Medical Records Documentation Used for Reviews

This protocol lists medical records documentation used and which may be required, when applicable for reviews. This content is developed using the clinical criteria in UnitedHealthcare medical policies in conjunction with the guidance provided by UnitedHealthcare physicians and pharmacists with experience in reviewing service requests for coverage. This medical record documentation content was developed in an effort to decrease the need for repeated requests for additional information and to improve turnaround time for coverage decisions.

We reserve the right to request more information, if necessary. Medical record documentation content used for case review(s) may vary among various UnitedHealthcare Commercial, UnitedHealthcare Community Plan, and UnitedHealthcare Medicare Advantage benefit plans.

This content is provided for reference purposes only and may not include all services or codes. Listing of a service or code in this protocol does not imply that it is a covered or non-covered health service or code. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws.

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Service	Codes	Medical Records Used for Reviews
Ablative Treatment for Spinal Pain	22899 64633 64634 64635 64636	Medical notes documenting the following, when applicable: 1. Details about the patient characteristics: a. Functional Impairment due to facet pain 2. Detailed about the diagnostic Facet Joint Injection and/or Facet Nerve Block (i.e., Medial Branch Block) a. Procedure note which includes precise location of the needle tip and whether or not sedation was administered; and if administered, provide anesthesia record b. Percentage of pain relief with Facet Joint Injection and/or Facet Nerve Block (i.e., Medial Branch Block) using a validated pain scale c. Duration of improvement from diagnostic Facet Joint Injection and/or Facet Nerve Block (i.e., Medial Branch Block) 3. Details about the requested procedure a. Specific identification of side and level b. Temperature of procedure c. Duration of ablation 4. For repeat ablations, details about the prior ablation a. Percentage of pain relief with prior ablation using a validated pain scale measured before and at least 10 weeks after initial ablation, if applicable b. Duration of improvement from prior ablation
Abnormal Uterine Bleeding and Uterine Fibroids	0071T 0072T 37243	Medical notes documenting the following, when applicable: 1. Condition requiring procedure 2. Relevant physical exam 3. Signs and symptoms, including uterine bleeding and possible impact on activities of daily living (ADLs) 4. Co-morbid medical condition(s), including, when applicable: a. Presence or absence of anemia b. Presence or exclusion of thyroid diseases c. Presence or exclusion of bleeding disorder d. Exclusion of pregnancy e. Presence or absence of pelvic or abdominal pain or discomfort f. Presence or absence of urinary frequency or urgency g. Presence or absence of dyspareunia 5. Reports of all recent imaging studies and applicable diagnostics, including: a. Results of cervical cytology b. Results of endometrial biopsy c. Results of hysteroscopy with dilatation and curettage (D & C) d. Uterine or fibroid (s) measurements by imaging within the last year e. Presence or absence of ureteral compression 6. History of past relevant procedure(s)/ surgery (ies) 7. Prior therapies/treatments tried, failed, or contraindicated; include the dates, duration, and reason for discontinuation
Airway Clearance Devices	A7025 A7026 E0483	Medical notes documenting the following, when applicable: 1. Diagnosis

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		2. Current prescription from physician 3. Failed standard treatments to adequately mobilize retained secretions 4. CT scan report confirming diagnosis of bronchiectasis if applicable 5. Frequency of exacerbations requiring antibiotic therapy 6. Duration and frequency of productive cough 7. For **continuation** beyond the two-month trial, medical notes documenting a. Patient tolerance of the device b. Efficacy in using the device (member's response to therapy)
Ambulance Service – Non-Emergency Air Transport	A0430 A0431 A0435 A0436 S9960 S9961	Include the following: 1. Date of Service 2. Ordering physician's name and phone# (if request is made to Air Ambulance provider) 3. Physician order and documentation by Physician explaining the reason for Air Ambulance transport 4. Any additional equipment or personnel needed for transport 5. Member's diagnosis and chief complaint 6. Physician notes evaluating members current condition / clinical summary) including: a. Co-morbidities b. Current functional limitations c. Description of members inpatient (IP) stay and progress if applicable 7. Describe where member is traveling from (facility name & contact name/ phone number) 8. Describe where member is traveling to (facility name & contact name (phone number) 9. Mileage (one-way) for transport including air mileage and land mileage for transport
Apheresis	36514	Medical notes documenting the following, when applicable: 1. Medical history, including transfusion history 2. Diagnosis 3. Treatment plan
Articular Cartilage Defect Repairs	27412 27415 27416 28446 29866 29867 29879 J7330 S2112	Medical notes documenting the following, when applicable: 1. Complete report(s) of diagnostic imaging (MRI, CT Scan, x-rays and bone scan) a. Documented closure of skeletal plates (age less than 18 years) b. Presence or absence of focal full-thickness articular cartilage defect c. Size and location of focal cartilage defect d. Outerbridge grade e. Joint space and alignment 2. Condition requiring procedure 3. Symptoms 4. Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking) 5. Pertinent physical examination of the relevant joint 6. Cause of defect; e.g., acute or repetitive trauma

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		7. Co-morbid medical condition(s) 8. Prior therapies/treatments tried, failed, or contraindicated; include the dates and reason for discontinuation 9. Date of previous surgery(ies) to the same joint 10. Physician's treatment plan including pre-op discussion 11. If the location is being requested as an inpatient stay, provide office notes to support at least one of the following: a. Surgery is bilateral b. Member has significant co-morbidities. Include the list of comorbidities and current treatment c. Member does not have appropriate resources to support post-operative care after an outpatient procedure. Include the barriers to care as an outpatient
Articular Cartilage Defect Repairs - Autologous Chondrocyte Transplantation - Implant material	**Implant material:** J7330	**Note**: Prior Authorization request must be received from the surgeon preforming the Autologous Chondrocyte Transplantation (27412, S2112) before the implant authorization can be processed. Refer to the documentation requirements for CPT code 27412 and HCPCS S2112 for specific information needed to authorize the implantation. The laboratory providing the implant material should provide the following information: Thank you for your prior authorization request for autologous cultured chondrocytes, implant (J7330). In order for your request to be processed a prior authorization request must also be received from the surgeon preforming the Autologous Chondrocyte Transplantation (27412, S2112). In an effort to streamline the processing of your prior authorization request, provide the following: 1. Surgeon Name: 2. Surgeon/ Practice Address: 3. Surgeon/ Practice Phone: 4. Surgeon/ Practice Fax: 5. Surgeon/ Practice Email: 6. We also ask you provide the following information (if available) related to the Autologous Chondrocyte Transplantation (27412, S2112): a. Diagnosis (ICD-10 code(s)) b. Location where procedure will take place c. Members Age, if patient is of pediatric age, indicate status of growth plates d. Cause of defect e. Size of the defect f. Location of the defect g. Treatments tried, failed, contraindicated (e.g., physical therapy, braces, and/or nonsteroidal anti-inflammatory drugs (NSAIDs), debridement,

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		microfracture, drilling/abrasion arthroplasty, or osteochondral allograft/autograft)
Attended Polysomnography (Sleep Study) for Evaluation of Sleep Disorders	95805 95807 95808 95810 95811	Medical notes documenting the following, when applicable: 1. Diagnosis or suspected diagnosis 2. Physical exam including the member height, weight and BMI 3. Clinical signs and symptoms 4. Co-morbid conditions including pulmonary, cardiac, neuromuscular disease/neurodegenerative, neurologic 5. Reports of all recent imaging studies and applicable diagnostics, including when applicable: a. Previous sleep study (ies) include type and date b. Epworth Sleepiness score c. Spirometry d. NYHA heart failure class e. Left ventricular ejection fraction f. Arterial PaCO2 results 6. Treatments tried, failed, or contraindicated. Include the dates and reason for discontinuation 7. If requesting 95811, indicate whether the request is for PAP titration or split night study a. For a member already on PAP therapy, provide most recent print out for compliance 8. Name and address of the facility where the procedure will be performed 9. For CPT 95805, Multiple Sleep Latency Testing (MSLT) and Maintenance of Wakefulness Testing (MWT), include notes that Excessive Sleepiness have been excluded
Balloon Sinus Ostial Dilation (Sinuplasty)	31295 31296 31297 31298	Medical notes documenting the following, when applicable: 1. Diagnosis 2. History of illness 3. Recent physical exam 4. Signs and symptoms 5. Treatments tried, failed, or contraindicated; include the dates and reason for discontinuation (e.g. intranasal corticosteroids, antibiotic therapy, nasal lavage/irrigation) 6. Recent CT scan report including the date of scan, documenting the following: a. Which sinus has the disease, including side b. The extent of disease including the percent of opacification or the use of a scale such as the Modified Lund-Mackay Scoring System c. Whether the images were taken pre- or post-medical management 7. Upon request, recent CT scan images: a. That show the abnormality for which surgery is being requested b. Are the optimal images to show the abnormality of the affected area including, when applicable the use of a scale such as the Modified Lund-Mackay Scoring System to define the severity

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		c. Labeled with the date taken and the applicable case number obtained at time of notification, or member's name and ID number NOTE: CT images can be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 8. For Chronic Rhinosinusitis also including the following: a. Evidence that the sinusitis involves frontal, maxillary, or sphenoid sinuses b. Planned procedure, including if the procedure will be part of a functional endoscopic sinus surgery (FESS) 9. For Recurrent Acute Rhinosinusitis also include the number of episodes per year of Acute Rhinosinusitis
Bariatric Surgery	**Initial:** 43644 43645 43647 43648 43659 43770 43771 43772 43773 43774 43775 43843 43845 43846 43847 43848 43881 43882 43886 43887 43888 64590 64595 **Subsequent :** 43860 43865	For **initial** bariatric surgery, provide medical notes documenting **all** of the following: 1. Height 2. Weight 3. Current and five-year history of BMI (body mass index) 4. Diet history 5. Co-morbidities 6. Medical treatment tried and failed including diet and exercise 7. Psychological evaluation by a licensed behavioral health professional 8. Nutritional consult 9. Name of the facility where the procedure will be performed 10. For **subsequent** bariatric surgery, provide medical notes documenting **all** of the above in addition to the following: a. Previous unsuccessful medical treatment b. Initial bariatric surgery performed and date and subsequent complications that require further surgical intervention
Beds and Mattresses	E0194 E0265 E0266 E0296 E0297 E0300 E0302 E0304 E0316 E0328 E0329	Medical notes documenting the following, when applicable: 1. Current prescription (written order) from physician, including: a. Initial, ongoing, or replacement request b. Rental or purchase c. Specific HCPCS code(s) for item and each accessory requested d. Equipment make, model and price quotation e. If replacement, current device used, date of initial acquisition, status of warranty and reason for replacement 2. Medical notes documenting the following, when applicable: a. Diagnosis and detail of member condition(s) or risk(s) b. Current transfer and bed mobility skills c. Current functional limitations with regards to activities of daily living d. Member weight and height e. Reason for positioning of the body not accommodated with a standard bed f. Ability to transfer from a fixed height bed with or without assistance g. Medical need for variable height bed h. Prior approaches tried, failed, or contraindicated; include the dates and reason for discontinuation

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		3. Physician treatment plan 4. For safety enclosures with beds in addition to the above, also include the following when appropriate: a. Evaluation for contraindications to use of the equipment b. Member assessment for physical, environmental, and behavioral factors c. Physician directed written monitoring plan
Behavioral Health Services	All codes	Provider should call the number on the member's identification (ID) card when referring for any mental health or substance abuse/ substance use services
Breast Reconstruction	11970 11971 15771 19303 19316 19325 19328 19330 19340 19342 19350 19357 19361 19364 19367 19368 19369 19370 19371 19380 19396 L8600	NOTE: These documentation requirements only apply when a Pre-Determination is requested. Mastectomy after a diagnosis of breast cancer does not require Prior Authorization/Advance Notification. Medical notes documenting the following, when applicable: 1. Diagnosis 2. History of the medical condition(s) requiring treatment or surgical intervention 3. Chief complaint, including history of the complaint 4. Relevant medical and family history 5. Relevant surgical history, including dates and whether the surgery is for removal, replacement (of an implant, specify type, silicon or saline), or revision of a previous surgery 6. Upon request, we may require the specific diagnostic image(s) that show the abnormality for which surgery is being requested. Consultation with requesting surgeon may be of benefit to select the optimal images NOTE: Diagnostic images must be labeled with: a. The date taken b. Applicable case number obtained at time of notification, or member's name and ID number on the image(s) Submission of diagnostic imaging is required via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 7. Reports of all recent imaging studies and applicable diagnostics 8. For **CPT codes 19370 and 19371** require submission of high-quality color photograph(s) **Note**: All photographs must be labeled with the: a. Date taken b. Applicable case number obtained at time of notification, or member's name and ID number on the photograph(s) Submission of color photographs can be submitted via the external portal at www.uhcprovider.com/paan; faxes of color photos will not be accepted 9. Complications which necessitate the need for removal of the prosthetic Note: For capsular contracture include Baker grade and functional impairment 10. Physicians plan of care, including estimated volume of breast tissue per breast to be removed
Breast Reduction Surgery	19316 19318	Medical notes documenting the following, when applicable: 1. Diagnosis

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		2. History of the medical condition(s) requiring treatment or surgical intervention, including: a. History of the chief complaint and associated symptoms b. Estimated risk of breast cancer 3. Physical exam including member's height and weight 4. Reports of recent imaging studies and applicable diagnostic tests (within 1 year), including to rule out: a. Tumor or malignant changes of the breast b. Orthopedic, neurologic, rheumatologic, endocrine or metabolic condition 5. Description of physiologic functional impairments (e.g., back pain, grooving from bras straps, skin breakdown, paresthesias, etc.) 6. For a diagnosis of macromastia, include high quality color photograph(s); all images must be labeled with the a. Date taken b. Applicable case number obtained at time of notification or member's name and ID number on the photograph(s) NOTE: Submission of color image(s)are required and can be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 7. **Reduction mammoplasty** documentation should include: a. The evaluation and management note for the date of service b. The note for the day the decision to perform surgery was made 8. Physicians plan of care, including estimated volume of breast tissue per breast to be removed
Brow Ptosis and Eyelid Repair	15820 15821 15822 15823 21280 21282 67900 67901 67902 67903 67904 67906 67908 67909 67911 67914 67915 67916 67917 67921 67922 67923 67924 67950 67961 67966	Medical notes documenting the following, when applicable: 1. History of condition requiring treatment 2. Visual complaints, including functional impairments that interfere with activities of daily living (ADL) and ruling out other causes 3. Eye exam including best corrected visual acuity in both eyes 4. Treatments tried, failed, or contraindicated. Include the dates and reason for discontinuation 5. Recent diagnostic testing including: a. Peripheral or Superior Visual Fields automated, reliable, un-taped and taped including percent improvement or number of degrees improvement b. Reason Visual Field testing is not feasible 6. Marginal reflex distance (MRD-1) 7. High-quality photograph(s); all photos must be: a. Full face, eye level, frontal and lateral with the member looking straight ahead, light reflex visible and centered b. Labeled with the date taken and the applicable case number obtained at time of notification, or member's name and ID number on the photograph(s) NOTE: Submission of color photos can be submitted via the external portal at www.uhcprovider.com/paan; faxes of color photographs will not be accepted

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Cardiac Catheterization with or without Angiography	93452 93453 93454 93455 93456 93457 93458 93459 93460 93461	Medical notes documenting the following, when applicable: 1. Current prescription 2. Physician office notes that include: a. Diagnosis, including suspected diagnosis, the necessity to evaluate a condition and treatment planning b. Relevant history & physical, including history of cardiac trauma c. Reports of all recent imaging studies and applicable diagnostics (i.e. EKG/ ECG) d. Documentation of signs and symptoms; including onset, duration, and frequency
Cardiac Event Monitoring	33285 E0616	Medical notes documenting the following, when applicable: 1. Physician Order 2. Pertinent diagnoses or symptoms 3. Conditions putting the member at high risk for arrhythmias 4. Result of non-invasive cardiac monitoring unless contraindicated, or non-diagnostic, to include duration of monitoring 5. Test results supporting cardiac etiology (e.g. electrophysiological studies, Tilt Table testing, relevant imaging results, etc.) unexplained symptoms, or unexplained syncopal episodes
Carrier Testing for Genetic Diseases	81412 81443 81479	Medical notes documenting the following, when applicable: 1. Personal history of the condition, if applicable, including age at diagnosis 2. Family history relevant to condition being tested 3. Genetic testing results of family member, if applicable, and reason for testing 4. Ethnicity/ancestry (e.g., Ashkenazi Jewish), if reason for testing 5. Any prior genetic testing results on affected individual in the family 6. Genetic counseling (if available)
Catheter Ablation for Atrial Fibrillation	93653 93656	Medical notes documenting the following, when applicable: 1. Diagnosis 2. Recent physical exam 3. Signs and symptoms including onset, duration, and frequency 4. Reports of all recent imaging studies and applicable diagnostics 5. Treatments tried and failed including but not limited to: a. Medications (date and duration) b. Surgical procedures (date) 6. Physician treatment plan
Cell-Free Fetal DNA Testing	0060U 0327U 81420 81479 81507	Medical office notes documenting the following, when applicable: 1. Maternal age 2. History of prior pregnancy with a trisomy, if applicable 3. History of parental balanced Robertsonian translocation 4. Abnormal first- or second-trimester screening test result 5. Counseling provided by genetic counselor or prenatal provider on the risks and benefits of testing using Shared Decision Making

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Certified Nursing Assistant (CAN) or Home Health Aide for Adults 21 and Older for Florida Community Plan	T1021	Note that T1021 is subject to a Coverage Determination Guideline, which can be found at UHCprovider.com/policies > Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan > Certified Nursing Assistant (CNA) or Home Health Aide for Adults Age 21 and Older (For Florida Only). A written order, a plan of care, as well as a fully documented Letter of Medical Necessity, including attestation of physical examination or medical consultation, are necessary. The Letter of Medical Necessity form can be found at: uhc.provider.com / Health Plans by State / Florida / UnitedHealthcare Community Plan of Florida Homepage / Prior Authorization and Notification. Refer to the above Coverage Determination Guideline for complete requirements.
Chromosome Microarray Testing (Non-Oncology Conditions)	81228 81229 81349 81479 0209U S3870	Medical notes documenting the following, when applicable: 1. Personal history of the condition, if applicable, including age at diagnosis 2. Complete family history (usually three-generation pedigree) relevant to condition being tested 3. Genetic testing results of family member, if applicable, and reason for testing 4. Ethnicity/ancestry (e.g., Ashkenazi Jewish), if reason for testing 5. Any prior genetic testing results 6. How clinical management will be impacted based on results of genetic testing 7. Genetic counseling (if available)
Clinical Trials	S9990 S9991 S9988	Provider should call the number on the member's ID card when referring for any clinical trial.
Cochlear Implants & Other Auditory Implants	69930 L8614 L8619	Medical notes documenting the following, when applicable: 1. Diagnoses and relevant medical history, including vaccination status or waiver 2. Degree and frequencies of sensorineural hearing impairment on each side 3. Treatments tried, failed, or contraindicated. Include the dates and reason for discontinuation 4. Physical exam and reports of recent relevant imaging studies, including: a. Presence or absence from middle ear infection or mastoid cavity b. An accessible cochlear lumen that is structurally suited to implantation c. Presence or absence of lesions in the auditory nerve and acoustic areas of the central nervous system d. Presence or absence of tympanic membrane perforation 5. Other applicable diagnostic tests 6. Member's cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation 7. Proposed procedure(s) including a. Type of cochlear implant or other auditory implant including the name of the device b. Whether this request is part of a staged procedure

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Continuous Glucose Monitoring (CGM)	A4226 A4238 A4239 A9274 A9276 A9277 A9278 E0784 E0787 E1399 E2102 E2103	**Insulin Delivery** Medical notes documenting the following: 1. Provide the member's current type of diabetes (i.e. type I type II or Gestational) 2. Member's lab results and office notes from within the last three (3) months 3. Treatment plan 4. Current signed physician order 5. Provide the type of make and model of the device requested **CGM Initial Request** Medical notes documenting the following: 1. Provide the member's current type of diabetes (i.e. type I type II or Gestational) 2. Member's lab results and office notes from within the last three (3) months 3. Treatment plan 4. Current signed physician order 5. Provide the type of make and model of the device requested **CGM Continuous Use** Medical notes documenting the following: 1. Provide the member's current type of diabetes (i.e. type I type II or Gestational) 2. Member's lab results from within the last six (6) months 3. Treatment plan 4. Current signed physician order 5. Provide the type of make and model of the device requested
Continuous Positive Airway Pressure (CPAP)	E0601	For an **initial** request, medical codes documenting the following, when applicable: 1. Current (within the last year) prescription from physician 2. Physician office notes that include face-to-face clinical evaluation prior to the sleep test to assess for obstructive sleep apnea 3. Sleep study that includes apneal hypopnea index (AHI) (using a 4% decline in oxygen saturation definition of hypopnea) and clinical symptoms noted during the study 4. Documentation that appropriate instructions were provided on the use of the device Provide the following for a **continuation** request: 1. Face-to-face clinical re-evaluation by the treating physician with documentation of the clinical response to PAP therapy treatment trial 2. Objective evidence of adherence to use of the PAP device, reviewed by the treating physician To **requalify** for CPAP due to failed CPAP trial**:** 1. Date of failed CPAP trial period 2. Face-to-face clinical re-evaluation by the treating physician to determine the etiology of the failure to respond to PAP therapy

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		For Medicare only: Repeat sleep test in a facility-based setting (Type 1 study). This may be a repeat diagnostic, titration or split-night study **Replacement** CPAP: 1. Age of the current device 2. Reason as to why the device needs to be replaced rather than repaired 3. If the device is five years or older, a face-to-face evaluation by the treating physician that documents that the member continues to use and benefit from the PAP device
Core Decompression for Avascular Necrosis	21299 27299	Medical notes documenting the following, when applicable: 1. Radiographic reports 2. Condition requiring procedure 3. Associated co-morbidities 4. Medical/surgical therapies tried and failed 5. Member's degree of pain and functional disability 6. Proposed procedure
Cosmetic & Reconstructive	14000 14001 14020 14021 14041 14061 14302 15570 15572 15574 15730 15733 15734 15738 15740 15756 15769 15771 15773 17999 19316 19325 21137 21138 21139 21172 21175 21179 21180 21181 21182 21183 21184 21208 21209 21230 21235 21248 21249 21255 21256 21260 21261 21263 21267 21268 21275 21295 21296 21299 28344 30540 30545 30560 30620 L8600 Q2026	Medical notes documenting the following, when applicable: 1. History of medical conditions requiring treatment or surgical invention which includes all of the following: a. To prove medical necessity, a well-defined physical/physiologic abnormality resulting in a medical condition that requires treatment b. Recurrent or persistent functional impairment caused by the abnormality 2. Clinical studies/tests addressing the physical/physiologic abnormality confirming its presence and degree to which it causes impairment 3. High-quality color image(s) of the physical/physiologic abnormality: NOTE: All image(s) must be labeled with the: a. Date taken and b. Applicable case number obtained at time of notification, or member's name and ID number on the image(s) Submission of color image(s) are required and can be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 4. Physician plan of care with proposed procedures and whether this request is part of a staged procedure; indicate how the procedure will improve and/or restore function
Cosmetic & Reconstructive – Tissue Transfer (Flap) Repair	15730 15733 15734 15736 15738 15740 15756	Medical notes documenting the following, when applicable: 1. History of medical conditions requiring treatment or surgical intervention, including: a. A well-defined physical/physiologic abnormality resulting in a medical condition that requires treatment b. Recurrent or persistent functional deficit caused by the abnormality 2. Clinical studies/tests addressing the physical/physiologic abnormality confirming its presence and degree to which it causes impairment 3. Color photos, where applicable, of the physical and/or physiological abnormality 4. Physician plan of care with proposed procedures including expected outcome

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Custom Ankle-Foot Orthoses (AFO) and Knee-Ankle-Foot Orthoses (KAFO)	L1904 L1920 L1932 L1951 L1960 L2000 L2005 L2010 L2020 L2030 L2034 L2036 L2037 L2038 L2040 L2126 L2128 L2136 L2232 L4631	Medical notes documenting the following, when applicable: 1. Current prescription from physician 2. Physician office notes with the following a. The reason for the orthotic i. Diagnosis including diabetes b. Physical exam related to support the need of the orthotic. Include the neurological, circulatory, skin and musculoskeletal examination that supports the request c. Duration the condition is expected to persist d. Physician documentation indicating weakness or instability of the knee, ankle or foot requiring support in more than one plane e. Physician office notes indicating a neurological, circulatory or orthopedic condition(s) that supports the need for a custom orthotic f. Detailed documented clinical from the physician to support a custom orthosis versus a prefabricated device g. Functional impairment that is interfering with activities of daily living (meals, walking, getting dressed, driving) h. Date and type of injury/ surgery, if applicable 3. Orthotist notes to include the following: a. Equipment quote with billing codes and cost b. Reason for the orthotic 4. If **replacement:** provide age of current orthotic and reason for replacement
Custom Knee Orthotic (KO)	L1810 L1820 L1832 L1834 L1843 L1844 L2387 L2800	Medical notes documenting the following, when applicable: 1. Current prescription from physician 2. Physician office notes with the following: a. The reason for the orthotic b. Diagnosis c. Physical exam related to support the need of the orthotic Include the neurological, circulatory, skin and musculoskeletal examination that supports the request d. Documentation of deformity of the leg or knee e. Size of thigh and calf f. Sufficiency of muscle mass g. Documentation that pediatric orthotics for small limbs or straps with additional length for large limbs have been ruled out h. Functional impairment that is interfering with activities of daily living (meals, walking, getting dressed, driving) i. Date and type of injury/ surgery, if applicable 3. Orthotist notes to include the following: a. Equipment quote with billing codes and cost b. Reason for the orthotic 4. If a **replacement:** Provide age of current orthotic and reason for replacement
Decompression Unspecified Nerves	64722	Physician office notes including: 1. Condition requiring procedure 2. History and physical by the attending/ treating Physician

Service	Codes	Medical Records Used for Reviews
		3. Symptoms and functional impairment 4. Pertinent imaging studies 5. History and duration of unsuccessful conservative therapy, when applicable
Deep Brain and Cortical Stimulation	61863 61864 61867 61868 61885 61886 L8679 L8680 L8682 L8685 L8686 L8687 L8688	Medical notes documenting the following, when applicable: 1. Diagnosis 2. Specify specific procedure 3. History of the medical condition(s) requiring treatment or surgical intervention, including: a. Condition interference with activity of daily living 4. Documentation of signs and symptoms; including onset, duration, and frequency, including: a. Seizures history including number of seizures per month 5. Physical exam 6. Relevant medical history, including: a. Medical co-morbidities b. Psychiatric co-morbidities 7. Treatments tried, failed, or contraindicated. Include the dates and reason for discontinuation 8. Current medications used to treat condition, include start date 9. Relevant surgical history, including previous movement disorder surgery and dates a. Reports of all recent imaging studies and applicable diagnostics, including: b. Results of imaging for skeletal deformities and cervical myelopathy c. Results of brain MRI d. Results of video electroencephalographic (EEG) monitoring e. Results of levodopa challenge f. Results of Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) 10. Physician treatment plan, including: a. Member understanding of surgical risk, complications and need for follow-up b. Planned placement of electrodes for preoperative mapping
Electric Tumor Treatment Therapy (TIFT)	E0766	Medical notes documenting the following, when applicable: For treatment of **newly diagnosis glioblastoma** 1. Physician Order 2. Diagnosis 3. Physician notes to include the following a. Documenting prior treatment with Radiation Therapy b. Provide results of the Karnofsky Performance Status (KPS) or Eastern Cooperative Oncology Group (ECOG) Performance Status c. Documentation that the member has been counselled that the device must be worn at least 18 hours daily d. Documentation that member is only taking Temozolomide for cancer drug For treatment of a **reoccurrence of glioblastoma** 1. Physician Order

Service	Codes	Medical Records Used for Reviews
		2. Diagnosis 3. Physician notes to include the following: a. Provide results of the Karnofsky Performance Status (KPS) or Eastern Cooperative Oncology Group (ECOG) Performance Status b. Documentation that the member has been counselled that the device must be worn at least 18 hours daily For **continued therapy** 1. Date and results of the most recent MRI imaging prior to the request to continue therapy 2. Documentation that member is taking Temozolomide as the only cancer drug 3. Provide results of the Karnofsky Performance Status (KPS) or Eastern Cooperative Oncology Group ECOG Performance Status 4. Documentation that the member has been wearing the device for at least 18 hours per day
Electrical and Ultrasound Bone Growth Stimulators	E0747 E0748 E0749 E0760	**Electrical and Bone Growth Stimulators (E0747, E0748 & E0749)** Medical notes documenting the following, when applicable: 1. Current physician prescription or order 2. Any risk factors that apply: a. Member with co-morbid conditions such as diabetes, obesity, osteoporosis, or current tobacco use that could compromise bone healing b. Spondylolisthesis (including grade) c. If the member has had or will be having a spinal fusion, include the following: i. Date of surgery, either past or future and number of vertebral levels fused; or ii. Documentation of failed spinal fusion and date of reoperation of same site **Ultrasonic Bone Growth Stimulators (E0760)** Medical notes documenting the following, when applicable: 1. Current physician prescription or order 2. Date, site and type of fracture 3. Diagnostic imaging reports 4. Treatment of the fracture, including treatment already completed (date of surgery(ies) if applicable) and treatment planned
Electrical Stimulation and Electromagnetic Therapy for Wounds	E0769 G0281	Medical notes documenting the following, when applicable: 1. Current prescription from physician 2. Diagnosis 3. Wound stage and size 4. Prior treatment duration and response 5. Plan of treatment
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation - Functional	63650 63655 63663 63664 63685 64555 L8679 L8680 L8682 L8685 L8686 L8687 L8688	Medical notes documenting the following, when applicable: 1. Date of spinal cord injury and/or restorative surgery 2. Specific device to be implanted 3. Intact lower motor units (both muscle and peripheral nerve)

Service	Codes	Medical Records Used for Reviews
Neuromuscular Stimulation (FES)		4. Muscle and joint stability for weight bearing and the ability to support upright posture independently 5. Muscle contractions and sensory perception response 6. Transfer ability and independent standing tolerance 7. Hand and finger dexterity 8. Absence of hip and knee degenerative disease 9. Absence of history of long bone fracture secondary to osteoporosis 10. High level of motivation, commitment and cognitive ability for device use
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation - Neuromuscular Electrical Stimulators (NMES)	L8679 L8680 L8682 L8685 L8686 L8687 L8688	Medical notes documenting the following, when applicable: 1. Current prescription from physician 2. Diagnoses for the condition(s) needing treatment 3. Clinical notes including: a. History b. Physical exam c. Laboratory testing 4. Physician treatment plan
Enteral Nutrition (Tube Feedings)	B4102 B4103 B4104 B4149 B4150 B4152 B4153 B4155 B4158 B4159 B4160 B4161 B9000 B9002 B9004 B9006 B9998	Medical notes documenting the following, when applicable: 1. Current prescription from physician 2. Office notes and clinical documentation that includes: a. The name of the formula b. The diagnosis for which the formula is being prescribed c. The member's current height and weight d. Copy of a nutritional evaluation e. Documentation of the member's daily dietary/ calorie intake f. Documentation whether the formula is the member's sole source of nutrition g. Documentation that a feeding tube is in place and in use 3. If a pump is ordered, include the following documentation: a. Justification as to why gravity feed is not satisfactory b. Rate of infusion
Epidural Steroid Injections for Spinal Pain	62320 62322 64484	For **initial** Injection medical notes documenting the following, when applicable: 1. Diagnosis 2. History of the medical condition(s) requiring treatment or surgical intervention 3. Documentation of signs and symptoms; including onset, duration, and frequency 4. Physical exam demonstrating presence of radicular pain 5. Relevant medical history related to the spine or surrounding tissues 6. Treatments tried (e.g. pharmacotherapy, exercises), failed, or contraindicated; include the dates, duration of treatment and reason for discontinuation 7. Relevant surgical history, including dates 8. Reports of all recent imaging studies and applicable diagnostics 9. Physician treatment plan, including: a. Location of proposed injection (side and level) b. Plan for use of fluoroscopic, CT or ultrasound guidance

Service	Codes	Medical Records Used for Reviews
		10. **For subsequent injection,** in addition to the above, also include the following: a. Response to initial epidural injection, including i. Duration of the effect ii. Percentage of pain reduction
Facet Joint Injections for Spinal Pain	64490 64493	For the **initial injection** provide medical notes documenting the following, when applicable: 1. Diagnosis 2. Documentation of history of the medical condition(s), signs and symptoms; include onset, duration, and frequency, finding suggesting facet joint origin, severity of pain on a 1-10 scale after conservativie treatment (e.g., pharmacotherapy, exercises) 3. Physical exam, including presence of findings on facet loading maneuvers 4. Relevant medical and surgical history; including history of previous spinal procedures/interventions, including but not limited to previous facet injection and previous surgery(ies) 5. Treatments tried, failed, or contraindicated; include the dates, duration of treatment and reason for discontinuation 6. Reports of all recent imaging studies and applicable diagnostics 7. Physician treatment plan, including: a. Location of proposed injection (side and level) b. Plan for radiofrequency joint denervation/ablation procedure 8. For **second injection** in addition to the above, also include the response to initial facet injection, including: a. Level, side and date of initial and second injection b. Duration of the effect c. Description of functional improvement of physical functions
Functional Endoscopic Sinus Surgery (FESS)	31240 31253 31254 31255 31256 31257 31259 31267 31276 31287 31288	Medical notes documenting the following, when applicable: 1. Diagnosis 2. History of illness 3. Recent physical exam 4. Signs and symptoms 5. Treatments tried, failed, or contraindicated; include the dates and reason for discontinuation (e.g. intranasal corticosteroids, antibiotic therapy, nasal lavage/irrigation) 6. Recent CT scan report including the date of scan, documenting the following: a. Which sinus has the disease, including side b. The extent of disease including the percent of opacification or the use of a scale such as the Modified Lund-Mackay Scoring System c. Whether the images were taken pre- or post-medical management 7. Upon request, recent CT scan images: a. That show the abnormality for which surgery is being requested b. Are the optimal images to show the abnormality of the affected area including, when applicable the use of a scale such as the Modified Lund-Mackay Scoring System to define the severity

Service	Codes	Medical Records Used for Reviews
		c. Labeled with the date taken and the applicable case number obtained at time of notification, or member's name and ID number NOTE: CT images can be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 8. For Recurrent Acute Rhinosinusitis also include the number of episodes per year of Acute Rhinosinusitis
Gastrointestinal Motility Disorders, Diagnosis and Treatment	43647 43648 43881 43882 64590 64595	Medical notes documenting the following, when applicable: 1. Diagnosis 2. Relevant history to include symptomatology 3. Physical findings 4. Results of diagnostic tests and imaging studies 5. Co-morbidities 6. Medical treatments tried, failed and contraindicated 7. Current physician treatment plan, if applicable
Gastrointestinal Pathogen Nucleic Acid Detection Panel Testing for Infectious Diarrhea	0097U 87505 87506 87507	Medical notes documenting the following, when applicable: 1. Current diagnosis 2. History of illness and date of onset 3. Co-morbidities 4. Results of blood cultures and other lab tests 5. Number of pathogen targets being tested 6. Physician treatment plan based on the results of panel testing
Gender Dysphoria	14000 14001 14041 15734 15738 15750 15757 15758 15769 15771 15773 15820 15821 15822 15823 15830 15847 15877 15878 15879 17999 19303 19316 19318 19325 19350 21121 21123 21125 21127 21137 21138 21139 21172 21175 21179 21180 21208 21209 21210 30400 30410 30420 30430 30435 30450 53410 53430 54125 54400 54401 54405 54520 54660 54690 55175 55180 55970 55980 56625 56800 56805 57110 57335 58150 58180 58260 58262 58290 58291 58541 58542 58543 58544 58550 58552 58553 58554 58570 58571 58572 58573 58661 58720 58940 64856 64892 64896 67900	Medical notes documenting the following, when applicable: 1. The number of months member has completed continuous hormone therapy or reason for medical contraindication or non-indication 2. A written clinical assessment from a Qualified Healthcare Professional experienced in treating Gender Dysphoria, who has independently assessed the individual. The assessment should include all of the following: a. Persistent, well-documented gender dysphoria b. The member is capable to make a fully informed decision and to consent for treatment c. Member's age d. Results of psychosocial-behavioral evaluation including management of coexisting mental health condition 3. Treatment plan that includes ongoing and follow-up care by a Qualified Healthcare Professional experienced in treating Gender Dysphoria, and whether request is part of a staged procedure 4. For **voice modification surgery**, in addition to the above, also include documentation of presurgical voice lessons and/or therapy 5. For **genital surgery**, in addition to the above, also include: a. Clinical written assessment from a second Qualified Healthcare Professional experienced in treating Gender Dysphoria, who has independently assessed the individual b. Documentation the member has completed at least 12 months of successful continuous full-time real-life experience in identified gender

Service	Codes	Medical Records Used for Reviews
Genetic Testing for Cardiac Disease	0237U 81410 81411 81413 81414 81439 81479	Medical notes documenting the following, when applicable: 1. Personal history of the condition, if applicable, including age at diagnosis 2. Complete family history (usually three-generation pedigree) relevant to condition being tested 3. Genetic testing results of family member, if applicable, and reason for testing 4. Ethnicity/ancestry (e.g., Ashkenazi Jewish), if reason for testing 5. Any prior genetic testing results 6. How clinical management will be impacted based on results of genetic testing 7. Genetic counseling (if available)
Genetic Testing for Hereditary Cancer	0101U 0102U 0103U 0129U 0238U 81162 81163 81164 81432 81433 81435 81436 81437 81438 81441 81479	Medical notes documenting the following, when applicable: 1. Personal history of the condition, if applicable, including age at diagnosis 2. Complete family history (usually three-generation pedigree) relevant to condition being tested 3. Genetic testing results of family member, if applicable, and reason for testing 4. Ethnicity/ancestry (e.g., Ashkenazi Jewish), if reason for testing 5. Any prior genetic testing results 6. How clinical management will be impacted based on results of genetic testing 7. Genetic counseling (if available)
Genetic Testing for Neuromuscular Disorders	0216U 0217U 0417U 81440 81460 81465 81479	Medical notes documenting the following, when applicable: 1. Personal history of the condition, if applicable, including age at diagnosis 2. Complete family history (usually three-generation pedigree) relevant to condition being tested 3. Genetic testing results of family member, if applicable, and reason for testing 4. Ethnicity/ancestry (e.g., Ashkenazi Jewish), if reason for testing 5. Any prior genetic testing results 6. How clinical management will be impacted based on results of genetic testing 7. Genetic counseling (if available)
Gynecomastia Surgery	19300	Medical notes documenting all of the following, when applicable: 1. History of the medical condition requiring treatment 2. Relevant history of prescribed medication 3. Screening for non-prescription and/or recreational drugs or substances (examples include, but are not limited to the following: testosterone, marijuana, asthma drugs, phenothiazines, anabolic steroids, cimetidine and calcium channel blockers) 4. Severity of pain and details of functional or physiological impairment (s) 5. Frontal and lateral high quality, color photographs of the torso including expected outcome NOTE: All images must be labeled with the: a. Date taken b. Applicable case number obtained at time of notification, or member's name and ID number Submission of photographs can be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 6. Treatment plan for proposed surgery

Service	Codes	Medical Records Used for Reviews
		7. Reports of all recent imaging studies and applicable diagnostic tests, including: a. Mammography b. Hormone testing (e.g., beta-human chorionic gonadotropin, estradiol, follicle-stimulating hormone, luteinizing hormone, prolactin, testosterone) c. Liver enzymes d. Serum creatinine e. Thyroid function studies
Hearing Aids and Devices Including Wearable, Bone-Anchored and Semi-Implantable	69710 69714 69717 69799 L8690 L8691 L8692	Medical notes documenting the following, when applicable: 1. What is being requested bone anchored, semi-implantable, implantable, etc. 2. Medical notes documenting all of the following: 3. Describe the type of hearing loss (sensorineural vs. conductive or mixed) 4. Severity and frequencies affected 5. Whether or not member is a candidate for an air-conduction hearing aid 6. For **replacement** of any components indicate date of initial purchase and the reason for replacement
Hospital Beds	**Fixed Height:** E0250 E0251 E0270 E0290 E0291 E0328 **Variable Height:** E0255 E0256 E0292 E0293 **Semi Electric:** E0260 E0261 E0294 E0295 E0329 **Total Electric:** E0265 E0266 E0296 E0297 **Heavy Duty:** E0301 E0302 E0303 E0304 **Pediatric:** E0300	**Fixed Height /Heavy Duty /Pediatric**: Medical notes documenting the following, when applicable: 1. Current prescription from physician 2. Office notes with clinical documentation identifying: a. The need for positioning of the body in ways not feasible with an ordinary bed; and/ or b. The need for positioning of the body in ways not feasible with an ordinary bed to alleviate pain; and/ or c. The need for the head of bed elevated more than 30 degrees and why; and/ or d. The need for traction equipment e. Member Weight **Variable Height**: Medical notes documenting the following, when applicable: 1. Current prescription from physician 2. Office notes with clinical documentation identifying: a. The need for positioning of the body in ways not feasible with an ordinary bed; and/ or b. The need for positioning of the body in ways not feasible with an ordinary bed to alleviate pain; and/ or c. The need for the head of bed elevated more than 30 degrees and why; and/ or d. The need for traction equipment e. Member weight 3. Explanation of requirement for height difference (to permit transfers to chair, wheelchair or standing position) 4. Current transfer and bed mobility skills 5. Current functional limitations with regards to activities of daily living **Semi-Electric**:

Service	Codes	Medical Records Used for Reviews
		Medical notes documenting the following, when applicable: 1. Current prescription from physician 2. Office notes with clinical documentation identifying: a. The need for positioning of the body in ways not feasible with an ordinary bed; and/ or b. The need for positioning of the body in ways not feasible with an ordinary bed to alleviate pain; and/ or c. The need for the head of bed elevated more than 30 degrees and why; and/ or d. The need for traction equipment e. Member weight 3. Rationale for requirement for frequent or immediate changes in body position 4. Susceptibility to ulcers, identify reasons
Hysterectomy	58150 58152 58180 58260 58262 58267 58270 58275 58280 58290 58291 58292 58294 58541 58542 58543 58544 58550 58552 58553 58554 58570 58571 58572 58573	Medical notes documenting the following, when applicable: 1. Primary indication for the hysterectomy 2. Physician office notes which includes the following: a. Complete history and physical exam including OB/GYN, surgical and co-morbid medical condition(s), including thyroid disease b. Symptoms attributable to pelvic disease, including: i. Duration ii. Severity iii. Relation to menstrual cycle iv. Impact on activities of daily living (ADL) c. Reports of relevant diagnostic evaluations, including: i. Laboratory (including genetic testing results) ii. Pathology (including biopsy results) iii. Imaging includes Ultrasound, MRI, CT, etc. iv. Prior procedure/operative reports d. Diagnostic procedures (e.g. endometrial sampling, PAP, laboratory studies, hysteroscopy or D&C) e. Reports of all treatments attempted, declined, contraindicated or failed or including dates and clinical response.
Implantable Beta-Emitting Microspheres for Treatment of Malignant Tumors	37243 79445 S2095	Medical notes documenting the following, when applicable: 1. Diagnosis 2. Eastern Cooperative Oncology Group (ECOG) score 3. Location of malignancy 4. Feasibility of resection 5. Is the condition refractory to or relapsed following systemic chemotherapy 6. Physician's treatment plan including plan for liver transplant
Implanted Electrical Stimulator for Spinal Cord	63685 63688 L8680 L8682 L8685 L8686 L8687 L8688 L8679	Medical notes documenting the following, when applicable: 1. Indicate if this request is for a trial or permanent placement; if for permanent placement, include: a. Percentage of pain reduction at least 50% pain relief with temporary implant

Service	Codes	Medical Records Used for Reviews
		b. Operative notes from the spinal cord stimulatory or dorsal root ganglion (DRG) trial 2. Condition requiring procedure 3. Physical examination 4. Prior therapies/treatments tried, failed, or contraindicated; include the dates and reason for discontinuation 5. Documentation of psychological evaluation 6. Physician plan of care 7. For revision or removal, include documentation, including: a. Details of complication b. Complete treatment plan
Implanted Spinal Drug Delivery Systems	62320 62322 62324 62325 62326 62327 62350 62351 62360 62361 62321 62362	Medical notes documenting the following, when applicable: 1. Condition requiring procedure 2. For **cancer related pain**: a. For trial: i. Presence and location of metastatic lesions ii. Presence or absence of increased intracranial pressure iii. Life expectancy iv. Treatments tried, failed, or contraindicated. Include the dates and reason for discontinuation b. For **implantation**, in addition to the above also provide the degree of pain reduction after trial 3. For **spasticity**: a. For trial i. Member's symptoms, pain, location, and severity including functional impairment that is interfering with activities of daily living (meals, walking, getting dressed, driving) ii. Results of Modified Ashworth Scale or Penn Spasm Frequency Scale iii. Treatments tried, failed, or contraindicated. Include the dates and reason for discontinuation iv. Psychiatric or substance use history v. Presence or absence of increased intracranial pressure b. For implantation, in addition to the above also provide: i. Degree of pain reduction after trial, if applicable ii. Score/ point reduction in the Modified Ashworth Scale or Penn Spasm Frequency Scale 4. For **chronic non-malignant pain**: a. For trial: i. Etiology of pain ii. Treatments tried, failed, contraindicated or refused. Include the dates and reason for discontinuation, contraindication or refusal. iii. Documentation of consideration given to additional treatments for underlying conditions iv. Psychiatric or psychosocial issues/ history

Service	Codes	Medical Records Used for Reviews
		b. For implantation, in addition to the above also provide the degree of pain reduction after trial
Infertility Diagnosis, Treatment and Fertility Preservation	55870 58321 58322 58323 58970 58974 58976 79648 89250 89251 89253 89254 89255 89257 89258 89259 89260 89261 89264 89268 89272 89280 89281 89335 89337 89398 89342 89343 89344 89346 89352 89353 89354 89356 S4011 S4013 S4014 S4015 S4016 S4022 S4023 S4025 S4026 S4028 S4030 S4031 S4035 S4037	Medical notes documenting the following, when applicable: 1. Initial history and physical 2. All clinical notes including rationale for proposed treatment plan 3. All ovarian stimulation sheets for timed intercourse, IUI and/or IVF cycles 4. All embryology reports 5. All operative reports 6. Laboratory report FSH, AMH, estradiol and any other pertinent information 7. Ultrasound report antral follicle count and any other pertinent information 8. HSG report 9. Semen analysis
Injectables for Reconstructive Procedures	Q2026	Medical notes documenting the following, when applicable: 1. History of medical conditions requiring treatment or surgical intervention which includes all the following: a. To prove medical necessity, a well-defined physical/physiologic abnormality resulting in a medical condition that requires treatment 2. High-quality color photograph(s); all photographs must be labeled with: a. Date taken b. Applicable case number obtained at time of notification, or member's name and ID number on the photograph(s) Submission of color image(s) are required and can be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted
Intensity Modulated Radiation Therapy (IMRT)	77385 77386 77387 77520 77522 77523 77525 G6015 G6016 G6017	Medical notes documenting the following, when applicable: 1. Specific condition and target volume requiring IMRT 2. Specific history of prior radiation therapy. Information to include sites of delivery, total dose and dose per fraction 3. A statement documenting the special need for performing IMRT vs Conventional or 3-Dimensional radiation treatment. a. If failure of dose constraints, cite the specific constraint, including protocol number, if applicable. NOTE: only Quantec or RTOG dose constraints are applicable 4. When applicable, for delivery of a prescribed radiation therapy course with IMRT, submit the dose prescription along with documentation in the form of a clearly labeled, color comparative 3D and IMRT plans including dose volume histogram and dose table, in absolute doses. When citing an RTOG dose constraint, provide the RTOG protocol number 5. An immediately adjacent area has been previously irradiated or will be irradiated, and abutting portals must be established with high precision For IMRT used for **breast cancer**, provide the above and answers to the following: 1. Will the left-sided internal mammary nodes be treated? 2. Will the patient be receiving partial breast irradiation (when dose is up to 5 fraction)?

Service	Codes	Medical Records Used for Reviews
		For IMRT used for **whole brain radiation**, provide the above documentation in addition to the following: 1. Presence or absence of brain metastasis 1. Results of the Eastern Cooperative Oncology Group (ECOG) performance status or Karnofsky performance status (KPS) status tests 2. Prognosis time period 3. Presence or absence of leptomeningeal disease
Interspinous Fusion and Decompression Devices	22849 22850 22852 22853 22854 22855 22859 22899	Medical notes documenting the following, when applicable: 1. Condition requiring procedure including origin of the back pain 2. Surgical history, including date(s) and outcome(s) 3. Upon request, we may require the specific diagnostic image(s) that show the abnormality for which surgery is being requested, which may include MRI, CT scan, X-ray, and/or bone scan; consultation with requesting surgeon may be of benefit to select the optimal images NOTE: When requested, diagnostic image(s) must be labeled with: a. The date taken b. Applicable case number obtained at time of notification, or member's name and ID number on the image(s) Upon request, diagnostic imaging must be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 4. Diagnostic image(s) report(s) by a radiologist, including presence or absence of: a. Degeneration of the disc b. Spondylolisthesis including Grade 5. Describe the surgical technique(s) planned, including name of interspinous bony fusion device requested and use of an interbody cage
Light and Laser Therapy	17106 17107 17108 17380 0479T 0480T 17999	Medical notes documenting the following, when applicable: 1. History of medical conditions requiring treatment or surgical intervention which includes all the following: a. Specific location and size of the lesion b. To prove medical necessity, a well-defined physical/physiologic abnormality resulting in a medical condition that requires treatment c. Recurrent or persistent functional impairment caused by the abnormality 2. Treatments tried, failed, contraindicated or on-going; include the dates, duration, and reason for discontinuation 3. Clinical studies/tests addressing the physical/physiologic abnormality confirming its presence and degree to which it causes impairment 4. High-quality color photograph(s); all photos must be labeled with the date taken and the applicable case number obtained at time of notification, or member's name and ID number on the photograph(s) a. Date taken b. Applicable case number obtained at time of notification, or member's name and ID number on the photograph(s) Submission of color image(s) are required and can be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted

Service	Codes	Medical Records Used for Reviews
		5. Physician plan of care with proposed procedures and whether this request is part of a staged procedure. Indicate how the procedure will improve and/or restore function
Liposuction for Lipedema	15877 15878 15879	Medical notes documenting the following, when applicable: 1. Diagnosis 2. Specific procedure requested and treatment plan, including post-operative plan of care 3. History of the medical condition(s) requiring treatment 4. Level of functional impairment 5. Physical exam including evidence of lipedema 6. High-quality color photographs. All photos must be labeled with the date taken and the applicable case number obtained at time of notification, or member's name and ID number on the photograph(s) 7. Relevant medical history 8. Treatments tried, failed, or contraindicated. Include the dates and reason for discontinuation, including: 9. Failure of the limb adipose hypertrophy to respond to recommended bariatric surgery or other medically supervised weight loss modalities 10. Relevant surgical history, including dates 11. Assessment of the cause of functional impairment by primary care provider or specialist in vascular conditions other than treating surgeon
Lower Extremity Endovascular Procedures	37220 37221 37224 37225 37226 37227 37228 37229	Medical notes documenting the following, when applicable: 1. Diagnosis 2. Relevant history and physical to include member symptoms and pertinent findings due ischemia 3. Treatments tried, failed, and/or contraindicated, including structured exercise program, pharmacologic therapy, and smoking cessation, if applicable 4. Details of functional disability(ies) interfering with work or activities of daily living (ADL) 5. Documentation of ischemic peripheral artery disease including Ankle-brachial index (ABI) 6. Diagnostic images (e.g., duplex ultrasound, computed tomography angiography [CTA], magnetic resonance angiography [MRA], or invasive angiography) documenting the location and severity of occlusion
Mechanical Stretching Devices (Dynamic and Static)	E1800 E1801 E1810 E1811 E1812 E1815 E1816 E1818 E1820 E1821 E1830	Medical notes documenting the following, when applicable: 1. Current prescription from physician 2. Physician office notes that indicate all of the following: a. The affected joint b. The date of injury/ surgery c. Previous treatments attempted d. Treatment plan, including proposed duration of use
Meniscus Implant and Allograft	29868	Medical notes documenting the following, when applicable: 1. Complete report(s) of diagnostic imaging (MRI, CT scan, x-rays and bone scan) NOTE: For pediatric age, indicate status of growth plates

Service	Codes	Medical Records Used for Reviews
		2. Condition requiring procedure 3. Severity of pain and details of functional disability(ies) interfering with activities of daily living (ADL) 4. Pertinent physical examination of the relevant joint 5. Co-morbid medical condition(s) 6. Prior therapies/treatments tried, failed, or contraindicated; include the dates, duration of treatment and reason for discontinuation 7. Degree of degenerative changes in surrounding cartilage, as measured by the Outerbridge Grade 8. If the location is being requested is an inpatient stay, provide documentation to support site of care
Mobility Devices, Options and Accessories	E0984 E0986 E1002 E1003 E1004 E1005 E1006 E1007 E1008 E1010 E1016 E1018 E1236 E1238 K0005 K0812 K0848 K0849 K0850 K0851 K0852 K0853 K0854 K0855 K0856 K0857 K0858 K0859 K0860 K0861 K0862 K0863 K0864 K0868 K0869 K0870 K0871 K0877 K0878 K0879 K0880 K0884 K0885 K0886 K0890 K0891	Medical notes documenting the following, when applicable: 1. Documentation of face-to-face encounter, within six months prior to the prescription (written order), from the treating practitioner including date, when applicable 2. Current prescription (written order) from physician, including: a. Initial or replacement b. Rental or purchase c. Specific HCPCS code(s) for item and each accessory requested d. Equipment make, model and price quotation e. Rationale for selection of specific device and accessories f. If repair or replacement, current device used, date of initial acquisition, status of warranty, as well as: i. Proper use and continued benefit ii. Date the member acquired the original equipment and original payer iii. Make, model, configuration and serial number of the existing equipment iv. Reason for repair or replacement v. Detailed equipment replacement/ repair quote vi. History of previous repairs vii. Replacement cost viii. If stolen, include police report 3. Diagnosis 4. Most recent member weight and height 5. For **Wheelchairs and Power Mobility Devices** - In addition to the above, provide medical notes documenting the following, when applicable: a. Current ambulation status b. Transfer status c. Functional limitations as related to activities of daily living (ADLs) and mobility activities of daily living (MRADLs) as well as risk of performing ADL d. Estimated duration of use e. Measurement of: i. Strength

Service	Codes	Medical Records Used for Reviews
		ii. Ability to move and distance moved with assistive equipment iii. Coordination deficits iv. Pain level f. Primary setting of wheelchair/power mobility device g. Current mobility assistance devices h. Prior device(s) tried, failed or contraindicated. Include the dates, duration of use and reason for discontinuation i. Home and safety evaluation assessment 6. For **Wheelchair, Seating, Options and Accessories** - In addition to the above, provide medical notes documenting the following, when applicable a. Safe utilization, tolerance and benefit of requested device b. Proper use and continued benefit c. Prior accessories/ options tried, failed, or contraindicated. Include the dates and reason for discontinuation
Molecular Oncology Companion Diagnostic Testing	0022U 0037U 0179U 0239U 0242U 81445 81449 81450 81451 81455 81479 81599	Medical notes documenting the following, when applicable: 1. Cancer type and stage 2. Results of prior comprehensive genomic profiling, if applicable 3. Proposed treatment based on results of genetic testing (if available)
Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions	0050U 0171U 0285U 0364U 81450 81451 81455 81479 81599	Medical notes documenting the following, when applicable: 1. Confirmed or suspected hematologic cancer type and stage, if available, date of diagnosis 2. Results of other diagnostic testing (e.g., blood smear, flow cytometry, FISH), if applicable 3. Proposed treatment based on results of genetic testing (if available)
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions	0018U 0022U 0026U 0037U 0047U 0048U 0179U 0211U 0239U 0242U 0244U 0245U 0250U 0285U 0287U 0288U 0306U 0307U 0326U 0334U 0379U 0388U 0391U 0409U 81445 81449 81455 81457 81459 81462 81463 81464 81479 81518 81519 81520 81521 81522 81523 81541 81542 81546 81552 81599	Medical notes documenting the following, when applicable: 1. Cancer type and stage including, if applicable, tumor size and nodal status 2. Results of other biomarker testing (e.g., estrogen receptor, HER-2 neu), if applicable 3. Proposed treatment based on results of genetic testing (if available)
naviHealth Admissions for Inpatient Rehabilitation Facility (IRF)	n/a	**Initial Admission:** Medical notes documenting the following, when applicable: 1. Hospital Face Sheet 2. History & Physical Document 3. Therapy Evaluations 4. Most Recent Therapy Notes (Within the Past 24-48 hours) 5. Most Recent Physician Note (Within the Past 24 hours) 6. Physician Orders Sheet/Medication List 7. Post-Procedure Notes 8. Nursing Admission Assessment **Continuation of Stay:** Medical notes documenting the following, when applicable:

Service	Codes	Medical Records Used for Reviews
		1. Therapy Evaluations (within the past 48 hours) 2. Most Recent Therapy Notes (within the past 24-48 hours) 3. Most Recent Physician Notes (within past 24 hours) 4. Most Recent Nursing Notes (within past 24 hours)
naviHealth Admissions for Long Term Acute Care (LTAC)	n/a	**Initial Admission:** Medical notes documenting the following, when applicable: 1. Hospital Face Sheet 2. History & Physical Document 3. Therapy Evaluations 4. Most Recent Therapy Notes (Within the Past 24-48 hours) 5. Most Recent Physician Note (Within the Past 24 hours) 6. Physician Orders Sheet/Medication List 7. Post-Procedure Notes 8. Nursing Admission Assessment **Continuation of Stay:** Medical notes documenting the following, when applicable: 1. Therapy Evaluations (within the past 48 hours) 2. Most Recent Therapy Notes (within the past 24-48 hours) 3. Most Recent Physician Notes (within past 24 hours) 4. Most Recent Nursing Notes (within past 24 hours)
naviHealth Admissions for Skilled Nursing Facility (SNF)	n/a	**Initial Admission:** Medical notes documenting the following, when applicable: 1. Hospital Face Sheet 2. History & Physical Document 3. Therapy Evaluations 4. Most Recent Therapy Notes (Within the Past 24-48 hours) 5. Most Recent Physician Note (Within the Past 24 hours) 6. Physician Orders Sheet/Medication List 7. Post-Procedure Notes 8. Nursing Admission Assessment **Continuation of Stay:** 1. Medical notes documenting the following, when applicable: 2. Therapy Evaluations (within the past 48 hours) 3. Most Recent Therapy Notes (within the past 24-48 hours) 4. Most Recent Physician Notes (within past 24 hours) 5. Most Recent Nursing Notes (within past 24 hours)
Negative Pressure Wound Therapy (NPWT) - Wound VAC	E2402	Medical notes documenting the following, when applicable: 1. Diagnosis requiring Negative Pressure Wound Therapy (NPWT) 2. History of the medical condition(s) requiring treatment 3. Recent physical exam 4. Signs and symptoms 5. Treatments tried, failed, or contraindicated; include the dates, duration of treatment and reason for discontinuation 6. Wound stage/ size/ location/ measurements

Service	Codes	Medical Records Used for Reviews
		7. Wound type (post-surgical, venous stasis, decubitus ulcer, diabetic neuropathic ulcer) 8. Date(s) of surgery including debridement 9. The date the NPWT (wound vacuum assisted closure (VAC)) was started 10. Favorable wound environment has been maintained with: a. Appropriate dressing/ dressing changes b. Adequate nutritional status c. Management of incontinence, if applicable d. Wound is free of the following: i. Active bleeding or exposed vasculature in the wound ii. Necrotic tissue, iii. Exposed bone, nerves or organs in vicinity of wound iv. Malignancy present in wound, v. Open fistula to an organ or body cavity within the vicinity of the wound vi. Uncontrolled soft tissue infection or osteomyelitis within vicinity of wound 11. If member is diabetic, the member is maintained on a diabetic management program 12. Member is turned and repositioned with the presence of a Stage III or IV pressure ulcer 13. If applicable, indicate when NPWT (wound VAC) has been used previously on the same type of wound with a favorable clinical response
Obstructive Sleep Apnea Treatment - Oral Appliances	E1399	Medical notes documenting the following, when applicable: 1. Documentation of most recent face-to-face encounter with prescribing physician, when applicable including face-to-face clinical evaluation by a qualified physician (MD or DO) trained in sleep medicine or with an Advanced Practice Provider (APP) working under the direct supervision of a sleep medicine physician 2. Current prescription (written order) from physician, including: a. Initial appliance or replacement b. If replacement, current device used and reason for replacement 3. Diagnosis, including confirmation the treating physician diagnosed the member with OSA 4. Results of sleep study including severity of the OSA (AHI, REI, or RDI values, etc.) 5. Prior treatments tried, failed, or contraindicated, including documentation of the member's intolerance or refusal of PAP, include the dates, duration of treatment and reason for discontinuation 6. If the oral appliance is being prescribed for reasons other than OSA, an explanation of why appliance is needed
Obstructive Sleep Apnea Treatment - Surgical	21142 21199 21206 21685 41599 42145 64553 64568 64570 L8679 L8680 L8686	Medical notes documenting the following, when applicable: 1. Diagnosis 2. Specific procedure being requested 3. History of the medical condition(s) requiring treatment or surgical intervention

Service	Codes	Medical Records Used for Reviews
		4. Documentation of signs and symptoms; including onset, duration, and frequency 5. Reports of all recent imaging studies and applicable diagnostic tests, including results of sleep study confirming diagnosis and severity of the OSA, including quantification of relevant indexes 6. Excessive daytime sleepiness documented with an Epworth Sleepiness Scale or other validated scale 7. Treatments tried, failed, or contraindicated. Include the dates, duration of treatment and reason for discontinuation, including: a. Failed trial or intolerance or refusal of Positive Airway Pressure (PAP) treatments b. Failed trial, intolerance or inappropriate patient anatomy for oral appliance therapy 8. In addition to the requirements above, medical notes documenting the following, when applicable for: a. For Mandibular Osteotomy, presence or absence of retrolingual or lower pharyngeal functional obstruction b. For Maxillomandibular Osteotomy and Advancement (MMA): presence or absence of craniofacial disproportion or deformities, with evidence of maxillomandibular deficiency c. For Implantable Hypoglossal Nerve Stimulation (adult): i. Body Mass Index (BMI) ii. Presence or absence of complete concentric collapse at the soft palate level iii. Percentage of central or mixed sleep apnea d. Implantable hypoglossal nerve stimulation (adolescent age 10-18 years with Down Syndrome): i. Surgical history or contraindication for adenotonsillectomy ii. Presence or absence of tracheostomy iii. Presence or absence of complete concentric collapse at the soft palate level confirmed by a medication induced sleep endoscopy test iv. Refusal of an MMA procedure for non-concentric palatal collapse
Office Based Procedures Site of Service for Commercial Plans	11402 11403 11404 11406 11420 11421 11422 11423 11424 11426 11442 19000 20552 20553 27096 31579 57460 64479 64490 64493 62270 62321 64633 64635	If the location being requested is anything other than the office, provide medical notes documenting the following, when applicable: 1. History 2. Physical examination including patient weight and co-morbidities 3. Surgical plan 4. Physician privileging information related to the need for the use of the hospital outpatient department 5. American Society of Anesthesiologists (ASA) score, as applicable
Orthognathic (Jaw) Surgery	21121 21123 21125 21127 21141 21142 21143 21145 21146 21147 21150 21151 21154 21155 21159 21160 21188 21193 21194 21195 21196 21198 21199 21206	Medical notes documenting the following, when applicable: 1. Condition requiring procedure 2. Comprehensive history of the medical condition(s) requiring treatment or surgical intervention; including:

Service	Codes	Medical Records Used for Reviews
	21208 21209 21210 21215 21240 21242 21244 21245 21246 21247 21248 21249 21255 21296 21299	a. A well-defined physical and/or physiological abnormality (e.g., congenital abnormality, functional or skeletal impairments) resulting in a medical condition that has required or requires treatment; and b. The physical and/or physiological abnormality has resulted in a functional deficit; and c. The functional deficit is recurrent or persistent in nature 3. Reports of all recent imaging studies and applicable diagnostic tests, including: a. Cephalometric tracings and analysis addressing the physical and/or physiological abnormality that confirm its presence and the degree to which it is causing impairment, with appropriate measurements, when applicable b. Radiologic image interpretations including lateral cephalometric radiograph, AP radiograph and panoramic radiograph 4. All related, supporting imaging (color photographs, radiologic images including lateral cephalometric radiograph, AP radiograph, and panoramic radiograph) must be diagnostic quality NOTE: All images must be labeled with the: a. Date taken b. Applicable case number obtained at time of notification, or member's name and ID number Submission of images can be submitted via the external portal at www.uhcprovider.com/paan; faxes of will not be accepted 5. Treating physician's plan of care including surgical treatment objectives, which must include the expected outcome for the improvement of the functional deficit
Orthotics	**Lower Body** L1630 L1640 L1680 L1685 L1700 L1710 L1720 L1730 L1755 L2280 L2320 L2520 L2525 L2526 L2627 L2628 L2861 L2999 L3000 L3010 L3020 L3160 L3201 L3202 L3203 L3204 L3206 L3207 L3208 L3209 L3211 L3212 L3213 L3214 L3215 L3216 L3221 L3250 L3251 L3252 L3253 L3254 L3255 L3257 L3265 L3320 L3485 L3649 L3960 L4050 L4055 L5611 L5647 L5649 L5673 L5683 L5845 L5962 **Upper Body** L0140 L0150 L0170 L0200 L0220 L0452 L0468 L0480 L0482 L0484 L0486 L0622 L0623 L0624 L0629 L0631 L0632 L0634 L0636 L0638 L0700 L0710 L0810 L0820 L0830 L0859 L0999 L1000 L1001 L1005 L1200 L1300 L1310 L1499 L3674 L3720	Medical notes documenting the following, when applicable: 1. Current prescription from physician 2. Provide the reason for the orthotic 3. Physician office notes documenting the following: a. Diagnosis including diabetes b. Physical exam related to support the need of the orthotic. Include the neurological, circulatory, skin and musculoskeletal examination that supports the request c. Functional impairment that is interfering with activities of daily living (meals, walking, getting dressed, driving) d. Date and type of injury/ surgery, if applicable 4. Orthotist notes to include the following: a. Equipment quote with billing codes and cost b. Reason for the orthotic 5. If a **replacement,** provide age of current orthotic and reason for replacement

Service	Codes	Medical Records Used for Reviews
	L3763 L3764 L3765 L3766 L3891 L3900 L3901 L3904 L3921 L3956 L3961 L3967 L3971 L3973 L3975 L3976 L3977 L3978 L4000 L4030 L4040 L4045	
Outpatient Surgical Procedures – Site of Service for Commercial Plans	See applicable code list in policy	If the location being requested is an outpatient hospital provide medical notes documenting the following, when applicable: 1. History 2. Physical examination including patient weight and co-morbidities 3. Surgical plan 4. Physician privileging information related to the need for the use of the hospital outpatient department 5. American Society of Anesthesiologists (ASA) score, as applicable 6. Specific criteria (see coverage rationale) that qualifies the individual for the site of service requested
Outpatient Surgical Procedures – Site of Service for Community Plans • Arizona (AZ) • Florida (FL) • Maryland (MD) • Michigan (MI) • Mississippi (MS) • Missouri (MO) • New Jersey (NJ) • New York (NY) • North Carolina (NC) • Ohio (OH) • Pennsylvania (PA) • Rhode Island (RI)	For applicable coding refer to Health Plans by State section of UHCprovider.com and select the appropriate state, then Community Plan to view codes included in the Site of Service program.	Medical notes documenting the following, when applicable: 1. History 2. Physical examination including patient weight and co-morbidities 3. Surgical plan 4. Physician privileging information related to the need for the use of the hospital outpatient department 5. American Society of Anesthesiologists (ASA) score, as applicable 6. Specific criteria (see coverage rationale) that qualifies the individual for the site of service requested

Service	Codes	Medical Records Used for Reviews
• Tennessee (TN) • Texas (TX) • Washington (WA)		
Pacemaker (Replacement of Batteries, Generator)	33212 33213 33221 33227 33228 33229 33230 33231 33240 33262 33263 33264	Medical notes documenting the following, when applicable: 1. Current prescription 2. Physician office notes that include: a. Documented non-reversible symptomatic bradycardia due to sinus node dysfunction b. Documented non-reversible symptomatic bradycardia due to second degree and/ or third degree atrioventricular block c. Relevant history & physical d. Relevant medication(s) taken e. Reports of all recent imaging studies and applicable diagnostics (i.e. EKG) f. Documentation of signs and symptoms; with onset, duration, and frequency
Pacemaker (replacement of lead electrodes)	33224 3225	Medical notes documenting the following, when applicable: 1. Relevant history & physical, including history of initial pacemaker placement 2. Relevant medication(s) taken 3. Reports of all recent imaging studies and applicable diagnostics (i.e. EKG) 4. Documentation of signs and symptoms; with onset, duration, and frequency
Pacemaker insertion (replacement)	33206 33207 33208 33249 33270	Medical notes documenting the following, when applicable: 1. Current prescription 2. Indicate whether this is an initial request, or replacement 3. Physician office notes that include: a. Documented non-reversible symptomatic bradycardia due to sinus node dysfunction b. Documented non-reversible symptomatic bradycardia due to second degree and/ or third degree atrioventricular block c. Relevant history & physical d. Relevant medication(s) taken e. Reports of all recent imaging studies and applicable diagnostics (i.e. EKG) f. Documentation of signs and symptoms; with onset, duration, and frequency
Panniculectomy and Body Contouring Procedures	15830 15847 15877 15878 15879	Medical notes documenting the following, when applicable: 1. Primary complaint, history of complaint, and physical exam, including: a. Grade of panniculus b. Body mass index (BMI) c. History of recent weight loss in lbs/kgs d. History of weight stability and duration e. History of dermatologic complications 2. Diagnosis of dermatologic complications (e.g., skin infection, ulcers, maceration, skin breakdown, etc.)

Service	Codes	Medical Records Used for Reviews
		3. Treatments (e.g., antibiotic, corticosteroid, antifungal) for dermatologic complications tried, failed, or contraindicated; include the dates, duration of treatment, and reason for discontinuation 4. Details of functional limitations due to pannus interfering with activities of daily living (ADL) 5. Relevant surgical history, including dates 6. Physician treatment plan, including specific and associated procedures 7. Upon request we may require high-quality color photographs a. For panniculectomy, photographs of a full-frontal view of the hanging pannus, a full-frontal view of pannus elevated that allows any skin damage can be evaluated, and a full lateral view of the hanging pannus b. All photographs must be labeled with the date taken and the applicable case number obtained at time of notification, or member's name and ID number on the photograph(s) NOTE: Submission of color photographs can be submitted via the external portal at www.uhcprovider.com/paan; faxes of color photographs will not be accepted
Patient Lifts	E0621 E0625 E0630 E0635 E0636 E0639 E0640 E1035 E1036	Medical notes documenting the following, when applicable: 1. Documentation of most recent face-to-face encounter with prescribing physician, when applicable 2. Current prescription (written order) from physician, when applicable including: a. Initial or replacement b. Rental or purchase c. Specific HCPCS code(s) for item and each accessory requested d. Equipment make, model and price quotation e. If replacement, current device used, date of initial acquisition, status of warranty and reason for replacement 3. Medical notes documenting the following, when applicable: a. Diagnosis b. Member's weight c. Inability to safely make transfers between bed and a chair, wheelchair, or commode without the use of a lift d. Requirement for supine positioning e. Proper use and continued benefit
Pectus Deformity Repair	21740 21742 21743	Medical notes documenting the following, when applicable: 1. Diagnosis 2. History of the medical condition(s) requiring treatment or surgical intervention 3. Documentation of functional limitation/impairment 4. Results of all recent imaging studies and applicable diagnostics, including results of: a. CT scan including Haller Index or Correction Index calculation b. Pulmonary function test – total lung capacity c. Echocardiogram including ejection fraction d. Exercise stress test including cardiopulmonary function values

Service	Codes	Medical Records Used for Reviews
		5. Treatments tried, failed, or contraindicated. Include the dates, duration of treatment and reason for discontinuation 6. Physician treatment plan
Pediatric Day Care for Community Plan: • Louisiana (LA) • Mississippi (MS) • Texas (TX)	T1025 T1026 T2002	Medical notes documenting the following, when applicable: 1. Current Physician order that is within 30 days of personally examining the member 2. Physician office notes that include: a. Member diagnosis, age, and letter of medical necessity b. Documentation of ongoing need for skilled nursing care and supervision, therapeutic interventions, or skillful observations c. Status as medically dependent or technologically dependent d. Documentation of member stability for outpatient services and risk status towards other persons e. Address whether delayed skilled intervention is expected to result in the following: i. Deterioration of a chronic condition; ii. Loss of function; iii. Imminent risk to health status due to medical fragility iv. Risk of death f. Documentation of current residence, including whether living with responsible adult or in any 24-hour care setting g. Relevant member history h. Treatment plan, including visit frequency and duration
Percutaneous Neuroablation for Severe Cancer Pain and Trigeminal Neuralgia	64620 64640	Medical notes documenting the following, when applicable: 1. Diagnosis 2. History of the medical condition(s) requiring treatment or surgical intervention 3. Documentation of signs and symptoms; including onset, duration, and frequency 4. Physical exam 5. Relevant medical history 6. Treatments tried, failed, or contraindicated. Include the dates and reason for discontinuation
Percutaneous Patent Foramen Ovale (PFO) Closure	93580	Medical notes documenting the following, when applicable: 1. History and co-morbid medical condition(s) 2. Documentation of member's symptoms 3. Complete report(s) of diagnostic imaging (MRI, CT Scan, X-rays) 4. Results of diagnostic testing performed to rule out other causes including, but not limited to, carotid disease, hypercoagulable states or atrial fibrillation; and 5. Documentation of an evaluation by a cardiologist and a neurologist and both are in agreement that the stroke is likely embolic in nature
Percutaneous Vertebroplasty and Kyphoplasty	22510 25111 22512 22513 22514 22515	Medical notes documenting the following, when applicable: 1. Onset of the condition, length and duration 2. Documentation of member's symptoms, pain, location, and severity including functional impairment that is interfering with activities of daily living (meals, walking, getting dressed, driving)

Service	Codes	Medical Records Used for Reviews
		3. History and co-morbid medical condition(s) 4. No evidence of spinal cord compression 5. Treatments tried and failed 6. Complete report(s) of diagnostic imaging (MRI, CT Scan, X-rays and/or bone scan) 7. Upon request we may require the specific diagnostic image(s) that show the abnormality for which surgery is being requested, which may include MRI, CT scan, X-ray, and/or bone scan; consultation with requesting surgeon may be of benefit to select the optimal images NOTE: When requested, diagnostic image(s) must be labeled with: a. The date taken b. Applicable case number obtained at time of notification, or member's name and ID number on the image(s) Upon request, diagnostic image(s) must be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted.
Pharmacogenetic Testing	0029U 0173U 0175U 0345U 0411U 0419U 81418 81479	Medical notes documenting the following, when applicable: 1. Diagnosis 2. History of illness, including treatments tried and failed 3. Genes included in the Panel 4. Name of lab performing test and name of test, if available 5. Physician treatment plan based on results of genetic testing
Physical and Occupational Therapy (PT/OT) – For Community Plans *Applicable to Community Plans that have a prior authorization requirement* • Arizona (AZ) • California • Florida (FL) • Hawaii (HI) • Indiana (IN) • Kansas (KS) • Kentucky (KY) • Maryland (MD) • Michigan (MI) • Nebraska (NE) • New York (NY) – HARP only • North Carolina (NC) • Ohio (OH)	For applicable coding refer to the Health Plans by State section of UHCprovider.com and select the appropriate state, then Community Plan to view codes included in the Outpatient Therapy program.	For Community Plan members for a service request for therapy (PT, OT) must be generated by an in-network physician. Provide required documentation indicated in the UHC Community Plan Coverage Determination Guidelines for physical and occupational therapy Request for the **initial therapy evaluation/ initial therapy visit** request should include the following: 1. Physician referral dated within 30 days of the request 2. Name and tax ID number of the servicing provider/facility 3. Medical notes documenting all of the following: a. Diagnosis and ICD-10 code(s) b. History & physical, including history of condition and limitations include the date of onset of illness and or injury c. Describe the functional impairment that impact health, safety and independence d. Provide a comparison of the prior level of function to the current level of function e. Provide current durable medical equipment being utilized and future durable medical needs identified f. Medical and surgical history, including any planned procedures or treatment g. Reports from any applicable imaging studies or diagnostic testing h. Short and long-term therapeutic goals and objectives:

Service	Codes	Medical Records Used for Reviews
• Rhode Island (RI) • Tennessee (TN) • Texas (TX) • Virginia (VA) • Washington (WA) • Wisconsin (WI)		i. Treatment frequency, duration, and anticipated length of treatment session(s) if applicable Requests for **continuation** of therapy visits should include medical notes documenting: 1. Clinically significant and measurable improvement of the member's condition 2. Start of care date 3. Time period covered by the report 4. Changes in prognosis, plan of care and/ or goals, with reason for change Request for **re-evaluation** should include medical notes documenting: 1. Date of last therapy evaluation/ revaluation 2. Update in prognosis, plan of care goals and clearly established discharge criteria with reasons for update 3. Updated plan of care must not be older than 90 days AND 4. Goals must be measurable, functional and time based If the Site of Service requested is an Outpatient Hospital clinic in addition to the above, provide medical notes documenting the following: 1. Clinical documentation to indicate why an in-network freestanding clinic is not an option 2. Indicate if therapy is part of an annual or semi-annual Comprehensive Care Management assessment clinic visit for any of the following: paraplegia, quadriplegia, or traumatic brain injury 3. Indicate if therapy is due to a complication of the following: major multiple trauma, recent amputation, post-acute stroke, or severe burn injury
Plagiocephaly and Craniosynostosis Treatment - Cranial Orthotic	S1040	Medical notes documenting the following, when applicable: 1. Current prescription from physician 2. Diagnosis and indication(s) for cranial orthosis 3. General physical exam related to support the need of the orthotic; include the neurological, circulatory, skin and musculoskeletal examination that supports the request, as well as presence or absence of torticollis 4. At least one of the following: a. Cranial vault asymmetry index (CVAI) b. Cephalic index (CI) c. Transcranial diameter difference (TDD) d. Cranial vault asymmetry (CVA) e. Children's Healthcare of Atlanta (CHOA) level For more details about the definition of these measurements, see InterQual criteria informational notes 5. Documentation of treatments tried, failed, contraindicated. Include the dates, duration, and reason for discontinuation, including: a. Repositioning b. Physical or occupational therapy 6. Orthotist notes to include the following: a. Equipment quote with billing codes and cost b. Reason for the orthotic c. Anthropometric Measurements

Service	Codes	Medical Records Used for Reviews
		7. Date of planned or completed craniosynotosis surgery, if applicable 8. Physician treatment plan, including: a. Plan to treat torticollis with cranial orthosis 9. In addition to the above, also provide the following for a request for continuation of treatment with a new cranial orthotic: a. Age of current orthotic b. Reason for replacement c. Adjustments/modifications to current cranial helmet if applicable d. Compliance with wear
Pneumatic Compression Devices	E0652	Medical notes documenting the following, when applicable: 1. Current prescription (written order) from physician, including: a. Initial or replacement b. Rental or purchase c. Specific HCPCS code(s) for item and each accessory requested d. Equipment make, model and price quotation e. Why the features of the device are needed f. If replacement, current device used, date of initial acquisition, status of warranty and reason for replacement 2. Medical notes documenting the following, when applicable: a. Member diagnosis b. Member symptoms c. Treatments tried, failed, or contraindicated. Include the dates and reason for discontinuation d. Treatment plan including: i. Pressure in each chamber ii. Frequency iii. Duration of each treatment
Preimplantation Genetic Testing and Related Services	58970 58974 76948 81228 81229 81479 89250 89251 89253 89254 89255 89258 89260 89261 89264 89268 89272 89280 89281 89290 89291 89342 89257 89352 S4011 S4015 S4016 S4022 S4037	For Preimplantation Genetic Testing (81228, 81229 and 81479): Medical notes documenting the following, when applicable: 1. Family history information related to the condition for which the member is being tested 2. Genetic testing results supporting the family history concerns [i.e., confirmation that the condition(s) being assessed for actually exist] 3. Genetic counseling documentation (if available) For Related Services: Medical notes documenting the following, when applicable (58970, 58974, 76948, 89250, 89251, 89253, 89254, 89255, 89258, 89260, 89261, 89264, 89268, 89272, 89280, 89281, 89290, 89291, 89342, 89257, 89352, S4011, S4015, S4016, S4022 and S4037): 1. Initial history and physical 2. All clinical notes including rationale for proposed treatment plan 3. All ovarian stimulation sheets for timed intercourse, IUI, and/or IVF cycles 4. All embryology reports 5. All operative reports

Service	Codes	Medical Records Used for Reviews
		6. Laboratory report FSH, AMH, estradiol, and any other pertinent information 7. Ultrasound report antral follicle count and any other pertinent information 8. HSG report 9. Semen analysis
Private Duty Nursing (PDN)	T1000	Medical notes documenting the following, when applicable 1. Home Health Certification (CMS-485) which includes the Plan of Care signed by a physician (M.D. or D.O.) or signed by an advanced practitioner (NP, CNS, or PA) in accordance with applicable law and regulation 2. Provide the clinical assessment including the days and hours of private duty nursing that is being requested (e.g.: 8 hours a day x 5 days a week (9 am – 5 pm)) 3. Details if the request is being made post-inpatient facility discharge 4. Provide details of the caregiver(s) status including: a. Willingness to participate b. Availability including: i. Hours in the home ii. Work schedule(s), including days and hours worked per day iii. Ability to learn and provide care 5. Consultation notes if the member is receiving services from subspecialist 6. Complete Medication Administration Record 7. Physician-ordered clinical assessment(s) including need and frequency for related services: a. Tracheostomy and status of airway issues b. Respiratory support, including: i. Oxygen therapy ii. Noninvasive positive pressure ventilation (NIPPV) iii. Mechanical ventilator status including documentation of weaning, if applicable iv. Need for nasal or oral suctioning v. Nebulizer treatments vi. High-frequency chest wall oscillation (HFCWO) vii. Chest Therapy c. Blood draws d. Feeding e. Elimination f. Seizure activity, frequency and applicable interventions needed g. Wound care including type of wound, type of dressing and frequency of dressing changes h. Assistance with Activities of Daily Living (ADLs) i. Use of a mobility device j. Ability to transfer k. Use of cast, splint, brace or assistance with passive range of motion l. Communication limitations m. Behavioral issues n. Cognitive or sensory impairment issues

Service	Codes	Medical Records Used for Reviews
Prostate Surgeries and Interventions	37243 52441 52442 53850 55874	Medical notes documenting the following, when applicable: 1. Diagnosis, including: a. Cancer risk group, including stage of disease b. Life expectancy c. Results of diagnostic prostate biopsy 2. History of the medical condition(s) requiring treatment or surgical intervention, including dates 3. Documentation of signs and symptoms; including onset, duration, and frequency 4. Physical exam, including result of digital rectal exam 5. Relevant medical history, including: a. List of current patient medication b. History of hematuria c. History of urinary incontinence d. Current urinary tract infection e. Allergy to nickel 6. Treatments tried, failed, or contraindicated; include the dates, duration and reason for discontinuation 7. Relevant surgical history, including dates 8. Reports of all recent imaging studies and applicable diagnostics including: a. Results of uroflow test (Q-max and postvoid residual (PVR) test) b. Results of urinalysis c. Results of PSA test d. Results of prostate biopsies e. Results of prostate volume via transrectal ultrasound (TRUS) f. Prostate volume g. Presence of signs or symptoms of obstruction h. Presence of protruding median lobe of the prostate 9. Physician treatment plan/surgical plan, including plans for pelvic lymph node dissection and radiotherapy
Prosthetic - Breast	A4280 L8000 L8001 L8002 L8010 L8015 L8020 L8030 L8031 L8032 L8035 L8039 S8460	Medical notes documenting the following, when applicable: 1. Current prescription from physician 2. Diagnosis 3. Previous breast surgery (ies), reason and date(s) 4. Indicate if initial or replacement a. Reason for replacement, if applicable b. Date received initial prosthetic, if applicable
Prosthetic - Eye and Face	**Eye:** L8043 L8044 L8049 **Face:** L8043 L8044 L8049	Medical notes documenting the following, when applicable: 1. Current prescription from physician 2. Diagnosis 3. Type of prosthetic and anatomical location 4. Physician office notes with clinical information documenting: a. Medical history related to the prosthetic including cause of facial defect b. Current and previous surgery (ies)

Service	Codes	Medical Records Used for Reviews
Prosthetic - Lower Extremity Prosthetics	L5010 L5020 L5050 L5060 L5100 L5105 L5150 L5160 L5200 L5210 L5230 L5250 L5270 L5280 L5301 L5321 L5331 L5400 L5420 L5530 L5535 L5540 L5585 L5590 L5616 L5639 L5643 L5649 L5651 L5681 L5683 L5703 L5707 L5724 L5726 L5728 L5780 L5795 L5814 L5818 L5822 L5824 L5826 L5828 L5830 L5840 L5845 L5848 L5856 L5858 L5930 L5960 L5966 L5968 L5973 L5979 L5980 L5981 L5987 L5988	Medical notes documenting the following, when applicable: 1. Vendor Coversheet with the narrative describing the request 2. Vendor invoice listing the HCPCS codes, make model description, indicate if the item is right or left 3. Other healthcare professional notes (i.e. physical therapist) 4. Current prescription 5. Physician office notes including documentation of: a. History related to the prosthetic request b. Examination findings to include strength, range of motion (ROM), condition of the contralateral limb, residual limb length and shape, and skin integrity of residual limb c. Co-morbidities d. Specify absent limb, including the date, level and etiology of amputation e. Current Functional classification level include specific examples and expected rehab potential f. Describe limitations to activities of daily living (ADLs) include assistive devices to facilitate ambulation within and outside the home g. Surfaces normally traversed include distance and environment h. Prosthetist notes to include medical justification for each of the requested prosthetic components 6. Specify if the request is for initial prosthetic, preparatory prosthetic, definitive prosthetic, replacement of the entire prosthetic leg, replacement of the prosthetic components/ accessories, or request for additional components and accessories 7. For **replacement** prosthesis, also include: a. The age of the current prosthesis and reason for replacement b. The components on the current prosthesis including socket, knee, foot, ankle, sock ply and liner thickness c. Describe changes in limb including, but not limited to, comparative residual limb measurements 8. For **socket replacement** also describe what adjustments have been tried and failed
Prosthetic - Miscellaneous	L5637 L5638 L6680 L6682 L7362 L7364 L7366 L7367 L8310 L8320 L8330 L8410 L8415 L8435 L8465 L8480 L8485 L8499 L8500 L8505 L8507 L8511 L8512 L8514 L8515 L8603 L8604 L8609 L8610 L8612 L8613 L8629 L8630 L8631 L8641 L8642 L8658 L8659 L8670 L8684 L8695 L8699	**Note:** Refer to anatomic site for detailed instructions (e.g., breast, eye, face, upper/ lower limb). For any prosthetic that does not fit into breast, eye, face, upper/lower limb categories submit the following: Medical notes documenting the following, when applicable: 1. Current prescription from physician 2. Physician office notes with clinical information documenting: a. Reason for prosthetic device b. Medical history c. Surgical history 3. Name of what is being requested, to include: a. Brand name b. Make and model c. Equipment quote

Service	Codes	Medical Records Used for Reviews
Prosthetic - Upper Extremity Myoelectric	L6026, L6621 L6696 L6697 L6881 L6882 L6884 L6925 L6935 L6945 L6955 L6975 L7007 L7008 L7009 L7045 L7180 L7181 L7190 L7191	Medical notes documenting the following, when applicable: 1. Vendor Coversheet with a narrative describing the request 2. Vendor invoice listing the HCPCS codes, make/ model description, indicate if the item is right or left. Include, make, model and pricing for unlisted codes. 3. Other healthcare professional notes if applicable (i.e. occupational therapist) 4. Current prescription 5. Professional qualification and training of the healthcare professional who performed the member evaluation 6. Physician office notes including documentation of: a. History related to the prosthetic request b. Co-morbidities c. Specify absent limb including the date, level and etiology of amputation d. Documentation of handedness e. Physical examination to include residual limb length and limb volume stability, skin integrity of residual limb, examination of contralateral limb, manual muscle testing and ROM examination f. Describe limitations to activities of daily living (ADLs) and instrumental ADLs (IADLs) without the prosthetic g. Prosthetist notes to include medical justification for each of the requested prosthetic components. Also, if applicable, documentation should include a description of the current prosthesis, to include the age and components of the current prosthetic arm h. Motivation to use device i. Member ability to tolerate prosthetic weight j. Member willingness and ability to participate in the training for the use of the prothesis (i.e. prosthetic rehabilitation) k. Member cognitive ability to operate prosthetic l. Environment in which the device will be used 7. Specify whether the prosthetic is an initial, replacement, preparatory or definitive or a request to upgrade 8. Rehabilitation plan 9. Final prosthetic proposal from ordering physician 10. For replacement prosthesis, also include: a. Age of the current prosthesis b. Reason for replacement c. Estimated cost of adjustment or repair if applicable 11. For a socket replacement include age of the current socket, reason for replacement, and comparative residual limb measurements showing a change in residual limb size, what adjustments have been made to the current socket to improve fit
Proton Beam Therapy	77385 77386 77520 77522 77523 77525 G6015 G6016	Medical notes documenting all of the following, when applicable: 1. History of medical condition requiring treatment 2. Documentation that sparing of the surrounding normal tissue cannot be achieved with standard radiation therapy techniques

Service	Codes	Medical Records Used for Reviews
		3. Evaluation includes a comparison of treatment plans for PBT, IMRT, and stereotactic body radiation therapy (SBRT) 4. For hypofractionated radiation, provide the prescribed total dose and dose per fraction 5. For delivery of radiation therapy course with standard fractionation, provide the dose prescription along with documentation in the form of a clearly labeled, color comparative proton, and IMRT dose volume histogram and dose table, in absolute doses noting that sparing of the surrounding normal tissue cannot be achieved with IMRT techniques 6. Note: If citing an RTOG dose constraint, provide the RTOG protocol number 7. Physician's treatment plan NOTE: The color comparative proton and IMRT dose volume histogram and dose table images can be submitted via the external portal at http://www.uhcprovider.com/paan; faxes of images will not be accepted.
Radiation Therapy: Fractionation, Image-Guidance, And Special Services	77014 77331 77370 77385 77386 77387 77401 77402 77412 77470 77520 77522 77523 77525 G6001 G6002 G6003 G6004 G6005 G6006 G6007 G6008 G6009 G6010 G6011 G6012 G6013 G6014 G6015 G6016 G6017	**Radiation Therapy Fractionation** Medical notes documenting the following, when applicable: 1. Diagnosis 2. History of present illness 3. Prior irradiated areas and their prescriptions 4. Proposed radiation prescription a. Number of fractions b. Dose per fraction c. Total dose **Image-guided Radiation Therapy (IGRT)** Medical notes documenting the following, when applicable: 1. Diagnosis 2. History of present illness 3. Current and previous treatments such as: a. Will you be radiating a previously irradiated area or an area directly adjacent to a previously irradiated area b. Will IGRT be used in conjunction with another radiation therapy modality c. Treatment modality 4. Patient BMI 5. Proposed treatment plan
Radiology Services	**Breast Imaging for Screening and Diagnosing Cancer** 76376 76377 76391 76498 77046 77047 77048 77049 0633T 0634T 0635T 0636T 0637T 0638T **Computed Tomographic (CT) Colonography** 74261 74262 74263 **CT Abdomen/ Pelvis**	Provider should call the number on the member's ID card when referring for radiology services. If the location being requested is an outpatient hospital provide medical notes documenting the following, when applicable: 1. Recent history 2. Physical examination including patient weight 3. Patient condition, allergy, chronic disease and surgical plan 4. Other specific criteria (see coverage rationale) that qualifies the individual for the site of service requested

Service	Codes	Medical Records Used for Reviews
	72192 72193 72194 74150 74160 74170 74176 74177 74178 75635 **CT Head** 70450 70460 70470 70480 70481 70482 70486 70487 70488 70490 70491 70492 **MRI Breast** 77046 77047 77048 77049 **MRI Head** 70551 70552 70553 70554 70555 70557 70558 70559 **MRI Joint Lower Extremity** 73721 73722 73723 **MRI Joint Upper Extremity** 73221 73222 73223 **MRI Spine** 72141 72142 72146 72147 72148 72149 72156 72157 72158 **MRI Spine/ Pelvis** 72195 72196 72197 **Positron Emission Tomography (PET)** 78459 78491 78492 78608 78609 78811 78812 78813 78814 78815 78816 A9515 A9526 A9552 A9580 A9587 A9588 G0219 G0235 G0252 S8085 **Site of Service - MRI/ CT Scan** 70450 70460 70470 70480 70481 70482 70486 70487 70488 70490 70491 70492 70496 70498 71250 71260 71270 71271 71275 72125 72126 72127 72128 72129 72130 72131 72132 72133 72191 72192 72193 72194 73200 73201 73202 73206 73700 73701 73702 73706 74150 74160 74170 74174 74175 74176 74177 74178 74261 74262 74263 75571 75572 75573 75574 75635 76380 76497 70336 70540 70542 70543 70544 70545 70546 70547	

Service	Codes	Medical Records Used for Reviews
	70548 70549 70551 70552 70553 70554 70555 71550 71551 71552 71555 72141 72142 72146 72147 72148 72149 72156 72157 72158 72159 72195 72196 72197 72198 73218 73219 73220 73221 73222 73223 73225 73718 73719 73720 73721 73722 73723 73725 74181 74182 74183 74185 75557 75559 75561 75563 76390 76498 77046 77047 77048 77049 77084 S8037 **Thyroid and Parathyroid** 78071 78072	
Radiopharmaceuticals	A9513 A9606 A9607 A9699 A9590	Medical notes documenting the following, when applicable: 1. Current prescription 2. Name and tax ID number of the servicing provider 3. Physician office notes that include: a. Member diagnosis b. Imaging reports demonstrating advancing disease c. Previous treatments rendered and response d. Requested dose, frequency, and interval
Respiratory Assistive Device – Bilevel Positive Airway Pressure (BIPAP) for Diagnosis of Obstructive Sleep Apnea (OSA) and Other Diagnoses	E0470 E0471 E0472	For **initial** three (3) month trial of therapy: 1. Current prescription from physician 2. Physician office notes indicating clinical condition and the following additional details: For **Obstructive Sleep Apnea (OSA)** include: 1. Face-to-face evaluation prior to sleep test to assess for OSA 2. Sleep test report scoring using 4% definition of hypopnea 3. Documentation of a trial of E0601 (CPAP) including clinical response For **Restrictive Thoracic Disorders** include: 1. Specific neuromuscular disease or thoracic cage abnormality and respiratory co-morbidities, AND 2. Arterial blood gas PaCo2 while awake and on prescribed FIO2, OR 3. Sleep oximetry study saturation results with minimum of 2-hour nocturnal recording while on prescribed FIO2, OR 4. For Neuromuscular disease only Maximal inspiratory pressure or forced vital capacity For **Severe COPD** include: 1. Arterial blood gas PaCo2 while awake and on prescribed FIO2 2. Sleep oximetry study saturation results with minimum of 2-hour nocturnal recording while on prescribed FIO2, 3. Documented evaluation of OSA and treatment with CPAP has been considered and ruled out For **Central Sleep Apnea or Complex Sleep apnea** include:

Service	Codes	Medical Records Used for Reviews
		1. A complete facility-based, attended polysomnogram that confirms CSA or CompSA, AND 2. Documents degree of improvement of the sleep-associated hypoventilation with the use of an E0470 or E0471 device on the settings that will be prescribed for initial use at home, while breathing the member's prescribed FIO2 For **Hypoventilation Syndrome** include: 1. Arterial blood gas PaCo2 while awake and on prescribed FIO2, AND 2. FEV1/ FVC spirometry results, AND 3. Arterial blood gas PaCO2, done during sleep or immediately upon awakening, and breathing the member's prescribed FIO2, or a facility-based polysomnogram of nocturnal recording time (minimum recording time of two (2) hours) For **continued rent to purchase of device** 1. Documentation in the member's medical record about the progress of relevant symptoms and member usage of the device up to that time 2. A signed and dated statement completed by the treating physician no sooner than 61 days after initiating use of the device, declaring that the member is compliantly using the device (# of hours per 24-hour period) and that the member is benefiting from its use For **Replacement** submit the following information: 1. Age and type of the current PAP therapy device 2. Reason as to why the device needs to be replaced 3. A recent face-to-face evaluation by the treating physician that documents continued compliance with benefit from the current PAP therapy
Rhinoplasty and Other Nasal Surgeries	30400 30410 30420 30430 30435 30450 30460 30462 30465 30560 30620 31242 31243 64999	Medical notes documenting the following, when applicable: 1. Diagnosis 2. Detailed history of nasal symptoms including evaluation and management notes for the date of service and the note for the day the decision to perform surgery was made 3. Evidence of chronic sinusitis with treatment, response, and duration 4. History of treatments tried, failed, or contraindicated 5. Specific diagnostic image(s) that show the abnormality for which surgery is being requested. Consultation with requesting surgeon may be of benefit to select the optimal images NOTE**:** Diagnostic images must be labeled with: a. The date taken and b. Applicable case number obtained at time of notification, or member's name and ID number on the image(s) Submission of diagnostic image(s) is required via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 6. Diagnostic imaging report(s) 7. Details of functional impairment, if applicable 8. Physician's plan of care

Service	Codes	Medical Records Used for Reviews
		9. High-quality color image(s) (full face photos in cases of post-traumatic nasal deformity) NOTE: All image(s) must be labeled with the: a. Date taken and b. Applicable case number obtained at time of notification, and member's name and ID number on the image(s) Submission of color image(s) is required via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 10. In addition to the above, additional documentation requirements may apply for CPT code 30560; refer to the Coverage Determination Guideline titled Cosmetic and Reconstructive Procedures
Sacral Nerve Stimulation for Urinary and Fecal Indications	64590 64595 L8679 L8680 L8682 L8685 L8686 L8687 L8688	Medical notes documenting the following, when applicable: 1. Diagnosis 2. History of the medical condition(s) requiring treatment, including: a. Origin of the dysfunction b. Presence or absence of bladder outlet obstruction c. Presence or absence of constipation 3. Signs and symptoms 4. Treatments tried, failed, or contraindicated; include the dates, duration of treatment and reason for discontinuation 5. Bladder capacity in milliliters 6. Individual's capacity to operate device 7. For permanent implantation, include percentage improvement of symptoms in response to a screening trial
Sacroiliac Joint Interventions	27279 27280 64451 G0259 G0260	Medical notes documenting the following, when applicable: 1. Condition requiring procedure 2. History and co-morbid medical condition(s), including presence or absence of somatoform disorder or generalized pain disorders 3. Member's symptoms including pain, location, severity and interference with activities of daily living (ADLs) 4. Physical exam, including: a. Specific location of tenderness b. Presence or absence of acute neurological deficits c. Results of at least three tests: i. Compression test ii. Distraction test iii. Patrick's or FABER test iv. Gaenslen's test v. Thigh thrust test vi. Sacral thrust test vii. Posterior provocation test 5. Reports of all recent imaging studies and applicable diagnostics 6. Treatments tried, failed, or contraindicated; include the dates, duration and reason for discontinuation

Service	Codes	Medical Records Used for Reviews
		7. Results of the fluoroscopically guided diagnostic intra-articular SIJ block(s) using local anesthetic (percent of pain reduction)
Screening Colonoscopy – Site of Service	45378 45380 45381 45384 45385 G0105 G0121	If the location being requested is an outpatient hospital, provide medical notes documenting of the following: 1. History relevant to procedure 2. Co-morbidities necessitating outpatient hospital setting 3. Physical examination, including patient weight 4. Planned procedure
Seat Lifts	E0172 E0627 E0628 E0629	Medical notes documenting the following, when applicable: 1. Current prescription from physician 2. Physician office notes with clinical information documenting: a. Diagnosis b. Whether the member is completely incapable of standing up from a regular armchair or any chair in his/ her home c. Whether the member has the ability to ambulate once standing d. Whether all appropriate therapeutic modalities to enable the member to transfer from a chair to a standing position (e.g., medication, physical therapy) have been tried and failed 3. Make, model, and type of lift 4. Price quote
Speech Generating Devices	E2502 E2504 E2506 E2508 E2510 E2511 E2512 E2599	Medical notes documenting the following, when applicable: 1. Diagnosis 2. Speech-language pathology written evaluation by a qualified speech and language pathologist, including: 3. Description of communication impairment (type, severity, language skills, cognition, anticipated course) 4. Description of cognitive and physical abilities as they relate to the use of the device 5. Rationale for selection of specific device and accessories 6. Prior treatments tried, failed, or contraindicated. Include the dates, duration of treatment and reason for discontinuation 7. Treating practitioner treatment plan and training schedule 8. Documentation of face-to-face encounter, within six months prior to the prescription (written order), from the treating practitioner including date, when applicable 9. Current prescription (written order) from treating physician consistent with and based upon the recommendation of a qualified speech and language pathologist, including: a. Initial or replacement b. Rental or purchase c. Specific HCPCS code(s) for item and each accessory requested d. Equipment make, model and price quotation e. If replacement, current device used, date of initial acquisition, status of warranty and reason for replacement

Service	Codes	Medical Records Used for Reviews
Speech Therapy (ST) – For Community Plans *Applicable to Community Plans that have a prior authorization requirements* • Arizona (AZ) • Florida (FL) • Louisiana (LA) • Mississippi (MS) • New Jersey (NJ) • Nebraska (NE) • New York (NY) – HARP only • Ohio (OH) • Tennessee's (TN)	For applicable coding refer to the Health Plans by State section of UHCprovider.com and select the appropriate state, then Community Plan to view codes included in the program	For Community Plan members for a service request for speech therapy must be generated by an in-network physician. Provide required documentation indicated in the applicable UHC Community Plan Coverage Determination Guidelines for speech therapy/ language pathology services Request for the **initial referral / order** prior to the speech language pathology or audiology evaluation. The order should include the following: 1. Physician referral dated within 30 days of the request 2. Name and tax ID number of the servicing provider/facility 3. Medical notes documenting all of the following: a. Diagnosis and ICD-10 code(s) pertinent to Speech Therapy request b. History & physical, including history of condition and limitations include the date of onset of illness and or injury, or exacerbation and any prior therapy treatment c. Describe the functional impairment that impact health, safety and independence d. Provide a comparison of the prior level of function to the current level of function e. Specialized/standardized assessments including name of the assessment, assessment scores and dates administered f. Short and long-term therapeutic goals and objectives: g. Treatment frequency, duration, and anticipated length of treatment session(s) if applicable h. Evaluation reports must include: 4. Documentation of collaboration with early intervention, head start, and public school programs (Individualized Family Service Plan (IFSP) or individualized education plan (IEP) may be required 5. If the current IEP is not available, the requesting therapist must include a description of the goals and objectives from both therapists 6. In addition to the above, if the member is bilingual or multilingual also include documentation of the member's primary language and identify any other languages spoken in the home Requests for **continuation** of therapy visits should include medical notes documenting: 1. Clinically significant and measurable improvement of the member's condition 2. Start of care date 3. Time period covered by the report 4. Changes in prognosis, plan of care and/ or goals, with reason for change Request for **re-evaluation** should include the elements required for an initial evaluation (above) as well as: 1. Update in prognosis, plan of care, goals and clearly established discharge criteria with reasons for update 2. Updated plan of care must not be older than 90 days AND 3. Goals must be measurable, functional and time based 4. Provide documentation to support site of care

Service	Codes	Medical Records Used for Reviews
		If the site of service requested is an outpatient hospital clinic in addition to the above, provide medical notes documenting the following: 1. Why an in-network freestanding clinic is not an option 2. Whether the therapy is part of an annual or semi-annual Comprehensive Care Management assessment clinic visit for any of the following: paraplegia, quadriplegia, or traumatic brain injury 3. Whether the therapy is due to a complication of the following: major multiple trauma, recent amputation, post-acute stroke, or severe burn injury
Spinal Fusion and Bone Healing Enhancement Products	20930 20931 22899	Medical notes documenting the following, when applicable: 1. Condition requiring procedure 2. History and co-morbid medical condition(s) 3. Member's symptoms, pain, location, and severity including functional impairment that is interfering with activities of daily living (meals, walking, getting dressed, driving) 4. Physical exam, including neurologic exam 5. History and duration of previous therapy, when applicable including: a. Physical therapy b. Medications (injections) c. Previous surgery d. Bracing e. Other attempted treatments 6. Whether the surgery will be performed with direct visualization or only with endoscopic visualization 7. Complete report(s) of diagnostic tests and imaging 8. Describe the surgical technique(s) planned [e.g., AxialLIF®, XLIF, ILIF, OLIF, LALIF, image-guided minimally invasive lumbar decompression (MILD®), percutaneous endoscopic discectomy with or without laser, etc.] 9. Specify the allograft product including brand name(s) to be used
Spinal Fusion and Decompression	22206 22207 22208 22210 22212 22214 22216 22220 22222 22224 22226 22532 22533 22534 22548 22551 22552 22554 22556 22558 22585 22590 22595 22600 22610 22612 22614 22630 22632 22633 22634 22800 22802 22804 22808 22810 22812 22830 22840 22841 22842 22843 22844 22845 22846 22847 22848 22849 22850 22852 22853 22854 22855 22586 22859 22899 63001 63003 63005 63012 63015 63016 63017 63020 63030 63035 63040 63042 63043 63044 63045 63046 63047 63048 63050 63051 63055 63056 63057 63064 63066 63075 63076 63077 63078 63081 63082 63085 63086 63087 63088 63090 63091 63101 63102 63103 63170 63172 63173 63185 63190 63191	Medical notes documenting the following, when applicable: 1. Condition requiring procedure 2. History and co-morbid medical condition(s) 3. Smoking history/status, including date of last smoking cessation 4. Member's symptoms, pain, location, and severity including functional impairment that is interfering with activities of daily living (ADLs) 5. Prior treatments tried, failed, or contraindicated. Include the dates, duration and reason for discontinuation 6. Failure of conservative therapy through lack of clinically significant improvement between at least two measurements, on a validated pain or function scale or quantifiable symptoms despite concurrent conservative therapies 7. Progressive deficits with clinically significant worsening based on at least two measurements over time 8. Surgical history, including date(s) and outcome(s) 9. Disabling symptoms

Service	Codes	Medical Records Used for Reviews
	63197 63200 63250 63251 63252 63265 63266 63267 63270 63271 63272 63275 63277 63280 63282 63285 63286 63287 63290 63300 63301 63302 63303 63304 63305 63306 63307 63308	10. Upon request, we may require the specific diagnostic image(s) that show the abnormality for which surgery is being requested, which may include MRI, CT scan, X-ray, and/or bone scan; consultation with requesting surgeon may be of benefit to select the optimal images Note: When requested, diagnostic image(s) must be labeled with: a. The date taken b. Applicable case number obtained at time of notification, or member's name and ID number on the image(s) Upon request, diagnostic imaging must be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 11. Diagnostic image(s) report(s) by a radiologist, including presence or absence of: a. Segment (s) instability b. Spinal cord compression c. Disc herniation d. Nerve root compression e. Quantification of subluxation, translation by flexion, angulation when appropriate f. Discitis g. Epidural abscess h. Scoliosis i. Kyphosis 12. Physical exam, including neurologic exam, including degree and progression of curvature (for scoliosis) a. Quantification of relevant muscle strength 13. Whether the surgery will be performed with direct visualization or only with endoscopic visualization 14. Complete report(s) of diagnostic tests, including: a. Results of biopsy(ies) b. Results of bone aspirate 15. Describe the surgical technique(s) planned 16. For revision surgery include documentation of: a. Clinical complications b. Relevant laboratory findings c. Relevant imaging d. Prior treatments for complications tried, failed, or contraindicated. Include the dates and reason for discontinuation
Stereotactic Body Radiation Therapy	32701 61796 61797 61798 61799 61800 63620 63621 77371 77372 77373 77432 77435 G0339 G0340	Medical notes documenting the following, when applicable: 1. Diagnosis 2. History of present illness 3. Patient performance status, when applicable, using Karnofsky Performance Status (KPS) score or Eastern Cooperative Oncology Group (ECOG) performance status 4. Relevant imaging report(s) 5. Proposed treatment plan

Service	Codes	Medical Records Used for Reviews
		6. Number of tumors present, their size and location 7. Stage of disease 8. Where the radiation will be delivered (anatomically) or to which organ, if applicable
Stress Echocardiogram	93350 93351	Medical notes documenting the following, when applicable: 1. Current prescription 2. Physician office notes that include: a. An electrical STRESS test alone is not useful or effective, and a STRESS echocardiogram is needed. Include results old electrical STRESS test b. Reports of all recent imaging studies and applicable diagnostics (i.e. EKG/ ECG) c. Documentation of signs and symptoms; including onset, duration, and frequency d. The member has significant valvular heart disease or high risk for CAD e. Provide the significance or the extent of myocardial ischemia (or scar), or to assess myocardial viability f. Relevant history & physical, including any planned surgery. g. Documentation that the service is requires to aid in diagnosis of hypertrophic or dilated cardiomyopathy or differentiate ischemic from non-ischemic cardiomyopathy h. List of medication(s) and treatment plan
Surgery of the Ankle	27700 27702 27703 29891 29892 29894 29895 29897 29898 29899	Medical notes documenting the following, when applicable: 1. Upon request we may require the specific diagnostic image(s) that show the abnormality for which surgery is being requested, which may include MRI, CT scan, X-ray, and/or bone scan; consultation with requesting surgeon may be of benefit to select the optimal images Note: When requested, diagnostic image(s) must be labeled with: a. The date taken b. Applicable case number obtained at time of notification, or member's name and ID number on the image(s) Upon request diagnostic image(s) must be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 2. Reports of all recent imaging studies and applicable diagnostic tests, including: a. Microbiological findings b. Synovial exam c. Erythrocyte sedimentation rate (ESR) d. C-reactive protein (CRP) 3. Condition requiring procedure 4. Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking) 5. Pertinent physical examination of the relevant joint 6. Co-morbid medical condition(s) 7. Prior therapies/ treatments tried, failed, or contraindicated. Include the dates and reason for discontinuation

Service	Codes	Medical Records Used for Reviews
		8. Date of previous failed surgery to the same joint, if applicable 9. Physician's treatment plan including pre-op discussion 10. For revision surgery, also include: a. Details of complication b. Complete (staged) surgical plan 11. If the location is being requested as an inpatient stay, provide medical notes to support the following, when applicable: a. Surgery is bilateral b. Member has significant co-morbidities; include the list of comorbidities and current treatment c. Member does not have appropriate resources to support postoperative care after an outpatient procedure; include the barriers to care as an outpatient
Surgery of the Elbow	24360 24361 24362 24363 24365 24370 24371 29830 29834 29835 29836 29837 29838	Medical notes documenting the following, when applicable: 1. Condition requiring procedure 2. Upon request, we may require the specific diagnostic image(s) that show the abnormality for which surgery is being requested, which may include MRI, CT scan, X-ray, and/or bone scan; consultation with requesting surgeon may be of benefit to select the optimal images Note: Diagnostic images must be labeled with: a. The date taken b. Applicable case number obtained at time of notification, or member's name and ID number on the image(s) Submission of diagnostic imaging is required via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 3. Reports of all recent imaging studies and applicable diagnostic tests) a. Microbiological findings b. Synovial fluid exam c. Erythrocyte sedimentation rate (ESR) d. C-reactive protein (CRP) 4. Pertinent physical examination of the relevant joint 5. Pain severity, circadian patterns of pain, location of pain, and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving) 6. Prior therapies/ treatments tried, failed, or contraindicated. Include the dates, duration and reason for discontinuation 7. Date of previous failed surgery to the same joint, if applicable 8. Physician's treatment plan, including pre-op discussion 9. For revision surgery, also include: a. Details of complication b. Complete (staged) surgical plan
Surgery of the Foot	28285 28289 28291 28292 28296 28297 28298 28299 29893	Medical notes documenting the following, when applicable: 1. Upon request we may require the specific diagnostic image(s) that show the abnormality for which surgery is being requested, which may include MRI, CT

Service	Codes	Medical Records Used for Reviews
		scan, X-ray, and/or bone scan; consultation with requesting surgeon may be of benefit to select the optimal images NOTE: When requested, diagnostic image(s) must be labeled with: a. The date taken b. Applicable case number obtained at time of notification, or member's name and ID number on the image(s) Upon request diagnostic image(s) must be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 2. Reports of all recent imaging studies and applicable diagnostic tests 3. Condition requiring procedure 4. Severity of pain, skin breakdown and details of functional disability(ies) impairment to include impact on activities of daily living (ADLs) 5. Pertinent physical examination of the relevant joint 6. Co-morbid medical condition(s) 7. Prior therapies/ treatments (e.g. padding, orthotic, footwear, physical therapy, activity modification, medications, etc.) tried, failed, or contraindicated. Include the dates, duration of treatment and reason for discontinuation 8. History of previous surgery(ies), if applicable 9. Physician's treatment plan including pre-op discussion 10. For revision surgery, also include: a. Details of complication b. Complete (staged) surgical plan 11. If the location is being requested as an inpatient stay, provide documentation to support site of care
Surgery of the Hand or Wrist	25441 25442 25443 25444 25446 25449 26531 26536 29840 29843 29844 29845 29846 29847	Medical notes documenting the following, when applicable: 1. Upon request we may require the specific diagnostic image(s) that show the abnormality for which surgery is being requested, which may include MRI, CT scan, X-ray, and/or bone scan; consultation with requesting surgeon may be of benefit to select the optimal images NOTE: When requested, diagnostic image(s) must be labeled with: a. The date taken b. Applicable case number obtained at time of notification, or member's name and ID number on the image(s) Upon request diagnostic image(s) must be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 2. Reports of recent imaging studies and applicable diagnostic tests, including: a. Microbiological findings b. Synovial exam c. Erythrocyte sedimentation rate (ESR) d. C-reactive protein (CRP) 3. Condition requiring procedure 4. Severity of pain and details of functional impairment to include impact on activities of daily living (ADLs) 5. Pertinent physical examination of the relevant joint 6. Co-morbid medical condition(s)

Service	Codes	Medical Records Used for Reviews
		7. Prior therapies/ treatments tried, failed, or contraindicated. Include the dates and reason for discontinuation 8. History of previous surgery(ies) to the same joint, if applicable 9. Physician's treatment plan including pre-op discussion 10. For revision surgery, also include: a. Details of complication b. Complete (staged) surgical plan 11. If the location is being requested as an inpatient stay, provide documentation to support site of care
Surgery of the Hip	27120 27125 27130 27132 27134 27137 27138 29914 29915 29916	Medical notes documenting the following, when applicable: 1. Upon request, we may require the specific diagnostic image(s) that show the abnormality for which surgery is being requested, which may include MRI, CT scan, X-ray, and/or bone scan; consultation with requesting surgeon may be of benefit to select the optimal images NOTE: When requested, diagnostic image(s) must be labeled with: a. The date taken b. Applicable case number obtained at time of notification or member's name and ID number on the image(s) Upon request, diagnostic imaging must be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 2. Diagnostic imaging report(s) 3. Condition requiring procedure 4. Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking) using a standard scale; such as Western Ontario and McMaster Universities Arthritis Index (WOMAC) or Hip Dysfunction and Osteoarthritis Outcome Score (HOOS) 5. Physician's treatment plan, including pre-op discussion 6. Pertinent physical examination of the relevant joint 7. Co-morbid medical conditions (cardiovascular diseases, hypertension, diabetes, cancer, pulmonary diseases, neurodegenerative diseases) 8. Prior therapies/treatments tried, failed, or contraindicated; include the dates and reason for discontinuation 9. Date of failed previous hip fracture fixation, if applicable 10. If the location is being requested as an inpatient stay, provide medical notes to support at least one of the following: a. Surgery is bilateral b. Member has significant co-morbidities; include the list of comorbidities and current treatment c. Member does not have appropriate resources to support post-operative care after an outpatient procedure; include the barriers to care as an outpatient 11. For revision surgery, include documentation of the complication and complete (staged) surgical plan

Service	Codes	Medical Records Used for Reviews
		12. In addition to the above, for **Femoroacetabular Impingement (FAI) Syndrome (29914, 29915, and 29916)**, also include radiographic reports of presence and severity of cartilage damage using Tönnis or Outerbridge grading
Surgery of the Knee	27412 27415 27416 27437 27438 27440 27441 27442 27443 27445 27446 27447 27486 27487 29866 29867 29870 29871 29873 29874 29875 29876 29877 29879 29880 29881 29882 29883 29884 29885 29886 29887 29888 29889 J7330 J7330	Medical notes documenting the following, when applicable: 1. Upon request we may require the specific diagnostic image(s) that show the abnormality for which surgery is being requested, which may include MRI, CT scan, X-ray, and/or bone scan; consultation with requesting surgeon may be of benefit to select the optimal images NOTE: When requested, diagnostic image(s) must be labeled with: a. The date taken b. Applicable case number obtained at time of notification, or member's name and ID number on the image(s) Upon request diagnostic image(s) must be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 2. Complete report(s) of diagnostic imaging (MRI, CT scan, X-rays and bone scan), including: a. Documented closure of skeletal plates (age less than 18 years) b. Presence or absence of focal full-thickness articular cartilage defect c. Size and location of focal cartilage defect d. Outerbridge grade e. Joint space and alignment 3. Reports of all recent applicable diagnostic tests, including: a. Microbiological findings b. Synovial exam c. Erythrocyte sedimentation rate (ESR) d. C-reactive protein (CRP) 4. Condition requiring procedure 5. Symptoms 6. Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking) 7. Cause of defect; e.g., acute or repetitive trauma 8. Pertinent physical examination of the relevant joint 9. Co-morbid medical condition(s) 10. Prior therapies/ treatments tried, failed, or contraindicated. Include the dates, duration, and reason for discontinuation 11. Date of failed previous surgery to the same joint, if applicable) 12. Physician's treatment plan including pre-op discussion 13. Consideration of arthroscopic approach, if applicable 14. For **revision** surgery, also include: a. Details of complication b. Complete (staged) surgical plan 15. If the location is being requested as an inpatient stay, provide documentation to support site of care

Service	Codes	Medical Records Used for Reviews
Surgery of the Shoulder	23470 23472 23473 23474 29805 29806 29807 29819 29821 29822 29823 29824 29825 29826 29827 29828	Medical notes documenting the following, when applicable: 1. Pertinent physical examination of the relevant joint 2. Severity of pain and details of functional disability(ies) interfering with activities of daily living (ADLs) 3. Upon request, we may require the specific diagnostic image(s) that shows the abnormality for which surgery is being requested, which may include MRI, CT scan, X-ray, and/or bone scan; consultation with requesting surgeon may be of benefit to select the optimal images NOTE: When requested, diagnostic images must be labeled with the: a. Date taken b. Applicable case number obtained at time of notification, or member's name and ID number on the image(s) Upon request, diagnostic imaging must be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 4. Reports of all recent imaging studies and applicable diagnostic tests including when applicable: a. Microbiological findings c. Synovial fluid cytology d. Erythrocyte sedimentation rate (ESR) e. C-reactive protein (CRP) 5. Condition requiring procedure, including relevant past history with dates 6. Physician's treatment plan including pre-op discussion 7. Feasibility of arthroscopic approach 8. Co-morbid medical condition(s) 9. Prior therapies/treatments tried, failed, or contraindicated; include the dates, duration, and reason for discontinuation 10. Member has the ability to participate in post-surgical rehabilitation 11. For revision surgery, also include: a. Details of complication b. Complete (staged) surgical plan c. If the location is being requested as an inpatient stay, provide medical notes to support site of service
Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins	36470 36471 36473 36474 36475 36476 36478 36479 37700 37718 37722 37780	Medical notes documenting the following, when applicable: 1. Diagnosis 2. History of the medical condition(s) requiring treatment or surgical intervention 3. Documentation of signs and symptoms; including onset, duration, frequency, and which extremity (right, left or both) 4. Pain or other symptoms that interfere with activities of daily living (ADL) related to vein disease including duration 5. Functional disability(ies), as documented on a validated functional disability scale, interfering with the ability to stand or sit for long periods of time (preparing meals, performing work functions, driving, walking, etc.) 6. Relevant medical history, including: a. DVT (deep vein thrombosis) b. Aneurysm

Service	Codes	Medical Records Used for Reviews
		c. Tortuosity 7. Physical exam, including: a. Which extremity (right, left or both) b. Vein(s) that will be treated (i.e., great saphenous vein (GSV) and small saphenous vein (SSV), etc.) c. Vein diameter including the specific anatomic location where the measurement was taken (i.e., proximal thigh, proximal calf, etc.) d. Duration of reflux including the position of member at the time of measurement and the anatomic location where the measurement was taken [i.e., standing, saphenofemoral junction (SFJ)] 8. Reports of recent imaging studies and applicable diagnostic tests 9. Prior non-invasive treatments of the veins that have been tried/ failed or were contraindicated. Include the dates, duration and reason for discontinuation 10. History of prior treatment complications (e.g. recurrent bleeding or significant hemorrhage) including the dates of occurrence 11. History of previous relevant vein procedure(s), if applicable 12. Proposed treatment plan with procedure code, including specific vein(s) that will be treated [e.g., great saphenous vein (GSV) and small saphenous vein (SSV), etc.], which extremity (left, right, or both), and date of procedure for each vein to be treated
Sympathetic Blockade	64520	Medical notes documenting the following, when applicable: 1. Diagnosis 2. History of the medical condition(s) requiring treatment or surgical intervention 3. Documentation of signs and symptoms; including onset, duration, and frequency 4. Physical exam 5. Relevant medical history 6. Treatments tried, failed, or contraindicated. Include the dates and reason for discontinuation
Total Artificial Disc Replacement	0098T 22856 22857 22858 22861 22862 22899	For **Cervical** and **Lumbar Surgery** Medical notes documenting the following, when applicable: 1. Diagnosis 2. Specific requested procedure 3. History of the medical condition(s) requiring treatment or surgical intervention, including: a. Level(s) of motor deficit b. Level(s) of sensory deficit c. Extremity weakness, numbness, pain, or loss of dexterity including unilateral or bilateral d. Gait disturbance, including investigation for other etiologies e. Bowel or bladder dysfunction, including investigation for other etiologies 4. History or signs of infection, malignancy, facet arthritis or spine instability at the level of disc replacement request 5. Documentation of signs and symptoms; including onset, duration, and frequency

Service	Codes	Medical Records Used for Reviews
		6. Physical exam, including: 7. Spasticity, including investigation for other etiologies 8. Relevant medical and surgical history, including: a. Osteoporosis or osteopenia b. Spondylosis, including severity and level c. Ankylosing spondylitis d. Rheumatoid arthritis e. Ossification of the posterior longitudinal ligament f. Presence or absence of fracture with deformity 9. Upon request, we may require the specific diagnostic image(s) that show the abnormality for which surgery is being requested, which may include MRI, CT scan, X-ray, and/or bone scan; consultation with requesting surgeon may be of benefit to select the optimal images NOTE: When requested, diagnostic image(s) must be labeled with: a. The date taken b. Applicable case number obtained at time of notification, or member's name and ID number on the image(s) Upon request, diagnostic imaging must be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted faxes will not be accepted 10. Treatments tried, failed, or contraindicated, include the dates and reason for discontinuation 11. Current medications used to treat condition, include start date 12. Reports of all recent imaging studies and applicable diagnostics, including results of imaging including specific spinal levels with pathology 13. Physician treatment plan 14. For **Lumbar Surgery**, in addition to the above, provide medical notes documenting the following, when applicable: a. Provide psychosocial-behavioral b. Documentation of instability (listhesis-, spondylolisthesis and grade) c. Provide the surgical technique to be used and the number of levels involved and their location
Total Artificial Heart and Ventricular Assist Devices	33927 33928 33975 33976 33979 33981 33982 33983	For any services related to total artificial heart, the provider should call the number on the member's ID card
Transcatheter Heart Valve Procedures	33361 33362 33363 33364 33365 33366 33369 33477	For **ALL** transcatheter valve procedures, provide medical notes documenting the following, when applicable: 1. Name of device being used, if available 2. Diagnosis 3. Co-morbidities 4. Treatments tried, failed, or contraindicated 5. Physician treatment plan 6. In addition to the above, provide medical notes documenting the following for **Aortic Heart Valve** a. New York Heart Association (NYHA) Classification

Service	Codes	Medical Records Used for Reviews
		b. One of the following: i. Mean aortic valve gradient ii. Peak aortic jet velocity iii. Aortic valve area c. Member has engaged in a Shared Decision Making conversation with an interventional cardiologist and an experienced cardiothoracic surgeon who have determined procedure is appropriate d. Facility where procedure will be performed 7. In addition to the above, provide medical notes documenting the following for **Aortic Transcatheter valve-in-valve (ViV) replacement** a. Name of failed device b. Surgical risk using PROM score 8. In addition to the above, provide medical notes documenting the following for **Pulmonary Heart Valve** a. Right ventricular outflow tract (RVOT) gradient or pulmonary regurgitation rate
Transplant of Tissue or Organs	All codes	For **new** transplants or for **transplants within the last year** Provider should call the number on the member's ID card when referring for any transplant service For **all other** transplant-related requests include: 1. Member history 2. Previous treatments tried 3. Current treatment plan
Treatment of Temporomandibular Joint Disorders	21050 21060 21198 21209 21240 21242 21243 21247 21299 E1399	Medical notes documenting the following, when applicable: 1. History of medical conditions requiring treatment or surgical invention including: 2. Signs and symptoms; including onset, duration, and frequency 3. All recent, related, supporting imaging must be diagnostic quality and labeled with the: a. Date taken b. Applicable case number obtained at time of notification or member's name and ID number Note: Images must be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 4. Recent applicable imaging and diagnostics 5. Prior therapies/treatments/surgeries to the same joint tried, failed, or contraindicated; include the dates, duration of treatment and reason for discontinuation 6. Treating physician's plan of care 7. For revision surgery, also include: a. Details of complication b. Complete (staged) surgical plan

Service	Codes	Medical Records Used for Reviews
Vagus and External Trigeminal Nerve Stimulation	61885 64553 64568 64570 E0770 E1399 L8679 L8680 L8682 L8683 L8685 L8686 L8687 L8688	Medical notes documenting the following, when applicable: 1. Specific diagnosis/condition 2. Medical and surgical history 3. Prior pharmacological agents tried to which the seizures have been refractory 4. Frequency of seizures 5. Documentation as to whether the member is not a candidate for epilepsy surgery, has failed surgery or refuses epilepsy surgery after Shared Decision Making discussion 6. Quality of Life assessment with quantifiable measures of date-to-life besides the occurrence of seizures
Ventilator	E0465 E0466	Medical notes documenting the following, when applicable: 1. Current prescription from physician including ventilator settings and hours of use per day 2. Face – to – face evaluation which includes a. Medical history and respiratory condition supporting the need for a ventilator versus CPAP or BIPAP b. Other therapies with settings trialed, failed or ruled out and clinical justification of failure 3. Additional testing to support need for ventilator vs. CPAP or BiPAP a. ABGs b. PFTs c. Overnight Oximetry d. Sleep Study 4. Physician Office Notes that include the following: a. Plan of Care to include the use as intermittent or continuous b. Member compliance with the treatment plan c. Prognosis
Video Electroencephalographic (VEEG) Monitoring and Recording	95700 95711 95712 95713 95714 95715 95716 95718 95720 95722 95724 95726	Medical notes documenting the following, when applicable: 1. Current prescription 2. Name and tax ID number of the servicing provider 3. Physician office notes that include a. Member diagnosis b. History c. Physical with the following results of resting EEG d. Prior seizure treatments, neuro imaging, medications e. Hospitalizations f. Seizure frequency and intensity g. All medications the member is taking h. All medications tried, failed and contraindicated, including names of the medicines and dates tried i. Dose, frequency, and the physician treatment plan 4. Provide documentation to support site of care
Whole Exome and Whole Genome Sequencing	0094U 0212U 0213U 0214U 0215U 0425U 0426U 81415 81416 81417 81425 81426	Medical notes documenting the following, when applicable: 1. Personal history of the condition, if applicable, including age at diagnosis

Service	Codes	Medical Records Used for Reviews
		2. Complete family history (usually three-generation pedigree) relevant to condition being tested 3. Genetic testing results of family member, if applicable, and reason for testing 4. Ethnicity/ancestry (e.g., Ashkenazi Jewish), if reason for testing 5. Any prior genetic testing results 6. How clinical management will be impacted based on results of genetic testing 7. Genetic counseling (if available)