



MEDICAL MUTUAL®

Prior Approval and Investigational Services

Services Requiring Prior Approval (revised November 2, 2018)

Please note: The terms prior authorization, prior approval, predetermination, advance notice, precertification, preauthorization and prior notification all refer to the same process.

CATEGORY	DETAILS	SUBMIT TO
Ambulance Services	Non-emergency air ambulance transportation	Care Management Web: http://navinet.force.com Or Fax: (216) 687-6818 Prior Approval Form
Cosmetic/Reconstructive Procedures*	Abdominoplasty/Panniculectomy Blepharoplasty, Brow Lift and Blepharoptosis Repair Breast Reconstruction and Related Procedures Laser Therapy for Treatment of Rosacea Mastectomy (Bilateral Prophylactic) Mastopexy Otoplasty Reduction Mammoplasty Rhinoplasty Septoplasty Surgical Repair of Pectus Deformities Surgical Treatment of Gynecomastia	Care Management Web: http://navinet.force.com Or Fax: (877) 321-6664 Prior Approval Form
Durable Medical Equipment (DME)/Prosthetics/Orthotics*	Bone Growth Stimulation: Electrical and Ultrasonic Conductive Garment for Delivery of TENS and NMES Continuous Glucose Monitoring Systems Cranial Orthosis for Plagiocephaly DME Misc. Items >\$1,000 Functional Electrical Stimulation High Frequency Chest Wall Oscillation System INR Monitoring System Knee Braces (Custom Fabricated) Mechanical Insufflation-Exsufflation Therapy Motorized Wheelchairs, Power Accessories and Power Operated Vehicles Pneumatic Compression Device Pressure Reducing Support Surfaces Prosthetics (microprocessor systems) Pulse Oximeter (home use) Speech-Generating Devices Tumor Treating (Treatment) Fields for Glioblastoma Multiforme Wearable Cardioverter Defibrillator (WED)	Care Management Web: http://navinet.force.com Or Fax: (877) 321-6664 Prior Approval Form

CATEGORY	DETAILS	SUBMIT TO
<p>Genetic Testing/Gene Expression/Microarray Analysis*</p>	<p>* All Genetic Testing, Gene Expression Testing and Microarray Analysis testing requires prior authorization (unless specified as not required). Prior to testing for hereditary conditions Genetic Counseling is required.</p> <p>Breast Cancer Susceptibility 1 (BRCA1) Breast Cancer Susceptibility 2 (BRCA2) Breast Cancer Susceptibility 1 and 2 Large Rearrangement Testing</p> <p>Chromosomal Microarray Analysis Gene Expression Assays for the Management of Breast Cancer Genetic Testing for Colorectal Cancer Susceptibility Genetic Testing for Inherited Disorders Surrogate Markers for Detection of Heart Transplant Rejection – Gene Expression Profiling (e.g., AlloMap)</p>	<p>Care Management Web: http://navinet.force.com Or Fax: (877) 321-6664 Prior Approval Form</p> <p>Care Management Fax: (877) 321-6664 Prior Approval Form</p>
<p>Injectables*</p>	<p>Abatacept (Orencia IV and SC) Adalimumab (Humira) Ado-trastuzumab emtansine (Kadcyla®) Aflibercept (Eylea®) Agalsidase beta (Fabrazyme®) Alemtuzumab (Lemtrada®) (when utilized for treatment of multiple sclerosis) Alglucosidase alfa (Lumizyme®, Myozyme®) Alirocumab (Praluent®) Alpha1-proteinase inhibitors (Aralast NP™, Glassia™, Prolastin®, Prolastin®-C, Zemaira™) Anakinra (Kineret®) Arsenic Trioxide (Trisenox) New requirement! Prior approval required effective 05/17/2018 Asparaginase Erwinia chrysanthemi (Erwinaze) Atezolizumab (Tecentriq®) Avelumab (Bavencio®) Axicabtagene ciloleucel (Yescarta®) Azacitidine (Vidaza®) Belimumab (Benlysta) Bendamustine (Treanda, Bendeka™) Benralizumab (Fasenra) New requirement! Prior approval required effective 01/21/2018 Berinert (C1 Esterase Inhibitor) Belatacept (Nulojix®) Bevacizumab (Avastin) (prior approval is required for all conditions except diabetic macular edema, macular edema following retinal vein occlusion, or neovascular (wet) age-related macular degeneration) Bivigam Blinatumomab (Blincyto®) Bortezomib (Velcade) Botulinum Toxin Type A and B Brentuximab vedotin (Adcetris®)</p>	<p>Medical Drug Management Web: www.express-path.com Fax: 1-866-620-4028 Phone: 1-866-620-4027 Prior Approval Form</p>

CATEGORY	DETAILS	SUBMIT TO
Injectables*	<p>Brodalumab (Siliq™)</p> <p>Burosumab (Crysvita) New requirement! Prior approval required effective 06/01/2018</p> <p>Cabazitaxel (Jevtana)</p> <p>Calcitonin Gene-Related Peptide (CGRP) Antagonists (Erenumab, Fremanezumab, Galcanezumab) New requirement! Prior approval required effective 06/01/2018</p> <p>Canakinumab (Ilaris®)</p> <p>Carfilzomib (Kyprolis®)</p> <p>Cemiplimab-rwlc (Libtayo) New requirement! Prior approval required effective 10/21/2018</p> <p>Cerliponase alfa (Brineura®)</p> <p>Certolizumab pegol (Cimzia)</p> <p>Cetuximab (Erbix®)</p> <p>C1 esterase inhibitor (Cinryze)</p> <p>C1 esterase inhibitor (Haegarda)</p> <p>Collagenase clostridium histolyticum (Xiaflex®)</p> <p>Copanlisib (Aliqopa®)</p> <p>Cuvitru (immune globulin subcutaneous 20% solution)</p> <p>Cyclophosphamide (when utilized for oncology conditions)</p> <p>Daclizumab (Zinbryta™)</p> <p>Daclizumab (Zinbryta™)</p> <p>Daratumumab (Darzalex™)</p> <p>Darbepoetin alfa (Aranesp®)</p> <p>Daunorubicin/cytarabine (Vyxeos®)</p> <p>Decitabine (Dacogen®)</p> <p>Denosumab (Xgeva®)</p> <p>Docetaxel (Docefrez™, Taxotere®)</p> <p>Doxorubicin hydrochloride (Doxil®, Adriamycin, Lipodox)</p> <p>Dupilumab (Dupixent®)</p> <p>Durvalumab (Imfinzi®)</p> <p>Ecallantide (Kalbitor)</p> <p>Eculizumab (Soliris®)</p> <p>Edaravone(Radicava®)</p> <p>Elapegedemase-lvlr (Revcovi™) New requirement! Prior approval required effective 10/18/2018</p> <p>Elosulfase alfa (Vimizim)</p> <p>Elotuzumab (Empliciti™)</p> <p>Emicizumab-kxwh (Hemlibra) New requirement! Prior approval required effective 02/28/2018</p> <p>Enzyme Replacement Therapy for Gaucher Disease</p> <p>Epoprostenol (Flolan, Veletri)</p> <p>Erenumab-aoe (Aimovig™)</p> <p>Eribulin mesylate (Halaven®)</p> <p>Erythropoietin alfa (Epogen®, Procrit®, Retacrit)</p> <p>Etanercept (Enbrel)</p> <p>Etelcalcetide (Parsabiv®)</p> <p>Eteplirsen (Exondys51)</p> <p>Evolocumab (Repatha®)</p> <p>Filgrastim (Neupogen®)</p> <p>Filgrastim-aafi (Nivestym™)</p> <p>Fligrastrim-sndz (Zarxio™)</p> <p>Flebogamma DIF</p> <p>Fremanezumab-vfrm (Ajovy™)</p>	<p>Medical Drug Management</p> <p>Web: www.express-path.com</p> <p>Fax: 1-866-620-4028</p> <p>Phone: 1-866-620-4027</p> <p>Prior Approval Form</p>

CATEGORY	DETAILS	SUBMIT TO
Injectables*	<p>Fulvestrant (Faslodex®)</p> <p>Galcanezumab-gnlm (Emgality™)</p> <p>Galsulfase (Naglazyme®)</p> <p>Gammagard (all forms)</p> <p>Gammaked</p> <p>Gammplex</p> <p>Gamunex (all forms)</p> <p>Gemcitabine HCL (Gemcitabine HCL, Gemzar®)</p> <p>Gemtuzumab Ozogamicin (Mylotarg®)</p> <p>Glatiramer acetate (Copaxone, Glatopa)</p> <p>New Drug Prior Approval Policy (Global Prior Approval)</p> <p>Golimumab (Simponi)</p> <p>Growth Stimulating Drugs</p> <p>Guselkumab (Tremfya)</p> <p>Histrelin (Vantas) New requirement! Prior approval required effective 10/21/2018</p> <p>Hizentra</p> <p>Icatibant (Firazyr®)</p> <p>Iloprost (Ventavis)</p> <p>Immune globulins (administered intravenous and subcutaneous)</p> <p>Infliximab (Remicade)</p> <p>Infliximab-dyyb (Inflectra®)</p> <p>Infliximab-abda (Renflexis®)</p> <p>Idursulfase (Elaprase®)</p> <p>Inotersen (Tegsedi) New requirement! Prior approval required effective 10/21/2018</p> <p>Inotuzumab Ozogamicin (Besponsa®)</p> <p>Interferon beta-1a (Avonex®, Plegridy™, Rebif®)</p> <p>Interferon beta-1b (Betaseron®, Extavia®)</p> <p>Ipilimumab (Yervoy®)</p> <p>Iobenguane I 131 (Azedra®) New requirement! Prior approval required effective 09/21/2018</p> <p>Irinotecan liposomal (Onivyde®)</p> <p>Ixabepilone (Ixempra®)</p> <p>Ixekizumab (Taltz®)</p> <p>Lanadelumab (Takhzyro®) New requirement! Prior approval required effective 09/21/2018</p> <p>Laronidase (Aldurazyme®)</p> <p>Leuprolide acetate (Eligard®, Lupron Depot, Lupron Depot-Ped®, Lupaneta Pack®)</p> <p>Lutetium Lu 177 dotatate (Lutathera®) New requirement! Prior approval required effective 03/01/2018</p> <p>Mepolizumab (Nucala®)</p> <p>Methoxy polyethylene glycol-epoetin beta (Mircera®)</p> <p>Mitoxantrone (Novatrone)</p> <p>Mogamulizumab-kpkc (Poteligeo®) New requirement! Prior approval required effective 09/21/2018</p> <p>Moxetumomab pasudotox-tdfk (Lumoxiti) New requirement! Prior approval required effective 10/21/2018</p> <p>Natalizumab (Tysabri)</p> <p>Necitumumab (Portrazza™)</p> <p>Nelarabine (Arranon)</p> <p>Nivolumab (Opdivo®)</p>	<p>Medical Drug Management</p> <p>Web: www.express-path.com</p> <p>Fax: 1-866-620-4028</p> <p>Phone: 1-866-620-4027</p> <p>Prior Approval Form</p>

CATEGORY	DETAILS	SUBMIT TO
	<p>Nusinersen (Spinraza®) Obinutuzumab (Gazyva®) Ocrelizumab (Ocrevus®) Octagam Octreotide acetate (Sandostatin®) Omacetaxine mepesuccinate (Synribo®) New requirement! Prior approval required effective 09/21/2018 Omalizumab (Xolair®) Ofatumumab (Arzerra) Olaratumab (Lartruvo®) Oxaliplatin (Eloxatin) Paclitaxel albumin-bound (Abraxane®) Panzyga New requirement! Prior approval required effective 12/01/2018 Pain Management Medications New requirement! Prior approval required effective 01/01/2018 Panitumumab (Vectibix®) Patisirin (Onpatro®) New requirement! Prior approval required effective 09/21/2018 Pegaptanib sodium (Macugen®) Pegvaliase-pqpz (Palynziq) New requirement! Prior approval required effective 07/21/2018 Pegfilgrastim (Neulasta®) Pegfilgrastim-jmdb (Fulphila™) Peginterferon alfa-2b (Sylatron™) Pegloticase (KRYSTEXXA) Pembrolizumab (Keytruda®) Pemetrexed (Alimta®) Pertuzumab (Perjeta®) Plasminogen (Rylpazim) New requirement! Prior approval required effective 06/01/2018 Privigen Ranibizumab (Lucentis®) Ramucirumab (Cyramza®) Recombinant C1 esterase inhibitor (Ruconest®) Repository Corticotropin Injection (H.P. Acthar Gel) Reslizumab (Cinqair®) Rituximab (Rituxan) Rituximab and Hyaluronidase (Rituxan Hycela) Romidepsin (Istodax®) Romiplostim (Nplate®) Sebelipase alfa (Kanuma) Secukinumab (Cosentyx™) Sargramostim (Leukine®) Sarilumab (Kevzara®) Siltuximab (Sylvant®) New requirement! Prior approval required effective 09/21/2018 Sipuleucel-T (Provenge) Synagis (Palivizumab) and RSV IVIG Respirgam Talimogene laherparepvc (Imlygic®) TBO-Filgrastim (Granix™) Testosterone cypionate (Depo®-Testosterone) Testosterone enanthate (Delatestryl®, Xyosted®) Testosterone pellet (Testopel®)</p>	<p>Medical Drug Management Web: www.express-path.com Fax: 1-866-620-4028 Phone: 1-866-620-4027 Prior Approval Form</p>

CATEGORY	DETAILS	SUBMIT TO
	Testosterone undecanoate (Aveed®) Tildrakizumab-asmn (Ilumya™) New requirement! Prior approval required effective 04/01/2018 Tisagenlecleucel (Kymriah®) Tocilizumab (Actemra IV and SC) Trabectedin (Yondelis®) Trastuzumab (Herceptin®) Trastuzumab-dkst (Ogivri™) Treprostinil (Remodulin, Tyvaso) Triamcinolone acetonide extended-release injectable (Zilretta™) Triptorelin (Triptodur) Ustekinumab (Stelara) Vedolizumab (Entyvio®) Vestronidase alfa-vjbc (Mepsevii) New requirement! Prior approval required effective 01/21/2018 Vincristine liposomal (Marqibo®) Viscosupplementation Injections (e.g., Durolane®, Euflexxa™, Gel-One®, Gelsyn-3™, GenVisc®, Hyalgan®, Hymovis®, Monovisc™, Orthovisc, Supartz™/Supartz FX, Synvisc®, Synvisc-One™, TriVIsco) Voretigene Neparvovec-rzyl (Luxturna) New requirement! Prior approval required effective 02/28/2018 Ziv-aflibercept (Zaltrap) Zoledronic acid (Zometa®)	

Inpatient Services	Medical/Surgical Admissions Acute Care Medical/Surgical Prior approval of normal deliveries is not required unless the length of stay for the mother or child exceeds 48 hours from the date of a vaginal delivery or 96 hours from the date of a C-section. Acute Physical Rehabilitation Long Term Acute Care (LTAC) Skilled Nursing Facility (SNF)	Submit through: https://Reviewlink.mmoh.com Or call 1-800-338-4114
	Behavioral Health Admissions Acute Care Psychiatric/Substance Abuse Residential Inpatient	Fax: 1-800-258-3186 Or Web: http://navinet.force.com
Outpatient Services:	Home Health Care (HHC): Home Health Aide Services Home Health Nursing Home Health Occupational Therapy Home Health Physical Therapy Home Health Speech Therapy	Home Healthcare Request Forms – For Non-contracting providers without access to NaviNet, please click here to access the home healthcare fax forms Web: http://navinet.force.com Fax: 1-800-677-8029

	<p>Imaging Computed Tomography (CT) Magnetic Resonance Imaging/Angiography (MRI/MRA) Myocardial perfusion (SPECT/PET) and cardiac blood pool imaging Other Nuclear Medicine Position Emission Tomography (PET)</p> <p>Please find full listing by procedure at: https://www.evicore.com/healthplan/MedMutualOH</p>	<p>Submit through eviCore Healthcare Web: https://www.evicore.com/pages/providerlogin.aspx Or Phones: 1-888-693-3211 Fax: 1-888-693-3210</p>
	<p>Therapy Not all plans require prior approval for therapy services (i.e., Mutual Health Services). Please contact the For Providers number on the back of the Covered Person’s ID card.</p> <p>Chiropractic/Osteopathic Manipulative Therapy Occupational Therapy Physical Therapy Speech Therapy</p> <hr/> <p>Behavioral Therapy Applied Behavioral Analysis (ABA) Therapy</p>	<p>Landmark DBA eviCore Web: https://uni.lmhealthcare.com/LHApps/</p> <p>Therapy Authorization Forms: Physical, Occupational or Speech Therapy Fax: 1-888-565-4225</p> <p>Chiropractic Services and Osteopathic Manipulation Fax: 1-800-599-8350</p> <hr/> <p>Care Management Web: http://navinet.force.com Or Fax: -1-877-321-6664 Prior Approval Form</p>
<p>Nursing</p>	<p>Private Duty Nursing</p>	<p>1-800-258-3175</p>
<p>Other Medical/Surgical/Diagnostic Services (furnished in a physician office, certified ambulatory surgery center, inpatient or outpatient hospital, or any other location)</p>	<p>Artificial Anal Sphincter for Treatment of Fecal Incontinence Artificial Intervertebral Disc Replacement Auditory Brainstem Implant Autologous Chondrocyte Implantation Bariatric surgery for obesity Bone Anchored Hearing Device (BAHA) Capsule (Wireless) Endoscopy – Esophagus through Ileum Carotid Artery Stenting Cochlear Implant Electrical Stimulation and Electromagnetic Therapy for the Treatment of Chronic Dermal Ulcers Electromagnetic Navigational Bronchoscopy Endoscopic Thoracic Sympathectomy for Treatment of Hyperhidrosis Gastric Electrical Stimulation for Treatment of Gastroparesis Gender Dysphoria Treatment Implantable Miniature Telescope – End Stage Age-Related Macular Degeneration Treatment Interspinous Process Decompression System (X-STOP) Intrastromal Corneal Ring Segments (Intacs) In Utero Fetal Surgery Kyphoplasty – Thoracic and Lumbar Laser Therapy – Vitiligo Longitudinal Gastrectomy (i.e., sleeve gastrectomy) Lumbar Spinal Fusion</p>	<p>Care Management Web: http://navinet.force.com Or Fax: 1-877-321-6664 Prior Approval Form</p>

	<p>Lung Volume Reduction Surgery (LVRS) for Severe Emphysema</p> <p>Neutron Beam Therapy</p> <p>Osteochondral Allografts and Autografts (OATS Mosaicplasty) for the Treatment of Focal Articular Cartilage Defects of the Knee</p> <p>Outpatient Telemetry Systems</p> <p>Phototherapy – Home Treatment of Dermatological Conditions (Other Than Vitiligo)</p> <p>Proton Beam Radiotherapy</p> <p>Psoriasis Laser Treatment</p> <p>Radiofrequency Ablation (RFA) for Treatment of Tumors</p> <p>Radiofrequency Volumetric Tissue Reduction</p> <p>Recombinant Human Bone Morphogenetic Protein-2 and Protein-7</p> <p>Sclerotherapy</p> <p>Spinal Cord Stimulation for Treatment of Chronic Pain</p> <p>Stereotactic Body Radiotherapy and Radiosurgery</p> <p>Strabismus Surgery if >11 Years of Age</p> <p>Surrogate Markers for Detection of Heart Transplant Rejection – Gene Expression Profiling (e.g., AlloMap)</p> <p>Total Ankle Replacement</p> <p>Transcatheter Valve Replacement/Implantation</p> <p>Transcranial Magnetic Stimulation (TMS) for Treatment of Depression</p> <p>Transurethral Radiofrequency Micro-Remodeling</p> <p>Uterine Artery Embolization for Treatment of Fibroids</p> <p>Uvulectomy</p> <p>Uvulopalatopharyngoplasty</p> <p>Vertebroplasty – Thoracic and Lumbar</p> <p>Virtual Colonoscopy (Computed Tomographic Colonography) – Diagnostic</p>	
<p>Transplants</p> <p>Total Artificial Heart Systems</p> <p>Ventricular Assist Devices</p>	<p>Transplantation –</p> <ul style="list-style-type: none"> • Blood component (e.g., Stem Cell, Bone Marrow) • Solid Organ (Except Corneal) • Pancreatic Islet Cell - Autologous <p>Total Artificial Heart Systems</p> <p>Ventricular Assist Devices</p>	<p>Care Management</p> <p>Web: http://navinet.force.com</p> <p>Or</p> <p>Fax: 1-877-321-6664</p> <p>Prior Approval Form</p>

Investigational Services* (revised November 1, 2016)

The health plan defines investigational procedures, therapies, devices and supplies as services that are not approved by governing bodies OR do not demonstrate comparable or superior outcomes to current practice standards as evidenced by peer-reviewed published literature and/or clinical trials.

Although not all-inclusive, the health plan considers the following services as investigational and not eligible for reimbursement. Additionally, any charge clearly related to an investigational service such as a hospitalization, outpatient service, office visit, diagnostic test, supply or medication will also be denied as investigational and not eligible for reimbursement.

DETAILS	SUBMIT TO
<p>Actigraphy Allergen Specific IgE Quantitative or Semiquantitative, Multiallergen Screen (Dipstick, Disk or Paddle) Allergy – Sublingual Immunotherapy Anal Fistula Plug Axial Lumbar Interbody Fusion (AxiaLIF) Biodegradable Capsule with a Radiofrequency Identification Tag to Determine Patency of the Gastrointestinal Tract (e.g., AGILETM Patency System) Bioidentical Hormone Therapy Bioimpedance Spectroscopy BioniCare BIO-1000 System for Treatment of Osteoarthritis of the Knee Breast Cancer Analysis Rearrangement Test (BART) Breast Ductal Lavage Capsule (wireless) Endoscopy – Esophagus Chelation Therapy for Chemical Endarterectomy Coblation Radiofrequency Microtenotomy (TOPAZ) for Treatment of Tendinosis Compounded Drugs Computed Tomographic Colonography-Screening Computer-Aided Detection Software Systems – Magnetic Resonance Imaging of the Breast Disc Biacuplasty Doppler Velocimetry (Uterine Artery) Electrical Stimulation for Treatment of Dysphagia) Electron Beam Computed Tomography Endobronchial Valve for Lung Volume Reduction Surgery and for Treatment of a Bronchopleural Fistula Endometrial Photodynamic Ablation Endoscopic Disc Decompression Endoscopic Therapy for Gastroesophageal Reflux Disease Endovascular Repair of Aortic Aneurysm Involving Visceral Branches/Vessels Evaluation of Vestibular Disorders Extracorporeal Magnetic Stimulation – Urinary Incontinence Extracorporeal Shock Wave Therapy (ESWT) for Muskuloskeletal Conditions Fiberoptic Ductoscopy Fluid-Ventilated Gas-Permeable Contact Lenses Gait Analysis Gastric Bubble (Balloon) Gastric Electrical Stimulation for Treatment of Obesity Hyperbaric Oxygen Therapy (Topical) Infrared Energy Therapy Interferential Stimulation Intra-Aneurysm Sac Pressure Monitoring Device Intrapulmonary Percussive Ventilation System</p>	<p>Care Management Fax: (877) 321-6664 Prior Approval Form</p>

DETAILS	SUBMIT TO
<p>Intravascular Stent without Distal Embolic Protection In Utero Repair of Myelomeningocele In Utero Tracheal Occlusion for Treatment of Congenital Diaphragmatic Hernia Kyphoplasty – Cervical Laser-assisted Uvulopalatoplasty Laser Discectomy – Nucleoplasty Magnetic Resonance Imaging-Guided High-Intensity Focused Ultrasound Ablation of Uterine Fibroids Manipulation Under Anesthesia of the Ankle, Elbow, Finger, Hip, Pelvis, Sacroiliac Joint, Spine, Temporomandibular Joint, Thumb and Wrist Microcurrent Electrical Therapy Non-Surgical Treatment of Obstructive Sleep Apnea: Oral Pressure Therapy Nucleoplasty – Laser Discectomy Osteochondral Autograft Transplantation of the Ankle Ovarian Adnexal Mass Assessment Score Test Systems (e.g., OVA1) Pancreatic Islet Cell Transplant – Allogeneic Percutaneous Disc Decompression Percutaneous Intradiscal Radiofrequency Thermocoagulation Percutaneous Neuromodulation Therapy Percutaneous Tibial Nerve Stimulation Phototherapy – Home Treatment of Vitiligo Pulsed Electrical Stimulation Radiofrequency Microtenotomy Tendinosis Radiofrequency Therapy for Treatment of Urinary Incontinence Robotic Surgical Systems Utilized for any Procedure other than Laparoscopic Prostatectomy Salivary Hormone Testing for Menopause Skin Substitutes for Wound Healing (Acticoat and E-Z Derm) Smooth Pursuit Neck Torsion Testing Suction-assisted Lipectomy Suit Therapy Surface Electrodiagnostic Studies – Lumbar Matrix Scan Surgical Treatment of Migraine Headaches Surrogate Markers for Detection of Heart Transplant Rejection – Breath Testing (e.g., Heartsbreath) Sympathetic Peripheral Autonomic Skin Potentialism (PAP's) Thermography Total Body Photography Transanal Radiofrequency Therapy for Fecal Incontinence Tumor Chemosensitivity and Chemoresistance Assays (e.g., ChemoFx®) Unicondylar Interpositional Spacer Vagal Nerve Stimulation for Treatment of Depression Vertebral Axial Decompression Vertebroplasty of the Cervical Spine Vestibular Autorotation Whole-Body Computed Tomography Wireless Gastrointestinal Motility Monitoring System</p>	<p>Care Management Fax: (877) 321-6664 Prior Approval Form</p>