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Commercial Preauthorization and Notification List

After reading the applicability of the preauthorization requirements below, access services, codes and medication by selecting the appropriate link:

Commercial July 2023 Medical (physical health)/Behavioral health preauthorization list, please click here

Commercial 2023 Medication preauthorization list, please click here

We have updated our preauthorization and notification list. This list applies to **all** commercial fully insured plans.* All services, items and medications that require preauthorization are included in this list.

Preauthorization is a process that Humana uses to determine if services are covered by a member's plan. This process must be followed before the services on this list are performed. The term "preauthorization" is the same as prior authorization, precertification or preadmission.

Humana requests notification for some services on this list. This is used to best serve our members. It allows us to place them in programs to provide support for their condition. This process is not the same as preauthorization. Humana does not approve or deny a notification.

It is important that preauthorization is obtained for services on this list. By not obtaining a preauthorization, the healthcare provider could be denied payment or there may be a reduction in benefits for the patient.

Humana does not require preauthorization or referrals for emergency services. Below are examples of an emergent situation:[1]

- The health of the sick or injured person (and/or fetus, if the person is pregnant) would be at serious risk
- Services are performed when the health of the person would suffer serious damage to bodily functions, organs or other body parts

Humana usually does not pay for care considered investigational and experimental. Please refer to the patient's Certificate of Coverage or contact Humana to ask if the care is covered.

Services or medications provided without preauthorization may still be reviewed for medical necessity. We recommend that a healthcare provider make a request for services or medications to verify the member's benefits.

When requesting a preauthorization, please have the following information available as applicable:

- Member's ID number, name and date of birth
- Date of service or hospital admission

[1]The list of examples above is not exhaustive

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- Procedure codes (up to a maximum of 10 per request)
- Diagnosis codes (primary and secondary) (up to a maximum of 6 per request)
- Service location
- Inpatient (acute hospital, skilled nursing, hospice)
- Outpatient (telehealth, office, home, off-campus outpatient hospital, on-campus outpatient hospital or ambulatory surgery center)
- Referral (office, off-campus outpatient hospital, on-campus outpatient hospital, ambulatory surgery center, other)
- Tax Identification Number (TIN) and National Provider Identifier (NPI) number of treatment facility where service is being rendered
- TIN and NPI number of the provider performing the service
- Caller/requestor's name/telephone number
- Attending physician's telephone number
- Relevant clinical information
- Discharge plans

Please submit all of the relevant clinical information at the time of the preauthorization request. This will speed up the process. If additional clinical information is required, we will request it.

Humana uses the following policies to determine medical necessity:
Medical and Pharmacy Coverage Policies

How to request preauthorization:
Except where noted via links on the following pages, preauthorization requests for **medical services** may be initiated:

- Online via https://www.Availity.com/(registration required)
- By calling Humana's interactive voice response line at 800-523-0023

Please note: Online preauthorization requests are encouraged. For certain preauthorization services requested via Availity, there is an option to complete a questionnaire. This may lead to a real-time approval. If an approval is not provided immediately, the information gathered will expedite the review.

Except where noted via links on the following pages, preauthorization for **medications** may be initiated:

- By sending a fax to 888-447-3430 (request forms are available at Humana.com/M**edpa)**
- By calling 866-461-7273 (available Monday – Friday, 6 a.m. – 8 p.m., Eastern time)

Notification will be provided if this list changes. However, it may be updated throughout the year if there are new-to-market medications or medical services.

Notification of determination:

The provider and member/authorized person receives notification of the decision once the authorization has been completed, pursuant to state requirements.

a) Determining whether a requested service, treatment, drug or device is covered under the terms of a covered person's health benefit plan;

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(b) Making utilization review determinations; and
(c) Notifying covered persons, authorized persons and providers acting on behalf of covered persons of its determinations.

*Plan Information:

- **Humana Medicare Advantage (MA):** This list does not affect Humana MA plans. To find a list for Humana MA, please see our page: Medicare Advantage and Dual Medicare-Medicaid Plans Preauthorization and Notification List.
- **Commercial fully insured:** The full list applies to patients with Humana commercial health maintenance organization (HMO) and preferred provider organization (PPO) coverage. Healthcare providers who participate in an independent practice association (IPA) or other risk network with delegated services are subject to the preauthorization list. They also should refer to their IPA or risk network for any questions or help processing their requests. Exclusions may change, and you can find current information by going to Humana.com/Provider. Once there, choose "Authorization & Referrals" and then pick your topic.
- **Administrative Services Only (ASO) groups**: Humana provides administrative services only to some employers, which means Humana manages the health plan and does not pay the claims. ASO groups may have plans with different rules.