The Precertification Through The Medical Review Program provision has been modified by the revision of the list of services/treatments that require precertification. The following list of treatments or services shall require precertification effective upon the date of your group’s renewal during 2016:

1. Inpatient admissions
2. Inpatient Rehabilitation Therapy admissions
3. Inpatient Skilled Nursing Facility, long term care, and sub-acute admissions
4. Inpatient mental health and chemical dependency admissions
5. Inpatient Residential Treatment
6. Non-Emergent (Scheduled) Air or Ground Ambulance
7. Pediatric Medically Necessary contact lenses
8. Low Protein Modified Foods
9. Clinical Trials
10. Medical Foods
11. Applied Behavioral Analysis (ABA)
12. Bariatric Surgery
13. Cardiac Rehabilitation
14. Dental & Endoscopic Anesthesia
15. Durable Medical Equipment
16. Genetic Testing
17. Habilitative Therapy (physical therapy, occupational therapy, and speech therapy)
18. Home Health & Home Infusion Services
19. Hospice (home, inpatient)
20. Infertility Procedures
21. Imaging Services: (Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography Angiography(CTA), Positron Emission Tomography (PET), Electronic Beam Computed Tomography (EBCT), SPECT, not including x-ray or ultrasound.
22. Outpatient Injectable Drugs
23. Outpatient Surgery (performed at hospital, ambulatory surgery center of licensed facility)
24. Orthotics/Prosthetics
25. Implantable prosthetics (includes breast, bone conduction, cochlear)
26. Pain Management services (radiofrequency ablation, implantable pumps, spinal cord stimulator, injections)
27. Radiation Therapy Services
28. Reconstruction Surgery
29. Outpatient Rehab Therapy (physical, occupational, speech, pulmonary)
30. TMJ/Orthognathic Surgery
31. Transplant Services (Including Pre & Post)
32. Outpatient procedures, limited to: Hyperbaric oxygen; Pill Endoscopy; Sclerotherapy; Stab phlebotomy; Plasma Pheresis (MS); Radiofrequency ablation; Anodyne Therapy; Enhanced External Counterpulsation (EECP); Sleep Studies; Resection; Vagal Nerve Stimulation; Corpus Colostomy surgery; Hemispherectomy; Uvulo-palato-pharyngoplasty (UPPP) & laser-assisted UPPP; Implants

IMPORTANT: If pre-certification is not obtained, benefits will be reduced even if the treatment or service is deemed Medically Necessary. If the treatment or service is deemed not to be Medically Necessary, the treatment or service will not be covered. If a Hospital Confinement or other Confinement is extended beyond the number of days first pre-certified without further pre-certification (concurrent review), benefits for the extra days: (1) will similarly be reduced; or (2) will not be covered if deemed not to be Medically Necessary.

THE ABOVE IS ONLY A SUMMARY OF THE PRECERTIFICATION PROVISIONS. UPON YOUR GROUP’S RENEWAL, PLEASE CONSULT YOUR 2016 KPIC CERTIFICATE OF INSURANCE FOR COMPLETE DETAILS REGARDING THE TERMS OF YOUR COVERAGE.