Y	DME	Y					Example: Holtor Monitor.
Evoked response test	Y	test	Y					
Exercise equipment	N	N/A	N/A					Benefit Exclusion
Experimental/investigational drugs & procedures	*	NA	Y	Y	Y		Y	*Case-by-Case. All of these come to WHA for benefit decision. Per Hayes, these are promising treatments but inconclusive regarding safety and/or efficacy. If determined to be experimental they are not a covered benefit because there is no clear medical consensus regarding their safety and/or efficacy. See Hayes for more specifics

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
External counterpulsation (EECP)	Y	DME	Y	Y	Y			Used to improve the coronary blood flow and thereby improve myocardial oxygenation of outpatients with chronic stable angina pectoris in whom additional medical or surgical therapy is contraindicated.
External infusion pumps								*See - INFUSION PUMPS*
Extracorporeal immunoadsorption (therapeutic apheresis)	Y	HIP	Y		Y			Approved for use with idiopathic thrombocytopenic purpura (ITP) after other treatments fail. Other uses may be investigational or experimental.
Extracorporeal membrane oxygenation (ECMO) for infants	Y	HIP	Y			Y		
Extracorporeal membrane oxygenation for adults with acute respiratory distress syndrome	Y	HIP	Y		Y			
Extracorporeal Shock Wave Therapy (ESWT)								*See – ESWT*
Extracranial-intracranial (EC-IC) arterial bypass surgery	Y	HIP	Y		Y			
Eye and ocular adnexa procedures	Y	OPS	Y					Review against InterQual and/or MCG criteria.
Eye examination	Y*	Opeye	N					*Annual eye examination by Optometrist or Ophthalmologist is covered (If member has the benefit). Coverage for the exam includes dilated exam, refraction exam with prescription if needed, med history and routine medical eye exam testing components. No prior auth required and may be provided under WHA's Advantage Referral Program. Note: contact lens fitting is not covered as part of an annual eye exam under the medical benefits. It may be covered under the member's vision benefit plan.
Eye glasses	N	N/A	N/A		Y			Benefit Exclusion. Eyeglasses not covered under medical benefits. **Note:** Members may have carve-out vision services rider (separate insurance), which may cover eyewear. Check benefits. *CROSS REFERENCE - CONTACT LENSES, INTRAOCULAR LENSES*
Eye, prosthesis	Y	Pros	Y					Standard eye prosthesis is covered.
Fabric wrapping of aortic aneurysms	N	N/A	N/A	Y	Y		Y	Fabric wraps, per Hayes, are not efficacious and patients have a high mortality rate. Experimental.
Facelifts and other procedures related to the aging process	N	N/A	N/A					Benefit Exclusion - Cosmetic

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Family and Diversity Support Benefit	Y	OV Oplab OPS Pharm	Y					Effective 7/1/2023, this benefit provides plan members with pregnancy support services (with no exclusion of gender or relationship status), and **without** a diagnosis of infertility. It also covers pre-implantation genetic testing, supporting members with rare and life-threatening genetic conditions.* **1. Pregnancy Support** Designed to demonstrate WHA's commitment to supporting diverse families who have not been diagnosed with medical infertility, this benefit will help members who are either single or in same-sex relationships as well as traditional couples as medically indicated. • Up to three (3) cycles of artificial insemination (AI), if medically necessary for women • Up to three (3) cycles of sperm retrieval or extraction procedure, if medically necessary for men • Medications for ovarian stimulation, including basic laboratory tests as well as basic imaging tests related to fertility workup **2. Pre-implantation Genetic Testing** This supports the needs of a member (or first-degree relative) with a specified** rare and life-threatening genetic condition as they plan for pregnancy and require support to conceive. * Refer to the Copayment Summary for cost, details, exclusions, and limitations. An eligible member may be referred by their doctor for these services; prior authorization is required. WHA provides this additional and distinctive benefit at no additional premium. ** Refer to the specified list of covered diagnoses. REFERENCE THE FAMILY AND DIVERSITY SUPPORT BENEFIT PROCESS
Family planning	Y	OV	N					
Family therapy/counseling	Y**	BHOP	Y					**See mental health coverage guidelines in EOC. Refer to OptumHealth Behavioral Solutions of California.
Fecal Microbiota Transplant	Y	HOP	Y				Y	For refractory C. Diff infection only. All other uses are still investigational
Feeding pumps and supplies								*See - ENTERAL SOLUTIONS AND SUPPLIES*

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Fertility Preservation	Y	OV OP	Y					Fertility preservation is covered for members who will be undergoing a medically necessary treatment that can result in infertility. • Services for women include egg retrieval and storage for up to one year per diagnosis and complete treatment cycle. • Services for men includes sperm storage for up to one year per diagnosis and complete treatment cycle. • Age 16 years of age or older at time of egg or sperm retrieval • Requests for ages less than 16 years – may be experimental / investigational – refer to WHA.
Fetal fibronectin	Y	Tinj Or HIP	Y		Y		Y	Indicated for pregnant women with signs and symptoms of pre-term labor who have intact membranes, < 3cm of cervical dilation, and singleton pregnancies.
Fetal monitoring (Electronic) during labor & delivery	Y	HIP	N					
Fetal reduction surgery	Y	HIP	Y		Y		Y	Fetal reductions are used to reduce the number of fetuses in a multiple pregnancy to decrease the mother's morbidity and increase the viability of the remaining fetus or fetuses, or to abort a fetus with detectable malformations.
Fetal stress test	Y	OV	N					
Fine needle biopsy	Y	OV	N					
Flat feet, treatment of	N	N/A	N/A					Benefit Exclusion
Flu shots	Y	IMM Pharm	N					Group risk if obtained by PCP. Pharmacy if obtained at a contracted pharmacy.
Flutter devices for cystic fibrosis								*See - CHEST PERCUSSORS*
Food Supplements								*See - ENTERAL SOLUTIONS AND SUPPLIES*
Foot care (Podiatry)								*See - PODIATRY*
Foot orthotics (Orthotics)								*See - ORTHOTICS*
Formulas - adult								*See - ENTERAL SOLUTIONS ANDSUPPLIES*
Formulas- infant								*See - ENTERAL SOLUTIONS ANS SUPPLIES*
Fragile X	Y	test	Y					Genetic test. Requires genetic counseling prior to test. Medically necessary when results will affect treatment plan. See MCG, InterQual or IDNA (available from WHA) for criteria.
Functional cortical mapping	Y	test	Y		Y			
Functional Medicine								*See - HOMEOPATHIC TREATMENT/SERVICE*
Gamete intra-fallopian transfer (GIFT)								*See - GIFT*
Gamma radiotherapy (Gamma Knife)	Y	HIP	Y		Y			
Gamma-interferon for chronic granulomatous disease	Y	Tinj	Y		Y	Y		
Gastric banding/gastric wrapping								*See - BARIATRIC SURGERY*
Gastric bubble or balloon, morbid obesity treatment								*See - BARIATRIC SURGERY*

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Gastric bypass surgery, treatment for Morbid Obesity (including vertical sleeve, lap band, Roux-en-y, etc.)								*See - BARIATRIC SURGERY*
Gated cardiac scans	Y	Oprad	N					
Gel-flotation pad and mattress	Y	DME	Y		Y			For stage III or IV decubitus ulcers or for wheelchair or bed confined patients.
Gender reassignment surgery, (Female to male or male to female)	Y	HIP/OPS	Y	Y	Y			*See - TRANSGENDER SERVICES*
Genetic counseling	Y	OV	Y					Appropriate for evaluation of how inherited diseases and conditions might affect the patient and their family, also how family and medical histories may impact the chance of disease occurrence or recurrence. Consider referral to CCS and GHPP program for possible long-term assistance with chronic care costs, etc.
Genetic testing	Y*	Oplab	Y		Y		Y	*Case-by-Case basis. Not a covered benefit for paternity testing or when considered experimental. Test results must be expected to make an impact on the treatment plan for the member. Some specific genetic tests are listed in this grid with their criteria. If not listed, refer to WHA for evaluation as possibly experimental. WHA uses IDNA to assist in genetic testing reviews. Standard genetic tests to diagnose fetal disorders when member is pregnant are covered. *CROSS REFERENCE – BART® & BRACAnalysis® or HARMONY* *CROSS REFERENCE – WHOLE EXOSOME SEQUENCING* *NON-INVASIVE PRENATAL GENETIC TESTING, AUTISM, AFP*
Genicular Nerve Block	Y	test	Y					Not experimental for knee pain with osteoarthritis.
GIFT (Gamete Intra-Fallopian Transfer)	*	OPS	Y					*Always verify specific Infertility Benefits for each member as they vary by plan. Infertility benefits may be included in the plan or as a separate rider. If no infertility benefits, infertility drugs are not covered either. If covered – limited to one per Lifetime Lifetime refers to services obtained during the member's life, including services provided under any other health insurance.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Glideabout chairs	Y	DME	Y		Y			If Plan determines that patient's condition is such that there is a medical need for this item and it has been prescribed by patient's physician in lieu of a wheelchair, coverage is limited to those rollabout chairs having casters of at least five (5) inches in diameter and specially designed to meet the needs of ill, injured or otherwise impaired individuals; coverage is not intended to extend to the wide range of chairs with smaller casters as found in general use at home, offices and institutions for many purposes not related to the care or treatment of ill or injured persons. *CROSS REFERENCE - WHEELCHAIRS*
Glucose Monitor (Glucometer)	Y	DME	Y					Covered for both Type I and Type II DM, regardless of insulin dependence – used for greater control over blood sugars. Need to obtain from Group's contracted Supplier. *CROSS REFERENCE - CONTINUOUS GLUCOSE MONITORING*
Glucose test strips	Y	Pharm	N					Covered under pharmacy benefit – three months Supply allowed at one time with three co-payments each. Covered for all types of diabetes, including diet controlled.
Gradient pressure dressings	Y	Sply	Y					Supply - Used to reduce hypertrophic scarring and joint contractures following burns.
Granulocyte colony-stimulating factor G-CSF	Y	Tinj	Y					
Granulocyte-macrophage colony-stimulating factor GM-CSF	Y*	Tinj	Y		Y			*Case-by-case review to determine medical necessity.
Group therapy	Y**	BHOP	Y					**Refer to OptumHealth Behavioral Solutions of California. Case-by-case based on medical necessity with no limitations.
Growth hormones for Adults or Children	Y	Tinj	Y		Y		Y	See WHA Pharmacy Prior Auth Criteria
GYN laparoscopy	Y	OPS	Y					
Gynecomastia-male (surgery for)	N*	N/A	N/A					Surgery for gynecomastia is generally found to be cosmetic and not a covered benefit. In rare cases it may be medically necessary *Mastectomy for males is appropriate for breast malignancy or as part of gender reassignment *See - TRANSGENDER SERVICES*
GYN yearly exam	Y	OV	N					Patients allowed to self-refer; may use Advantage Referral.
H-WAVE Stimulator	Y	DME	Y		Y			*See - ELECTRONIC NERVE STIMULATOR*

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Habilitative Services (different from Rehabilitative)	Y*	OPS	Y					Covered when medically necessary, to assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. Habilitative services may be needed for persons born with a certain medical condition (such as cerebral palsy, muscular dystrophy) who never had the abilities requiring services to improve function. Rehabilitative services are for those persons who need services to improve or restore functions/abilities they once had, but were diminished due to injury, illness, disease, etc.
Hair transplants	N	N/A	N/A					Cosmetic – Benefit Exclusion
Hammertoe surgery	Y	OPS	Y					Must be medically necessary.
Harmony Non-invasive Prenatal Genetic Testing for Aneuploidies	Y*	Oplab	Y					*Case-by-Case basis. Harmony non-invasive prenatal genetic testing for pregnant women may be covered when appropriate. Indications for considering the use of cell free fetal DNA are: • Maternal age 35 years or older at delivery • Fetal ultrasonographic findings indicating an increased risk of aneuploidy • History of prior pregnancy with a trisomy positive test result for aneuploidy, including first trimester, sequential, or integrated screen, or a quadruple screen • Parental balanced Robertsonian translocation with increased risk of fetal trisomy 13 or trisomy 21 *CROSS REFERENCE - GENETIC TESTING*
Health education, classes	Y*	OV	Y					*Case-by-Case review. Covered benefit for diabetics to teach self-management of their disease within the network. Other health education classes may also be a covered benefit if disease-specific education is recommended. WHA members may attend health education classes hosted by other contracted entities.
Hearing aid	N*	Sply	Y					*Only covered for a few groups Check EOC and co-payment summaries for coverage details. If covered, usual benefit has a dollar limit and minimum wait time for replacement. Must obtain hearing aid from TruHearing. Brand name “Esteem” is considered a hearing aid device even though it is secured internally behind the ear. Audio Shoe or Semi-Implantable Electromagnetic Hearing Aids are NOT A COVERED BENEFIT *CROSS REFERENCE - BONE ANCHORED HEARING AID and COCHLEAR IMPLANT*

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Hearing testing/screening	Y*	Ophear	Y					Performed to determine status of member's hearing when physician feels assessment is needed. Check member's co-pay summary for coverage details. *If newborn has a hearing loss, test/screening has no cost-share (i.e., no co-pay) under Preventive Health regs. Group risk.
Heart catheterization/coronary Angiogram	Y	OPS or HIP	Y					
Heart transplantation	Y	HIP	Y	Y	Y	Y		Usually performed at UCSF. Medical group to send evaluation to WHA for transplant authorization decision. *CROSS REFERENCE - TRANSPLANT*
Heart-lung transplant	Y	HIP	Y	Y	Y	Y	Y	Usually performed at UCSF. Send evaluation to WHA for transplant auth decision.
Heart-lung-liver transplant	N	N/A	N/A	Y			Y	Considered Experimental/Investigational by Hayes.
Hearts, artificial and assist devices	Y	HIP	Y	Y	Y	Y	Y	
Heating lamps	Y	DME	Y					Approved if medical staff determines patient's medical condition is one for which the application of heat in the form of a heating lamp is therapeutically effective. Over the counter items are not covered benefits.
Heating pad, electric	Y	Sply	N					Supply - Standard heat pad only. Approved if medical staff determines patient's medical condition is one for which the application of a heat pad is therapeutically effective. Over the counter items are not a covered benefit.
Heel wedge/lifts	Y	Sply	Y					Supply - Cover for conditions causing leg length problems
Hemodialysis equipment	Y	DME	Y					PA for initial request only, can auth for 6 months if eligibility checked
Hemophilia, blood clotting factor	Y	Oplab	Y					
Hepatitis B vaccine for infants	Y	IMM	N					Follow American Academy of Pediatrics (AAP) guidelines.
Hepatitis C medications	Y*	IMM	Y					New FDA approved drugs in 2014 require that patient has validated liver damage (St 2, 3 or 4) via Fibroscan Ultrasound or liver biopsy results.
Hernia repair (Herniorrhaphy)	Y	OPS	Y					
Heroin Detox	Y**	N/A	Y					** Refer to OptumHealth Behavioral Solutions of California.
HiB vaccine (Hemophilus Influenza)	Y	IMM	N					
High Dose Chemotherapy Treatment	Y	HIP or HOP	Y	Y	Y	Y	Y	
High-frequency chest wall compression (HFCC) – vibration vests								*See - CHEST PERCUSSORS*
Hip Resurfacing Hip Resurfacing using Computer/Robotic Assist	Y N	HIP N/A	Y N/A		y		Y Y	Resurfacing is standard of care. Computer assist THR or resurfacing is considered experimental. *CROSS REFERENCE - TOTAL HIP REPLACEMENT*

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
His bundle study	Y	test	Y					May be approved for the following conditions: Patients with complex ongoing acute arrhythmias; patients with intermittent or permanent heart block in whom pacemaker implantation is being considered; those who have recently developed heart block secondary to myocardial infarction; and heart catheterization, endocardial electrical stimulation.
Histocompatibility testing (HLA – Human Leukocyte Antigen)	Y	test	Y					May be allowed in preparation for a kidney or bone marrow transplant; in preparation for blood platelet transfusion; or for those patients who are suspected of having ankylosing spondylitis (when other methods are not appropriate or have been inconclusive).
HIV – viral load testing	Y	Oplab	N					
HIV testing	Y	Oplab	N					
HLA-DNA typing	Y	Oplab	Y		Y			Must be medically necessary.
Holtor monitor (cardiac)	Y	DME	Y					Included in initial PA if part of surgery or after-care, and if done through network cardiologist office.
Home birth delivery	N	N/A	N/A					Benefit Exclusion Network Nurse Midwife assist okay, but must deliver in licensed, network facility, not at home or in non-contracted birthing center.
Home Health Care (i.e., part-time/intermittent skilled nursing; PT, OT, ST; social worker visits, infusion therapy & HH aide services)	Y	HH	Y					See patient's individual EOC for specific HH coverage benefits and limitations. Benefits usually limited to 100 total visits per calendar year (total includes nursing, therapy, infusion therapy, & social service visits as medically necessary). HH aide services may be covered on an intermittent, temporary basis if part of the skilled nursing care plan (no more than 4 hrs/day). HH aide care up to 4 hrs counts as 1 visit. Skilled care (ex: Nurse, ST/PT/OT) are covered up to 3 visits per day, with a 2 hour limit per visit. Each visit is counted separately toward 100 visits per maximum allowed per year. Services must be prescribed by a plan physician and provided in the member's home (location must be within the qualifying service area). Rehab therapies (ST, OT, PT) are covered when medically necessary; patient must be making progress. See WHA's "Home Health Care Services" policy & procedure for more details. **Custodial, respite care or private duty nursing (shift care) are <u>not</u> covered in any setting.**
Home Health Infusion (Intravenous Therapy)	Y	HH	Y					
Home health mental health care	Y	BHOP	Y					Refer to OptumHealth Behavioral Solutions of California.
Home modifications	N	N/A	N/A					Benefit Exclusion Includes any ramps, structural assessments, construction, etc.
Homeopathic Treatment/Service	N*	N/A	Y					*Not typically a covered benefit, but category is sometimes too broad to deny outright; review individual request to make sure treatment/service is truly an alternative method and not the current standard of care. (e.g., some reviewers may believe acupuncture falls into this category, yet it is now an acceptable alternative treatment that is a covered benefit through Landmark for most members) Functional medicine would fall under this category

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Home oxygen therapy for migraine and/or cluster headaches								*See - OXYGEN AND SUPPLIES*
Home oxygen/Supplies								*See - OXYGEN AND SUPPLIES*
Home phototherapy - Bili Light (fluorescent lamp, bili blanket & wallaby blanket)								*See - PHOTOTHERAPY*
Home uterine activity monitoring (i.e., TOCOS)	Y*	DME	Y		Y	Y		*Case-by-case review using InterQual and/or Milliman criteria. *CROSS REFERENCE - TOCOLYTIC THERAPY*
Hormone assay	Y	Oplab	Y					Blood test
Hormone therapy for prostatic cancer	Y	Tinj	Y		Y	Y		
Hospice	Y	HIP or HH	Y					Pt must be terminal and require palliative care only; (e.g. the Member's life expectancy is six months or less). Hospice services must be provided in the Member's home or facility within the network/service area. See EOC
Hospital based birthing room	Y	HIP	Y					Network Midwives are a covered benefit if delivery services provided in qualified WHA Network facility.
Hospital beds/ - standard - semi-electric - electric	Y	DME	Y					Covered for patients with conditions requiring frequent positioning of the body. If special attachments needed, requires physician Rx. Electric powered bed may be covered if medically necessary. (Overbed tables <u>not</u> covered; considered a convenience item) *CROSS REFERENCE - DME*
Hospital Bed Side Rails	*Y	DME	N					*Case-by-Case. Side rails may be covered when they are an integral part of, or accessory to, a hospital bed.
Hospital services in connection with dental care	Y	HIP or HOP	Y		Y			Medically necessary services only *CROSS REFERENCE - DENTAL CARE ANESTHESIA.*
Hoyer lift	Y	DME	Y					Covered for therapeutic use with patients who suffer from conditions such as muscular dystrophy or other neuromuscular diseases when it has been determined that the patient will benefit from the device therapeutically.
HPV testing	Y	test	N					HPV testing provided at no charge to women when done every 3 years starting at age 30.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
HPV Vaccine	Y	IMM/ Pharm	N					FDA-approved HPV immunization covered based on ACIP recommendations. As of June 2019 – for ages 9 -26 years for girls and boys. For Adults Aged 27 through 45 Years: - Vaccination Consideration: HPV vaccination can be considered for some adults aged 27 through 45 years who are not adequately vaccinated. CDC recommends that these adults discuss with their healthcare provider whether HPV vaccination may be beneficial for them, as many in this age group may have already been exposed to HPV. Special Populations: - Immunocompromised persons (including those with HIV infection) who are vaccinated before their 15th birthday should receive a three-dose series, due to their increased risk of HPV infection and related diseases. This is all ages and is based on provider- patient discussion after risk assessment for cervical cancer. ***See Pharmacy Prior Auth Criteria on WHA website***
Human chorionic gonadotropin (HCG) or other drugs for purpose of weight control	N	N/A	N/A					Benefit Exclusion
Humidifier (oxygen or CPAP)	Y	DME	Y					Covered if a medical humidifier has been prescribed for use in connection with medically necessary durable medical equipment for purposes of moisturizing oxygen (ex: with CPAP). May cover non-heated (E0561) or heated humidifier (E0562) when ordered by treating physician for use with covered CPAP device. Document med necessity; candidates for heated humidity may include: pts prone to mouth leaks, pts with chronic nasal symptoms, the elderly, and pts taking meds which may results in dryness of nasal mucosa (e.g., anti-hypertensive drugs, antidepressants). *CROSS REFERENCE - CPAP*
Humidifier (room or central)	N	N/A	N/A					Not a covered benefit
Hydraulic lift (seat/sling)								*See - HOYER LIFT*
Hydrogen Breath Test for SIBO	N	N/A	N/A					Experimental / investigational for evaluation of small intestine bacterial overgrowth (SIBO)
Hydrophilic contact lenses, corneal bandage	Y	Pros	Y					Prosthetic *CROSS REFERENCE – CONTACT LENSES*
Hyperbaric oxygen therapy (HBO)	Y	HIP	Y					
Hypodermic injectors	Y	Pharm	Y					For diabetic only – pharmacy benefit

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Hypoglossal Nerve Stimulator	Y	OV or OPS	Y					Effective 3/1/2024, this is a covered benefit if the device is Food and Drug Administration (FDA)-approved status. Hypoglossal nerve neurostimulation (e.g., Inspire II System, Inspire 3028 system for Upper Airway Stimulation (UAS) Therapy) medically necessary for the treatment of moderate to severe obstructive sleep apnea when all of the following criteria are met: • Member is 18 years of age or older; *and* • Body mass index (BMI) is less than 35 kg/m2; *and* • A polysomnography (NPSG) is performed within 24 months of first consultation for Inspire implant; *and* • Member has predominantly obstructive events (defined as central and mixed apneas less than 25% of the total AHI); *and* • Apnea hypopnea index (AHI) is 15 to 100 events per hour attended NPSG; *and* • Member has a minimum of one month of CPAP monitoring documentation that demonstrates CPAP failure (defined as AHI greater than 15 despite CPAP usage) or CPAP intolerance (defined as less than 4 hours per night, 5 nights per week); *and* • Absence of complete concentric collapse at the soft palate level as seen on a drug-induced sleep endoscopy (DISE) procedure; *and* • No other anatomical findings that would compromise performance of device (e.g., tonsil size 3 or 4 per tonsillar hypertrophy grading scale) • Inability to use PAP greater than5 nights per week; use is defined as greater than 4 hours of use per night
Hyperthermia for treatment of cancer	N	N/A	N/A			Y		Considered Investigational/experimental by Hayes for whole body hyperthermia to treat cancer.
Hysterectomy with or without robotic assistance	Y	HIP	Y		Y			
Hysterectomy, sterilization without medical underlying diagnosis	Y	HIP	Y					Can only be performed for an underlying medical condition. Not a benefit if sole reason is for sterilization. May be covered for gender reassignment surgery *See - TRANSGENDER SERVICES*
Ilizarov method (type of bone lengthening process)	Y	HIP	Y		Y			
Imitrex- oral, injections or spray (Migraine Headaches)	Y	Pharm	Y					Oral meds and spray - paid under pharmacy benefit. Injectables - paid under medical benefit <u>Note</u>: If member requires greater amount of medication per month than the limitations – ordering physician must submit statement/letter of medical justification to WHA for review by WHA Medical Director/Pharmacist.
Immobilizer, extremity	Y	DME	N					

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Immunizations, routine/age specific	Y	IMM	N					Per AAP and CDC guidelines. As ordered and deemed medically necessary by MD. Includes Hepatitis A & B, HPV and Meningitis (if medically appropriate for at risk population).
	Y	Pharm	N					*Effective 6/1/2024,* members that are 9 years old or older may get routine immunizations that are recommended by ACIP at a contracted OptumRX pharmacy. Some of these vaccines include tetanus, diphtheria, pertussis (Tdap); human papillomavirus (HPV); measles, mumps, and rubella; pneumococcal; meningococcal.
Employer request Travel Request	N Y		N/A N					*CROSS REFERENCE - TRAVEL IMMUNIZATIONS*
Immunology – transfer factor	N	N/A	N/A					
Immunosuppression therapy	Y	HIP or HOP	Y		Y			Involves the administration of drugs that reduce the activity of the body's immune system. Given after Transplant surgery and to halt the progress of autoimmune disorders.
Immunotherapy for frequent aborters (Intravenous Immunoglobulin)	N*	N/A	N/A	Y	Y			*Considered Experimental / Investigational
Immunotherapy for malignant disease	Y*	HIP or HOP	Y					Stimulation of the immune system to treat cancer. *Case-by-Case review by WHA if no other options available to member.
Impotence treatment, devices								*See - PENILE PROSTHESIS*
Impotence, diagnosis	Y	OV & Oplab	Y					
Impotence, pharmacological treatment	Y	Pharm	Y	Y	Y			limits on amount dispensed
Incontinence treatment, mechanical/hydraulic devices (implanted artificial urinary sphincters)	Y*	HIP	Y		Y	*	Y	*Case-by-case review
Incontinent Supplies (Diapers, Chuxs)	N	NA	N/A					Benefit Exclusion
Induced lesions of nerve tracts	Y	HIP	Y		Y		Y	Used to control chronic or acute pain primarily for terminal cancer, trigeminal neuralgia or lumbar degenerative arthritis.
Infant apnea monitors	Y	DME	Y					Case Management recommended for long-term use; continued authorizations based on event recording documentation.
Infant formulas								*See - ENTERAL/PARENTERAL NUTRITION*

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Infertility testing and related services	Y*	OV & Oplab	Y		Y			*Always verify specific Infertility Benefits for each member as they vary by plan. Infertility benefits may be included in the plan or as a separate rider. Note – Diagnosis of Involuntary Infertility must be confirmed by a qualified provider. If no infertility benefits, infertility drugs are not covered either. Lifetime refers to services obtained during the member's life, including services paid privately or provided under any other health insurance. Note: For CalPERS IUI ***only***: "Lifetime" refers to any attempts, treatments or services rendered during the member's coverage under a Western Health Advantage plan at any time during
Infertility – pharmacologic treatment Including Male infertility injectables	Y	Pharm	Y		Y			If member does not have Infertility Benefits then infertility meds are an exclusion. Under Infertility Benefit – coverage includes: • Oral meds: Pharmacy benefit • Injectables: Medical benefit • Male injectables: Medical benefit w/a 50% co-pay are covered with NO limitations/cycles, etc.
Infertility – surgical treatment including reversals	N	OPS	N/A					Benefit Exclusion: services/supplies to reverse voluntary surgical induced infertility (i.e., tubal ligation and vasectomy reversal surgeries are not covered benefits).
Infusion pumps, external	Y	DME	Y		Y			Also see Insulin Pumps if appropriate
Infusion pumps, implantable	Y	OPS	Y		Y			
Inhalators (nebulizers)	Y	DME	Y					If patient's ability to breathe is severely impaired
Injectable medications	Y	Tinj	Y					Most injectables, with the exception of insulin, require prior authorization by the Medical Group or WHA's Pharmacist. If the injectable medication is approved, all related supplies will also be approved. Self injectables are Plan risk for most groups. *CROSS REFERENCE – ALLERGY INJECTIONS*
Injectable – THERAPEUTIC	Y	OV or Tinj	N/A					When an office visit and therapeutic injectable are required during the same office visit, the higher co-pay of the two is the only payment to be made by the patient.
Inpatient Alcohol/Substance Abuse Rehabilitation programs (i.e. Betty Ford Center, etc)	**	BHIP	Y					**See EOC for coverage details; refer to OptumHealth Behavioral Solutions of California.
INR, Home Testing / Monitoring	Y	DME	Y					Refer to MCG or Medicare NCD for criteria

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Insulin and associated Supplies Non-insulin dependent diabetic	Y Y	Pharm DME (monitor) 	Y Y					If the patient has a pharmacy benefit, insulin, syringes, needles, lancets, and other miscellaneous Supplies (to administer insulin or operate glucometer) are covered under the pharmacy program and co-payments are per the patient's plan requirements under "Brand Name" drugs. Blood Glucose Monitors are covered under DME and all applicable co-payments apply. Prior auth is only needed for blood glucose monitors, which must be obtained from Group's contracted Supplier. Prescription is all that is needed for pharmacy Supplies, which must be obtained from contracted pharmacy. If the patient does not have a pharmacy benefit, it is covered by medical benefit (mandated by law). Insulin, Glucometers are covered under DME benefit.
Insulin injectors without needles	Y	Pharm	Y		Y			Generally used when a patient can no longer find a suitable site for injection. Pharmacy benefit
Insulin pumps, external	Y	DME	Y		Y			For adults, pregnant women, and adolescents with type 1 diabetes who have not achieved optimal glycemic control with multiple daily injections or who find it difficult to administer or comply with multiple daily injection therapy. Replacement pumps are considered medically necessary if no longer covered under warranty, malfunctioning, and can't be refurbished/repaired.
Insulin pumps, implantable	Y	HIP or HOP	Y		Y			For implantable insulin pump therapy for patients with insulin-dependent (type 1) diabetes mellitus who have not achieved adequate glycemic control with intensive SC insulin therapy via MDI or external insulin pump For implantable insulin pump therapy for patients with insulin-requiring non-insulin-dependent (type 2) diabetes mellitus who have not achieved adequate glycemic control with intensive SC insulin therapy via MDI or external insulin pump
Integra, artificial skin	Y	HIP	Y		Y	Y		
Interferon (Betaseron) Beta-1b	Y	Tinj	Y		Y			
Interleukin II therapy	Y	Tinj	Y		Y			
Intermittent positive pressure devices (HIPPB)	Y	DME	Y					
Intestinal bypass surgery, treatment for obesity								*See - BARIATRIC SURGERY*
Intracardiac catheter ablation	Y	HIP	Y					*See - ABLATION, CARDIAC*
Intracavernosal injections for the diagnosis and treatment of organic impotence	Y*	HOP	Y		Y			*Case-by-case review
Intracranial depth electrodes	Y	HIP	Y					Generally considered to be part of the surgical procedure and cannot be unbundled.
Intradialytic parenteral nutrition, hemodialysis patients								See parenteral nutrition.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Intraocular lenses (*except* Toric, Crystalens, ReStor lens)	Y*	Pros	Y					Prosthetic – Used to replace an eye lens that has been removed because of cataract, disease, trauma or is congenitally absent (aphakia). Standard IOLs only are covered for cataract removal patients. *Note: Toric lenses (to correct astigmatism), and Crystalens and Restor intraocular lenses are considered premium lenses (i.e., not standard). The latter are meant to reduce the need for reading glasses after cataract surgery, which is a "convenience item" and therefore not medically necessary. *CROSS REFERENCE - CATARACT EXTRACTION*
Intraocular photography	Y	test	Y					
Intraoperative ventricular mapping	Y	HIP	Y		Y			The objective of the mapping is to find the site of tachycardia for operative intervention.
Intraspinal delivery of morphine for chronic intractable pain of malignant or non-malignant origin	Y	HIP	Y				Y	
Intraoperative facial nerve monitoring	Y	HIP	Y					
Intrauterine device (IUD) (Contraception/birth control)								*See - CONTRACEPTIVES*
Intravenous immune globulin (IVIG)	Y	HIP or HOP	Y		Y			See WHA Pharmacy Prior Auth Criteria
Intravenous pyelogram (IVP)	Y	HOP	Y					Procedure must meet criteria
In-utero fetal surgery	N*	N/A	Y	Y	Y	Y	Y	*Varies by procedure.
In-vitro fertilization and associated drugs (IVF)	*	OPS	Y					*Check for separate insurance rider. Benefit not provided under Medical insurance. If covered, may have one Gamete intra-fallopian transfer (GIFT) or IVF per lifetime. (Lifetime is defined to include services provided under any HMO plan or any other health insurance or any other payment method.) *Some Plans do not cover IVF, but offer artificial insemination services (there is a difference). Check coverage carefully.
Ionic versus nonionic contrast agents	Y	test	Y					
Irrigating kit and supplies	Y	Sply	Y					Non-reusable Supply: hygienic item, approval with medical necessity
Iontophoresis	N*	OPS	N/A	Y	Y			*Standard of care for hyperhidrosis only. Most other uses are still experimental/investigational. Refer to WHA for review.
Isolated Intestinal Transplant	Y	HIP	Y	Y	Y	Y	Y	Case by case review
iStent	Y	OPS	Y		Y			
ITI mechanical percussor	Y	DME	Y					*CROSS REFERENCE - CHEST PERCUSSORS*
IV stand/pole	Y	DME	Y					If medically indicated
"Jobst" pressure garments (medical Support hose)								*See - COMPRESSION GARMENTS*
Jobst pneumatic appliances	Y	DME	Y					If the appliance(s) has been prescribed for use with a medically necessary Jobst pneumatic compressor Covered if patient had intractable edema of the extremities

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Joint aspirations, injections	Y	HOP	N					
Joint Replacement Surgery	Y	HIP	Y					Covered benefit based on medical necessity for knee, hip, shoulder, etc.
Keratoplasty	*	OPS	Y	*				*Covered only when medically necessary, otherwise may be considered Experimental. (Ex: penetrating keratoplasty may be medically necessary to improve poor visual acuity due to opaque cornea or to restore corneal structure after injury/persistent infection, but is considered experimental if solely to correct astigmatism or other refractory error. Keratoplasty is not covered when adequate vision can be achieved with glasses or contact lenses.
Keratotomy	N	N/A	N/A					Not a covered benefit.
Ketogenic diet for seizure control	Y	Sply	Y	Y	Y			
Kidney transplantation	Y	HIP	Y	Y	Y	Y	Y	UCD or UCSF usual centers used for WHA members. Medical group to forward completed evaluation to WHA for Transplant prior auth. *CROSS REFERENCE - TRANSPLANTS*
Kidney-pancreas transplantation	Y	HIP	Y		Y	Y	Y	Probably performed at UCSF
Knee immobilizer	Y	DME	N					Covered – requires establishment of medical necessity.
Kinetic leg exercisers (CPM)	Y	DME	Y					1-6 weeks
Kyphoplasty	Y	HIP	Y		Y		Y	Investigational/Experimental for some uses
Labiaplasty	Y*	OPS	Y	Y				*Traditionally cosmetic and not a benefit. However, review for medical necessity on a case-by-case basis.
Lactation consultant								*See - BREASTFEEDING, SUPPLIES, SUPPORT & COUNSELING*
Laminectomy (cervical or lumbar vertebrae)	Y	HIP	Y					See InterQual and/or MCG criteria – generally approved if patient fails conservative treatments.
Lancets – diabetic monitoring	Y	Pharm	N					Covered under pharmacy benefit at generic co-pay for Members' Rx plan. If no Pharm benefit, cover under DME.
Laparoscopic Surgery								Use MCG or InterQual for criteria
Laryngectomy Supplies	Y	Sply	Y		Y			Supply
Larynx-artificial	Y	Pros	Y					Prosthetic
Laser angioplasty	Y	HIP	Y		Y			Use MCG or InterQual for criteria
Laser Dye Therapy – Pulsed [PDL]								*See - PULSE DYE LASER*
(Scanning) Laser Polarimetry for Detection and Monitoring of Glaucoma								*See - SCANNING LASER POLARIMETRY*
Laser prostatectomy for benign prostatic hyperplasia	Y	OPS	Y	Y	Y			
Laser surgery	Y	HIP or OPS	Y		Y			Procedure must meet criteria and not be investigational. *CROSS REFERENCE - PULSE DYE LASER*
Laser Trabeculoplasty	Y	HIP or OPS	Y					Indicated for open angle glaucoma when patient fails medical treatment by: - Target intraocular pressure cannot be reached medically. - Optic nerve damage continues despite reaching intraocular pressure goals. - Patient is unable to comply with or tolerate medical therapy.
Laser uvulopalatoplasty	Y	OPS	Y		Y		Y	Use MCG or InterQual for criteria
Lasik surgery (PRK) - eye								*See - PHOTOREFRACTIVE KERATECTOMY (PRK)*

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Lenses (contact) and glasses								*See - EYEGLASSES, CONTACT LENSES*
LifeVest System (external/wearable Cardiac Defibrillator to prevent sudden cardiac arrest)	Y	DME	Y		Y			*See - WEARABLE CARDIOVERTER / DEFIBRILLATOR VEST*
Lifts- electric, hydraulic, etc (Patient Lifts)								*See - HOYER LIFT*
Ligation or Deformities of fallopian tube(s)								*See - TUBAL LIGATION*
Light therapy for seasonal affective disorders (SAD)	N	N/A	N/A					
Liposuction	N*	N/A	N/A					*Generally cosmetic – Benefit Exclusion, but in some cases may be part of a medical repair/correction or reconstructive procedure deemed medically necessary.
Liquid protein diet	N	N/A	N/A					Benefit Exclusion
Lithotripsy	Y	OPS	Y					Procedure must meet criteria
Liver transplantation	Y	HIP	Y	Y	Y	Y	Y	Usually performed at UCSF for WHA members. Medical group to send completed evaluation to WHA for Transplant prior auth decision *CROSS REFERENCE - TRANSPLANTS*
Liver-kidney transplantation	Y	HIP	Y	Y	Y	Y	Y	Usually performed at UCSF for WHA members. Medical group to send completed evaluation to WHA for Transplant prior auth decision *CROSS REFERENCE - TRANSPLANTS*
Long-term care services (custodial or maintenance)								*See - CUSTODIAL CARE*
Loop electrosurgical excision procedure (LEEP)	Y	HIP	Y		Y			
Lumbar disc disease – diagnosis	Y	OV & Oprad	Y					Use MCG or InterQual for criteria
Lumbar Traction – Saunders, etc.								See - *TRACTION DEVICES*
Lung reduction surgery for chronic obstructive pulmonary disease	N*	N/A	Y	Y	Y	Y	Y	*Considered medically necessary in specific cases.
Lung transplant	Y	HIP	Y	Y	Y	Y	Y	Refer to UCSF. Medical group to send completed evaluation to WHA for Transplant prior auth decision. *CROSS REFERENCE - TRANSPLANT*
Lupron depot injections	Y	OV	Y					
Lyme disease – diagnosis	Y	Oplab	Y		Y			The laboratory tests currently in use are 1) indirect fluorescent antibody test (IFA) and more frequently, 2) enzyme-linked immunosorbent assay (ELISA) test.
Lyme disease – treatment	Y	OV	Y		Y			Case Management may be required if patient has chronic arthritic Lyme or chronic Lyme neuroborreliosis.
Lymphadema clinic/massage therapy	Y	Opreh	Y		Y			
Lymphedema pumps	Y	DME or Sply	Y					See MCG for criteria *CROSS REFERENCE - COMPRESSION GARMENTS*
Lymphocyte immune globulin therapy	Y	HIP or HOP	Y		Y	Y		Used primarily for rejection therapy in conjunction with conventional immunosuppression therapy after transplantation, as well as for patients with severe aplastic anemia and a suitable bone marrow donor cannot be found.
Magnetic resonance angiogram (MRA)	Y*	Oprad	Y	Y	Y			Use MCG or InterQual for criteria

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Magnetic resonance imaging – surface coil devices	Y	Oprad	Y					Follow MCG, InterQual or radiology guidelines
Magnetic resonance imaging – gating techniques	Y	Oprad	Y					Follow MCG, InterQual or radiology guidelines
Magnetic resonance imaging (MRI)	Y	Oprad	Y					Follow MCG, InterQual or radiology guidelines
Magnetic resonance venography	Y	Oprad	Y		Y			Approved uses are: preoperative evaluation in portal hypertension, post-surgical follow-up for portocaval and splenorenal shunts, patients in whom eformit material cannot be administered due to adverse reactions or lack of venous access, patients at risk for deep vein thrombosis, such as following acetabular fracture or orthopedic surgery, and for patients in whom vascular disease is suspected but contrast venography findings are normal.
Makoplasty (surgical robotic assistance)	*	N/A	*	*	*		Y	Effective July 1, 2023, the following procedure is covered: • Makoplasties, hip/knee surgeries with robotic assistance *CROSS REFERENCE- ROBOTIC ASSISTED PROCEDURES/SURGERY*
Mammogram (diagnostic)	Y	Oprad	Y					
Mammogram – 3D / tomosynthesis	Y	Oprad	Y					3D Mammograms are not experimental for evaluation in dense breasts. 3D Mammograms are considered Experimental / investigational for all other indications.
Mammogram (screening and preventative) – *routine*	Y	Oprad	N					Frequency based on risk factors, beginning at 35 years of age a screening mammogram can be done every one to two years.
Mammogram – Automated Whole Breast Ultrasonography	N	Oprad	Y					Not medically necessary if ordered as a routine precaution when regular mammogram results are inconclusive due to dense breast tissue only. The standard of care would be a screening ultrasound, possibly directed toward areas of concern. If patient is high-risk, with lifetime risk of breast CA, MRI of breasts may be warranted.
Mammoplasty, augmentation	N	N/A	N/A					Cosmetic – Benefit Exclusion
Manometry, esophageal	Y	test	N					
Marriage and family counseling	Y**	BHOP	Y					**Refer to OptumHealth Behavioral Solutions of California.
Masks - oxygen - surgical	Y	Sply	N					Supply
Massage therapy	N	N/A	N/A					Not a benefit except for treatment of lymphedema *See - LYMPHEDEMA*
Mastectomy bra	Y	Pros	Y					Covered up to 3 brassieres required to hold a Prosthetic Device per year.
Mastectomy prosthesis	Y	Pros	Y					Prosthetic – Covered after mastectomy, up to 3 inserts per year unless growth occurs or medical condition changes requiring additional consideration.
Mastopexy	N	N/A	N/A					Cosmetic surgery – Benefit Exclusion

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Maternity care and delivery	Y*	HIP	Y*					*After initial pregnancy diagnosis, pre- & post-natal visits, lab tests, and necessary/related ultrasounds, no co-pays for member. Note: Co-pays & deductibles for hospital delivery and applicable pro-fees related to delivery still apply.
Mattress – - Air - Floatation - Gel - Pressure	Y	DME	Y					Covered only where hospital bed is medically necessary. (Separate charge for replacement mattress should not be allowed where hospital bed with mattress is rented.)
Maxi-Mist	Y	DME	Y					Covered if patient's ability to breathe is severely impaired
Medical social worker- MSW	Y	OV	N					May be provided under Home Health services
Medical Supplies	Y	Sply	Y					Supply; except for disposable incontinence items such as diapers, Chux bedliners, etc.
Med injectors	Y	Pharm	Y					Pharmacy benefit
Medically Supervised replacement formula for morbid obesity treatment (ex; Medifast)	N	N/A	N/A					Benefit Exclusion
Meniscal allograft	N*	N/A	Y	Y	Y			*Considered Investigational/Experimental. Case-by-Case review by WHA if no other options available to member.
Metatarsal bars	Y	Pros	Y					Prosthetic
Methadone treatment	Y	N/A	Y		Y			Usually for Heroin addiction
Microarray	Y	Test	Y					Genetic test. Requires genetic counseling prior to test. Medically necessary when results will affect treatment plan. See MCG, InterQual or IDNA (available from WHA) for criteria.
Micromanipulation for male factor infertility	Y	OV	Y	Y	Y		Y	*Always verify specific Infertility Benefits for each member as they vary by plan. Infertility benefits may be included in the plan or as a separate rider. Approved for low sperm count, malformed sperm, reduced viability of sperm, or a combination of the three.
Midwives, nurse	Y	HIP	Y					When available in WHA network and approved by medical Group. Services must be provided at a WHA contracted birthing center. *Home delivery births are NOT a covered benefit.
Mobile geriatric chair (not the same as motorized scooter)								*See - GLIDEABOUT CHAIRS, WHEELCHAIRS*
Molded ear plugs	Y	Sply	Y					Supply – Approved for chronic otitis media or post-op ear surgery.
Molecular breast imaging (MBI)	N	OPrad	Y	Y	Y		N	Experimental; refer to WHA
Molteno implants	Y	Pros	Y					Prosthetic – Implants for treatment of glaucoma
Monoclonal antibody treatment for gram-negative sepsis	Y	HIP	Y	Y	Y			If approved, follow Infectious Disease Society of America's guidelines.
Morbid obesity surgery								*See - BARIATRIC SURGERY*
Motorized wheelchairs/scooter								*See - WHEELCHAIRS*
MRI								*See - MAGNETIC RESONANCE IMAGING*
Myelogram	Y	Oprad	Y					
Myocardial laser revascularization								See - *TRANSMYOCARDIAL LASER REVASCULARIZATION.*
Myocardial perfusion imaging	Y	Oprad	Y					

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Myoelectric prosthesis	Y*	Pros	Y		Y			*Case-by-case review to determine medical necessity and patient's motivation for use of devices and independence.
Myofacial pain dysfunction syndrome (temporomandibular joint syndrome – TMJ)	Y	OV OPS	Y					Trigger point injections a benefit if medical necessity established.
Myringotomy or tympanostomy	Y	OPS	Y					
Nasal Expiratory Resistance Device (Provent Therapy)								*See – PROVENT THERAPY*
Naturopathic Treatment/Service								*See - HOMEOPATHIC TREATMENT/SERVICE*
Nebulizers	Y	DME	Y					
Neck halter C-collar	Y	Sply	N					Supply
Neonatal hearing test/screening								*See - HEARING TESTING*
Nerve condition studies (EMG etc)	Y	test	N					
Neupogen	Y	Tinj	Y					
Neuromuscular electrical stimulator (TENS/PENS/Interfeential Therapy/H-Wave)								*See - ELECTRONIC NERVE STIMULATOR*
Neuromuscular testing	Y	test	N					An example is an EMG test.
Neuropsychological assessment for infectious disease sequelae	Y	test	Y				Y	Considered appropriate for individuals with suspected cognitive deficits and also for asymptomatic HIV patients who may have symptoms too subtle to be clinically apparent.
Neuropsychological testing	Y	test	Y					Use MCG or InterQual for criteria. .Should be done as outpatient except in exceptional circumstances where necessary to proceed with inpatient treatment.
Neutron radiation therapy (Neutron Beam radiation)	Y	HOP	Y					
Newborn care	Y	HIP	N					Newborn coverage is provided under mother's assigned medical group for first 30 days. During the first 30 days of coverage if a newborn requires care or a prescription, the pharmacy has to bill for the prescription under the mother's name and ID number until the child is assigned his/her own PCP with new ID card. If the pharmacy refuses the only other option is for the member to pay for the prescription and submit the receipt for reimbursement.
Nocturnal airway patency device	Y	Sply	Y					Supply – Used in treatment of sleep apnea
Non-Medical transportation	N	N/A	N/A					Not a covered benefit *CROSS REFERENCE - AMBULANCE SERVICE*
Noninvasive complex lymphedema therapy	Y	HOP	Y		Y			
Non-invasive peripheral vascular diagnostic studies	Y	test	Y					
Non-network facility/physician	Y	HIP	Y		Y			Covered if services not available in WHA network and are prior authorized by the Group's UM.
Non-stress test (NST) – obstetrical	Y	test	N					
Norplant system (insertion/implant contraception methods)								*See – CONTRACEPTIVES,*
Norwood procedure	Y	HIP	Y					Used for treatment of hypoplastic left heart syndrome.
Nose repair (rhinoplasty and septoplasty)	Y	OPS	Y		Y			Not covered if cosmetic – follow InterQual and/or MCG criteria.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Nuclear medicine (radionuclide imaging procedures)	Y	test	Y					
Nutrition – enteral/parenteral therapy								*See - ENTERAL/PARENTERAL SOLUTIONS AND SUPPLIES*
Nutritional counseling and education	Y*	OV	Y					*Case-by-Case review. May be approved if used as an alternative/conservative approach when teaching is required for better patient compliance to treatment regime.
Nutrition Counseling for weight management	Y#	OV	Y					#New benefit 2022: • As of 1/22 - large and small group only (does not include CalPERS). • As of 1/23 – large, small, and individual groups (does not include CalPERS). For BMI>25 or 85th percentile, eating disorder under mental health treatment, weight loss of >20% in prior 12 months due to medical condition. See full criteria and # of visit details in separate document "Nutritional Counseling for Weight Management" Note: CalPERS eligibility for this benefit to be effective 1/1/24
Nutritional Support – oral	Y*	OV	Y		Y			*Case-by-Case review. May be approved based on medical necessity. *CROSS REFERNCE – INFANT FORMULAS AND ENTERAL/PARENTERAL SOLUTIONS*
Obesity, non-surgical treatment	*	OV	Y		Y			*Related services, such as nutritional counseling, can be approved on case-by-case basis if part of a conservative treatment regime, and if provided within WHA Network.
Observation status in Hospital *No prior auth required if direct from ER	Y	HOP	N *					Notification needed within 1 business day for concurrent review; review against InterQual and/or MCG guidelines/other nationally recognized guidelines. ER Co-pay still applies for Observation stays
Obstetrical ultrasound/sonogram								*See - ULTRASOUND, OB*
Occipital Nerve Block	Y	OPS	Y					For treatment of migraines
Occupation related conditions: - Cancers - Respiratory - Injuries - Related Diseases	Y	See specific service	Y					Until established as Workers' Compensation, continue to authorize – report to claims for TPL recovery investigation if Workman's Comp.
Occupational therapy	Y	Opreh	Y					Covered as long as medically necessary. OT – for autistic children or developmental delays may be medically necessary for specific functional needs. Sensory Integration therapy is considered Experimental / Investigational *See - SENSORY INTEGRATION THERAPY*
Office Visit w/injectable	Y	OV or Tinj	N					When a member has an outpatient visit & injectable given during that visit only one co-payment applies (charge member the higher of the two, not both).

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Onco-type testing (genomic assay) – for Early Stage I & II ER+ Breast CA	Y	OPlab	Y					test to assist in developing appropriate treatment plan. *CROSS REFERENCE – BRACANALYSIS*
Oncotype Dx	Y	OPlab	Y		Y			Screening test for prostate cancer – not experimental *CROSS REFERENCE – DECIPHER*
Ophthalmological services	Y	OV	Y					No PA if network provider and done as an office-based procedure; all OP/IP procedures require PA. Patient has direct access (self-refer/no PA) for annual dilated eye exam if member has benefit and service is provided in network.
Optune	Y	DME	Y		Y			For use in patients with Glioblastoma
Oral surgery	Y	OPS	Y		Y			Case-by-case review, as must be medically necessary and not related to a dental condition or dental need.
Oral surgery of the temporomandibular joint (TMJ) or jaw trauma	Y*	OPS	Y					*Please refer to arthroscopy of TMJ joint. This is covered on a case-by-case basis.
Oral vitamins and minerals	N	N/A	N/A					Benefit Exclusion – Except for pre-natal vitamins.
Organ transplants (refer to specific organs)								See specific organ. Complete transplant evaluation before sending transplant request to WHA for authorization.
Orthodontia	*	Pros	Y		Y			*Case-by-case review. Can be approved if part of treatment program for TMJ. *CROSS REFERENCE - DENTAL CARE*
Orthognathic surgery	Y*	HIP	Y		Y	Y	Y	*Case-by-case basis. Approve for deformities of the face, skeletal jaw deformities, jaw disharmony, cleft lip, cleft palate and dento-facial deformities.
Orthopedics								
- Boston back brace	Y	Pros	Y					Prosthetic
- Milwaukee back brace	Y	Pros	Y					Prosthetic
- Knee immobilize	Y	DME	Y					
- Long leg brace	Y	Pros	Y					Prosthetic
- Pelvic harness	Y	Sply	Y					Supply – Covered – approve for congenital hip on newborns. Life span – 12 weeks
- Plastic Support jackets	Y	Pros	Y					Prosthetic
- Prosthesis	Y	Pros	Y					Prosthetic
- Rotator straps	Y	Sply	Y					Supply
- Short leg brace Dennis Brown bar	Y	Pros	Y					Prosthetic
Steel toe guard - Toronto brace	Y Y	DME	Y Y					Supply – Covered – approve for surgical stabilization of metatarsal joint. Not covered for employment – medical necessity only. Covered – approve for Legg Perthes disease. Criteria: if newly diagnosed in 4-10 year olds. Review if case is 2-4 years old.
- Williams	Y	DME	Y					Covered – approve only if patient has first tried a lumbar corset
Orthopedic shoes, braces and appliances	Y	Pros	Y					Prosthetic – Case-by-case review. Braces are a DME benefit, otherwise it is a medical Supply. Shoes are reimbursed if an integral part of the brace. Shoes alone and over-the-counter items (i.e., arch Supports, etc.) are not a benefit. Covered for members with Diabetes.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Orthosis, cranial	Y	DME	Y					Covered for infants post cranial reconstruction surgeries. May be medically necessary for moderate to severe positional cranial deformities in infants May be experimental as a treatment for very severe positional cranial deformity or with associated congenital anomalies.
Orthosis, holo-cerv., bk	Y	DME	Y		Y			
Orthotics	Y	Orth	Y					Case-by-case review to establish medical necessity for specific diagnoses. DMHC requires health plans to cover orthotics for some specific Diagnoses, such as cerebral palsy, spina bifida, neuromuscular deformities, etc To cover, there must be a specific medical necessity reason established for each request One (1) pair of shoes with the device that is needed each time to correct the deformity or medical condition. The intent of the coverage is to provide one (1) functional pair of shoes/device to correct the current medical problem. Cervical orthoses. The cervical orthoses treats cervical disease and injury by influencing the motion of the neck by assisting, resisting, blocking, or unloading part of the head weight. Spinal orthotics. These are usually prescribed for scoliosis, hyper- and hypokyphosis and hyper- and hypolordosis. Limb orthotics. These are used to substitute for absent motor power, to assist weak segments, to Support segments, which require immobilization, to provide traction, or for the attachment of devices. These are usually prescribed for the wrist, thumb, fingers, shoulder, elbow, ankle and the foot. Supportive devices of the feet such as: wedges, heel straps, pads, etc. must be reviewed on a case-by-case basis for medical necessity when there is an underlying foot condition. MCG criteria available Not covered if the item is an "OTC" or related to sports needs where arch supports, metatarsal support, etc. may be necessary.
Osseointegrated hearing device (aka Bone anchored hearing aid - BAHA)								See - *BONE ANCHORED HEARING DEVICE*
Osteopathic Manipulation Treatment (OMT)								*See - CHIROPRACTOR SERVICES*
Osteotomy Supplies	Y	Sply	N					Supply – This is a medical benefit.
Otoplasty	Y	HIP	Y					Request must be accompanied with pictures that demonstrate defect.
Out of Area Student Benefit								*See - STUDENT COVERAGE – OUT OF AREA*
Outpatient IV therapy	Y	HH or HOP	Y					
Outpatient psychotherapy	Y*	BHOP	Y					*Case-by-Case basis. See mental health benefit. Refer to OptumHealth Behavioral Solutions of California.
Overbed Table (for hospital bed at home)	N	NA	NA					Benefit Exclusion. Convenience item

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Oxygen and Supplies - Carts - Humidifiers - Iron Lung - Life-O-gentank - Lindi oxygen – Walker system - Medasphere – Portable - Marx centrator	Y	DME	Y					If long-term, can be authorized in blocks of 6 months, once WHA eligibility for this time frame established. May also be used to treat Migraine Headaches. Review for medical necessity. Covered benefit for COPD patients, if PO2 is 55 on room air. Allow for 2-3 months. Medicare guidelines: 02 needs to be below 55. If PRN order, call physician each month to verify necessity. See home oxygen criteria. Concentrator – non-ambulatory low flow continuous 02 for home bound patient. Requests E-tank as back-up 1-3 liter flow. Liquid – requires high oxygen flow 4-8 liter, ambulatory or active patient that requires portable system for work, etc. H-tank –P02 with e cylinder only. Covered – if patient's ability to breathe is severely impaired.
Pacemaker monitors	Y	DME	Y					
Pain management – HIP and OP	Y	HOP or HIP	Y		Y	Y		May be outpatient or inpatient but most programs are outpatient. Inpatient pain management services require case-by-case review. Long-term inpatient rehabilitation is typically not covered. Check EOC.
Pallidotomy for Treatment of Parkinson's Disease	Y	HIP	Y	Y	Y	Y		Covered for stereotactic pallidotomy.
Pancreas transplantation	Y	HIP	Y	Y	Y	Y		UCD is preferred site Medical group to send completed evaluation to WHA for Transplant prior auth decision *CROSS REFERENCE - TRANSPLANT*
Panniculectomy, body sculpture procedures	*	HIP	Y	Y	Y			*Traditionally cosmetic and not a benefit. However, review for medical necessity on a case-by-case basis. Use MCG criteria.
Papnet testing-see Computer assisted rescreening of pap smears	Y	test	Y					For use of PAPNET and AutoPap as quality control mechanisms and Supplements to conventional microscopic screening of gynecologic smears in the retrospective screening of manually diagnosed negative smears.
PAP smear (routine)	Y	OV	N					Allowed annually and as medically indicated. Annual Pap will now include HPV screening and option of any FDA approved cervical screening test as referred by health care provider.
Paradoxical vocal fold motion - speech therapy for asthmatics	*	OV	Y					*Case-by-Case
Parenteral nutrition solutions and Supplies (Total Parenteral Nutrition – TPN)	Y	HH	Y					Solutions and Supplies covered in full as medical Supplies. Infusion pump and stand covered under DME benefits. Inpatient is part of hospital benefits.
Partial Hospitalization for mental health	Y**	BHOP	Y		Y			Review against BH/MH criteria/practice standards. **Refer to OptumHealth Behavioral Solutions of California.
Patella resurfacing	Y	HIP	Y		Y			Decided during surgery, usually for patients receiving a Total Knee Replacement. Not recommended for patients with osteoarthritis or rheumatoid arthritis.
Paternity testing	N	N/A	N/A					Benefit Exclusion
PDL								*CROSS REFERENCE - PHOTODYNAMIC THERAPY* for Specific Diagnosis
Peak-flow meters	Y	DME	Y	`				
Pectus excavatum reconstruction	*	HIP	Y		Y			*Not covered if for cosmetic reasons only

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Pediatric Gait Trainer (aka Supportive Walker)	Y	DME	Y		Y			May be indicated for under 18 y/o to assist with ambulation due to acquired injury or chronic condition, mod – max support that standard assist devices (ie standard walker or crutches) is not feasible. MCG criteria available.
Penile and testicular Implants	*	Pros	Y					*Prosthetic – Case-by-case review. Covered benefit if medically necessary. Not covered for psychological impotence or transsexual
Percussors	Y*	DME	Y					*Covered for mobilizing respiratory tract secretions in patients with chronic obstructive lung disease, chronic bronchitis or emphysema, when patient or operator of powered percussor has received appropriate training by a physician or therapist, and no one competent to administer manual therapy is available. Not generally recommended for use in treatment of patients in Medicare age group.
Percutaneous electrical nerve stimulation (PENS)								*See - ELECTRONIC NERVE STIMULATOR*
Percutaneous lumbar discectomy (PLD)	Y	HIP	Y					
Percutaneous transluminal angioplasty, obstructive lesions of the aortic arch vessels	Y	HIP	Y	Y	Y			
Percutaneous transluminal angioplasty (PTA), arteriosclerotic obstructions in the lower extremities	Y	HIP	Y		Y			
Percutaneous transluminal angioplasty, arteriovenous dialysis fistulas	Y	HIP	Y		Y			
Percutaneous transluminal coronary angioplasty (PTCA)	Y	HIP	Y		Y			
Percutaneous transluminal renal angioplasty (PTRA), stenotic lesions of the renal arteries	Y	HIP	Y		Y			
Phacoemulsification procedure, cataract extraction	Y	OPS	Y		Y			Allowed as an accepted method for cataract extraction.
Photochemotherapy and phototherapy	Y	HIP or HOP	Y					
Photocoagulation	Y	HOP	Y		Y			Appropriate treatment for exudative senile macular degeneration – reduces risk of severe visual loss.
Photodynamic Therapy for Acne	N	N/A	N/A					Experimental; Not a covered benefit
Photodynamic Therapy for Actinic Keratoses (head, neck, arms and legs only)	Y*	HIP Or HOP	Y		Y			*Covered for non-hyperkeratotic actinic keratoses on the head, neck, arms and legs in patients who have no specific contraindications to treatment. To be reviewed on a Case-by-Case basis when requested for the Arms and Legs.
Photodynamic Therapy for Barrett's Esophagus and Esophageal Cancer	Y	HIP or HOP	Y		Y			For palliation of patients with completely or partially obstructing esophageal cancer who cannot be treated satisfactorily with YAG laser therapy
Photodynamic Therapy for Head and Neck Cancer	N	N/A	Y	Y	Y			Considered Experimental/Investigational by Hayes

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Photodynamic Therapy for Lung Cancer	Y	HIP or HOP	Y		Y			For early-stage, microinvasive endobronchial non-small cell lung cancer in patients for whom surgery and radiotherapy are not indicated. For the reduction of obstruction and palliation of symptoms in patients with advanced-stage, completely or partially obstructing endobronchial non-small cell lung cancer.
Photopheresis- extracorporeal	Y	HOP or HIP	Y		Y			
Photorefractive keratectomy (PRK)	N	N/A	N/A					Benefit Exclusion. PRK & LASIK surgeries are NOT covered benefits.
Phototherapy light and related Supplies (Newborn jaundice)	Y	DME	Y					Home phototherapy for newborn jaundice is covered when medically appropriate and patient does not have risk factors. Follow AAP guidelines. Requires frequent bilirubin levels and possible home nursing for home based phototherapy
Phototherapy unit to treat bipolar disorder	N	N/A	N/A					
Phrenic nerve stimulation	Y	test	Y		Y			
Physical therapy - Inpatient Outpatient - HHC -	Y Y Y	Opreh OV HH	N Y Y					Covered as long a medically necessary. Must show progress.
Placebo injections and drugs	N	N/A	N/A					Not medically necessary
Plantar Fasciitis (Chronic) Extracorporeal Shock Wave Therapy								*See - SHOCK WAVE THERAPY*
Plasmapheresis								*See - APHERESIS*
Plastic/reconstructive surgery								See - *RECONSTRUCTIVE SURGERY*
Plastic Support jacket	Y	Pros	Y					Prosthetic
Play therapy	N	N/A	N/A					Benefit Exclusion
Pneumatic walking splints	Y	Sply	Y					Supply – Benefit when medically necessary and for appropriate post-operative use.
Podiatry services	Y	OV	Y					Limited to medical and/or surgical services medically necessary. Routine nail cutting for patients without an underlying documented peripheral vascular disorder is not covered.
Polypropylene ankle foot orthosis	Y	Orth	Y					For management of congenital deformities and motor dysfunction due to neurological disease.
Polysomnography (sleep studies)								*See – SLEEP STUDIES*
Pool therapy								*See - AQUATIC THERAPY*
Porcine skin dressing	Y	Sply	N					Supply
Portable infusion pumps	Y	DME	Y					Generally approved to increase independence and mobility of patient. Drug must be FDA approved.
Portable laboratory or x-ray	Y	Oprad	N					No prior authorization needed if patient confined to a SNF or ICF emergency portable X-rays subject to retrospective review.
Portable paraffin baths	Y	DME	Y					Request must document that patient has completed a successful trial period of paraffin heat therapy.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Posey products	Y	Sply	Y					Supply – Includes: pelvic holder (breezline), pelvic holder (nylon), tie back vest (breezline), O.R. table body holder, limb holder, head halter, budget vest, safety vest (ties), safety belt, safety roll, belt, mini pelvic holder, "y" wheelchair safety belt. Review for medical necessity. Requires Rx.
Positron Emission Tomography (PET) for: - Neurological Applications - Oncologic Applications - Cardiac Conditions	Y	Oprad	Y		Y			
Post Mastectomy/lumpectomy reconstructive breast surgery								*See - BREAST RECONSTRUCTION*
Posterior rhizotomy (selective) for treatment of spasticity in cerebral palsy								*See - SELECTED DORSAL RHIZOTOMY*
Post-operative visit(s) or postpartum visits	Y	HIP	N					Routine 1-6 week post-natal visit should be included in global surgical or OB fee and already authorized with delivery.
Postural Boards	Y	DME	Y					Covered if patient has a documented pulmonary condition
Postural drainage & pulmonary exercise	Y	HIP or HOP						
Power generators (as back-up for ventilator if electrical power fails)	N	N/A	N/A					Not a covered benefit. Generator is not considered medical equipment by WHA.
Pre-discharge DME	Y*	DME	Y					*If part of hosp discharge order and item meets criteria, charges should not start until day of discharge, even when equipment delivered early for patient/caregiver teaching purposes.
Premarital blood testing	N	N/A	N/A					Benefit Exclusion
Premenstrual syndrome diagnosis and treatment	Y	OV	Y					
Prenatal vitamins	Y	Pharm	N					Pharmacy benefit. OTC vitamins not covered.
Pressure reducing mattress or bed	Y*	DME	Y					*Use MCG Guidelines to review for static or reactive mattress or mattress overlay. Ambulatory guidelines include DME codes.
Pressure relief wheelchair pads	Y	DME	Y					Review if medically necessary to prevent decubiti.
Private duty nursing (shift care)								*See - HOME HEALTH CARE*
Prolastin replacement therapy for emphysema caused by alpha antitrypsin deficiency	Y	HIP	Y	Y	Y	Y		
Prophylactic mastectomy	Y	HIP	Y	Y	Y		Y	Approved for women who are carriers of BRCA1 or BRCA2 gene mutation. Also for women who have a strong family history of breast cancer and whose BRCA gene mutation carrier is unknown or negative.
Prophylactic oophorectomy	Y*	HIP	Y	Y	Y		Y	*Approved for women who are carriers of BRCA1 or BRCA2 who are members of families with a hereditary cancer syndrome i.e., site-specific ovarian cancer syndrome or breast-ovarian cancer syndrome.
Prophylactics (condoms) and non-prescription spermicidal foams/jellies/sprays								*See - CONTRACEPTIVES*
Proscar for Benign Prostatic Hypertrophy (BPH)	Y	Pharm	Y				Y	Approved for men for treatment of mild to moderate BPH caused predominantly by mechanical obstruction or with this and small prostate.
Prostatectomy-Robotically Assisted	Y	HIP	Y					Not considered experimental.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Prostate Cancer Testing								*See - DECIPHER and/or ONCOTYPE DX*
Prosthesis repair	Y	N/A	Y					Not covered if from misuse, abuse or loss
Prosthesis replacement	Y	N/A	Y					Not covered if from misuse, abuse or loss
Prosthetic devices – rental – purchase	Y Y	Pros	Y Y					**Standard** prosthetic artificial limbs are covered. Myobionic or myoelectric artificial limbs require Medical Director review.
Proton beam therapy	Y	HIP or HOP	Y		Y		Y	Proton beam therapy is a form of external radiotherapy in which positively charged subatomic particles (protons) are precisely targeted to a specific tissue mass using a sophisticated stereotactic treatment planning and delivery system. Proton beams can deliver a higher target dose with lower normal tissue exposure than is possible with conventional photon irradiation, thereby improving local control of tumors and reducing acute and late complications. Approved for intracranial arteriovenous malformations, melanomas, particularly small to intermediate size tumors, skull base chordomas and chondrosarcomas.
Provent Therapy (Nasal Expiratory Resistance Device)	*	Sply	Y					Provent consists of 2 foam inserts with small bidirectional valves worn on each nostril to aid breathing during sleep. Per MCG (21st Edition): Provent therapy may be indicated for patients with obstructive sleep apnea [who breathe through their nose] when **ALL** of the following are present: - CPAP is not an option - Obstructive sleep apnea - No chronic obstructive pulmonary disease or other lung diseases - No heart failure - No life-threatening drop in arterial oxygen saturation (below 75%) during diagnostic sleep study
Psychoanalysis	Y**	BHOP	Y					**Refer to OptumHealth Behavioral Solutions of California.
Psychotherapy	Y**	BHOP	Y					**Refer to OptumHealth Behavioral Solutions of California.
PTEN Hamartoma Tumor Syndrome (PHTS) - genetic testing	Y	Test	Y					Genetic test. Requires genetic counseling prior to test. Medically necessary when results will affect treatment plan. Appropriate for patients suspected of having a PHTS diagnosis based on clinical presentation, with or without family history. Other uses may be experimental/investigational
Pulmonaide	Y	DME	Y					
Pulmonary artery catheterization	Y	HIP	Y					
Pulmonary function tests (PFT)	Y	test	N					
Pulmonary rehabilitation	Y	Opreh	Y		Y			Follow Medical Necessity guidelines
Pulse Dye Laser	Y	OPS	Y					Case-by-Case basis. For Port Wine stains; superficial or mixed hemangiomas; post involutional hemangiomas or telangiectasia in children/adults to alleviate or prevent medical or psychological complications; Used to treat keloid scars Deep hemangiomas are an exclusion.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Pulse oximeter	Y	DME	Y					
Punctum plug / implant	Y	OPS	Y					Used for dry eye, keratitis sicca or kerato conjunctivitis sicca.
PUVA treatment for psoriasis (Psoralen-ultraviolet-light)	Y	OV	Y					Ultra Violet Light Therapy. Also covered for vitiligo, but not for acne (experimental).
Rabies vaccination	Y	Tinj	Y					Eligible for post exposure coverage and pre-exposure coverage if Member is at increased risk; vaccination is not covered if required by an employer as a condition of employment. There is a potential for TPL (dog bite, etc).
Radial keratotomy	N	N/A	N/A					Benefit Exclusion
Radiation therapy	Y	HOP	Y					
Radiofrequency Ablation (RFA) for Cervical and/or Low Back Pain	Y	HIP	Y					Not experimental/investigational for many indications. Experimental/Investigational for SI joint and Genicular nerve
Radiofrequency Ablation (RFA) for Varicose Veins								*See - ENDOVENOUS LASER FOR VARICOSE VEINS*
Radiofrequency Ablation of Sacroiliac joint	Y	OPS	Y					Not experimental
Radiofrequency Ablation of Uterine Fibroids	Y	OPS	Y					Not experimental, includes ultrasound guidance, ex: Acessa procedure
Radiofrequency catheter ablation, Cardiac								*See - ABLATION, CARDIAC*
Radioimmunoassay	Y	test	Y					
Radiological procedures	Y	Oprad	Y					No PA for flat films only; all others require case-by-case review for medical necessity. Co-payments for radiological services, regardless of where performed, (OP hospital or free-standing radiation centers) are not applicable, and services are covered in full.
Radionuclide imaging procedures (nuclear medicine)	Y	test	Y					
Radionuclide therapy for palliative treatment of bone metastases in prostatic carcinoma	Y	HOP	Y		Y	Y	Y	For patient with bone pain associated with prostatic cancer when other accepted modes of therapy such as hormonal manipulation, have been unsuccessful in relieving bone pain: A = Strontium- 89 A = Samarium-153
Reconstructive Surgery	Y	HIP OPS	Y		Y			Reconstructive surgery is to improve function or to create a normal appearance, to the extent possible or to repair “abnormal structures” of the body that are caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease are covered. Reconstruction to achieve symmetry/normal appearance after mastectomy/lumpectomy, etc. is also a covered benefit. Cosmetic Surgery is a benefit exclusion. *CROSS REFERENCE – COSMETIC SURGERY, BREAST RECONSTRUCTION*
Recreational therapy	N	N/A	N/A					Benefit Exclusion
Reduction mammoplasty	Y	HIP or OPS	Y		Y			An accepted surgical procedure if requested for medical reasons and determined to be medically necessary and not for cosmetic purposes.
Refractive keratoplasty	N	N/A	N/A					Benefit Exclusion
Renal and peritoneal dialysis								*See - DIALYSIS*

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Renal autotransplant	Y	HIP	Y	Y	Y	Y		Surgical transfer of tissue from one part of the body to another part.
Respirators, ventilators, all supplies and service contract	Y	DME	Y					
Respiratory Syncytial Virus (RSV) Vaccine and monoclonal antibody	Y	IMM *Pharm	N					Based on current ACIP recommendations: • Adults 60 years of age and older may receive a single dose of RSV vaccine as clinically indicated. Updated on 6/21/23 • Pregnant persons- RSV vaccine from 32 to 36 weeks gestation. Updated 9/23/23 • RSV Monoclonal Antibody- Nirsevimab, for Infants and Young Children – Updated on 8/3/23 • Infants aged <8 months born during or entering their first RSV season). This can be administered at birth in the hospital or outpatient setting • Children aged 8 to 19 months who are at increased risk of severe RSV disease and entering their second RSV season *Pharmacy – available for pregnant individuals only. Please review current ACIP guidance on additional administration protocols.
Respiratory therapy	Y	Opreh	N					
Respite care	N*	N/A	N/A					*Not a covered benefit (May be provided by Hospice for patients enrolled in Hospice)
Restraints, any type (body, chest, wrist or ankle)	Y	Sply	Y					Supply
Reversal of a surgical sterilization procedure	N	N/A	N/A					Benefit Exclusion
Rhinoplasty or septoplasty	Y	OPS	Y		Y			Only if medically necessary, not cosmetic
Rhizotomy (selective or functional posterior)	Y	OPS	Y		Y	Y		*See - SELECTED DORSAL RHIZOTOMY*
Rhytidectomies (removal of wrinkles)	N	N/A	N/A					Cosmetic – Benefit Exclusion
Rib belt	Y	Sply	Y					Supply – purchase item
Robotic Assisted Surgeries	Y	OPS	Y				Y	The following procedures are covered: • Prostatectomies and hysterectomies • Hip/knee surgeries with robotic assistance, effective 7/1/2023 *CROSS REFERENCE – MAKOPLASTY*
Rogaine for alopecia areata (hair loss)	N	N/A	N/A					Cosmetic – Benefit Exclusion
Rollabout chair								*See GLIDEABOUT CHAIR*
Rotator straps	Y	Sply	Y					Supply – Covered for torsion of femur or tibia. Purchase item
Roux-en-Y Bariatric Surgery								See BARIATRIC SURGERY
Rubber rings, sheets and donuts	N	N/A	N/A					Benefit Exclusion. Personal comfort or convenience items not a covered benefit

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Sacroiliac Joint Fusion	Y	OPS or HIP	Y		Y			Not experimental in carefully selected cases.
Sacroiliac Joint Radiofrequency Ablation (SI RFA)								*See – RADIOFREQUENCY ABLATION SACROILIAC JOINT*
Saline breast implants								*See - BREAST IMPLANTS*
Scalp Hypothermia								*See – COOLING CAP*
Scanning Laser Polarimetry	Y	test	Y				Y	Scanning laser polarimetry measures the thickness of the human retinal nerve fiber layer (RNFL). Since glaucoma is associated with thinning of the RNFL and vision loss may not occur until there has been significant nerve fiber damage, it has been proposed that an objective method for quantifying this damage may provide an early and sensitive method of detecting and monitoring glaucoma. SLP is a method of detecting damage to the retinal nerve fiber layer due to glaucoma in high-risk individuals, such as African Americans over age 40 or whites over age 65, patients with a family history of glaucoma, and patients with diabetes, ocular hypertension, or severe myopia, when visual field results are insufficient, when *reliable* visual field testing cannot be performed, or when a discrepancy exists between the clinical appearance of the optic nerve and the visual fields.
Scar revision surgery (functional restoration)	Y*	HIP or OPS	Y		Y			Not covered if cosmetic
Scleral shell prosthesis	Y	Pros	Y					
Sclerotherapy for varicose veins	Y	OPS	Y		Y			Follow InterQual or MCG – approve if medically necessary.
Sclerotherapy for joint & ligaments	N	N/A	N/A				Y	Considered Experimental/Investigational by Hayes.
Sclerotherapy for Esophageal Varices	Y	HIP	Y					Only for the treatment of bleeding primary esophageal varices caused by cirrhosis
Scoliosis screening	Y	OV	N					
Scooter								See - *WHEELCHAIRS*
Selected dorsal rhizotomy	Y	HIP	Y	Y	Y	Y	Y	Used primarily with spastic cerebral palsy where the patient has the capacity for independent ambulation prior to surgery. If patient has CCS coverage: coordinate with CCS on specific physicians and hospitals where this procedure must be performed, Case Managers may want to coordinate long-term therapy with Shriner's Hospital.
Sensory evoked potential (SEP)	Y	test	Y					Measurement of electrical activity in an arm or leg.
Sensory Integration Disorder - Behavioral Therapy	N*	OP	Y	Y	Y		Y	Experimental if requested services are for Applied Behavioral Therapy. If patient also has a definitive diagnosis of Autism/Asperger's, pervasive development disorder, refer request to OptumHealth Behavioral Solutions of California. *CROSS REFERENCE AUSTISM TREATMENT, APPLIED BEHAVIORAL THERAPY, SPEECH THERAPY*

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Sensory Integration Therapy	N	N/A	N/A				Y	Experimental/Investigational – specific CPT codes for this may be requested as part of OT or PT. Components may be incorporated in traditional OT or PT for covered conditions so caution should be used in reviewing – are the codes for this service included, if not, consider as a standard OT/PT request
Sensory testing	Y	test	Y					For cerebral palsy and other specific neurological conditions or congenital anomalies. Sensory Integration Therapy is still experimental.
Septoplasty	Y	OPS	Y					Covered if not cosmetic
Serum antigen (allergy serum)								See ALLERGY INJECTIONS
Sexual dysfunction/inadequacy	Y	Pharm	Y					Covered if organic cause. Medications for ED are covered with limitations on number of pills dispensed per month.
Sex Transformation								*See - GENDER RE-ASSIGNMENT*
Sexually transmitted disease (STD) diagnosis and treatment	Y	OV & OPlab	N					
Sheepskins	Y	Sply	Y					Supply - Approved if medically necessary and justified
Shock Wave Therapy (Extracorporeal) for Chronic Plantar Fasciitis	Y*	HOP/ OPS	Y					High Energy Shock Wave Therapy (HE ESWT) is no longer considered experimental for treatment of chronic plantar fasciitis that is of at least 6 months duration and has failed conservative treatment. Low Energy Shock Wave Therapy (LE ESWT) is still considered experimental.
Short Stature - Growth Hormones								See *GROWTH HORMONES*
Sigmoidoscopy – flexible (flex)	Y	OV	N					
Silicone gel breast implants, implantation and removal								See - *BREAST IMPLANTS*
Single Photon Emissions Computed Tomography (SPECT)								See - SPECT
Sitz bath	Y	DME	Y					Covered if medical staff determines patient has an infection or injury of the peritoneal area and the item has been prescribed by the patient's physician as a part of his planned regimen of treatment in the patient's home.
Skin lesions, excision of	Y	OPS	N					No PA if performed in office. Only if medically necessary.
Sleep apnea – Medical treatment	Y	OV	Y		Y			
Sleep apnea – surgical treatment								*See LASER UVULOPALATOPLASTY,* UVULOPALATOPHARYNGOPLASTY (UPPP)
Sleep studies – adult (polysomnography, Vitalog etc)	Y	test	Y		Y		Y	Covered for restless leg syndrome if meets medical necessity (may need to r/o seizure disorder)
Small bowel transplantation	Y	HIP	Y		Y			
SmartPill® (GI motility diagnostic tool)	N	N/A	N/A		Y		Y	Experimental. Not a covered benefit. The SmartPill® is a single use ingestible capsule that utilizes sensor technology to measure pressure, pH and temperature throughout the entire GI tract. Used with motility disorders. Does not take pictures. *CROSS REFERENCE CAPSULE ENDOSCOPY & ENDOSCOPY-CAPSULE*

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Smoking cessation program	N*	Pharm	N*					*Check EOC/benefits for individual. Tobacco counseling by PCP and generic prescription medications are covered. OTC aides such as Nicorette gum may not be covered. Participation in smoking cessation education classes should be encouraged; may be paid for by Group/health system.
Sonograms								See ULTRASOUNDS
Sound operated electrical patient call devices	N	N/A	N/A					Benefit Exclusion – Personal comfort or convenience
SPECT Single-Photon Emissions Computed Tomography	Y	OPrad	Y		Y			Imaging that involves the rotation of a photon detector array around the body to acquire data from multiple angles.
Splints	Y	Sply	Y					Supply
Speech Therapy	Y*	OP	Y					Covered by qualified speech therapist as long as medically necessary. Pt. must show progress. Benefit includes patients with a definitive diagnosis of Autism/Asperger's when determined to be medically necessary. May also be covered for patients with developmental speech disorders or delays when specific MCG criteria are met. *ST is still experimental for patients with auditory processing disorders, sensory integration disorders, etc.
Sperm analysis	Y	OPlab	Y					
Sperm banking	N	N/A	N/A					Benefit Exclusion
Spinal cord stimulation for the treatment of pain	Y	HOP	Y		Y		Y	For back and extremity pain of neurogenic origin. For extremity pain secondary to vascular disease. For pain secondary to severe, disabling reflex sympathetic dystrophy that has been unresponsive or refractory to conventional treatments for at least 6 months.
Spinal discography	Y	OPrad	Y					
Stem cell harvest and/or transplantation	Y	HIP	Y	Y	Y			Used for Autologous Bone Marrow Transplants Transplant evaluation must be completed before forwarding transplant request to WHA for authorization.
Stent implantation in peripheral vessels	Y	HIP	Y		Y			Approved only for obstruction of iliac arteries (may also be appropriate as first-line therapy in cases involving long or multiple stenoses, or stenoses in locations subject to recurrent obstruction; inappropriate in patients with diabetes mellitus or poor run-off).
Stereotactic radiosurgery	Y	OPS	Y		Y	Y	Y	Stereotactic radiosurgery is a single-session procedure that involves the precise 3-dimensional targeting of ionizing radiation to obliterate tissue in patients with vascular malformations, malignant or benign tumors, or functional disorders. Stereotactic radiosurgery obliterates the target tissue without delivering a significant proportion of the prescribed radiation dose to the surrounding normal tissue. Approved for patients with surgically inaccessible arteriovenous malformations and/or patients considered poor surgical risk. Also approved for patients with primary malignant or recurrent intracranial tumors who are at high risk for surgical complications and/or for those who have failed conventional therapy.
Stereotaxic depth electrode implantation	Y	OPS	Y		Y			

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Sterilization, elective	Y	OPS	Y					Follow ACOG guidelines For persons affiliated with a Group that does not perform this procedure within their Group, the Member has the right to use the Advantage Referral process.
Sterilization, reversal	N	N/A	N/A					Benefit Exclusion
Sterilization, permanent	Y	OPS	Y		Y			ESSURE device used as a method to provide permanent birth control is NOT experimental.
Stereotactic electroencephalography	Y	test	Y					
Stoma Supplies	Y	Sply	Y					Supply - Medical benefit
Storage of body parts, tissue and fluids	N	N/A	N/A					Benefit Exclusion - Only exception is autologous blood for surgery prep. *CROSS REFERENCE AUTOLOGUS BLOOD TRANSFUSION*
Strabismus surgery (crossed or turned eye)	Y	OPS	Y					
Student coverage – out-of-area	Y*#	ER or HIP	N Y#	Y#				*Covered for emergencies and appropriate urgent care only (by WHA if out of service area) – all routine or emergency/urgent follow-up care must be done while patient in service area. #New benefit. Effective 2022, for a small number of employer groups only. Limited to college students attending OOA, requires contracted telehealth first, specialist visits up to 3 OOA if contracted telehealth provider determines in person evaluation required. WHA to review and approve OOA specialist visits. (chiro/accu and mental health included – refer to Landmark/ OptumHealth Behavioral Solutions of California) Effective 01/01/2024, this is offered as an optional rider for Large Groups. *Check specific member benefits.*
Stress management classes	N	N/A	N/A					Benefit Exclusion
Stress test	Y	test	Y					If office-based, no PA required. If OB - see under Obstetrics.
Stryker flotation pads and mattresses	Y	DME	Y					Stage III or IV decubitus ulcer. Covered – only where hospital bed is medically necessary – requires medical review
Subcutaneous mastectomy	Y	HIP	Y					
Suction equipment and supplies- stationary and portable	Y	DME	Y					Covered if medical staff determines that the machine specified in the claim is medically required and appropriate for home use without technical or professional Supervision.
Support hose/garments (Over the Counter-OTC)								*See - COMPRESSION GARMENTS*
Surgical leggings	Y	Sply or DME	Y					Check HCPCS code for co-pay category. Pressure garments may be DME. Non-reusable supplies - not rental type item. Requires review for medical necessity
Surfactant replacement treatment	Y	HIP	Y		Y			
Surrogate services for pregnancy	N	N/A	N/A					Benefit Exclusion
Syringes – hypodermic	Y	Pharm	Y					Pharmacy benefit
Tap water iontophoresis devices	Y	DME	Y					If used for hyperhidrosis
Tattoos, removal of	N	N/A	N/A					Cosmetic – Benefit Exclusion

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Teaching - caregiver	Y*		Y					*Case-by-case review. If in hospital, no separate payment may be made; if under HHA, no separate payment may be made, but HHA services should be approved until caregiver competent in administering care.
Telehealth Visits / Consultations	Y	OV	Y*					Telehealth visits or consultations are simply another way to obtain an office visit. Authorization requirements and co-pays are the same as for any other type of office visit.
Telephone consultations (includes Consultation with Group's CM)	N*	N/A	N/A					*Cannot charge member
Temporomandibular joint (TMJ) splints								See TMJ MOUTH SPLINTS
Temporomandibular joint (TMJ) surgery	Y	HIP or OPS	Y	Y	Y			Approved when optimal dental and medical therapy has been unsuccessful and the patient continues to experience pain and malfunction of the joint that leads to a decrease in function. Covered for arthrotomy and arthroscopy.
TENS unit								*See –ELECTRONIC NERVE STIMULATOR*
Thallium scans	Y	OPrad	Y					
Thallium treadmill	Y	test	Y					
Therapeutic Abortion (TAB)	Y	OPS	Y					Some Groups may require prior auth.
Therapeutic drug assay	Y	test	N					
Thoracic duct drainage for kidney transplantation	Y	HIP	Y		Y			
Thrombolysis	Y	HIP	Y		Y			
Thyroid uptake scan	Y	OPrad	Y					
TMJ Mouth Splints	Y	DME	Y	Y	Y			Orthotic - Oral splints for TMJ should be covered when a clinical professional requests them for a member because TMJ has been determined to be a medical (not a dental) condition per medical and community standards. WHA benefits cover surgeries for this condition in certain cases. If network orthodontist requests the splint, can be approved. If non-contracted orthodontist is requesting a splint, make sure WHA network provider validates the member's condition (e.g., did the member's PCP make the referral and request authorization for the device?--if so, that should suffice).
Tocolytic therapy for preterm labor, including monitoring (TOKOS monitor)	Y*	DME	Y		Y			*Case-by-Case review using InterQual and/or MCG criteria. Set up by home health with use in tocolytic therapy and monitoring. Requires medical review. *CROSS REFERENCE - HOME UTERINE MONITORING*
Tonsillectomy or adenoidectomy	Y	OPS	Y					
Total Ankle Arthroplasty (Ankle Replacement)								*See - ANKLE REPLACEMENT*
Total Hip Replacement with Hard-on-Hard Prosthesis	N*	N/A	Y	Y				*Both procedures considered Investigational/Experimental by Hayes. CROSS REFERENCE – HIP RESURFACING
Total Hip Replacement with computer (robotic) assist	N*	N/A	Y	Y				
Total Parenteral Nutrition (TPN)								*See PARENTERAL NUTRITION*
Tracheostomy speaking valve	Y	Pros	Y					

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Trapeze bar	Y	DME	Y					Covered if patient is bed confined and the patient needs a trapeze bar to sit up because of respiratory condition, to change body position for other medical reasons, or to get in and out of bed. Usually used in conjunction with a hospital bed and overbed bar rental.
Traction devices	*	DME	Y	Y	Y			*May be covered (depending on type) if patient has orthopedic impairment requiring traction equipment which prevents ambulation during the period of use. Cervical traction NOT experimental, but Lumbar traction is considered Experimental per Hayes rating (rated D).
Transcutaneous Electrical Nerve Stimulation (TENS)	Y	DME	Y					*See - NEUROMUSCULAR ELECTRICAL STIMULATORS*
Transdermal nicotine patches	Y	Pharm	Y					See Nicotine patches
Transesophageal echocardiography (TEE)	Y	test	Y		*			
Transfusion services	Y	HIP	N					
Transgender services	Y*	OV, BH, OPS, HIP, etc.	Y	Y*	Y	Y		Hormone therapy, BH counseling/therapy and related surgeries are covered when medically necessary. See WHA's Transgender P&P for specifics. (Med necessity criteria is primarily based on WPATH guidelines Sept 2022 8h Edition). *WHA holds risk for any related surgeries; Refer only surgeries to WHA for case-by-case review. *Adolescents under 18 may be eligible with parental or legal guardian consent in accordance with Standards of Care (SOC) 8.
Transmyocardial laser revascularization	N*	N/A	Y	Y	Y		Y	*Considered Investigational/Experimental by Hayes. Case-by-Case review at WHA.
Transplants (organ, bone marrow & stem cell)	Y	HIP	Y	Y	Y	Y		See specific organ/type of transplant for specifics. Transplant Eval is approved by medical group. Transplant Center authorized is at the discretion of the medical group. Medical Group must Submit Transplant Eval report to WHA for approval of the Transplant. WHA Preferred Transplant Centers are UCD and UCSF however group determines which center to direct member to. Legislation (AB 228) prohibits discrimination of persons infected with HIV with respect to transplants.
Trans-telephonic monitoring of pacemakers	Y	N/A	Y					
Trans-tracheal oxygen therapy (TTOT)	Y	DME	Y					
Trans-urethral microwave Thermotherapy (TUMT)	Y	test	Y	Y	Y			Standard of care.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Trans-urethral needle ablation therapy (TUNA)	Y	HIP	Y					Transurethral needle ablation (TUNA) is a nonsurgical procedure in which low-level radiofrequency (RF) energy is delivered through needles to a localized area of the prostate, with the goal of relieving symptoms associated with benign prostatic hyperplasia. For the treatment of men with symptomatic BPH severe enough to warrant surgical treatment but who wish to preserve ejaculatory function or who are not suitable candidates for surgery. This rating is based on the assumption that prostate cancer has been eliminated as a diagnosis in these patients.
Travel expenses	N	N/A	N/A					Benefit Exclusion
Travel immunizations and medications	Y	IMM	N					Covered when directed by MD or as recommended by CDC for the country/region to be visited. Member may be directed to public health clinic when necessary. (i.e. the county) depending on availability of immunizations at Member's Medical Group. Not covered if employer is sending member to another country for business purposes. *CROSS REFERENCE - IMMUNIZATIONS; ROUTINE AGE SPECIFIC*
Treadmills- cardiac, cardiolyte , thallium etc	Y	test	N					
Treadmills- exercise	N	N/A	N/A					Benefit Exclusion based on Personal comfort or convenience items.
Trigger point injections – myofacial pain syndrome	Y	OP OPS	Y					See *MYOFACIAL PAIN SYNDROME (TMJ)*
Tubal ligation	Y	OPS	Y					Reversals are excluded
Tuberculosis diagnosis and treatment	Y	OV	N					
Twister cables	Y	DME	Y					Covered – torsion femur or tibia. Purchase item
Tympanoplasty	Y	OPS	Y	Y	Y			
Ultrafiltration	Y	DME	N					
Ultrasound diagnostic procedures	Y	OPrad	N					
Ultrasound OB, initial	Y	OPrad	N					1st OB U/S, no PA required. After initial pregnancy diagnosis, no co-pay for related/necessary pre-delivery ultrasounds.
Ultrasound OB – 2nd or more	Y*	OPrad	*					*May require Case-by-Case review to justify medical necessity per Med Group protocols. No co-pay if medically necessary.
Umbilical Cord Blood Stem Cell Transplantation	Y	HIP	Y	Y	Y		Y	Covered only for UCBSCT in patients who meet all eligibility requirements for ALL BMT but for whom a suitable bone marrow donor cannot be found and a suitable cord blood sample with a maximum of 3 HLA mismatches is available.
Unna boot	Y	Pros	Y					Prosthetic - Requires medical review. Covered if medically necessary
Upper GI series	Y	OPrad	N					
Urgent care services	Y	UC	N					Covered for appropriate use
Urinary catheters and supplies	Y	Sply	Y					Medical Supply benefit
Urodynamic studies	Y	test	N					
Uterine Artery Embolization	Y	HIP	Y					Covered for patients with confirmed, symptomatic uterine fibroids who would be considered candidates for surgical therapy, but who, for medical or other reasons, do not wish to undergo surgery. All other conditions considered Investigational/Experimental by Hayes.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Uvulopalatopharyngoplasty (UPPP)	Y	OPS	Y		Y			
Vabra aspiration	Y	HOP	N					
Vaccines								See- *IMMUNIZATIONS AND TRAVEL IMMUNIZATIONS*
Vacuum-assisted closure for wound healing (Negative Pressure Wound Therapy)	Y	HH	Y	Y	Y		Y	Patients should have the overall capacity to heal, and the wound must be free of necrotic tissue.
Vasectomy	Y	FP/OV	N					In-office procedure. Reversal not covered. Effective 1/1/2024, based on the Contraceptive Equity Act of 2022, this is a part of Family Planning but will remain as an in-office procedure. This change is applicable to all Commercial plans across the board on January 1, 2024, unless excluded by the plan, consistent with Federal and State law.
Venogram	Y	OPrad	N					
Ventilators	Y	DME	Y		Y			OK to rent or purchase – consider purchase if long-term but only after patient stable on ventilator and it is the ventilator of choice for the patient – usually this is after 3 months; if purchased, allow monthly service contract. DME Benefit.
Ventricular artery surgery	Y	HIP	Y					Follow InterQual and/or MCG criteria.
Vestibular Rehabilitation for treatment of vestibular & balance disorders	Y	OPreh	Y				Y	Particle repositioning maneuvers: - For benign paroxysmal positional vertigo - For benign positional vertigo other than paroxysmal Vestibular rehabilitation: - For dizziness of vestibular origin Considered Investigational/Experimental for: - Bilateral vestibular paresis - Meniere's disease and acoustic neuroma patients recovering from vestibular ablative surgery
Vestibuloplasty (surgery on gums and jaws)	Y	OPS	Y					Only covered if medically necessary
Vitamin B 12 Injections	Y	TInj	Y					Injections are Group responsibility.
Vitrectomy	Y	OPS	Y					Used for proliferative diabetic retinopathy or uveitis and other reasons (e.g., detached retina repair)
Voice Prosthesis	Y	Pros	Y					
Voiding cystourethrography	Y	OPrad	N					
Walkers	Y	DME	Y					Covered if patient's condition impairs ambulation. Also see DME for general guidelines for all DME items.
Water and pressure pads & mattresses	Y	DME	Y					Covered for Stage II or IV decubitus ulcers. Covered – only where hospital bed is medically necessary.
Water softening system- dialysis equipment	Y	DME	Y					Covered for home dialysis
Water therapy w/PT treatment regime	Y	OPreh	Y					Med necessity needed

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Wearable Cardioverter/Defibrillator Vest (ex: LifeVest System)	y	DME	Y		Y			Not experimental. Designed to perform the same functions as an automatic ICD or external defibrillator, but is worn outside the body and is therefore noninvasive. It is a combination of 2 devices: 1) as a cardioverter it uses low-energy electrical shocks to return heart undergoing V-tach to normal rhythm; 2) as a defibrillator it uses high-energy shocks.
Weight loss aids	N	N/A	N/A					Benefit Exclusion. Includes commercial products such as food and OTC liquid supplements or drugs.
Weight Loss Programs	N*	N/A	N/A					*Not a covered benefit for programs such as Jenny Craig, Weight Watchers, Atkins, Richard Simmons, Curves or Gym Exercise Programs.
Weight Reduction Assistance	Y	OV	Y					May be covered if ordered by PCP, including consultation with Nutritionist, Educational Classes on weight reduction, nutrition, and exercise through Member's specific Medical Group program. Note: WHA offers discounts to WHA members to local selected fitness centers.
Wheelchairs - Standard - Electric - Electric cart - Batteries - Battery charger	Y	DME	Y					Covered – if patient's condition is such that the alternative would be chair or bed confinement. Rollabout chair or wheelchair – not both. Wheelchairs provided as a benefit under the WHA plan are standard models except in extenuating circumstances when electric chairs are needed to meet basic medical needs. A standard wheelchair is one that meets the minimum functional requirements of the Member. Requests for other than basic wheelchair requires Medical Director review. Use Medicare Guidelines. *CROSS REFERENCE DME*
Wheelchair seating systems	Y	DME	Y					Requires medical review. Used primarily for spinal cord injuries and severe neuromuscular disorders. Frequently used for children in place of replacing a wheelchair as the child grows.
Whirlpool bath equipment (standard)	Y	DME	Y					Covered if patient is homebound and has a condition for which the whirlpool bath can be expected to provide substantial therapeutic benefit justifying its cost.
Wigs and hair pieces	Y	Pros	Y					Prosthetic – Limited to one per lifetime up to $750 – for hair loss due to medical reason such as alopecia, chemotherapy, but not due to aging.
Withdrawal treatments for narcotic addiction	Y**	HIP	Y					Short- term detox covered under medical benefits (usually 3 days). **Refer to OptumHealth Behavioral Solutions of California. Check EOC.

Services/Procedures	Benefit Covered/Category		P.A Req.	Notification WHA	M.Dir	CM	Hayes Criteria Y/N	Comments
Wound-Non Healing – Procuren and Platelet-Derived Growth Factors for treatment of Chronic Non-healing Wounds	Y	Pharm	Y				Y	Regranex – For recombinant platelet-derived growth factor (becaplermin) in patients with lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have adequate blood supply to the lower extremities. Who are not experiencing wound infection, are not on antibiotic therapy, and whose wounds are not burn-related. To be used as a comprehensive wound-healing approach.
X-Rays								See RADIOLOGICAL PROCEDURES
Yoga Instruction/Classes	N	N/A	N/A					Benefit Exclusion based on Personal comfort & convenience item