

Appendix B: Foundation PPO Health Plan Prior Authorization Requirements Effective January 1, 2008

The following services (marked with an X) require prior authorization to receive maximum financial coverage and to avoid any penalties for non-compliance, depending on the specifics of the health plan.

Services provided by out of plan (non-contracted) providers are covered at a reduced benefit level and incur a higher cost to the member.

Service	SJHS – Humboldt	PALCO	Trinidad Rancheria	Blue Lake Rancheria
Biopharmaceuticals	X	X	X	X
Durable Medical Equipment (DME) >\$250 (use purchase price if equipment will be rented)	X	X	X	X
Genetic Testing	Not Covered	X	X	Not Covered
Home Health Services	X	X	X	X
Hospital – Inpatient services (non-emergent only)	X	X	X	X
Hospital – Outpatient services, excluding lab and plain x-ray (non-emergent only) (lab & plain x-ray= no authorization required)	X	X	X	X
Imaging – CT, MRI, Pet Scans	X	X	X	X
Infusion Therapy (excluding chemotherapy)	All outpatient	Home only	All outpatient	All outpatient
Mental Health and Substance Abuse Treatment - Facility-based inpatient or outpatient	X	X	X	Not Covered
Rehabilitative Therapy Services: Acupuncture, Chiropractic Care, Physical Therapy, Speech Therapy & Occupational Therapy	Auth after 10 combined rehab visits	Auth after 14 combined rehab visits	Auth after 12 combined rehab visits	Auth after 12 combined rehab visits
Professional Services, over \$500 allowed by CPT code (includes professional & technical, if split billed)		X		
Transplants (organ and tissue), peripheral stem cell replacement, and similar procedures	X	X	X	X