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	Medical Records Used for Reviews
Ablative Treatment for Spinal Pain	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	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	Medical notes documenting the following, when applicable: 1. Diagnosis 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

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	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 Transport (Ground or Air)	Include the following: 1. Date of Service 2. Ordering physician's name and phone# 3. Physician including reason for requested transport method 4. Any additional equipment or personnel needed for transport 5. Member's diagnosis and chief complaint 6. Member's current condition including: a. Co-morbidities b. Current functional limitations c. Description of members inpatient stay and progress if applicable 7. Where member is traveling **from** including facility name, contact name and phone number 8. Where member is traveling **to** including facility name, contact name and phone number 9. Mileage for transport including air mileage and land mileage for transport
Apheresis	Medical notes documenting the following, when applicable: 1. Medical history, including transfusion history 2. Diagnosis 3. Treatment plan
Bariatric Surgery	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	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

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	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 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
Breast Imaging for Screening and Diagnosing Cancer	Provider should call the number on the member's ID card when referring for radiology services. Medical notes documenting the following, when applicable: 1. Recent history and physical 2. Documentation to support medical necessity (i.e., family history, prior treatment, genetic testing results, other imaging studies and diagnostic results, etc.) 3. Applicable CPT code
Breast Reconstruction	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

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Breast Reduction Surgery	Medical notes documenting the following, when applicable: 1. Diagnosis 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. Physicians plan of care, including estimated volume of breast tissue per breast to be removed
Brow Ptosis and Eyelid Repair	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
Cardiac Event Monitoring	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 Panels for Genetic Diseases	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

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	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	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	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
Chromosome Microarray Testing (Non-Oncology Conditions)	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. Any prior genetic testing results 5. Genetic counseling (if available)
Clinical Trials	Provider should call the number on the member's ID card when referring for any clinical trial.
Cochlear Implants	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
Computed Tomographic Colonography	Provider should call the number on the member's ID card when referring for radiology services Medical notes documenting the following, when applicable: 1. Recent history and physical 2. Co-morbid medical condition(s)

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	3. Documentation to support medical necessity 4. Applicable CPT code
Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes	**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. Frequency and severity of hypoglycemic events, including glucose level 5. Current signed physician order 6. Provide the type of make and model of the device requested **CGM Continued Use** Medical notes documenting the following: 1. Provide the member's current type of diabetes (i.e. type I type II or Gestational) 2. Physician assessment and lab results within the last 6 months including adherence to the prescribed CGM regimen and treatment plan 3. Treatment plan 4. Current signed physician order 5. Provide the type of make and model of the device requested
Core Decompression for Avascular Necrosis	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	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)

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	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	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
Deep Brain and Cortical Stimulation	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
Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements - Ventilator	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

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	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 Prognosis
Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements - Orthotics	Medical notes documenting the following, when applicable: 1. Current prescription from physician 2. Provider office notes including: a. Diagnosis 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 (ADL's) d. 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
Electric Tumor Treatment Field Therapy	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 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	**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

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	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 for the Treatment of Pain and Muscle Rehabilitation - Functional Neuromuscular Stimulation (FES)	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) 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)	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
Epidural Steroid Injections for Spinal Pain	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 10. **For subsequent injection,** in addition to the above, also include the following: a. Response to initial epidural injection, including

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	i. Duration of the effect ii. Percentage of pain reduction
Facet Joint and Medial Branch Block Injections for Spinal Pain	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
Gastrointestinal Motility Disorders, Diagnosis and Treatment	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	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	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

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	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
Genetic Testing for Cardiac Disease	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	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	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	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

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	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
Habilitation and Rehabilitation Therapy (Occupational, Physical and Speech) – For Community Plans	For Community Plan members provide documentation as indicated in the UHC Community Plan Medical Policy for **Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech)** Request for the **initial therapy evaluation/ initial therapy visit**: A provider (PCP) (MD, DO, PA, or NP) or appropriate specialist referral for the speech, physical and occupational therapy evaluation must be on file prior to the completion of the evaluation, unless this requirement is exempted by the state. The therapy evaluation report must include all of the following: 1. A statement of the member's medical history; and 2. A comparison prior level of function to current level of function, as applicable; and 3. A description of the member's functional impairment including its impact on their health, safety, and/or independence; and 4. A clear diagnosis including the appropriate ICD-10 code; and 5. Reasonable prognosis, including the member's potential for meaningful and significant progress; and 6. Baseline objective measurements (current versions of Standardized Assessments), including a description of the member's current deficits and their severity level which include: a. Current Standardized Assessment scores, age equivalents, percentage of functional delay, criterion-referenced scores and/or other objective information as appropriate for the member's condition or impairment b. Standardized assessments administered must correspond to the delays identified and relate to the long- and short-term goals c. Standardized assessments results will not be used as the sole determinant as to the medical necessity of the requested initial therapy visit d. If the member has a medical condition that prevents them from completing standardized assessment(s), alternative could include: i. The therapist provides in-depth objective clinical information using task analysis to describe the member's deficit area(s) in lieu of standardized assessments ii. The therapist should include checklists, caregiver reports or interviews, and clinical observation The initial authorization for therapy must also include a **Plan of Care (POC)**. Providers must develop a member's POC based on the results of the evaluation. The POC must include **all** the following: 1. Functional or physical impairment; and 2. Short and long-term therapeutic goals and objectives: 3. Treatment goals should be specific to the member's diagnosed condition or functional or physical impairment 4. Treatment goals must be functional, measurable, attainable and time based 5. Treatment goals must relate to member-specific functional skills and 6. Treatment frequency, duration, and anticipated length of treatment session(s)

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	Re-evaluations must be completed at least once every twelve months or more frequently based on state regulatory requirements to support the need for on-going services. Re-evaluations performed more often than once should only be completed when the member experiences a significant change in Functional Level in their condition or functional status. The documentation must be reflective of this change. Re-evaluations must include current Standardized Assessment scores, percentage of functional delay, criterion referenced scores or other objective information as appropriate for the member's condition or impairment. The therapy re-evaluation report must include all of the following: 1. Date of last therapy evaluation; and 2. Number of therapy visits authorized, and number of therapy visits attended; and 3. Compliance to home program; and 4. Description of the member's current deficits and their severity level documented using objective data; and 5. Objective demonstration of the member's progress towards each treatment goal: 6. Using consistent and comparable methods to report progress on long- and short-term treatment goals established 7. For all unmet goals, baseline and current function so that the member's progress towards goals can be measured and 8. An updated statement of the prescribed treatment modalities and their recommended frequency/duration; and 9. A brief prognosis with clearly established discharge criteria; and 10. An updated individualized POC must include updated measurable, functional and time-based goals: a. The updated POC/progress summary must not be older than 90 days; and b. If the majority of the long and short-term goals were not achieved, the plan of care must include a description of the barriers or an explanation why the goal(s) needed to be modified or discontinued and 11. A revised POC that the treating therapist has not made a meaningful update to support the need for continued services will not be accepted. In addition, the notation of the percentage accuracy towards the member's goals alone is not sufficient to establish a need for continued, Medically Necessary therapy All **treatment session** notes must include: 1. Date of treatment 2. Specific treatment(s) provided that match the CPT code(s) billed 3. Start and stop time in treatment 4. The individual's response to treatment 5. Skilled ongoing reassessment of the individual's progress toward the goals 6. All progress toward the goals in objective, measurable terms using consistent and comparable methods 7. Any problems or changes to the POC 8. Member or caregiver involvement in and feedback about home program activities 9. Signature and date of the treating provider For **Group Therapy** the documentation must include all of the following: 1. Prescribing provider's order for group therapy; and 2. Individualized treatment plan that includes frequency and duration of the prescribed group therapy and individualized treatment goals; and 3. Name and signature of licensed therapist providing supervision over the group therapy session; and 4. Specific treatment techniques utilized during the group therapy session and how the techniques will restore function 5. Start and stop times for each session; and 6. Group therapy setting or location; and 7. Number of clients in the group

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	For **feeding and swallowing** evaluations, all of the following must be submitted: 1. Interview/case history; and 2. Medical/clinical records including the potential impact of medications, if any; and 3. Physical examination; and 4. Previous screening and assessments; and 5. Collaboration with providers and other caregivers a. During assessment, therapist's determine whether the member is an appropriate candidate for treatment and/or management; this determination is based on findings that include medical stability, cognitive status, nutritional status, and psychosocial, environmental, and behavioral factors and 6. Assessment must result in one or more of the following outcomes: a. Description of the characteristics of swallowing function, including any breakdowns in swallow physiology b. Diagnosis of a Swallowing Disorder c. Determination of the safest and most efficient route (oral vs. non-oral) of nutrition and hydration intake d. Identification of the effectiveness of intervention and support e. Recommendations for intervention and support for oral, pharyngeal, and/or laryngeal disorders f. Prognosis for improvement and identification of other relevant factors, if appropriate **Discharge criteria** includes but is not limited to all of the following (as applicable): 1. Treatment goals and objectives have been met 2. Functional abilities have become comparable to those of others of the same chronological age and gender 3. The desired level of function that has been agreed to by the member and provider has been achieved 4. The skill of a therapist or other licensed healthcare professional (within the scope of his/her licensure) is not required 5. The member exhibits behavior that interferes with improvement or participation in treatment and efforts to address these factors have not been successful 6. In some situations, the member, family, or designated guardian may choose not to participate in treatment, may relocate, or may seek another provider if the therapeutic relationship is not satisfactory. Therefore, discharge is also appropriate in the following situations, provided that the member/client, family, and/or guardian have been advised of the likely outcomes of discontinuation: a. There is a request to be discharged or request continuation of services with another provider b. The individual is transferred or discharged to another location where ongoing service from the current provider is not reasonably available; efforts should be made to ensure continuation of services in the new locale c. The member is unable to tolerate treatment because of a serious medical, psychological, or other condition
Hearing Aids and Devices Including Wearable, Bone-Anchored and Semi-Implantable	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
Hysterectomy	Medical notes documenting the following, when applicable: 1. Primary indication for the hysterectomy 2. Physician office notes which includes the following:

Service	Medical Records Used for Reviews
	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.
Implanted Electrical Stimulator for Spinal Cord	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 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	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

Service	Medical Records Used for Reviews
	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 b. For implantation, in addition to the above also provide the degree of pain reduction after trial
Infertility Diagnosis, Treatment and Fertility Preservation	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	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)	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)? For IMRT used for **whole brain radiation**, provide the above documentation in addition to the following: 1. Presence or absence of brain metastasis

Service	Medical Records Used for Reviews
	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	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	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 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	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)

Service	Medical Records Used for Reviews
	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	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
Lower Extremity Prosthetics	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
Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Service	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

Service	Medical Records Used for Reviews
	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
Mechanical Stretching Devices	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
Mobility Devices, Options and Accessories	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 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

Service	Medical Records Used for Reviews
	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	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	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	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)	**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 Long Term Acute Care (LTAC)	**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

Service	Medical Records Used for Reviews
	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)	**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 - Wound VAC	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 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

Service	Medical Records Used for Reviews
	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 and Central Sleep Apnea Treatment - Oral Appliances	Medical notes documenting the following, when applicable: 1. Diagnosesis 2. Documentation of most recent face-to-face evaluation with prescribing qualified physician (MD or DO), trained in sleep medicine or an Advanced Practice Provider (APP) under the direct supervision of a sleep medicine physician 3. Current written order from physician, including: a. Initial appliance or replacement b. If replacement, current device used and reason for replacement 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, including if positive airway pressure (PAP) resulted in no therapeutic efficacy or patient refusal or intolerance 6. If the oral appliance is being prescribed for reasons other than OSA, an explanation of why appliance is needed
Obstructive and Central Sleep Apnea Treatment - Surgical	Medical notes documenting the following, when applicable: 1. Diagnosesis 2. Specific procedure being requested 3. History of the medical condition(s) requiring treatment or surgical intervention 4. Reports of recent applicable imaging studies and diagnostic tests (e.g., Epworth Sleepiness Scale) 5. Results of sleep study confirming diagnosis and severity of the OSA 6. Treatments tried, failed, or contraindicated; include the dates, duration of treatment, and reason for discontinuation, also include if positive airway pressure (PAP) resulted in no therapeutic efficacy or patient refusal or intolerance 7. 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	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

Service	Medical Records Used for Reviews
Orthognathic (Jaw) Surgery	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: 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
Outpatient Surgical Procedures – Site of Service for Commercial Plans	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
Panniculectomy and Body Contouring Procedures	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.) 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 for the evaluation of any skin damage, and a full lateral view of the hanging pannus

Service	Medical Records Used for Reviews
	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	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	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 5. Treatments tried, failed, or contraindicated. Include the dates, duration of treatment and reason for discontinuation 6. Physician treatment plan
Percutaneous Neuroablation for Pancreatic Cancer Pain, Severe Cancer Pain, and Trigeminal Neuralgia	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	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

Service	Medical Records Used for Reviews
Percutaneous Vertebroplasty and Kyphoplasty	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) 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 Panel Testing	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
Plagiocephaly and Craniosynostosis Treatment - Cranial Orthotic	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 7. Date of planned or completed craniosynotosis surgery, if applicable 8. Physician treatment plan, including: a. Plan to treat torticollis with cranial orthosis

Service	Medical Records Used for Reviews
	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	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	For **Preimplantation Genetic Testing** 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: 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
Private Duty Nursing	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:

Service	Medical Records Used for Reviews
	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
Prostate Surgeries and Interventions	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

Service	Medical Records Used for Reviews
	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
Proton Beam Therapy	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 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	**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
Rhinoplasty and Other Nasal Surgeries	Medical notes documenting the following, when applicable: 1. Diagnosis

Service	Medical Records Used for Reviews
	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 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	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	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

Service	Medical Records Used for Reviews
	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 7. Results of the fluoroscopically guided diagnostic intra-articular SIJ block(s) using local anesthetic (percent of pain reduction)
Screening Colonoscopy – Site of Service	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	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
Sinus Surgeries and Interventions	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 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. In addition to the above, for balloon sinus ostial dilation to treat Chronic Rhinosinusitis also include for which specific sinus (es) the intervention is planned

Service	Medical Records Used for Reviews
Sleep Studies	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
Speech Generating Devices	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
Spinal Fusion and Bone Healing Enhancement Products	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

Service	Medical Records Used for Reviews
	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	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 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:

Service	Medical Records Used for Reviews
	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 and Stereotactic Radiosurgery	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 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
Surgery of the Ankle	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. Symptoms 5. Severity of pain and details of functional disability(ies) interfering with activities of daily living 6. Pertinent physical examination of the relevant joint 7. Consideration 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. Date of previous failed surgery to the same joint, if applicable 11. Physician's treatment plan including pre-op discussion a. Pre-op discussion b. Additional intervention(s) or product(s) to be used during the procedure 12. For revision surgery, also include: a. Details of complication b. Complete (staged) surgical plan 13. If the location is being requested as an inpatient stay, documentation to support site of care
Surgery of the Elbow	Medical notes documenting the following, when applicable: 1. Condition requiring procedure

Service	Medical Records Used for Reviews
	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	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 3. Condition requiring procedure 4. Symptoms 5. Severity of pain, skin breakdown and details of functional disability(ies) impairment to include impact on activities of daily living (ADLs) 6. Pertinent physical examination of the relevant joint 7. Co-morbid medical condition(s) 8. 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 9. History of previous surgery(ies), if applicable 10. Physician's treatment plan including: a. Pre-op discussion b. Additional intervention(s) or product(s) to be used during the procedure 11. For revision surgery, also include:

Service	Medical Records Used for Reviews
	a. Details of complication b. Complete (staged) surgical plan 12. If the location is being requested as an inpatient stay, provide documentation to support site of care
Surgery of the Hand or Wrist	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) 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	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

Service	Medical Records Used for Reviews
	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 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	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 f. Ligament tear location and grade 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 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: a. Pre-op discussion b. Additional intervention(s) or product(s) to be used during the procedure 13. Consideration of arthroscopic approach, if applicable

Service	Medical Records Used for Reviews
	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
Surgery of the Shoulder	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	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 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.)

Service	Medical Records Used for Reviews
	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 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	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 for the Spine	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 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:

Service	Medical Records Used for Reviews
	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	For any services related to total artificial heart, the provider should call the number on the member's ID card
Transarterial Radioembolization (TARE)/ Selective Internal Radiation Therapy (SIRT) for the Treatment of Malignant Cancers of the Liver	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
Transcatheter Heart Valve Procedures	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 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

Service	Medical Records Used for Reviews
Treatment of Temporomandibular Joint Disorders	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
Upper Extremity Prosthetic Devices	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

Service	Medical Records Used for Reviews
	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
Vagus and External Trigeminal Nerve Stimulation	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
Video Electroencephalographic (VEEG) Monitoring and Recording	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	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)