

Comprehensive Medical and Dental Program

AUTHORIZATION GUIDELINES

These Authorization Guidelines are used in the Prior Authorization (PA) and decision-making process for special medical therapies and services.

These guidelines do not represent a standard of care, nor are they intended to dictate an exclusive course of management. Since medical research, physician practice patterns, and health care technology are continuously evolving, please note that the information contained in these guidelines may be updated.

| <u>Subject</u> | <u>Revised</u> |
|--|-----------------------|
| • Allergy Skin Testing vs Skin Prick Testing..... | 8/13 |
| • Circumcision | 8/13 |
| • Consults by Developmental/Behavioral Pediatricians..... | 6/13 |
| • Cranial Banding (Cranial Orthosis) | 8/13 |
| • Extraction of Impacted Third Molar Teeth..... | 9/13 |
| • Frenectomy Indications for Ankyloglossia..... | 8/13 |
| • Genetic Testing | 4/13 |
| • Intrauterine Devices (IUDs)..... | 4/13 |
| • Medical Marijuana | 5/13 |
| • Medically-Necessary Orthodontia | 5/13 |
| • Myringotomy and Tympanostomy Tube Insertion..... | 3/13 |
| • Neuropsychological Testing | 10/13 |
| • Occupational, Physical and Speech Therapy Services | 6/13 |
| • Procedural Sedation | 8/13 |
| • Recombinant Growth Hormone Use in Children | 5/13 |
| • Sensory and Auditory Integration and Facilitated Communication for Children | 6/13 |
| • Synagis Administration..... | 8/14 |
| • Travel Out Of Country | 9/13 |
| • Vision Therapy..... | 8/13 |
| • Wart Removal | 4/13 |