United Healthcare Community Plan

Effective Date: June 1, 2026

Medical Records Documentation Used for Reviews: Community Plan

These guidelines do not apply to the following states: Idaho, Indiana, Kansas, Kentucky, Nebraska, New Jersey, New Mexico, North Carolina, Ohio, Pennsylvania, and Tennessee. Refer to the applicable medical policy for additional information.

These guidelines list 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 Community Plans.

This content is provided for reference purposes only and may not include all services. Listing of a service in these guidelines does not imply that it is a covered or non-covered health service. Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the services requested.

 These guidelines are regularly reviewed, updated, and subject to change.

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Service	Medical Records Used for Reviews
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. Comorbid 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. Specific device being requested and if request is for initial trial or on-going request 3. Treatments tried, failed, or contraindicated to adequately mobilize retained secretions, include the dates, duration, and reason for discontinuation 4. Results of all recent relevant imaging and diagnostic testing 5. Comorbidities 6. Frequency of exacerbations requiring antibiotic therapy 7. Duration and frequency of productive cough 8. For **continuation** beyond the two-month trial, also include: a. Proper use b. Patient tolerance of the device c. 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. Comorbidities b. Current functional limitations

Service	Medical Records Used for Reviews
	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. Comorbidities 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 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

Service	Medical Records Used for Reviews
	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
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

Service	Medical Records Used for Reviews
	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
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 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 as documented by electrocardiogram (ECG), Holter, or rhythm strip 2. Recent physical exam within the last 3 months 3. Signs and symptoms including onset, duration, frequency and whether the arrhythmia is symptomatic, paroxysmal, and/or persistent 4. Reports of all recent imaging studies and applicable diagnostics, including:

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	a. Electrolytes within the last 6 months b. Thyroid Stimulating Hormone (TSH) within the last 12 months c. Assessment for myocardial ischemia, e.g. stress test within the last 12 months d. Left ventricular ejection fraction by echocardiography or multigated acquisition (MUGA) 5. Treatments tried, failed, or contraindicated. Include the dates, duration and reason for discontinuation 6. Physician treatment plan
Cell-Free Fetal DNA Testing	Medical office notes documenting the following, when applicable: 1. Individual undergoing testing is alloimmunized or at risk for alloimmunization due to maternal RhD status, including presence or absence of red cell antigen antibodies 2. Paternal genotyping shows heterozygosity for RhD or paternal RhD status is unknown 3. Member has been offered and declined invasive diagnostic testing (e.g., amniocentesis, chorionic villus sampling (CVS)) for fetal genotype
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)
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

Service	Medical Records Used for Reviews
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
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) 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

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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. Specific procedure being requested 3. History of the medical condition(s) requiring treatment or surgical intervention, including conditions interfering with activities of daily living a. Documentation of signs and symptoms; including onset, duration, and frequency, including: seizures history and number of seizures per month 4. Physical exam 5. Relevant medical history, including: a. Medical comorbidities b. Psychiatric comorbidities 6. Treatments tried, failed, or contraindicated. Include the dates, duration, and reason for discontinuation 7. Current medications used to treat condition, include start date 8. Relevant surgical history, including previous movement disorder surgery and dates 9. Reports of all recent imaging studies and applicable diagnostics, including: a. Results of imaging related to skeletal deformities and cervical myelopathy b. Results of brain MRI c. Results of video electroencephalographic (EEG) monitoring d. Results of levodopa challenge e. 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

Service	Medical Records Used for Reviews
Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements - Home Mechanical Ventilator (HMV)	Medical notes documenting the following, when applicable: 1. Current prescription from physician including: a. Initial or ongoing request b. Indicate if the HMV request is for primary, secondary or backup c. Device being requested (include make and model if available), device settings, and hours of use per day d. If following a hospital admission, what device settings were used in the facility 2. Medical history and respiratory condition supporting the need for an HMV versus PAP or RAD 3. Therapies and/ or treatments tried, failed, or contraindicated. Include the dates, duration, and reason for discontinuation 4. Comorbidities 5. Results of relevant recent diagnostic testing to support need for ventilator vs. RAD or PAP only, including: a. ABGs b. PFTs, if available c. Overnight oximetry, if available d. Sleep study, if available 6. Physician plan of care, including a. Use as intermittent, nocturnal, or continuous b. Respiratory and/or airway treatment plan c. Member compliance with the treatment plan 7. For **ongoing request**, in addition to the above, also include: a. Re-evaluation by pulmonologist and/ or treating physician within 12 months b. Proper use and continued benefit c. Member compliance with HMV, including device download, if available
Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements - 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: d. Initial or replacement e. Rental or purchase f. Specific HCPCS code(s) for item and each accessory requested g. Equipment make, model and price quotation h. Rationale for selection of specific device and accessories i. 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

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	5. For **Wheelchairs and Power Mobility Devices** in addition to the above, also include 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 i. Home and safety evaluation assessment 6. For **Wheelchair, Seating, Options and Accessories** in addition to the above, also include 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
Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements - 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. Diagnosis 4. Member's weight 5. Inability to safely make transfers between bed and a chair, wheelchair, or commode without the use of a lift 6. Requirement for supine positioning 7. Proper use and continued benefit
Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements - 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 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

Service	Medical Records Used for Reviews
	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 10. If **replacement**, current device used, date of initial acquisition, status of warranty 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

Service	Medical Records Used for Reviews
Electrical and Ultrasonic Bone Growth Stimulators	Medical notes documenting the following, when applicable: For **Electrical Bone Growth Stimulators** 1. Condition requiring procedure 2. Comorbid conditions that could compromise bone healing 3. Relevant diagnostic imaging reports, including: a. Size of fracture gap, if applicable b. Evidence of skeletal maturity 4. Previous treatments of the fracture tried, failed, or contraindicated; include the dates, duration of treatment, and reason for discontinuation 5. History of previous spinal fusion surgery (ies), include: a. Date(s) of previous surgery b. Site and number of previous vertebral levels fused 6. Physician's treatment plan For **Ultrasonic Bone Growth Stimulators** 1. Condition requiring treatment 2. Date, site and type of fracture 3. Relevant diagnostic imaging reports, including: a. Size of fracture gap, if applicable b. Evidence of skeletal maturity 4. Previous treatments of the fracture tried, failed, or contraindicated; include the dates, duration of treatment, and reason for discontinuation 5. Relevant surgical history, including dates 6. Physician's treatment plan
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation - Functional Neuromuscular Stimulation (FES)	Medical notes documenting the following, when applicable: 1. History of condition requiring procedure, including dates of injury/ surgery, as well as the following: a. Intact lower motor units (both muscle and peripheral nerve) b. Muscle and joint stability for weight bearing and the ability to support upright posture independently c. Muscle contractions and sensory perception response d. Independent transfer ability and standing tolerance e. Hand and finger dexterity f. Presence or absence of hip and knee degenerative disease g. Presence or absence of history of long bone fracture secondary to osteoporosis 2. Specific device to be implanted 3. Prior relevant surgery (ies) 4. Member's motivation level, commitment, and cognitive ability for device use 5. Physician treatment plan
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation - Neuromuscular Electrical Stimulators (NMES)	Medical notes documenting the following, when applicable: 1. Specific device being requested and if request is for initial trial, on-going application or replacement 2. Diagnosis 3. History of condition requiring treatment 4. Relevant physician exam

Service	Medical Records Used for Reviews
	5. Results of all recent relevant imaging and diagnostic testing 6. Comorbidities 7. Physician treatment plan
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation - Transcutaneous Electrical Nerve Stimulation (TENS)	Medical notes documenting the following, when applicable: 1. Condition requiring treatment 2. Specific device being requested and if request is for initial trial, on-going application or replacement 3. Physician treatment plan 4. For replacement, also include current device used and reason for replacement
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 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 conservative 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

Service	Medical Records Used for Reviews
FDA Cleared or Approved Companion Diagnostic Testing	Medical notes documenting the following, when applicable: 1. Results and dates of prior companion diagnostic testing and/ or comprehensive genomic profiling, if applicable 2. Intended drug(s) for which the companion diagnostic test is approved 3. Diagnosis and clinical stage 4. Disease response to most recent systemic therapy and/or disease recurrence or progression, if applicable 5. Intended tissue source(s)
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. Comorbidities 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 Treatment	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. Date and results of psychosocial-behavioral evaluation including management of coexisting mental health condition 3. Treatment plan that includes ongoing and follow-up care by a Qualified Healthcare Professional experienced in treating Gender Dysphoria, and whether request is part of a staged procedure 4. For **voice modification surgery**, in addition to the above, also include documentation of presurgical voice lessons and/or therapy 5. For **genital surgery**, in addition to the above, also include: a. Clinical written assessment from a second Qualified Healthcare Professional experienced in treating Gender Dysphoria, who has independently assessed the individual b. Documentation the member has completed at least 12 months of successful continuous full-time real-life experience in identified gender
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)

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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 7. Reports of all recent imaging studies and applicable diagnostic tests, including: a. Mammography b. Hormone testing (e.g., beta-human chorionic gonadotropin, thyroid function studies, sex hormone binding globulin, estradiol, follicle-stimulating hormone, luteinizing hormone, prolactin, and testosterone) c. Liver enzymes d. Serum creatinine e. Alpha-fetal protein

Service	Medical Records Used for Reviews
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: a. Describe the type of hearing loss (sensorineural vs. conductive or mixed) b. Severity and frequencies affected c. Whether or not member is a candidate for an air-conduction hearing aid 3. 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. Relevant personal and family history of the medical condition(s) requiring treatment 3. Relevant physical exam 4. Comorbid medical condition(s), including thyroid disease 5. Signs and symptoms attributable to pelvic disease, including: a. Duration b. Severity c. Relation to menstrual cycle d. Impact on activities of daily living (ADL) 6. All recent reports of relevant imaging studies and diagnostic tests 7. All recent relevant surgical and diagnostic procedures history (e.g. endometrial sampling, PAP, laboratory studies, hysteroscopy or D&C) 8. Treatments tried, failed, or contraindicated; include the dates, duration, and reason for discontinuation 9. Physician treatment plan
Implantable Loop Recorders and Wearable Heart Rhythm Monitors	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
Implanted Electrical Stimulator for the Spinal Cord	Medical notes documenting the following, when applicable: 1. Indicate if this request is for a trial or permanent placement, include: a. Percentage of pain reduction with trial b. Operative notes from the spinal cord stimulator or dorsal root ganglion (DRG) trial 2. Condition requiring procedure 3. Physical examination 4. Signs and symptoms 5. Prior therapies/treatments tried, failed, or contraindicated; include the dates, duration, and reason for discontinuation 6. Comorbid medical condition(s) 7. Mental health disorder or substance use history 8. Physician plan of care 9. For **revision or removal**, also include:

Service	Medical Records Used for Reviews
	a. Details of complication b. Complete treatment plan
Injectable Dermal Fillers and Bulking Agents	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 2. Results of the Eastern Cooperative Oncology Group (ECOG) performance status or Karnofsky performance status (KPS) status tests 3. Prognosis time period 4. Presence or absence of leptomeningeal disease

Service	Medical Records Used for Reviews
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: 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. Upon request we may require high-quality color photographs. All photographs must be labeled with: a. The date taken b. 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
	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 7. Relevant medical history 8. Treatments tried, failed, or contraindicated. Include the dates, duration and reason for discontinuation 9. Relevant surgical history, including dates 10. 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. Indicate whether the service is being requested for initial procedure or for treatment of in-stent restenosis 2. Diagnosis 3. Relevant history and physical to include member symptoms and pertinent findings due to ischemia with specific description of location, aggravating, and alleviating factors of limb pain 4. Treatments tried, failed, and/or contraindicated, include the dates, monitoring protocol for exercise therapy specific to peripheral vascular disease (PVD). Include method, dates and duration of attempted smoking cessation trial, and reason for discontinuation (e.g. pharmacologic therapy) 5. Details of functional disability(ies) interfering with work or activities of daily living (ADL) 6. Documentation of ischemic peripheral artery disease including Ankle-brachial index (ABI) or Toe-brachial index (TBI) if non-compressible 7. All applicable diagnostic images (e.g., duplex ultrasound, computed tomography angiography [CTA], magnetic resonance angiography [MRA], or digital subtraction angiography) including the anatomic location, severity of occlusion, and dates
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. Comorbidities 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

Service	Medical Records Used for Reviews
	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
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
Minimally Invasive Procedures for the Treatment of Upper Gastrointestinal Diseases	Medical notes documenting the following, when applicable: 1. Condition requiring procedure 2. Relevant history to include symptomatology 3. Relevant physical findings 4. Results of recent diagnostic tests and imaging studies 5. Comorbidities 6. Treatments tried, failed, or contraindicated, include the dates, duration, and reason for discontinuation 7. Physician treatment plan
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)
Negative Pressure Wound Therapy	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,

Service	Medical Records Used for Reviews
	iii. Exposed bone, nerves or organs in vicinity of wound iv. Malignancy present in wound, v. Open fistula to an organ or body cavity within the vicinity of the wound vi. Uncontrolled soft tissue infection or osteomyelitis within vicinity of wound 11. If member is diabetic, the member is maintained on a diabetic management program 12. Member is turned and repositioned with the presence of a Stage III or IV pressure ulcer 13. If applicable, indicate when NPWT (wound VAC) has been used previously on the same type of wound with a favorable clinical response
Obstructive and Central Sleep Apnea Treatment - Oral Appliances	Medical notes documenting the following, when applicable: 1. Diagnosis 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. Diagnosis 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

Service	Medical Records Used for Reviews
	iv. Refusal of an MMA procedure for non-concentric palatal collapse
Orthognathic (Jaw) Surgery	Medical notes documenting the following, when applicable: 1. 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 2. All recent, clear, high quality diagnostic imaging including: a. Cephalometric tracings and analysis addressing the physical and/or physiological abnormality and the degree to which it is causing impairment b. Radiologic images and interpretations including lateral cephalometric posteroanterio and panoramic radiographs NOTE: All images must be labeled with the: i. Date taken ii. 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 will not be accepted
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 comorbidities 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 Surgery	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 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)

Service	Medical Records Used for Reviews
	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
Percutaneous Patent Foramen Ovale (PFO) Closure	Medical notes documenting the following, when applicable: 1. Condition requiring procedure 2. History of the medical condition(s) requiring treatment 3. Comorbidities 4. Signs and symptoms including onset, duration, and frequency 5. Relevant recent diagnostic imaging report(s) 6. Results of recent diagnostic testing performed to rule out other causes including, but not limited to, carotid disease, hypercoagulable states or atrial fibrillation 7. Evaluation by a cardiologist and a neurologist and both are in agreement that the stroke is likely embolic in nature
Percutaneous Vertebroplasty and Kyphoplasty	Medical notes documenting the following, when applicable: 1. Condition requiring procedure 2. Onset of the condition, including dates and duration 3. Signs and symptoms, including pain, location, and severity, and functional impairment that interferes with activities of daily living 4. Comorbidities 5. Presence or absence of evidence of spinal cord compression 6. Treatments tried, failed, or contraindicated, include the dates, duration, and reason for discontinuation 7. Results of all recent relevant imaging, including assessment of bone density 8. 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
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

Service	Medical Records Used for Reviews
	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 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; include affected anatomical site, when applicable b. Member symptoms c. Member ambulation status d. Treatments tried, failed, or contraindicated; include the dates, duration, and reason for discontinuation e. Member or caregiver willing and able to manage device f. Treatment plan including: i. Pressure in each chamber ii. Frequency iii. Duration of each treatment iv. Ongoing decongestive therapy program, wound care, or edema management v. Education regarding monitoring schedule and treatment response vi. For ongoing, include proper use and continued benefit
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 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

Service	Medical Records Used for Reviews
	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: 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: c. Tracheostomy and status of airway issues d. 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 e. Blood draws f. Feeding g. Elimination h. Seizure activity, frequency and applicable interventions needed i. Wound care including type of wound, type of dressing and frequency of dressing changes j. Assistance with Activities of Daily Living (ADLs) k. Use of a mobility device l. Ability to transfer m. Use of cast, splint, brace or assistance with passive range of motion n. Communication limitations o. Behavioral issues p. Cognitive or sensory impairment issues

Service	Medical Records Used for Reviews
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 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 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) for the specific individual 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 NOTE: If citing an RTOG dose constraint, provide the RTOG protocol number The color comparative proton and IMRT dose volume histogram and dose table images can be submitted via the external portal at www.uhcprovider.com/paan; faxes of images will not be accepted. 6. Physician's treatment plan 7. For **re-irradiation**, also include, the history of prior radiation therapy and need for the additional course of radiation therapy to the same anatomical site

Service	Medical Records Used for Reviews
Radiation Therapy: Fractionation, Image-Guidance, and Special Services	**Radiation Therapy Fractionation** Medical notes documenting the following, when applicable: 1. Radiation Oncologist notes 2. Diagnosis and stage 3. History of present illness and conditions 4. History of prior surgical treatment 5. Prior irradiated areas and their prescriptions 6. Proposed treatment plan, including 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. Radiation Oncologist notes 2. Diagnosis and stage 3. History of present illness and conditions 4. 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 d. History of prior surgical treatment 5. Patient BMI 6. Comparison plans, dose-volume histogram, clinical target volume margins, target motion documented by imaging 7. Proposed treatment plan
Rhinoplasty and Other Nasal Surgeries	Medical notes documenting the following, when applicable: 1. Diagnosis 2. Detailed history of nasal symptoms including detailed notes with specific date(s) related to evaluation and management 3. Relevant surgical history, including dates 4. Evidence of rhinosinusitis 5. Treatments tried, failed, or contraindicated; include the dates, duration of treatment and reason for discontinuation 6. 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 image(s) is required via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 7. Diagnostic imaging report(s) 8. Details of functional impairment, if applicable 9. Physician's plan of care

Service	Medical Records Used for Reviews
	10. High-quality color photographs, including but not limited to full face, that clearly show the deformity/dynamic collapse/complication being treated. The photograph must be labeled with: a. Date taken 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
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

Service	Medical Records Used for Reviews
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
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. Comorbid conditions including pulmonary, cardiac, neuromuscular disease/neurodegenerative, neurologic 5. History of chronic (>3 months) opiate use including frequency, dose and duration 6. 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 7. Treatments tried, failed, or contraindicated. Include the dates, duration, and reason for discontinuation 8. Name and address of the facility where the procedure will be performed 9. **For CPT95811**, indicate whether the request is for PAP titration or split night study and for a member already on PAP therapy, provide most recent print out for compliance 10. **For CPT 95805**, Multiple Sleep Latency Testing (MSLT) and Maintenance of Wakefulness Testing (MWT), include notes that Excessive Sleepiness have been excluded 11. **For Attended Repeat Testing and/or appliance adjustment**, in addition to the above, also include reason why repeat study should be performed

Service	Medical Records Used for Reviews
Spinal Fusion and Bone Healing Enhancement Products	Medical notes documenting the following, when applicable: 1. Condition requiring procedure 2. History and comorbid medical condition(s) 3. Member's symptoms, pain, location, and severity including functional impairment that is interfering with activities of daily living (meals, walking, getting dressed, driving) 4. Physical exam, including neurologic exam 5. History and duration of previous therapy, when applicable including: a. Physical therapy b. Medications (injections) c. Previous surgery d. Bracing e. Other attempted treatments 6. Whether the surgery will be performed with direct visualization or only with endoscopic visualization 7. Complete report(s) of diagnostic tests and imaging 8. Describe the surgical technique(s) planned [e.g., AxialLIF®, XLIF, ILIF, OLIF, LALIF, image-guided minimally invasive lumbar decompression (MILD®), percutaneous endoscopic discectomy with or without laser, etc.] 9. Specify the allograft product including brand name(s) to be used
Spinal Fusion and Decompression	Medical notes documenting the following, when applicable: 1. Condition requiring procedure 2. History and comorbid 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

Service	Medical Records Used for Reviews
	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. Complete report(s) of diagnostic tests, including: a. Results of biopsy(ies) b. Results of bone aspirate 14. Describe the surgical technique(s) planned 15. For **revision surgery** include documentation of: a. Clinical complications b. Relevant laboratory findings c. Relevant imaging d. Prior treatments for complications tried, failed, or contraindicated. Include the dates and reason for discontinuation
Stereotactic Body Radiation Therapy 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. Life expectancy 5. Relevant imaging report(s) 6. Proposed treatment plan 7. Number of tumors present, their size and location 8. Stage of disease 9. 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

Service	Medical Records Used for Reviews
	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. Comorbid 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 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, including: a. Microbiological findings b. Synovial fluid exam c. Erythrocyte sedimentation rate (ESR) d. C-reactive protein (CRP) 4. Symptoms 5. Pertinent physical examination of the relevant joint 6. Pain severity, circadian patterns of pain, location of pain, and details of functional disability(ies) interfering with activities of daily living (ADL) 7. Prior therapies/ treatments tried, failed, or contraindicated. Include the dates, duration and reason for discontinuation 8. Date of previous failed surgery to the same joint, if applicable 9. Physician's treatment plan, including pre-op discussion 10. For **revision surgery**, also include: a. Details of complication b. Complete (staged) surgical plan

Service	Medical Records Used for Reviews
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. Comorbid 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: 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

Service	Medical Records Used for Reviews
	6. Comorbid 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. Complete diagnostic interpretation of imaging findings including, at a minimum: a. Relevant clinical information b. Detailed report of imaging findings c. Impression d. Specialty(ies) of the provider(s) who interpreted the images 2. For femoroacetabular impingement (FAI) syndrome (CPT codes 29914, 29915, and 29916), also include radiographic reports of presence and severity of cartilage damage using Tönnis or Outerbridge grading 3. In addition, 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. Condition requiring procedure 5. 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) 6. Physician's treatment plan, including pre-op discussion 7. Pertinent physical examination of the relevant joint 8. Comorbid medical conditions (cardiovascular diseases, hypertension, diabetes, cancer, pulmonary diseases, neurodegenerative diseases) 9. Prior therapies/treatments tried, failed, or contraindicated; include the dates and reason for discontinuation 10. Date of failed previous hip fracture fixation, if applicable 11. 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 comorbidities; 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

Service	Medical Records Used for Reviews
Surgery of the Knee	Medical notes documenting the following, when applicable: 1. Complete diagnostic interpretation of imaging findings including, at a minimum: a. Relevant clinical information b. Detailed report of imaging findings, including at least the following: i. Documented closure of skeletal plates (age less than 18 years) ii. Presence or absence of focal full-thickness articular cartilage defect iii. Size and location of focal cartilage defect iv. Outerbridge grade v. Joint space and alignment vi. Ligament tear location and grade c. Impression d. Specialty(ies) of the provider(s) who interpreted the images 2. In addition, 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 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. Comorbid 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 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 medical notes to support at least one of the following:

Service	Medical Records Used for Reviews
	a. Surgery is bilateral b. Member has significant comorbidities; 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
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. Comorbid 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 12. 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, including: a. DVT (deep vein thrombosis) b. Aneurysm c. Tortuosity d. Previous relevant vein procedure(s) 3. 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 (e.g Venous Clinical Severity Score (VCSS) or the Venous Disability Score (VDS)), interfering with the ability to stand or sit for long periods of time (e.g., performing work functions, driving, walking, etc.)

Service	Medical Records Used for Reviews
	6. Physical exam, including: a. Which extremity (right, left or both) b. Vein(s) that will be treated (e.g., great saphenous vein (GSV) and/ or small saphenous vein (SSV), etc.) c. Vein diameter including the specific anatomic location where the measurement was taken (e.g., proximal thigh, proximal calf, etc.) d. Duration of reflux and the anatomic location where the measurement was taken 7. Reports of recent imaging studies and applicable diagnostic tests 8. Prior therapies/ treatments that have been tried, failed, or contraindicated. Include the dates, duration and reason for discontinuation and complications (e.g., recurrent bleeding or significant hemorrhage, DVT or superficial vein thrombosis (SVT) etc.) 9. 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
Total Artificial Disc Replacement for the Spine	Medical notes documenting the following, when applicable: 1. Diagnosis 2. Specific procedure requested 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 detailed neurological findings 7. 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 8. Relevant imaging and diagnostic testing, including documentation of instability 9. Upon request, we may require the specific diagnostic image(s) that show the abnormality for which surgery is being requested, which may include MRI, CT scan, X-ray, and/or bone scan; consultation with requesting surgeon may be of benefit to select the optimal images NOTE: When requested, diagnostic image(s) must be labeled with: a. The date taken b. Applicable case number obtained at time of notification, or member's name and ID number on the image(s) Upon request, diagnostic imaging must be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted faxes will not be accepted 10. Treatments tried, failed, or contraindicated, include the dates, duration, and reason for discontinuation 11. Current medications used to treat condition, include start date(s)

Service	Medical Records Used for Reviews
	12. Reports of all recent imaging studies and applicable diagnostics, including results of imaging including specific spinal levels with pathology 13. Physician treatment plan, including surgical technique to be used and the number of levels involved and their location 14. For **lumbar surgery**, also include the psychosocial-behavioral evaluation 15. For **total artificial disc removal or replacement**, also include: a. Details of complication b. Surgical plan
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. Site and type of primary malignancy and metastatic lesion(s) 4. Candidacy for surgery 5. Is the condition refractory to or relapsed following systemic chemotherapy 6. Physician's treatment plan including plan for liver transplant
Transcatheter Procedures for Heart Valve Conditions	For **ALL** transcatheter valve procedures, provide medical notes documenting the following, when applicable: 1. Name of device being used, if available 2. Diagnosis 3. Comorbidities 4. Treatments tried, failed, or contraindicated. Include the dates, duration, and reason for discontinuation 5. Physician treatment plan 6. For **Aortic Heart Valve replacement** also include: 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. For **Aortic Transcatheter valve-in-valve replacement** also include: a. Name of failed device b. Surgical risk using PROM score 8. For **mitral valve repair** also include: a. Mitral regurgitation (MR) grade NYHA Classification b. Surgical risk using PROM score c. Physician composition of the care team 9. For **Pulmonary Heart Valve** also include: a. Right ventricular outflow tract (RVOT) gradient b. Pulmonary regurgitation rate 10. For **Tricuspid Heart Valve repair** also include: a. Tricuspid Regurgitation (TR) b. Stage NYHA Classification Pulmonary artery systolic pressure

Service	Medical Records Used for Reviews
	c. Surgical risk d. Physician composition of the care team
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. Comorbidities 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

Service	Medical Records Used for Reviews
	8. Rehabilitation plan 9. Final prosthetic proposal from ordering physician 10. For **replacement prosthesis**, also include: a. Age of the current prosthesis b. Reason for replacement c. Estimated cost of adjustment or repair if applicable 11. For a **socket replacement include age of the current socket**, reason for replacement, and comparative residual limb measurements showing a change in residual limb size, what adjustments have been made to the current socket to improve fit
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
Vertebral Body Tethering for Scoliosis	Medical notes documenting the following, when applicable: 1. Condition requiring procedure 2. Signs and symptoms 3. Treatments tried, failed, or contraindicated; include the dates, duration, and reason for discontinuation, including: a. Failed external bracing b. External bracing is not/no longer indicated secondary to severe scoliosis c. There is clinical documentation of intolerance to external brace wear as prescribed despite reasonable efforts to improve brace comfort, fit, and wear compliance 4. Member has engaged in a Shared Decision Making conversation with a pediatric orthopedic spine surgeon 5. Results of all recent relevant imaging along with radiologist's written report, including: a. Standing posteroanterior and lateral b. Traction and or bending scoliosis radiographs c. Cobb Angle d. Sanders Skeletal Maturity Staging System 6. Name of the facility where procedure will be performed 7. Institutional Review Board (IRB) protocol documentation 8. Enrollment in the Institutional Review Board protocol 9. Name and specialty of the physician that will perform the surgery 10. Physician treatment plan 11. For **revision surgery**, also include reason for revision
Video Electroencephalographic (VEEG) Monitoring and Recording	Medical notes documenting the following, when applicable: 1. Current order 2. Name and tax ID number of the servicing provider 3. Physician office notes that include a. Member diagnosis b. History

Service	Medical Records Used for Reviews
	c. Seizure treatments and medication tried, failed or contraindicated, include dates, duration and reason for discontinuation d. Results of all recent imaging and diagnostic tests, including: i. Routine or spot electroencephalogram (EEG) ii. Laboratory tests iii. Neuro imaging e. Seizure-related hospitalization(s), including dates f. Seizure semiology and frequency g. All medications the member is taking 4. If inpatient is requested, provide documentation to support site of care
Whole Exome and Whole Genome Sequencing	Medical notes documenting the following, when applicable: 1. Signs or symptoms of the individual being tested including age at onset 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. All relevant previous diagnostic / genetic testing results and dates 5. How clinical management will be impacted based on results of genetic testing 6. Name and specialty of the provider ordering the testing 7. For **Reanalysis**, in addition to the above, also include: a. Date of initial Whole Exome or Whole Genome testing b. New data or symptoms since last analysis 8. For **Prenatal**, in addition to the above, also include a. Source of the specimen b. Number and nature of congenital abnormality(ies)