US Family Health Plan/TX HIX/Medicare Advantage
Plan Benefits and Authorization Requirements
Effective 03/23/2018

Utilization Management Prior Authorization List

Legend

Yes = PRIOR AUTHORIZATION REQUIRED No = NO PRIOR AUTHORIZATION REQUIRED

ALL OUT OF NETWORK REQUESTS REQUIRE PRIOR AUTHORIZATION

DISCLAIMER: A PRIOR AUTHORIZATION DOES NOT GUARANTEE THAT BENEFITS WILL BE PAID

Service	USFHP	NM MA	TX HIX	NM HIX	NCHD
A					
Ablation, Cryosurgical, of Fibroadenoma	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Abrasion Treatment, Dermabrasion, Salabrasion	Yes	Yes	Yes	Yes	NOT COVERED
Acupuncture (max 35 sessions per year)	NOT COVERED	Yes	Yes	Yes	NOT COVERED
Adenosine/Cardiolyte Stress Test	Yes	Yes	Yes	Yes	Yes
Allergy Injections	No	No	No	No	NOT COVERED
Allergy Testing	No	No	No	No	Yes
Ambulance, Ground, Emergency	No	No	No	No	No
Ambulance, Ground, Non Emergency - Except tranfers from facility to facility.	Yes	Yes	Yes	Yes	Yes
Ambulance, Air	Yes	Yes	Yes	Yes	Yes
Ambulatory Blood Pressure Monitoring	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Angiogram	Yes	Yes	Yes	Yes	Yes
Anoscopy	No	No	No	No	No

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Aortogram	Yes	Yes	Yes	Yes	Yes
Arteriogram	Yes	Yes	Yes	Yes	Yes
Arthroscopy w/o repairs	No	No	No	No	Yes
Artificial Insemination	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Audiological/Audiometric Testing	No	No	No	No	Yes
Augmentation Mammoplasty	Yes	Yes	Yes	Yes	Yes
AV Graft/Fistula for Hemodialysis	No	No	No	No	Yes
B					
Bariatric Surgery (Vertical Banding, Lap Band, etc.)	Yes	Yes	NOT COVERED	Yes	NOT COVERED
Barium Swallow, Modified	No	No	No	No	Yes
Bath/Shower Chair	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	No
Bed Board	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	No
Biofeedback	No	No	No	No	NOT COVERED
Bio Wellness Scan (CPT 95921, 95922)	No	No	No	No	NOT COVERED
Biopsy/Local Anesthesia/Office Setting	No	No	No	No	Yes
Bladder Aorta Scan	No	No	No	No	Yes
Bladder Stimulator	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Blepharoplasty	Yes	Yes	Yes	Yes	Yes
Blood Transfusion	No	No	No	No	No
Bone Density, DEXA	No	No	No	No	No
Bone Growth Stimulator	Yes	Yes	Yes	Yes	NOT COVERED
Bone Marrow Aspiration/Biopsy	No	No	No	No	Yes
Botullinum Toxin A Injection (Botox)	Yes	Yes	Yes	Yes	Yes
Bra-Post Mastectomy (Second Siloquette-vendor)	No	No	No	No	Yes
Brachytherapy	Yes	Yes	Yes	Yes	Yes
Braces (Orthopedic)	No if less than $500	No if less than $500	No if less than $500	No if less than $500	Yes
BRCA 1 & 2	Yes	Yes	Yes	Yes	Yes
Breast Biopsy, Excisional	No	No	No	No	Yes
Breast Biopsy, Local/Needle	No	No	No	No	Yes
Breast Implant Removal	Yes	Yes	Yes	Yes	Yes
Breast Prosthesis	No	No	No	No	Yes
Breast Pump (Manual, Electric)	No	No	No	No	Yes
Bronchoscopy	Yes	Yes	Yes	Yes	Yes
BSGI (Breast-Specific Gamma Imaging)	NOT COVERED	NOT COVERED	Yes	Yes	NOT COVERED
C					
Cane	No	No	No	No	No
Cardiac Catheterization, Stent, Angioplasty	Yes	Yes	Yes	Yes	Yes

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Cardiac Monitor, Insertable (Reveal)	Yes	Yes	Yes	Yes	Yes
Cardiac Rehabilitation (max 36 sessions/6 weeks)	No	No	No	No	No
CardioChek	NOT COVERED	NOT COVERED	No	No	NOT COVERED
Cardioversion	No	No	No	No	No
Cast, Application and Removal	No	No	No	No	No
Cataract Extraction	No	No	No	No	Yes
Chelation Therapy	Yes	Yes	Yes	Yes	Yes
Chemical Exfoliation for Acne	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Chemo FX Assay	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Chemotherapy (excludes research protocols)	Yes	Yes	Yes	Yes	Yes
Child Developmental/Behavioral Evaluations & Testing (Non-routine)	Yes	Yes	Yes	Yes	Yes
Chiropractic Treatment (max 35 session per year)Not a USFHP benefit	NOT COVERED	Yes	Yes	Yes	Yes
Circumcision	No	No	No	No	NOT COVERED
Cisternogram	No	No	No	No	Yes
Clinical Trials (See NCI)	Yes	Yes	Yes	Yes	NOT COVERED
Cochlear Implant	Yes	Yes	Yes	Yes	NOT COVERED
Cognitive Function Testing (CPT 96103, 96116, 96120)	Yes	Yes	Yes	Yes	Yes
Cold Therapy Devices	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Colonoscopy	No	No	No	No	Yes
Colostomy Supplies	No	No	No	No	No
Colposcopy	No	No	No	No	Yes
Commode, Bedside specifc to 3-n-1	No	No	No	No	No
Continuous Glucose Monitoring System (CGMS)	Yes	Yes	Yes	Yes	NOT COVERED
Counseling (In Network Mental Health)	No	No	No	No	Yes
CPAP Machine	No	No	No	No	Yes
CPAP Supplies (auto auth, 2 per max)	No	No	No	No	Yes
CPM Machine	Yes	Yes	Yes	Yes	Yes
Craniomandibular Joint (CMJ) (does not refer to TMJ)	Yes	Yes	Yes	Yes	NOT COVERED
Crutches (1 per year max)	No	No	No	No	No
CT Scans/CT Myelograms/CT Angiogram	No	No	No	No	No
Custodial Care (nursing home is member's home)	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Cystometrogram (CMG)	No	No	No	No	No
Cystoscopy	No	No	No	No	No
Cystourethroscopy	No	No	No	No	No
D					
Debridement-Wounds	No	No	No	No	No
Defibrillator, External (Zoll Life Vest, 3 months max)	Yes	Yes	Yes	Yes	NOT COVERED
Dental Implants	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED

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Dental Procedures & Supplies-N/A	Yes	Yes	Yes	Yes	Yes
Diabetic Supplies	No	No	No	No	No
Dialysis (Hemodialysis or Peritoneal)	Yes	Yes	Yes	Yes	Yes
Diapers	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Diathermy Machine	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Diabetic Education	No	No	No	No	No
Discogram	No	No	No	No	No
Doppler	No	No	No	No	No
Drug Abuse (In Network Mental Health)	No	No	No	No	NOT COVERED
Drug, 17P	No	No	No	No	No
Drugs (High Cost-See separate list)	Yes	Yes	Yes	Yes	Yes
Drug Screening for Pain Management Patients	No	No	No	No	No
Durable Medical Equipment	Yes over $500	Yes over $500	Yes over $500	Yes over $500	Yes over $250
Durable Medical Equipment, Convenience/Hygienic/Environmental Control Items	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
E					
Echocardiogram	No	No	No	No	No
Electric Wheelchair	Yes	Yes	Yes	Yes	Yes
Electroencephalogram (EEG)	No	No	No	No	No
Electrocardiogram (EKG)	No	No	No	No	No
Electrolysis	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Electromyogram (EMG)	No	No	No	No	Yes
Elevator	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Endoscopy	Yes	Yes	Yes	Yes	Yes
Endoscopy, Gastrointestinal (EGD)	Yes	Yes	Yes	Yes	Yes
Enteral Nutrition/Enteral Feedings	Yes	Yes	Yes	Yes	Yes
Epidural Steroid Injection (ESI)	Yes	Yes	Yes	Yes	Yes
ERCP	Yes	Yes	Yes	Yes	Yes
ERMI Extensionater/Flexionater	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Erectile Dysfunction Treatment (Max 3 per week)	No	No	NOT COVERED	NOT COVERED	NOT COVERED
Esophageal Motility (Oral Capsule Camera)	Yes	Yes	Yes	Yes	Yes
Event Monitor (Holter Monitor)	Yes	Yes	Yes	Yes	Yes
Exercise Equipment	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Exercise Programs	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Extracorporeal Shock Wave involving Plantar Fascia	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Eye Examinations-Annual or Routine	No	No	No	No	Yes
F					
Family Planning	Meritain	NOT COVERED	No	No	NOT COVERED
Foot Care, Non-Routine (injury/trauma)	No	No	No	No	No

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Foot Care Routine(corns,calluses,nail trims,debridement) Diagnosis Diabetes Mellitus Required	No	No	No	No	Yes
Foot Board	No	No	No	No	NOT COVERED
G					
Gastric Emptying Study	Yes	Yes	Yes	Yes	Yes
Gastric Bypass	Yes	Yes	Yes	Yes	NOT COVERED
Genetic Counseling	Yes	Yes	Yes	Yes	Yes
Genetic Testing	Yes	Yes	Yes	Yes	Yes
Glucometer/Test Strips	No	No	No	No	No
Grab Bar	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
H					
Hair Transplant	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Hearing Aid	NOT COVERED	NOT COVERED	Yes	Yes	Yes
Hearing Exam/Hearing Aid Evaluation	No	No	No	No	No
HIDA-Hepatobiliary ductal system imaging	Yes	Yes	Yes	Yes	Yes
Hip Replacement	Yes	Yes	Yes	Yes	Yes
HNPCC Genetic Screening	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Home Health Care (SNV, PT, OT, SP, HHA)	Yes	Yes	Yes	Yes	Yes
Home Infusion	Yes	Yes	Yes	Yes	Yes
Home visit, Physician	No	No	No	No	NOT COVERED
Hospice Care	Yes	Yes	Yes	Yes	Yes
Hospital Bed	Yes	Yes	Yes	Yes	Yes
Humidifier	NOT COVERED	No	No	No	No
Hydrotherapy (Pool Therapy)	Yes	Yes	Yes	Yes	NOT COVERED
Hyperbaric (HBO)	Yes	Yes	Yes	Yes	Yes
Hypnosis	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Hysterectomy	Yes	Yes	Yes	Yes	Yes (Only Oncology)
Hysteroscopy	Yes	Yes	Yes	Yes	Yes
I					
I & D Procedures	No	No	No	No	No
Immunizations & Vaccinations, Routine	No	No	No	No	No
Immunizations & Vaccinations for Travel	No	No	No	No	NOT COVERED
Incontinence Pads	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Induction of Labor	No	No	No	No	No
Infertility & Impotence Services	MERITAIN	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Inpatient Hospital Admissions	Yes	Yes	Yes	Yes	No if at Spohn
Insulin Pumps	Yes	Yes	Yes	Yes	Yes
Intra articular Injection	Yes	Yes	Yes	Yes	Yes
In-Vitro Fertilization	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED

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K					
Knee Replacement	Yes	Yes	Yes	Yes	Yes
Kyphoplasty	Yes	Yes	Yes	Yes	Yes
L					
Laboratory Studies (In Network), Office Setting	No	No	No	No	No
Laboratory Studies (Out of Network), Office Setting	Yes	Yes	Yes	Yes	Yes
Laryngoscopy	Yes	Yes	Yes	Yes	Yes
Laser Treatment for Psoriasis	No	No	No	No	NOT COVERED
Lasik Surgery	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Light/Ultraviolet Therapy	No	No	No	No	NOT COVERED
Long Term Care (Custodial Care)(Nursing Home is member home)	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Low Vision Rehabilitation-Follow up check plan benefit	Yes	Yes	Yes	Yes	NOT COVERED
Lumbar Puncture	No	No	No	No	No
Lymphedema Pump-USFHP has a covered benefit	Yes	Yes	Yes	Yes	Yes
Lymphedema Therapy	Yes	Yes	Yes	Yes	Yes
M					
Mammogram (Routine, Diagnostic, Screening, Spot Compression)	No	No	No	No	No
Mammoplasty, Reduction	Yes	Yes	Yes	Yes	Yes
Massage	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Maternity Services, Pre and Post Natal	No	No	No	No	Yes
MBI (Molecular Breast Imaging)-Need CPT codes	Yes	Yes	Yes	Yes	Yes
Mohs Surgery	No	No	No	No	Yes
MRA	Yes	Yes	Yes	Yes	Yes
MRI, Open MRI	Yes	Yes	Yes	Yes	Yes
MRCP	Yes	Yes	Yes	Yes	Yes
MUGA (Multiple Gated Acquisition)	No	No	No	No	Yes
Myocardial Perfusion Imaging (SPECT)	Yes	Yes	Yes	Yes	Yes
N					
NCI Clinical Trials	Yes	Yes	Yes	Yes	NOT COVERED
Nebulizer	No	No	No	No	No
Negative Pressure Wound Therapy Pump (KCI)	Yes	Yes	Yes	Yes	Yes
Nerve Block	No	No	No	No	Yes
Neuromuscular Stimulator (implanted)	Yes	Yes	Yes	Yes	Yes
Neuropsychological Testing (In Network)	No	No	No	No	Yes
Nuclear Medicine Studies only including: Thyroid Scans-See List by system: Endocrine System; Hematopoietic & Lymphatic System; Gastrointestinal System; Musculoskeletal System; Cardiovascular System; Respriatory System; Nervous System; Genitourinary System; Therapeutic	No	No	No	No	Yes
Nutritional Counseling (exception diabetic education)	Yes	Yes	Yes	Yes	Yes

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O					
Observation Stay (2 days only)	Yes	Yes	Yes	Yes	No if at Spohn
Office Visit, PCP	No	No	No	No	No
Office Visit, Specialist (In Network)	No	No	No	No	See List
Oncotype DX	Yes	Yes	Yes	Yes	Yes
Oral Surgery	Yes	Yes	Yes	Yes	NOT COVERED
Orthodontia	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Ostomy Supplies	No	No	No	No	No
Oxygen Equipment, Portable and Stationary	Yes	Yes	Yes	Yes	Yes
P					
Pacemaker Monitoring (CPT 93279-93298)	No	No	No	No	No
Pacemaker Telephonic Checks (monthly)	No	No	No	No	No
PAD/PDD (Arterial Studies, CPT 93922)	No	No	No	No	No
Psychiatric Care (In Network)	No	No	No	No	No
Patient Lifts	Yes	Yes	Yes	Yes	Yes
PET Scan	Yes	Yes	Yes	Yes	Yes
Phlebotomy	No	No	No	No	No
Physicals, Annual Routine	No	No	No	No	No
Physicals, Annual Sports	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Physical Therapy	Yes	Yes	Yes	Yes	Yes
Pneumatic Compression Device and Sleeve	Yes	Yes	Yes	Yes	Yes
Podiatry Services	No	No	No	No	Yes
Polysommography (Sleep Study)	Yes	Yes	Yes	Yes	Yes
Port-a-Cath Flush-Outpt Hospital	No	No	No	No	No
Port-a-Cath Flush-Office Based	No	No	No	No	No
Port-a-Cath Insertion	No	No	No	No	Yes
Post Mastectomy Bra	No	No	No	No	Yes
Post Mastectomy Prosthesis	No	No	No	No	Yes
Post Mastectomy Reconstructive Breast Surgery (prior auth needed)	Yes	Yes	Yes	Yes	Yes
Private Duty Nurse	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Proctosigmoidoscopy	No	No	No	No	Yes
Psoralen & Ultraviolet Light Therapy (PUVA)	No	No	No	No	NOT COVERED
Psychological Testing (In Network)	No	No	No	No	No
Psychotherapy (In Network)	No	No	No	No	No
Pulmonary Function Test	No	No	No	No	No
Pulmonary Stress Test	No	No	No	No	NOT COVERED
Pulmonary Rehabilitation (max 36 sessions/6 weeks total)	No	No	No	No	Yes
Punctum Plug	No	No	No	No	Yes

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R					
Radiology, Office Setting, X-Ray	No	No	No	No	No
Radiation Therapy	Yes	Yes	Yes	Yes	Yes
Ramps	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Reconstructive (Plastic) Surgery Ex: Trauma, Oncology	Yes	Yes	Yes	Yes	Yes
Rehabilitation	Yes	Yes	Yes	Yes	Yes
Residential Treatment Center (In Netowrk)	No	No	No	No	NOT COVERED
Respite Care	Yes	Yes	NOT COVERED	NOT COVERED	NOT COVERED
Retinal Detachment	No	No	No	No	No
Robotic Assisted Surgery	Yes	Yes	Yes	Yes	NOT COVERED
S					
Scar Revision	Yes	Yes	Yes	Yes	Yes
Scintimammography	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
School Physical Exam	No	No	No	No	NOT COVERED
Shoe Inserts (diabetic max 6 per year)	Yes	Yes	Yes	Yes	Yes
Shoes, Custom Diabetic Shoes (max 6 per year)	Yes	Yes	Yes	Yes	Yes
Shunts, Glacoma	No	No	No	No	Yes
Smoking Cessation Counseling	No	No	No	No	NOT COVERED
Speech Therapy	Yes	Yes	Yes	Yes	Yes
Stress Test- Treadmill test	No	No	No	No	No
Surgical Sterilization (male and female)	Meritain	NOT COVERED	Female Covered;Male Not covered	Female Covered;Male Not covered	NOT COVERED
Skilled Nursing (Home Health)	Yes	Yes	Yes	Yes	Yes
T					
TAVR	Yes	Yes	Yes	Yes	NOT COVERED
Telemedicine	No	No	No	No	NOT COVERED
TENS Unit-Vendor needed	No	No	No	No	No
Thoracentesis	Yes	Yes	Yes	Yes	Yes
Thoracoscopy, Diagnostic	Yes	Yes	Yes	Yes	Yes
TMJ Treatment	Yes	Yes	Yes	Yes	NOT COVERED
Toilet Seat, Raised	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	No
Total Disc Arthroplasty, Artificial Disc	Yes	Yes	Yes	Yes	Yes
Traction Equipment	No	No	No	No	No
Transfusions	No	No	No	No	No
Transplants	Yes	Yes	Yes	Yes	NOT COVERED
Transuretheral Resection of Bladder Tumor (TURBT)	Yes	Yes	Yes	Yes	Yes
Travel /Transport Chair	No	No	No	No	No

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Trigger Finger	No	No	No	No	Yes
U					
Ultrasound	No	No	No	No	No
Urethral Pressure Profile (UPP)	No	No	No	No	No
Urodynamic Studies	No	No	No	No	No
Uroflowmetry (UFR)	No	No	No	No	No
Urostomy Supplies	No	No	No	No	No
Uterine Artery Embolizaton (UAE)	Yes	Yes	Yes	Yes	Yes
V					
VANTAS (Histrelin Implant)	Yes	Yes	Yes	Yes	Yes
Varicose Vein Treatment	Yes	Yes	Yes	Yes	Yes
Vasectomy	Meritain	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Ventricular Assist Device	Yes	Yes	Yes	Yes	NOT COVERED
Vitrectomy	No	No	No	No	Yes
Voiding Pressure Study (VP)	No	No	No	No	No
VRT (Vestibular Rehab Therapy)	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
W					
Walker, Rolling	No	No	No	No	No
Wheelchair, Standard	No	No	No	No	No
Wheelchair Cushion	No	No	No	No	No
Whirlpool (Portable & Built In)	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Whole Body Bone Scan	Yes	Yes	Yes	Yes	Yes
Wig (oncology related, max 1 per year)	No	No	No	No	NOT COVERED
X					
Y					

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