Auth Number	Provider Specialty	Place of Service	Service	Diagnosis	Denial Decision Reason	Denial Overturned on Internal Appeal	Denial Oveturned by an Independent Review Organization
7845304	Oncology	Outpatient	Surgery	Z15.01	As stated in the 2020 Platinum Sendero Evidence of Coverage (EOC Platinum 2020) pages 34-35: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. …Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 4. Charges for prophylactic services including, but not limited to, prophylactic mastectomy or any other services performed to prevent a disease process from becoming evident in the organ tissue at a later date;	No	No
3642821	OB/Gyn	Outpatient	Genetic Testing	R68	The reason for this decision is: After reviewing the documentation provided it was determined that she does not have a personal or family history of breast, ovarian, tubal or peritoneal cancer or an ancestry associated with BRCA1/2 gene mutation, therefore, testing is not recommended. JAMA. 2019;322(7):652-665. doi:10.1001/jama.2019.10987 https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/brca-related-cancer-risk-assessment-genetic-counseling-and-genetic-testing1?ds=1&s=brca The requested genetic testing MultiSite 3 BRACAnalysis does not meet medical necessity as required by the 08142019 IdealCare Evidence of Coverage page 76, "Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient's condition; • Performed in the most cost effective setting required by the patient's condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational."	No	No
4923517	Oncology	Outpatient	Genetic Testing	C79.61	As stated in the Sendero Evidence of Coverage (20190814) pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. …Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 38. Genetic testing, counseling or services;	No	No
4514387	OB/Gyn	Outpatient	Genetic Testing	Z80.0 Z80.49	As stated in the Sendero Evidence of Coverage (20190814) pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. …Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 38. Genetic testing, counseling or services;	No	No

3819810	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	As stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), Page 9: “Unless preauthorized by Sendero or part of covered Emergency Care, Out-of-Network Benefits are considered Excluded Services and are not Covered Services by Sendero. You are responsible for the full cost of Excluded Services. Covered Services are Medically Necessary, appropriate, preauthorized by Sendero and/or included in your benefits. Excluded Services do not count toward your deductible, copayment and Maximum Out of Pocket amounts. If Medically Necessary, covered services are not available through an In-Network Provider, Your Primary Care Provider (PCP) may request a Preauthorization for You to see an Out-of-Network Provider.” IdealCare has contracted in-network providers that can provide the requested service. You may choose to see an in network practitioner for the requested services, prior authorization will not be required. Additionally, as stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), pages 37-41: “General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. … Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 1. Services provided by a non-participating provider, except when: a) Authorized by Sendero; or b) The following services are Medically Necessary to render Emergency Care: • Professional ambulance service; or • Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;”	No	No
2877382	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	As stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), Page 9: “Unless preauthorized by Sendero or part of covered Emergency Care, Out-of-Network Benefits are considered Excluded Services and are not Covered Services by Sendero. You are responsible for the full cost of Excluded Services. Covered Services are Medically Necessary, appropriate, preauthorized by Sendero and/or included in your benefits. Excluded Services do not count toward your deductible, copayment and Maximum Out of Pocket amounts. If Medically Necessary, covered services are not available through an In-Network Provider, Your Primary Care Provider (PCP) may request a Preauthorization for You to see an Out-of-Network Provider.” IdealCare has contracted in-network providers that can provide the requested service. You may choose to see an in network practitioner for the requested services, prior authorization will not be required. Additionally, as stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), pages 37-41: “General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. … Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 1. Services provided by a non-participating provider, except when: a) Authorized by Sendero; or b) The following services are Medically Necessary to render Emergency Care: • Professional ambulance service; or • Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;”	No	No

2729074	Substance abuse	Inpatient	Residential Treatment	F10.20	have one of the following items under the criteria point Functioning, in reviewing the clinical provided, you did not have any of the following: • Frequent Interpersonal conflict • High risk of relapse • Improved ability to apply relapse prevention skills • Socially withdrawn • Unable to ask for help • Unable to establish positive staff or peer relationships The clinical basis for this decision is: The requested continued Residential Treatment does not meet medical necessity as required by the 08142019 IdealCare Evidence of Coverage page 76, "Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient's condition; • Performed in the most cost effective setting required by the patient's condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational."	No	No
9211183	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	We reviewed all the information we received from your provider to support the request for approving 40 hours per week of direct treatment services (CPT code 97153). We also sought the opinion of a physician who is an expert in diagnosing and treating childhood behavioral disorders and is Board Certified in Pediatrics and Neurology with Special Qualifications in Child Neurology. Based on our review, we are unable to authorize the requested number of hours. This is because, in the opinion of the expert, while there is no question that your child meets our criteria for direct treatment with applied behavioral analysis (ABA) therapy, your child's level of impairment does not justify the number of hours requested for ABA therapy. However, the level of impairment does justify 32 hours a week of direct treatment (CPT code 97153), and we are able to authorize ABA therapy for one month at this intensity. We based our decision on Interqual's 2020 Behavioral Procedures for Applied Behavior Analysis Treatment for Autism Spectrum Disorder.	No	No
4881473	OMS	Outpatient	Tooth extraction	B20, K00.2, Z86.2	As stated in the 20200814 Sendero Evidence of Coverage (EOC) pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. …Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 17. Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes including, but not limited to, excision of partially or completely un-erupted impacted teeth, any oral or periodontal Surgery and preoperative and postoperative care, implants and related procedures, orthodontic procedures, and any dental services related to a Bodily Injury or Illness except as expressly provided in this Contract;	No	No
6319945	PCP	Outpatient	DME	M51.26, R26.81	As stated in the 2020 Sendero Platinum Evidence of Coverage (EOC) pages 34-38: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. …Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 84. Scooters or motorized transportation equipment, escalators, elevators, ramps, modifications or additions to living/working quarters or transportation vehicles;	No	No
6085896	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	We reviewed all the information we received from your provider to support the request for approving 35 hours per week of direct treatment services (CPT code 97153). therapy. Your child has been in ABA for treatment for over 2 years and is making good progress, having mastered a third of their current treatment goals and making significant progress on the majority of the rest. However, the level of impairment and functioning does justify 25 hours a week of direct treatment (CPT code 97153), and we are able to authorize ABA therapy for three months at this intensity.	No	No

1626076	OB/Gyn	Inpatient	Surgery	N80.0, N80.3, N94.6	Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient's condition; • Performed in the most cost effective setting required by the patient's condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational." The clinical basis for this decision is: After reviewing the documentation provided it was determined that member does not meet the April 2020 InterQual Procedures Subset Hysterectomy +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy guidelines as you did not have endocervical adenocarcinoma in situ by biopsy, you did not have cervical intra-epithelial neoplasia (CIN) 2, CIN 2,3, or CIN 3 by biopsy, you did not have fibroids by imaging in premenopausal woman, you did not have fibroids by imaging in postmenopausal woman you did not have endometrial hyperplasia with cellular atypia by biopsy or dilatation and curettage (D & C), you did not have abnormal uterine bleeding in premenopausal woman, you did not have postmenopausal bleeding, you did not have chronic pelvic inflammatory disease (PID), you did not have endometriosis by laparoscopy, you did not have chronic abdominal or pelvic pain, unknown etiology, you did not have Stage I or IA or IB endometrial cancer by pathology, you did not have adenomyosis suspected by imaging, you did not have suspected ovarian cancer by imaging, you did not have suspected tubal cancer by imaging, you did not have tubo-ovarian abscess (TOA) by imaging, you did not have postpartum uterine bleeding ≤ 24 hours post delivery, you did not have uterine prolapse, you did not have Lynch II syndrome, you did not have BRCA1 or BRCA2 gene mutation by genetic testing and you did not have gestational trophoblastic disease by imaging.	No	No
3382052	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	The requested home speech therapy two visits per week for fifty-two visits does not meet medical necessity as required by 08142019 IdealCare Evidence of Coverage page 76, "Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient's condition; • Performed in the most cost effective setting required by the patient's condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational." After reviewing the documentation provided it was determined that member does not meet the April 2020 InterQual Outpatient Rehabilitation & Chiropractic Subset Pediatric Rehabilitation guidelines for speech therapy frequency of two visits per week as the documentation did not indicate that the majority of speech	No	No
0897258	Internal Medicine	Outpatient	Genetic Testing	D45	As stated in the Sendero Evidence of Coverage (20190814) pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. …Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 38. Genetic testing, counseling or services;	No	No

7565321	Rheumatology	Outpatient	Office visit	R09.1	As stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), Page 9: “Unless preauthorized by Sendero or part of covered Emergency Care, Out-of-Network Benefits are considered Excluded Services and are not Covered Services by Sendero. You are responsible for the full cost of Excluded Services. Covered Services are Medically Necessary, appropriate, preauthorized by Sendero and/or included in your benefits. Excluded Services do not count toward your deductible, copayment and Maximum Out of Pocket amounts. If Medically Necessary, covered services are not available through an In-Network Provider, Your Primary Care Provider (PCP) may request a Preauthorization for You to see an Out-of-Network Provider.” IdealCare has contracted in-network providers that can provide the requested service. You may choose to see an in network practitioner for the requested services, prior authorization will not be required.Additionally, as stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), pages 37-41: “General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. … Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 1. Services provided by a non-participating provider, except when: a) Authorized by Sendero; or b) The following services are Medically Necessary to render Emergency Care: • Professional ambulance service; or • Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;”	No	No
4325546	Internal Medicine	Outpatient	Speech Therapy	F84.0	As stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), Page 9: “Unless preauthorized by Sendero or part of covered Emergency Care, Out-of-Network Benefits are considered Excluded Services and are not Covered Services by Sendero. You are responsible for the full cost of Excluded Services. Covered Services are Medically Necessary, appropriate, preauthorized by Sendero and/or included in your benefits. Excluded Services do not count toward your deductible, copayment and Maximum Out of Pocket amounts. If Medically Necessary, covered services are not available through an In-Network Provider, Your Primary Care Provider (PCP) may request a Preauthorization for You to see an Out-of-Network Provider.” IdealCare has contracted in-network providers that can provide the requested service. You may choose to see an in network practitioner for the requested services, prior authorization will not be required. Additionally, as stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), pages 37-41: “General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. … Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 1. Services provided by a non-participating provider, except when: a) Authorized by Sendero; or b) The following services are Medically Necessary to render Emergency Care: • Professional ambulance service; or • Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;”	No	No
5164162	Family Medicine	Outpatient	Psychologist	F41.1	As stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), Page 9: “Unless preauthorized by Sendero or part of covered Emergency Care, Out-of-Network Benefits are considered Excluded Services and are not Covered Services by Sendero. You are responsible for the full cost of Excluded Services. Covered Services are Medically Necessary, appropriate, preauthorized by Sendero and/or included in your benefits. Excluded Services do not count toward your deductible, copayment and Maximum Out of Pocket amounts. If Medically Necessary, covered services are not available through an In-Network Provider, Your Primary Care Provider (PCP) may request a Preauthorization for You to see an Out-of-Network Provider.” IdealCare has contracted in-network providers that can provide the requested service. You may choose to see an in network practitioner for the requested services, prior authorization will not be required. Additionally, as stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), pages 37-41: “General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. … Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 1. Services provided by a non-participating provider, except when: a) Authorized by Sendero; or b) The following services are Medically Necessary to render Emergency Care: • Professional ambulance service; or • Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;”	No	No

9908720	Addiction	Inpatient	Residential Treatment	F10.20	As stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), Page 9: “Unless preauthorized by Sendero or part of covered Emergency Care, Out-of-Network Benefits are considered Excluded Services and are not Covered Services by Sendero. You are responsible for the full cost of Excluded Services. Covered Services are Medically Necessary, appropriate, preauthorized by Sendero and/or included in your benefits. Excluded Services do not count toward your deductible, copayment and Maximum Out of Pocket amounts. If Medically Necessary, covered services are not available through an In-Network Provider, Your Primary Care Provider (PCP) may request a Preauthorization for You to see an Out-of-Network Provider.” IdealCare has contracted in-network providers that can provide the requested service. You may choose to see an in network practitioner for the requested services, prior authorization will not be required. Additionally, as stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), pages 37-41: “General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. … Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 1. Services provided by a non-participating provider, except when: a) Authorized by Sendero; or b) The following services are Medically Necessary to render Emergency Care: • Professional ambulance service; or • Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;”	No	No
2477214	Pediatrics	Inpatient	Inpatient hospitalization	R68	As stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), Page 9: “Unless preauthorized by Sendero or part of covered Emergency Care, Out-of-Network Benefits are considered Excluded Services and are not Covered Services by Sendero. You are responsible for the full cost of Excluded Services. Covered Services are Medically Necessary, appropriate, preauthorized by Sendero and/or included in your benefits. Excluded Services do not count toward your deductible, copayment and Maximum Out of Pocket amounts. If Medically Necessary, covered services are not available through an In-Network Provider, Your Primary Care Provider (PCP) may request a Preauthorization for You to see an Out-of-Network Provider.” IdealCare has contracted in-network providers that can provide the requested service. You may choose to see an in network practitioner for the requested services, prior authorization will not be required. Additionally, as stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), pages 37-41: “General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. … Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 1. Services provided by a non-participating provider, except when: a) Authorized by Sendero; or b) The following services are Medically Necessary to render Emergency Care: • Professional ambulance service; or • Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;”	No	
6597395	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	We reviewed all the information we received from your child’s provider to support the request for approving 40 hours per week of direct treatment services (CPT code 97153) for a 6 month period, as well as 8 hours per week for supervision (CPT code 97155), one hour per week of parent training (CPT code 97156) and 8 hours over a 6 month period for assessment services (CPT code 97151). Based on our review, we are unable to authorize the requested number of hours. This is because while it is clear that your child continues to meet our criteria for continued direct treatment with applied behavioral analysis (ABA) therapy, your child’s level of impairment does not justify the number of hours requested. Your child has been in ABA treatment since January of 2019 and is making good progress, as demonstrated by having mastered half of their current treatment goals and making substantial progress on the rest. However, we are able to authorize 25 hours of direct treatment services per week, as well as 6 hours per week for CPT code 97155, one hour per week of CPT code 97156 and 4 hours of 97151 spread out across the authorization, based on your child’s current level of impairment and functioning and need for continued treatment. Although your provider asked for an authorization period of 6 months, since Sendero’s Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder requires reassessment be conducted every 90 days for continued authorization, we are unable to authorize services for a 6 month period but are able to authorize these services for a period of 3 months. We based our decision on InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders, as well as Sendero’s Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder.	No	No

5781937	Neuro Pysch	Outpatient	Office visit	G31.84	The requested total neuropsychological evaluation and testing does not meet medical necessity as required by 08142019 IdealCare Evidence of Coverage page 76, "Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient's condition; • Performed in the most cost effective setting required by the patient's condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational." The clinical basis for this decision is: After reviewing 2020 InterQual BH Procedures Subset Neuropsychological and Developmental Testing, the submitted medical records indicated that the provider has not documented specific questions that testing is intended to answer, referring or testing provider has not confirmed that questions are not answerable by a comprehensive clinical evaluation or that questions can be answered more rapidly by testing and provider has not specified how the test results will be used to determine or modify treatment or evaluate response to treatment.	No	No
3096056	Addiction Psychiatrist	Inpatient	Residential Treatment	F10.20, F11.20	The requested continued residential treatment does not meet medical necessity as required by 08142019 Sendero Evidence of Coverage page 76, "Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient's condition; • Performed in the most cost effective setting required by the patient's condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational." • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient's condition; • Performed in the most cost effective setting required by the patient's condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational." • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient's condition; • Performed in the most cost effective setting required by the patient's condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational." After reviewing 2020 InterQual BH Procedures Subset Substance Use Disorder, Residential Treatment Center guidelines we are unable to authorize this request at this time. The reason we are denying this request is that the information provided did not show that you had any of the following, both of which are required for approval:At least one significant impairment in functioning within the last week and at least one significant clinical symptom such as chronic severe pain or severe cravings.	No	No

0914886	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	We reviewed all the information we received from your child's provider to support the request for approving 40 hours per week of direct treatment services (CPT code 97153) for a 6 month period, as well as 8 hours per week for supervision (CPT code 97155), one hour per week of parent training (CPT code 97156) and 8 hours over a 6 month period for assessment services (CPT code 97151). Based on our review, we are unable to authorize the requested number of hours. This is because while it is clear that your child continues to meet our criteria for continued direct treatment with applied behavioral analysis (ABA) therapy, your child's level of impairment does not justify the number of hours requested. Your child has been in ABA treatment since since September of 2019, and is making good progress, as demonstrated by having mastered three quarters of their current treatment goals and making substantial progress on the rest. However, we are able to authorize 30 hours of direct treatment services per week, as well as 6 hours per week for CPT code 97155, one hour per week of CPT code 97156 and 4 hours of 97151 spread out across the authorization, based on your child's current level of impairment and functioning and need for continued treatment. Although your provider asked for an authorization period of 6 months, since Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder requires reassessment be conducted every 90 days for continued authorization, we are unable to authorize services for a 6 month period but are able to authorize these services for a period of 3 months. We based our decision on InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders, as well as Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder.	No	No
4482010	GI	Outpatient	Colonscopy and EGD	Z12.11 and R10.13	The reason for this decision is: As stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), Page 9: "Unless preauthorized by Sendero or part of covered Emergency Care, Out-of-Network Benefits are considered Excluded Services and are not Covered Services by Sendero. You are responsible for the full cost of Excluded Services. Covered Services are Medically Necessary, appropriate, preauthorized by Sendero and/or included in your benefits. Excluded Services do not count toward your deductible, copayment and Maximum Out of Pocket amounts. If Medically Necessary, covered services are not available through an In-Network Provider, Your Primary Care Provider (PCP) may request a Preauthorization for You to see an Out-of-Network Provider." IdealCare has contracted in-network providers that can provide the requested service. You may choose to see an in network practitioner for the requested services, prior authorization will not be required. Additionally, as stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), pages 37-41: "General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. … Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 1. Services provided by a non-participating provider, except when: a) Authorized by Sendero; or b) The following services are Medically Necessary to render Emergency Care: • Professional ambulance service; or • Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;"	No	No
1900103	Pain Management	Outpatient	Office visit	M48.062	As stated in the 2020 Sendero EOC (20190814) pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. If a claim is denied as being Experimental or Investigational, you have the right to seek an Independent Federal External Review. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 5. Services which are Experimental or Investigational, or related to such, whether incurred prior to, in connection with, or subsequent to the service which is Experimental or Investigational except as expressly provided in this Contract.	No	No

6104600	DME	Outpatient	DME	F84.0 and R48.8	As stated in the 20190814 Sendero Evidence of Coverage pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. If a claim is denied as being Experimental or Investigational, you have the right to seek an Independent Federal External Review. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 89. Communication system, telephone, television or computer systems and related equipment or similar items or equipment; and 90. Communication devices except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx	No	No
8197671	Addiction	Inpatient	Inpatient behavioral health admission	F10.20, F14.10, F16.10, and F41.9	As stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), Page 9: "Unless preauthorized by Sendero or part of covered Emergency Care, Out-of-Network Benefits are considered Excluded Services and are not Covered Services by Sendero. You are responsible for the full cost of Excluded Services. Covered Services are Medically Necessary, appropriate, preauthorized by Sendero and/or included in your benefits. Excluded Services do not count toward your deductible, copayment and Maximum Out of Pocket amounts. If Medically Necessary, covered services are not available through an In-Network Provider, Your Primary Care Provider (PCP) may request a Preauthorization for You to see an Out-of-Network Provider." IdealCare has contracted in-network providers that can provide the requested service. You may choose to see an in network practitioner for the requested services, prior authorization will not be required. Additionally, as stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), pages 37-41: "General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. … Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 1. Services provided by a non-participating provider, except when: a) Authorized by Sendero; or b) The following services are Medically Necessary to render Emergency Care: • Professional ambulance service; or • Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;" The clinical basis for this decision is: You received care at an out of network facility. According to your Evidence of Coverage, on page 12, in the section entitled, "Use of Non Participating Providers", "Except for emergencies, you must obtain Sendero's approval (a referral) for out-of-network services when (covered) medically necessary services are not available in-network because no network physician or provider is available". La Hacienda Treatment Center is an out of network facility and there are multiple facilities and programs within 30 miles of your home that provide substance use disorder treatment. However, because the services you received on 6/13/20 and 6/14/20 were necessary to stabilize you under an emergency status due to the alcohol withdrawal you were experiencing, we are approving those two days of care (under authorization 2438444) but all days of care after 6/14/20 are denied. This is because at that point you were no longer at serious risk of harm from alcohol withdrawal.	No	No

5816988	Pediatric GI	Outpatient	DME	K50.00 and R63.4	As stated in the 2020 Sendero Evidence of Coverage (20190814) pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. If a claim is denied as being Experimental or Investigational, you have the right to seek an Independent Federal External Review. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 35. Over the counter medical items or supplies that can maybe prescribed by a Healthcare Practitioner but are also available without a written order or Prescription, except for Preventive Services;	No	No
5635995	Urology	Outpatient	Office visit	N48.6	As stated in the 2020 Sendero Platinum EOC pages 34 -38: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. If a claim is denied as being Experimental or Investigational, you have the right to seek review of the denial by an Independent External Review. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 14. Sexual dysfunction;	No	No
2422965	Ophthalmology /Reconstructio n	Outpatient	Outpatient surgery	L90.5, R52 and S01.91XS	As stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), Page 9: “Unless preauthorized by Sendero or part of covered Emergency Care, Out-of-Network Benefits are considered Excluded Services and are not Covered Services by Sendero. You are responsible for the full cost of Excluded Services. Covered Services are Medically Necessary, appropriate, preauthorized by Sendero and/or included in your benefits. Excluded Services do not count toward your deductible, copayment and Maximum Out of Pocket amounts. If Medically Necessary, covered services are not available through an In-Network Provider, Your Primary Care Provider (PCP) may request a Preauthorization for You to see an Out-of-Network Provider.” IdealCare has contracted in-network providers that can provide the requested service. You may choose to see an in network practitioner for the requested services, prior authorization will not be required. Additionally, as stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), pages 37-41: “General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. … Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 1. Services provided by a non-participating provider, except when: a) Authorized by Sendero; or b) The following services are Medically Necessary to render Emergency Care: • Professional ambulance service; or • Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;”	No	No

5358272	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	We reviewed all the information we received from Action Behavior Center to support the request for approving 40 hours per week of direct treatment services (CPT code 97153) for a 6 month period, as well as 8 hours per week for supervision (CPT code 97155), one hour per week of parent training (CPT code 97156) and 8 hours over a 6 month period for assessment services (CPT code 97151). Based on our review, we are unable to authorize the requested number of hours. This is because while it is clear that your child continues to meet our criteria for continued direct treatment with applied behavioral analysis (ABA) therapy, your child's level of impairment does not justify the number of hours requested. Your child has been in ABA treatment since September 2018, and is making good progress, as demonstrated by having mastered half of his current treatment goals, including four of eight identified challenging behaviors and is making substantial progress on the rest. However, based on your child's current level of impairment and functioning and need for continued treatment, we would be able to authorize 20 hours of direct treatment services per week, as well as four hours per week for CPT code 97155, one hour per week of CPT code 97156 and four hours of 97151 spread out across the authorization, assuming there is a willingness to accept this. Although your provider asked for an authorization period of 6 months, since Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder requires reassessment be conducted every 90 days for continued authorization, we are unable to authorize services for a 6 month period but are able to authorize these services for a period of 3 months, assuming there is a willingness to accept this. We based our decision on InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders, as well as Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder.	No	No
7995313	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	We reviewed all the information we received from your child's provider to support the request for approving 40 hours per week of direct treatment services (CPT code 97153) for a 37 week period, as well as 8 hours per week for supervision (CPT code 97155), one hour per week of parent training (CPT code 97156) and 8 hours over a 6 month period for assessment services (CPT code 97151). Based on our review, we are unable to authorize the requested number of hours. This is because while it is clear that your child continues to meet our criteria for continued direct treatment with applied behavioral analysis (ABA) therapy, your child's level of impairment does not justify the number of hours requested. Your child has been in ABA treatment since February of 2019 and is making reasonable progress, as demonstrated by having mastered nearly 20% of the current treatment goals and making substantial progress on more than half the rest. However, we are able to authorize 30 hours of direct treatment services per week, as well as 6 hours per week for CPT code 97155, one hour per week of CPT code 97156 and 4 hours of 97151 spread out across the authorization, based on your child's current level of impairment and functioning and need for continued treatment. Although your provider asked for an authorization period of 6 months, since Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder requires reassessment be conducted every 90 days for continued authorization, we are unable to authorize services for a 37 week period but are able to authorize these services for a period of 3 months. We based our decision on InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders, as well as Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder.	Yes	No
4114965	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	We reviewed all the information we received from Action Behavior Center to support the request for approving 40 hours per week of direct treatment services (CPT code 97153) for a 6 month period, as well as 8 hours per week for supervision (CPT code 97155), one hour per week of parent training (CPT code 97156) and 8 hours over a 6 month period for assessment services (CPT code 97151). Based on our review, we are unable to authorize the requested number of hours. This is because while it is clear that your child continues to meet our criteria for continued direct treatment with applied behavioral analysis (ABA) therapy, your child's level of impairment does not justify the number of hours requested. Your child has been in ABA treatment since January 2020 and is making overall progress on most of his current treatment goals, including five of nine identified challenging behaviors. However, based on your child's current level of impairment and functioning and need for continued treatment, we would be able to authorize 20 hours of direct treatment services per week, as well as four hours per week for CPT code 97155, one hour per week of CPT code 97156 and four hours of 97151 spread out across the authorization, assuming there is a willingness to accept this. Although your provider asked for an authorization period of 6 months, since Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder requires reassessment be conducted every 90 days for continued authorization, we are unable to authorize services for a 6 month period but are able to authorize these services for a period of 3 months, assuming there is a willingness to accept this. We based our decision on InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders, as well as Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder.	Yes	No

5612932	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	We reviewed all the information we received from Action Behavior Center to support the request for approving 40 hours per week of direct treatment services (CPT code 97153) for a 6 month period, as well as 8 hours per week for supervision (CPT code 97155), one hour per week of parent training (CPT code 97156) and 4 hours over a 6 month period for assessment services (CPT code 97151). The record we received indicates that Timothy does not attend any type of school program, and that, "School is not an appropriate option". Based on this information, we are unable to authorize any additional hours. This is because the InterQual guidelines on which we base our decisions (InterQual Criteria, 2020 Edition, July Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders) require that if the patient is 6 years of age or older that they be in some form of schooling. This is in part because U.S. federal law requires public schools to provide appropriate educational services for minors who have disabilities or special educational needs. If there is information that would provide additional support and justification for the lack of any school involvement, we may be able to reconsider this decision.	No	No
8694765	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	We reviewed all the information we received from Action Behavior Center to support the request for approving 40 hours per week of direct treatment services (CPT code 97153) for a 6 month period, as well as 8 hours per week for supervision (CPT code 97155), one hour per week of parent training (CPT code 97156) and 4 hours over a 6 month period for assessment services (CPT code 97151). Based on our review, we are unable to authorize the requested number of hours. This is because while it is clear that your child continues to meet our criteria for continued direct treatment with applied behavioral analysis (ABA) therapy, your child's level of impairment does not justify the number of hours requested. Your child has been in ABA treatment since December 2019, and is making good progress, as demonstrated by having mastered over half of his current treatment goals, including five of eight identified challenging behaviors and is making substantial progress on the rest. However, based on your child's current level of impairment and functioning and need for continued treatment, we would be able to authorize 20 hours of direct treatment services per week, as well as four hours per week for CPT code 97155, one hour per week of CPT code 97156 and four hours of 97151 spread out across the authorization, assuming there is a willingness to accept this. Additionally, we have identified two areas that require further clarification. One is that your child may well be eligible for Early Childhood Special Education (ECSE) Services, which are free and fall under the Texas public school program and include a range of services could be helpful to your child. More information can be found here: http://texasprojectfirst.org/node/167. It is not clear from the documentation we reviewed that these services have been considered and the clinical guidelines upon which we base our decisions require that there be involvement of the school system if the child is 3 years or older. Another area that requires clarification is whether your child would benefit from resumption of the speech and/or occupational therapy that they were receiving prior to starting treatment with Action Behavior Centers, particularly in light of documentation in the medical record that they are making minimal progress with vowel sounds. Our clinical guideline requires that consideration be given to the possible need for alternative therapies such as speech and occupational therapy and that the provision of ABA services not interfere with these types of treatment if needed. Although your provider asked for an authorization period of 6 months, it is Sendero policy to authorize no longer than three months. Because of the need for these concerns to be addressed, we can authorize a period of one month to allow your provider to address these concerns, preferably in writing. We based our decision on Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder, as well as InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders.	No	No

5358272	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	We reviewed all the information we received from Action Behavior Center to support the request for approving 40 hours per week of direct treatment services (CPT code 97153) for a 6 month period, as well as 8 hours per week for supervision (CPT code 97155), one hour per week of parent training (CPT code 97156) and 8 hours over a 6 month period for assessment services (CPT code 97151). Based on our review, we are unable to authorize the requested number of hours. This is because while it is clear that your child continues to meet our criteria for continued direct treatment with applied behavioral analysis (ABA) therapy, your child's level of impairment does not justify the number of hours requested. Your child has been in ABA treatment since September 2018, and is making good progress, as demonstrated by having mastered half of his current treatment goals, including four of eight identified challenging behaviors and is making substantial progress on the rest. However, based on your child's current level of impairment and functioning and need for continued treatment, we would be able to authorize 20 hours of direct treatment services per week, as well as four hours per week for CPT code 97155, one hour per week of CPT code 97156 and four hours of 97151 spread out across the authorization, assuming there is a willingness to accept this. Although your provider asked for an authorization period of 6 months, since Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder requires reassessment be conducted every 90 days for continued authorization, we are unable to authorize services for a 6 month period but are able to authorize these services for a period of 3 months, assuming there is a willingness to accept this. We based our decision on InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders, as well as Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder.	No	No
3246868	Internal Medicine	Outpatient	DME	G81.11	The requested continued power wheelchair does not meet medical necessity as required by Sendero 2020 Platinum Evidence of Coverage page 69, "Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: 1. In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; 2. Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; 3. Not primarily for the convenience of the patient or Healthcare Practitioner; 4. Clearly substantiated and supported by the medical records and documentation concerning the patient's condition; 5. Performed in the most cost effective setting required by the patient's condition; 6. Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and 7. Not Experimental or Investigational." The clinical basis for this decision is: After reviewing April 2020 InterQual CP: Durable Medical, Equipment Subset: Wheelchairs, Power guidelines we are unable to authorize this request at this time. The reason we are denying this request is that the information provided did not show that caregiver is unable to safely and efficiently propel manual wheelchair.	Yes	No

4152974	Psych	Outpatient	Neuro Psych Testing	R41.3	The requested neuropsychological testing does not meet medical necessity as required by 08142019 IdealCare Evidence of Coverage page 76, “Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient’s condition; • Performed in the most cost effective setting required by the patient’s condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational.” The clinical basis for this decision is: After reviewing the documentation provided it was determined that member does not meet the April 2020 InterQual Procedures Criteria Subset: Neuropsychological and Developmental Testing as the referring provider has not confirmed that questions are not answerable by a comprehensive clinical evaluation or that questions can be answered more rapidly by testing and provider has not specified how the test results will be used to determine or modify treatment. Neurology evaluation to further evaluate the memory loss was ordered and has not been completed to date.	No	No
7481162	Urology	Outpatient	Outpatient Service	C61	As stated in the 2020 Sendero EOC (20190814) pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. If a claim is denied as being Experimental or Investigational, you have the right to seek an Independent Federal External Review. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 5. Services which are Experimental or Investigational, or related to such, whether incurred prior to, in connection with, or subsequent to the service which is Experimental or Investigational except as expressly provided in this Contract.	No	No
9958040	Pediatrics	Outpatient	DME	F84.0, R15.9, R32	As stated in the 2020 Sendero EOC (20190814) pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. If a claim is denied as being Experimental or Investigational, you have the right to seek an Independent Federal External Review. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 35. Over the counter medical items or supplies that can maybe prescribed by a Healthcare Practitioner but are also available without a written order or Prescription, except for Preventive Services;	No	No

5240101	PCP	Home	Home Health	F80.1, G40.909, R62.0	As stated in the 2020 Sendero Evidence of Coverage pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. If a claim is denied as being Experimental or Investigational, you have the right to seek an Independent Federal External Review. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 7. Services exceeding the amount of benefits available for a particular service; Additionally, the 2020 Summary of Benefits and Coverage for IdealCare Expanded Bronze On Exchange indicates that home health care visits are limited to 60 visits per year. Coverage period is 1/1/2020 through 12/31/2020.	No	No
8870530	PCP	Outpatient	Imaging	M54.30	As stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), Page 9: “Unless preauthorized by Sendero or part of covered Emergency Care, Out-of-Network Benefits are considered Excluded Services and are not Covered Services by Sendero. You are responsible for the full cost of Excluded Services. Covered Services are Medically Necessary, appropriate, preauthorized by Sendero and/or included in your benefits. Excluded Services do not count toward your deductible, copayment and Maximum Out of Pocket amounts. If Medically Necessary, covered services are not available through an In-Network Provider, Your Primary Care Provider (PCP) may request a Preauthorization for You to see an Out-of-Network Provider.” IdealCare has contracted in-network providers that can provide the requested service. You may choose to see an in network practitioner for the requested services, prior authorization will not be required. Additionally, as stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), pages 37-41: “General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. … Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 1. Services provided by a non-participating provider, except when: a) Authorized by Sendero; or b) The following services are Medically Necessary to render Emergency Care: • Professional ambulance service; or • Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;”	No	No
3097642	Neurology	Outpatient	DME	G35	As stated in the 2020 Sendero Evidence of Coverage pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. If a claim is denied as being Experimental or Investigational, you have the right to seek an Independent Federal External Review. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 35. Over the counter medical items or supplies that can maybe prescribed by a Healthcare Practitioner but are also available without a written order or Prescription, except for Preventive Services;	No	No

6647093	Urology	Outpatient	Surgery	N48.6	As stated in the 2020 Sendero Evidence of Coverage pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. If a claim is denied as being Experimental or Investigational, you have the right to seek an Independent Federal External Review. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 14. Sexual dysfunction;	No	No
9355754	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	We reviewed all the information we received from your child's provider to support the request for approving 40 hours per week of direct treatment services (CPT code 97153) for a 6 month period, as well as 8 hours per week for supervision (CPT code 97155), one hour per week of parent training (CPT code 97156) and 8 hours over a 6 month period for assessment services (CPT code 97151). Based on our review, we are unable to authorize the requested number of hours. This is because while it is clear that your child continues to meet our criteria for continued direct treatment with applied behavioral analysis (ABA) therapy, your child's level of impairment does not justify the number of hours requested. Your child has been in ABA treatment since September, 2019, and is making good progress, as demonstrated by having mastered a third of their current treatment goals, including five of seven identified challenging behaviors and is making progress on the rest. However, based on your child's current level of impairment and functioning and need for continued treatment, we would be able to authorize 20 hours of direct treatment services per week, as well as four hours per week for CPT code 97155, one hour per week of CPT code 97156 and four hours of CPT code 97151 spread out across the authorization, assuming you and your child's provider are willing to accept this. Although your provider asked for an authorization period of 6 months, since Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder requires reassessment be conducted every 90 days for continued authorization, we are unable to authorize services for a 6 month period but are able to authorize these services for a period of 3 months. We based our decision on InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders, as well as Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder.	No	No
7752959	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	Based on our review, we are unable to authorize this request. This is because the medical record provided failed to document the following information, all of which are required for approval: • The Behavior analyst coordinates with school or early intervention program. A documented transition plan for return to school or early intervention program. • The Behavior analyst coordinates with all other allied health services and has obtained specific information on types of services provided AND number of hours per week for each type of service AND behaviors or deficits targeted. This is particularly relevant for this member who is reported to be receiving both speech and occupational therapy, as well as a psychiatric medication from an unidentified prescriber. • There must be a comprehensive evaluation explicitly identifying the need for and recommending the use of applied behavior analysis for the treatment of ASD performed by member's primary care provider or specialty physician (e.g. developmental pediatrician, pediatric neurologist, pediatric psychiatrist, etc.) • Specification regarding the diagnosis of Autism Spectrum Disorder as to whether there is accompanying intellectual impairment and/or language impairment We based our decision on InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders, as well as Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder. If the missing information detailed above is provided through clear and specific documentation from the actual medical record, we may be able to reconsider this decision.	No	No

2375642	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	Based on our review, we are unable to authorize this request. This is because the medical record provided failed to document the following information, all of which are required for approval: • The Behavior analyst coordinates with school or early intervention program and has obtained specific information on types of services provided AND number of hours per week for each type of service AND behaviors or deficits targeted. A documented transition plan for return to school or early intervention program • The Behavior analyst coordinates with all other allied health services and has obtained specific information on types of services provided AND number of hours per week for each type of service AND behaviors or deficits targeted • There must be a comprehensive evaluation explicitly identifying the need for and recommending the use of applied behavior analysis for the treatment of ASD performed by member's primary care provider or specialty physician (e.g. developmental pediatrician, pediatric neurologist, pediatric psychiatrist, etc.) • A preliminary fade plan • Specification regarding the diagnosis of Autism Spectrum Disorder as to whether there is accompanying intellectual impairment and/or language impairment We based our decision on InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders, as well as Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder. If the missing information detailed above is provided through clear and specific documentation from the actual medical record, we may be able to reconsider this decision.	No	No
8761023	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	We reviewed all the information we received from Building BLOCS to support the request for approving 30 hours per week of direct treatment services (CPT code 97153) for a 3 month period, as well as 3 hours per week for supervision (CPT code 97155), one hour per week of parent training (CPT code 97156) and 3 hours over a 3 month period for assessment services (CPT code 97151). Based on our review, we are able to authorize the all the requested services except for the 30 hours per week of direct treatment services (CPT code 97153). This is because while it is clear that your child continues to meet our criteria for continued direct treatment with applied behavioral analysis therapy, your child's level of impairment does not justify the number of hours requested. Your child has been in applied behavioral analysis treatment since September 2016, and is making good progress utilizing 25 hours per week of direct treatment services, as demonstrated by a decrease in requesting items after being told, "no" previously, learning to communicate his needs and wants to reduce challenging behaviors, learning to play with toys for longer periods of time, starting to join in family activities, showing a decrease in throwing objects over the last month, and showing very large communication gains in a short period of time since the introduction of a communication device. However, based on your child's current level of impairment and functioning and need for continued treatment, we would be able to authorize 20 hours of direct treatment services per week for 3 months (CPT code 97153), assuming there is a willingness to accept this. We based our decision on Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder, as well as InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders.	No	No

5710328	Neurology	Outpatient	Imaging	G95.9, M54.16	MEMBER DENIAL REASON The requested Magnetic resonance imaging (MRI)) (Magnetic resonance imaging (MRI) is a special machine that takes pictures of the inside of the body, like an x-ray but more detailed) of the lumbar spine (the lower portion of the backbone) was denied because the information provided did not say that you had taken non-steroidal anti-inflammatory medications (NSAIDs), which are medications like ibuprofen or aspirin, or acetaminophen, which is a medication like Tylenol, for at least 3 weeks. Also you did not go to outpatient physical therapy or do a home exercise for at least 6 weeks and you did not modify your activity for at least 6 weeks. The clinical basis for this decision is the April 2020 InterQual CP: Imaging Subset: Imaging, Spine, Lumbar guidelines. PROVIDER DENIAL REASON The requested lumbar MRI does not meet medical necessity as required by Sendero 2020 Evidence of Coverage page 76, “Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient's condition; • Performed in the most cost effective setting required by the patient's condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational.” The clinical basis for this decision is the April 2020 InterQual CP: Imaging Subset: Imaging, Spine, Lumbar guidelines we are unable to authorize this request at this time. The reason we are denying this request is that based on the information provided you did not have NSAIDs or acetaminophen for at least 3 weeks, you did not have physical therapy or home exercise for at least 6 weeks and you did not have activity modification for at least 6 weeks.	No	No
81414	Physical Therapy	Outpatient	Physical Therapy	M62.838, N94.10	As stated in the 2020 Sendero Evidence of Coverage pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. If a claim is denied as being Experimental or Investigational, you have the right to seek review of the denial by an Independent External Review. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 14. Sexual dysfunction;	No	No

9351809	Physical Therapy	Outpatient	Physical Therapy	M62.83, R35.0, R39.15	As stated in the 2020 Sendero Evidence of Coverage pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. If a claim is denied as being Experimental or Investigational, you have the right to seek review of the denial by an Independent External Review. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 14. Sexual dysfunction;	No	No
8426406	Psychologist	Outpatient	Office visit	F43.23	As stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), Page 9: “Unless preauthorized by Sendero or part of covered Emergency Care, Out-of-Network Benefits are considered Excluded Services and are not Covered Services by Sendero. You are responsible for the full cost of Excluded Services. Covered Services are Medically Necessary, appropriate, preauthorized by Sendero and/or included in your benefits. Excluded Services do not count toward your deductible, copayment and Maximum Out of Pocket amounts. If Medically Necessary, covered services are not available through an In-Network Provider, Your Primary Care Provider (PCP) may request a Preauthorization for You to see an Out-of-Network Provider.” IdealCare has contracted in-network providers that can provide the requested service. You may choose to see an in network practitioner for the requested services, prior authorization will not be required. Additionally, as stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), pages 37-41: “General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. … Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 1. Services provided by a non-participating provider, except when: a) Authorized by Sendero; or b) The following services are Medically Necessary to render Emergency Care: • Professional ambulance service; or • Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;”	No	No
0950768	Eating Disorder	Outpatient	Partial Hospitalization	F50.01	In order to be able to approve this request, the member’s condition would have to have demonstrated significant functional impairment, such as having been transferred from an inpatient or residential treatment center within the 24 hours prior to admission, as well as severe symptoms within the last week, such as worsening angry outbursts multiple times during the week, and there would have to be evidence that treatment in a less intensive level of care, such as an eating disorder intensive outpatient program (IOP) would not be expected to be successful. Since these requirements were not met, we are unable to authorize this request. However, the member’s circumstances would meet our criteria for an eating disorder IOP and we would be able to authorize treatment at this level of care. We based our decision on InterQual Criteria, 2020 addition, March Release. BH: Procedures-subset: Child and Adolescent Psychiatry: Partial Hospitalization Program.	Yes	No

1489127	Oncology	Outpatient	Genetic Testing	C91.10	As stated in the 2020 Sendero Evidence of Coverage (pages 37-41): General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. If a claim is denied as being Experimental or Investigational, you have the right to seek an Independent Federal External Review. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 38. Genetic testing, counseling or services;	No	No
1138338	Oncology	Outpatient	Genetic Testing	C18.9, C78.7, Z80.9	MEMBER DENIAL REASON The requested genetic testing was denied because genetic testing is not a covered benefit. Genetic testing tests blood to find illnesses that run in families. HLA-B27 by PCR is a type of genetic test that look for certain proteins on the surface of white blood cells that may indicate you have certain types of diseases, but this test is not the only way to tell if you have certain diseases. We based this decision on your 2020 Sendero Evidence of Coverage, item #38 on page 39. PROVIDER DENIAL REASON As stated in the 2020 Sendero Evidence of Coverage (pages 37-41): General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. If a claim is denied as being Experimental or Investigational, you have the right to seek an Independent Federal External Review. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 38. Genetic testing, counseling or services;	No	No

2919318	Orthopedics	Outpatient	Genetic Testing	M40.204	MEMBER DENIAL REASON The requested genetic testing was denied because genetic testing is not a covered benefit. Genetic testing tests blood to find illnesses that run in families. HLA-B27 by PCR is a type of genetic test that look for certain proteins on the surface of white blood cells that may indicate you have certain types of diseases, but this test is not the only way to tell if you have certain diseases. We based this decision on your 2020 Sendero Evidence of Coverage, item #38 on page 39. PROVIDER DENIAL REASON As stated in the 2020 Sendero Evidence of Coverage (pages 37-41): General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. If a claim is denied as being Experimental or Investigational, you have the right to seek an Independent Federal External Review. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 38. Genetic testing, counseling or services;	No	No
9207857	Internal Medicine	Outpatient	Genetic Testing	D47.1	As stated in the 2020 Sendero Evidence of Coverage (pages 37-41): General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. If a claim is denied as being Experimental or Investigational, you have the right to seek an Independent Federal External Review. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 38. Genetic testing, counseling or services;	No	No

7672281	PCP	Outpatient	Moblie Cardiac Telemetry	R42	The requested mobile cardiac telemetry does not meet medical necessity as required by Sendero 2020 Evidence of Coverage page 76, “Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient's condition; • Performed in the most cost effective setting required by the patient's condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational.” The clinical basis for this decision is: After reviewing April 2020 InterQual Clinical Product: Procedures, Criteria Subset: Electrocardiography, Ambulatory we are unable to authorize this request at this time. Based on review of the information provided you did not have all three of the following: low or no risk for coronary artery disease (CAD), contributory conditions excluded and no murmur by physical examination. Additionally, Sendero does have in network providers for the requested services.	No	No
6925666	Pain Management	Outpatient	Office visit	M47.894	As stated in the Sendero Provider Manual effective 7/2020, page 4, section 1.0 – “Prior Authorization List” for Medical effective 7/27/2020 specifically states that pain management procedures including but not limited to, external implanted infusion pumps or stimulator devices, epidural steroid injections requires prior authorization. Page 40 section 6.4 Prior Authorization “Sendero requires that all services described on the prior authorization list be authorized prior to services being rendered.”	No	No
8213205	Neurology	Outpatient	Office visit	F03.90	The requested neuropsychological testing does not meet medical necessity as required by 2020 IdealCare Evidence of Coverage page 76, “Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient’s condition; • Performed in the most cost effective setting required by the patient’s condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational.” The clinical basis for this decision is: After reviewing the documentation provided it was determined that member does not meet the April 2020 InterQual Procedures Criteria Subset: Neuropsychological and Developmental Testing as the referring provider has not confirmed that questions are not answerable by a comprehensive clinical evaluation or that questions can be answered more rapidly by testing and provider has not specified how the test results will be used to determine or modify treatment.	No	No

9927000	PCP	Outpatient	Imaging	M54.5, M54.9	The requested lumbar and thoracic MRI does not meet medical necessity as required by Sendero 2020 Evidence of Coverage page 76, "Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient's condition; • Performed in the most cost effective setting required by the patient's condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational." The clinical basis for this decision is: After reviewing April 2020 InterQual CP: Imaging Subset: Imaging, Spine, Lumbar guidelines we are unable to authorize the lumbar MRI request at this time. The reason we are denying this request is that based on the information provided you have nonspecific low back pain and no neurological deficits. Lumbar MRI is not recommended for this condition. You did not have suspected lumbar disc herniation or foraminal stenosis (unilateral symptoms), you did not have radiculopathy post herniated disc surgery, you did not have suspected cauda equina syndrome, you did not have suspected lumbar spinal stenosis (bilateral symptoms), you did not have known lumbar spine fracture or suspected cord injury, you did not have spinal tumor, you did not have suspected bone metastasis, you did not have osteomyelitis, you did not have suspected disc space infection, you did not have epidural abscess, you did not have ankylosing spondylitis (AS), you did not have suspected nonunion after spinal fusion (pseudoarthrosis), you did not have preoperative planning for degenerative disc disease, and you did not have scoliosis by physical examination. After reviewing April 2020 InterQual CP: Imaging Subset: Imaging, Spine, Thoracic guidelines we are unable to authorize the thoracic MRI request at this time. The reason we are denying this request is that based on the information provided you did not have suspected thoracic disc herniation or foraminal stenosis, you did not have myelopathy (bilateral symptoms), you did not have suspected or known thoracic spine fracture or suspected cord injury, you did not have suspected nonunion after spinal fusion (pseudoarthrosis), you did not have spinal tumor, you did not have suspected bone metastasis, you did not have osteomyelitis, you did not have suspected disc space infection, you did not have epidural abscess, you did not have scoliosis by physical examination, and you did not have Multiple sclerosis (MS).	No	No
7444338	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	We reviewed all the information we received from Action Behavior Center to support the request for approving 35 hours per week of direct treatment services (CPT code 97153) for a 14 week period, as well as 8 hours per week for supervision (CPT code 97155), one hour per week of parent training (CPT code 97156) and 4 hours over a 14 week period for assessment services (CPT code 97151). Based on our review, we are unable to authorize the requested number of hours. This is because there are two criteria required for initial authorization of ABA services which were not met as follows: 1. There needs to be a clear fade plan that anticipates a reduction in hours as the member displays progress. Specifically, we make note of the fact that this member was attending school up until quarantine and is now unable to participate in online/remote learning. Therefore, a fade plan would need to address a transition back to school with ongoing ABA support once the quarantine is lifted. 2. There needs to be an explicit plan for care coordination involving the school system as well as those practitioners providing Speech and Occupational Therapies and the member's Neurologist We based our decision on InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders, as well as Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder.	No	No

5397556	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	We reviewed all the information we received from Action Behavior Center to support the request for approving 35 hours per week of direct treatment services (CPT code 97153) for a 6 month period, as well as 8 hours per week for supervision (CPT code 97155), one hour per week of parent training (CPT code 97156) and 8 hours over a 6 month period for assessment services (CPT code 97151). Based on our review, we are unable to authorize this request. This is because our criteria for approving continuation of ABA treatment include that there must be documentation of clear benefit to the member, as demonstrated by measurable changes in the frequency, intensity and/or duration of the specific behavior of interest, with at least 50% of targeted goals demonstrating progress as indicated by the data. However, this member is making little to no progress overall in spite of having received a very intensive level of services, including 40 hours per week of direct treatment services for approximately one and a half years. In particular, the clinical records provided document the following: • There is no indication of improvement in the VB MAPP master scoring form over the last 3 months (this is a structured test that measures the skill level of a child in a variety of areas such as language and social skills) • He remains almost completely nonverbal • Of 35 treatment goals documented in the clinical record, only 16 were either mastered or improved; of the rest, 5 demonstrated less than 50% progress, 12 documented no progress, and two documented worsening of performance, meaning that more than half of the goals showed far less than at least 50% improvement • Of 9 challenging behaviors, 2, including physical aggression, have worsened since baseline, 3 have shown minimal or no overall progress, and the other 4 have shown no more than 50% improvement. In summary, this child does not appear to be benefiting from intensive and sustained ABA treatment in a meaningful way. In order for us to reconsider authorization in the future, we would first require the providers and/or family to obtain a thorough reassessment of the member by a qualified physician, either a child psychiatrist, developmental pediatrician, or pediatric neurologist. This evaluation should include consideration of whether there may be other issues, including health related issues, that are preventing him from benefiting from ABA treatment and whether ABA is likely to be an appropriate treatment modality for him, given the current experience. We would also require that such an evaluation be coordinated with Sendero's case management department, as supported by the Additional Considerations section of the Sendero ABA policy: "If treatment plan objectives are not being met, independent review of care may be requested, and treatment reevaluated by an independent entity. " We based our decision on InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders, as well as Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder.	No	No
4913212	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	Based on our review, we remain unable to authorize the requested number of hours. This is because there continue to be two criteria previously referenced as required for initial authorization of ABA services which are still not met as follows: 1. As regards the Fade/Transition plan criterion in Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder, we note that since the original request, criteria were added to the "Transition Plan" section from the parent training section, and that criteria for fading or discharge from ABA were added. However, the current Fade/Transition plan still does not address a transition back to school and maintains that this is not appropriate at this time. This does not address the following request in the previous denial notification: "Therefore, a fade plan would need to address a transition back to school with ongoing ABA support once the quarantine is lifted." Again, as in the previous notification, we make note of the fact that this member was attending school under an IEP with associated school therapies up until quarantine. 2. As regards the criterion that there needs to be an explicit plan for care coordination involving the school system as well as those practitioners providing Speech and Occupational Therapies and the member's Neurologist, we note that the information provided in this regard in the current request is in no way different than in the original request. Therefore, this criterion remains not met. At a minimum, such a plan would include the names and/or titles of the exact entities to be contacted, the frequency of contact and time frame in which the contact will occur, as well as the mode of contact (phone call, written communication, etc.). We based our decision on InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders, as well as Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder.	No	No

5966349	Wound Care	Outpatient	Wound Care	S31.1055	As stated in the 2020 Sendero EOC (Platinum) pages 34-38: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. If a claim is denied as being Experimental or Investigational, you have the right to seek review of the denial by an Independent External Review. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 5. Services which are Experimental or Investigational, or related to such, whether incurred prior to, in connection with, or subsequent to the service which is Experimental or Investigational except as expressly provided in this EOC/Contract. The fact that a service is the only available treatment for a condition may not make it eligible for coverage if We deem it to be Experimental or Investigational;	No	No
7307506	EECP	Outpatient	Outpatient Service	G47.30, I25.118, I25.2, R06.09, R53.83, R73.6, Z95.5	As stated in the 2020 Sendero EOC (20190814) pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. If a claim is denied as being Experimental or Investigational, you have the right to seek an Independent Federal External Review. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 5. Services which are Experimental or Investigational, or related to such, whether incurred prior to, in connection with, or subsequent to the service which is Experimental or Investigational except as expressly provided in this Contract.	No	No
9387741	Psychiatric	Inpatient	Inpatient Psychiatric	R68	As stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), Page 9: “Unless preauthorized by Sendero or part of covered Emergency Care, Out-of-Network Benefits are considered Excluded Services and are not Covered Services by Sendero. You are responsible for the full cost of Excluded Services. Covered Services are Medically Necessary, appropriate, preauthorized by Sendero and/or included in your benefits. Excluded Services do not count toward your deductible, copayment and Maximum Out of Pocket amounts. If Medically Necessary, covered services are not available through an In-Network Provider, Your Primary Care Provider (PCP) may request a Preauthorization for You to see an Out-of-Network Provider.” IdealCare has contracted in-network providers that can provide the requested service. Additionally, as stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), pages 37-41: “General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. … Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 1. Services provided by a non-participating provider, except when: a) Authorized by Sendero; or b) The following services are Medically Necessary to render Emergency Care: • Professional ambulance service; or • Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;”	No	No

7686527	Oncology	Outpatient	Genetic Testing	C71.1	As stated in the 2020 Sendero Evidence of Coverage pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. …Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 38. Genetic testing, counseling or services;	No	No
6105064	OB/Gyn	Outpatient	OB Ultrasound	Z36.3	As stated in the Sendero Provider Manual effective 8/2020, page 5, section 1.0 – "Prior Authorization List" for Medical effective 8/2020 specifically states that OB ultrasounds greater than 4 unless done by Maternal-Fetal Medicine specialist requires prior authorization. Page 40 section 6.4 Prior Authorization "Sendero requires that all services described on the prior authorization list be authorized prior to services being rendered."	No	No
4565808	Eating Disorder	Outpatient	Partial Hospitalization	F50.2	We reviewed the clinical information provided and we determined that the member does not meet the criteria for Partial Hospitalization Program Level of Care. This means that we did not approve these services or treatment as of September 29, 2020. This denial is based on InterQual Criteria, 2020 addition, March Release. BH: Procedures-subset: Adult and Geriatric Psychiatry, Partial Hospitalization Program. Based on the medical information provided, it was determined that the member does not meet the criteria for Partial Hospitalization Program Level of Care.	No	No
0355858	Neuro Pysch	Outpatient	Neuro Psych Testing	R41.840	The requested neuropsychological testing does not meet medical necessity as required by 2020 Platinum IdealCare Evidence of Coverage page 69, "Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient's condition; • Performed in the most cost effective setting required by the patient's condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational." The clinical basis for this decision is: After reviewing the documentation provided it was determined that member does not meet the April 2020 InterQual Procedures Criteria Subset: Neuropsychological and Developmental Testing as the referring provider has not confirmed that questions are not answerable by a comprehensive clinical evaluation or that questions can be answered more rapidly by testing and provider has not specified how the test results will be used to determine or modify treatment.	Yes	No

1388612	PCP	Outpatient	Imaging	M53.3	The requested lumbar MRI does not meet medical necessity as required by Sendero 2020 Evidence of Coverage page 76, “Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient's condition; • Performed in the most cost effective setting required by the patient's condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational.” The clinical basis for this decision is: After reviewing April 2020 InterQual CP: Imaging Subset: Imaging, Spine, Lumbar guidelines we are unable to authorize the lumbar MRI request at this time. The reason we are denying this request is that based on the information provided you have sacroiliac pain and nonspecific low back pain with no neurological deficits. Lumbar MRI is not recommended for this condition. You did not have suspected lumbar disc herniation or foraminal stenosis (unilateral symptoms), you did not have radiculopathy post herniated disc surgery, you did not have suspected cauda equina syndrome, you did not have suspected lumbar spinal stenosis (bilateral symptoms), you did not have known lumbar spine fracture or suspected cord injury, you did not have spinal tumor, you did not have suspected bone metastasis, you did not have osteomyelitis, you did not have suspected disc space infection, you did not have epidural abscess, you did not have ankylosing spondylitis (AS), you did not have suspected nonunion after spinal fusion (pseudoarthrosis), you did not have preoperative planning for degenerative disc disease, and you did not have scoliosis by physical examination.	Yes	No
1992368	PCP	Outpatient	Imaging	M54.5	The requested lumbar MRI does not meet medical necessity as required by Sendero 2020 Evidence of Coverage page 76, “Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient's condition; • Performed in the most cost effective setting required by the patient's condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational.” The clinical basis for this decision is: After reviewing April 2020 InterQual CP: Imaging Subset: Imaging, Spine, Lumbar guidelines we are unable to authorize the lumbar MRI request at this time. The reason we are denying this request is that based on the information provided you have nonspecific low back pain with no neurological deficits. Lumbar MRI is not recommended for this condition. You did not have suspected lumbar disc herniation or foraminal stenosis (unilateral symptoms), you did not have radiculopathy post herniated disc surgery, you did not have suspected cauda equina syndrome, you did not have suspected lumbar spinal stenosis (bilateral symptoms), you did not have known lumbar spine fracture or suspected cord injury, you did not have spinal tumor, you did not have suspected bone metastasis, you did not have osteomyelitis, you did not have suspected disc space infection, you did not have epidural abscess, you did not have ankylosing spondylitis (AS), you did not have suspected nonunion after spinal fusion (pseudoarthrosis), you did not have preoperative planning for degenerative disc disease, and you did not have scoliosis by physical examination.	No	No

4865269	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	Based on our review, we are unable to authorize the requested number of hours. This is because there are requirements in Sendero's Policy for Applied Behavioral Analysis for the Treatment of Autism Spectrum Disorder which are not met: • A more detailed plan outlining how and when parent training takes place to ensure parent training goals are being met. We based our decision on Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder, as well as InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders.	No	No
1243812	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	Based on our review, we are unable to authorize the requested number of hours. This is because there are requirements in Sendero's Policy for Applied Behavioral Analysis for the Treatment of Autism Spectrum Disorder which are not met: • A comprehensive treatment plan is characterized by the following features: care coordination involving parent(s)/guardian(s)/caregiver(s), and educational providers. Specifically, clinical information states member is not school aged. Member is currently school aged at time of request. Also, no stated plan for resuming Speech and Language Pathology (SLP) or Occupational Therapy (OT) therapies in the future. • Transition/fade plan should address integration/re-integration within an educational setting for school aged children. Fade plan also states goal of "zero incidents of tantrums" may be reconsidered in regard to more age-appropriate behaviors. We based our decision on Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder, as well as InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders.	No	No
6355552	Psychiatric	Outpatient	Partial Hospitalization	F31.81, F43.10	Based on our review, we remain unable to authorize the requested extended days of PHP on 09/30/2020 and 10/01/2020. This is because the clinical information received and reviewed did not meet criteria for continued PHP. Specifically, the clinical information did not identify any reduction in function criteria such as Crisis while in treatment, After reviewing the July 2020 InterQual BH; Adult and Geriatric Psychiatry, Partial Hospitalization Program, we are unable to authorize this request at this time. The reason we are denying this request is based on the information provided you did not have at least one of the following criteria: after–hours crisis intervention within last week, arrest, eating disorder and unable to judge amount of food to eat at some meals, interpersonal conflict, maintaining hygiene only with frequent reminders or supervision, poor or intrusive boundaries causing altercations with others and requiring frequent staff intervention, psychiatric medication nonadherence and history of psychotic or bipolar or posttraumatic stress disorder, severe social withdrawal, unable to care for dependent children or vulnerable adults due to impaired judgment or unable to maintain adequate nutritional intake due to symptoms of psychiatric disorder We based our decision on InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Adult and Geriatric Psychiatry, Partial Hospitalization Program.	No	No
0951608	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	Based on our review, we are unable to authorize the requested number of hours. This is because there are requirements in Sendero's Policy for Applied Behavioral Analysis for the Treatment of Autism Spectrum Disorder which are not met: • A comprehensive treatment plan is characterized by the following features: care coordination involving parent(s)/guardian(s)/caregiver(s), and other providers. Records indicate member has received Speech and Language Pathology (SLP) and Occupational Therapy (OT) since July, however clinical information received from Action Behavior Centers shows no coordination between Action Behavior Centers and SLP/OT providers. • A more detailed plan outlining how and when parent training takes place to ensure parent training goals are being met as well. • Clinical information states member has made limited progress in particular toileting (i.e. "0%") since last authorization. Sendero's policy requires "measurable change in 50% of goals within 90 days." We based our decision on Sendero's Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder, as well as InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders.	No	No

4155490	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	1. All skills to be addressed in the treatment plan need to define the baseline-“to be determined” does not constitute an adequate assessment 2. The treatment plan needs to address the challenging behaviors identified by the parent, as well as the non compliance and perseverative speech identified in the assessment, specifically: a. PICA b. Aggression c. Elopement d. Tantrums 3. The report states, on page 14, “baseline to be collected within the first two weeks of treatment”, which suggest that the full picture of the member’s skill deficits and challenging behaviors has not been fully evaluated, and needs to be addressed in the submitted treatment plan 4. All instances where it is indicated that there is a need for baseline data-for example, top of page 22-need to be addressed by the completion of the gathering of baseline data 5. Parent/Caregiver Training goals state a baseline of “TBD”. As per #4 above, no goals should have a baseline of “TBD”. 6. The treatment plan states a Transition plan is “not appropriate at this time”. Sendero’s ABA policy clearly requires that a well articulated Transition plan be part of the initial treatment plan. 7. Regarding the requirement in Sendero’s ABA policy that there be a Plan for collaboration with school, other therapies and supports: The report indicates that the client has received SLP, PT, OT up until recently and attended school – indication of his return to these therapies and the school setting is not discussed in the transition plan and needs to be. Additionally, there needs to be a well articulate plan for collaboration with these other entities including time frames, names/titles of entities to be contacted and method of contact. 8. The Discharge Criteria include that the member will attain “age appropriate levels” on VB-MAPP, within 1.5 Standard Deviation on Vineland and that symptoms of ASD no longer a barrier – it is highly doubtful that levels of mastery are realistically achievable and need to be modified to levels of mastery that are more in keeping with typical outcomes of ABA therapy in moderately severe ASD. We based our decision on InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders, as well as Sendero’s Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder.	No	No
9475838	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	Based on our review, we are unable to authorize the requested number of hours. This is because there are requirements in Sendero’s Policy for Applied Behavioral Analysis for the Treatment of Autism Spectrum Disorder which are not met: • A comprehensive treatment plan is characterized by the following features: care coordination involving parent(s)/guardian(s)/caregiver(s), and other providers. Records indicate member has received Speech and Language Pathology (SLP) Occupational Therapy (OT) since June, however clinical information received from Action Behavior Centers shows no coordination between Action Behavior Centers and SLP/OT providers. • A more detailed plan outlining how and when parent training takes place to ensure parent training goals are being met as well. • Clinical information states member has masters 2 goals since last authorization. Sendero’s policy requires “measurable change in 50% of goals within 90 days.” We based our decision on Sendero’s Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder, as well as InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders.	No	No
7061989	BCBA	Outpatient	Applied Behavioral Analysis	F84.0	Based on our review, we are unable to authorize the requested number of hours. This is because there are two requirements in Sendero’s Policy for Applied Behavioral Analysis for the Treatment of Autism Spectrum Disorder which are not met: • There needs to be involvement of community resources to include at a minimum, the school district if the member is 3 or older • A comprehensive treatment plan is characterized by the following features: care coordination involving parent(s)/guardian(s)/caregiver(s), school (emphasis added) , state disability programs and other providers. These requirements are not met because the record provided states on page 3 that, “school is not an appropriate option for Timothy”. It should be noted in this regard that the member is currently 8 years and 5 months old. We based our decision on Sendero’s Policy for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder, as well as InterQual Criteria, 2020 Edition, March Release. BH: Procedures-Subset: Applied Behavioral Analysis for Autism spectrum Disorders.	No	No

3968430	Neurosurgeon	Inpatient	Elective Inpatient Surgery	M25.519, M54.2, M54.9, M79.605	As stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), Page 9: “Unless preauthorized by Sendero or part of covered Emergency Care, Out-of-Network Benefits are considered Excluded Services and are not Covered Services by Sendero. You are responsible for the full cost of Excluded Services. Covered Services are Medically Necessary, appropriate, preauthorized by Sendero and/or included in your benefits. Excluded Services do not count toward your deductible, copayment and Maximum Out of Pocket amounts. If Medically Necessary, covered services are not available through an In-Network Provider, Your Primary Care Provider (PCP) may request a Preauthorization for You to see an Out-of-Network Provider.” IdealCare has contracted in-network providers that can provide the requested service. Additionally, as stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), pages 37-41: “General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. … Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 1. Services provided by a non-participating provider, except when: a) Authorized by Sendero; or b) The following services are Medically Necessary to render Emergency Care: • Professional ambulance service; or • Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;”	No	No
8504194	Urology and Plastic Surgery	Outpatient	Outpatient surgery	F64.0	As stated in the 2020 Sendero EOC pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. If a claim is denied as being Experimental or Investigational, you have the right to seek an Independent Federal External Review. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 15. Sex change services, regardless of any diagnosis of gender role or psychosexual orientation problems;	No	No
3032720	Oncology	Outpatient	Genetic Testing	C18.2, C78.01, C79.89, Z87.891	As stated in the 2020 Platinum Sendero Evidence of Coverage pages 34 - 38: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. …Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 38. Genetic testing, counseling or services;	No	No

7674171	Oncology	Outpatient	Genetic Testing	C50.411, C78.7	As stated in the 2020 Sendero Evidence of Coverage pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. …Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 38. Genetic testing, counseling or services;	No	No
3890322	PCP	Outpatient	Speech Therapy	F80.0, F80.1, F82	As stated in the Sendero Provider Manual effective 8/2020, page 4, section 1.0 – "Prior Authorization List" for Medical effective 7/27/2020 specifically states that outpatient speech therapy (excluding initial evaluation) requires prior authorization. Page 40 section 6.4 Prior Authorization "Sendero requires that all services described on the prior authorization list be authorized prior to services being rendered."	No	No
4076545	Neurology	Outpatient	Office visit	G12.21	As stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), Page 9: "Unless preauthorized by Sendero or part of covered Emergency Care, Out-of-Network Benefits are considered Excluded Services and are not Covered Services by Sendero. You are responsible for the full cost of Excluded Services. Covered Services are Medically Necessary, appropriate, preauthorized by Sendero and/or included in your benefits. Excluded Services do not count toward your deductible, copayment and Maximum Out of Pocket amounts. If Medically Necessary, covered services are not available through an In-Network Provider, Your Primary Care Provider (PCP) may request a Preauthorization for You to see an Out-of-Network Provider." Sendero has contracted in-network providers that can provide the requested service. Additionally, as stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), pages 37-41: "General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. … Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 1. Services provided by a non-participating provider, except when: a) Authorized by Sendero; or b) The following services are Medically Necessary to render Emergency Care: • Professional ambulance service; or • Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;"	No	No

7646222	Psychiatric	Outpatient	Neuro Psych Testing	F33.2	As stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), Page 9: "Unless preauthorized by Sendero or part of covered Emergency Care, Out-of-Network Benefits are considered Excluded Services and are not Covered Services by Sendero. You are responsible for the full cost of Excluded Services. Covered Services are Medically Necessary, appropriate, preauthorized by Sendero and/or included in your benefits. Excluded Services do not count toward your deductible, copayment and Maximum Out of Pocket amounts. If Medically Necessary, covered services are not available through an In-Network Provider, Your Primary Care Provider (PCP) may request a Preauthorization for You to see an Out-of-Network Provider." IdealCare has contracted in-network providers that can provide the requested service. Additionally, as stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), pages 37-41: "General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. … Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 1. Services provided by a non-participating provider, except when: a) Authorized by Sendero; or b) The following services are Medically Necessary to render Emergency Care: • Professional ambulance service; or • Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;" The requested TMS treatment does not meet medical necessity as required by Sendero 2020 Evidence of Coverage page 76, "Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use;	No	No
1749812	Internal Medicine	Inpatient	Skilled Nursing Facility	I63.9	As stated in the Sendero Provider Manual effective 8/2020, page 4, section 1.0 – "Prior Authorization List" for Medical effective 7/27/2020 specifically states that outpatient speech therapy (excluding initial evaluation) requires prior authorization. Page 40 section 6.4 Prior Authorization "Sendero requires that all services described on the prior authorization list be authorized prior to services being rendered."	No	No

1041127	Psychiatric	Outpatient	Intensive Outpatient Program	F31.81, F43.10	Sendero currently has In-network providers that offer Intensive Outpatient Programs. As stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), Page 9: “Unless preauthorized by Sendero or part of covered Emergency Care, Out-of-Network Benefits are considered Excluded Services and are not Covered Services by Sendero. You are responsible for the full cost of Excluded Services. Covered Services are Medically Necessary, appropriate, preauthorized by Sendero and/or included in your benefits. Excluded Services do not count toward your deductible, copayment and Maximum Out of Pocket amounts. If Medically Necessary, covered services are not available through an In-Network Provider, Your Primary Care Provider (PCP) may request a Preauthorization for You to see an Out-of-Network Provider.” IdealCare has contracted in-network providers that can provide the requested service. Additionally, as stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), pages 37-41: “General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 1. Services provided by a non-participating provider, except when: a) Authorized by Sendero; or b) The following services are Medically Necessary to render Emergency Care: • Professional ambulance service; or • Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;”	No	No
8370743	OB/Gyn	Outpatient	Imaging	M54.5	The requested lumbar MRI does not meet medical necessity as required by Sendero 2020 Evidence of Coverage page 76, “Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient's condition; • Performed in the most cost effective setting required by the patient's condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational.” The clinical basis for this decision is: After reviewing April 2020 InterQual CP: Imaging Subset: Imaging, Spine, Lumbar guidelines we are unable to authorize the lumbar MRI request at this time. The reason we are denying this request is that based on the information provided, you have nonspecific low back pain with no documented neurological deficits. Lumbar MRI is not recommended for this condition. You did not have suspected lumbar disc herniation or foraminal stenosis (unilateral symptoms), you did not have radiculopathy post herniated disc surgery, you did not have suspected cauda equina syndrome, you did not have suspected lumbar spinal stenosis (bilateral symptoms), you did not have known lumbar spine fracture or suspected cord injury, you did not have spinal tumor, you did not have suspected bone metastasis, you did not have osteomyelitis, you did not have suspected disc space infection, you did not have epidural abscess, you did not have ankylosing spondylitis (AS), you did not have suspected nonunion after spinal fusion (pseudoarthrosis), you did not have preoperative planning for degenerative disc disease, and you did not have scoliosis by physical examination.	Yes	No

8527622	Psychiatric	Outpatient	Intensive Outpatient Program	F33.1, F41.1	As stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 10_16_2019), Page 14: "Unless preauthorized by Sendero or part of covered Emergency Care, Out-of-Network Benefits are considered Excluded Services and are not Covered Services by Sendero. You are responsible for the full cost of Excluded Services. Covered Services are Medically Necessary, appropriate, preauthorized by Sendero and/or included in your benefits. Excluded Services do not count toward your deductible, copayment and Maximum Out of Pocket amounts. If Medically Necessary, covered services are not available through an In-Network Provider, Your Primary Care Provider (PCP) may request a Preauthorization for You to see an Out-of-Network Provider." IdealCare has contracted in-network providers that can provide the requested service. Additionally, as stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), pages 37-41: "General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. … Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 1. Services provided by a non-participating provider, except when: a) Authorized by Sendero; or b) The following services are Medically Necessary to render Emergency Care: • Professional ambulance service; or • Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;"	No	No
0199050	PCP	Outpatient	Imaging	R10.13, R11.2	As stated in the Sendero Provider Manual effective 8/2020, page 4-5, section 1.0 – "Prior Authorization List" for Medical effective 7/27/2020 specifically states that CT/CTA Scans, MRIs & MRAS not provided in an inpatient or Emergency Room setting requires prior authorization. Page 40 section 6.4 Prior Authorization "Sendero requires that all services described on the prior authorization list be authorized prior to services being rendered."	No	No
5274868	Pediatric Dermatology	Outpatient	Office visit	D18.09	As stated in the 2020 Sendero Evidence of Coverage pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. …Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 9. Services, except for Emergency Care, relating to an Illness or Bodily Injury incurred as a result of the Covered Person. Services relating to an Illness or Bodily Injury as a result of: h) Except as otherwise provided in this Contract, cosmetic services, or any complication there from;	No	No
0992494	Gastroenterology	Outpatient	Genetic Testing	R79.89	As stated in the 2020 Sendero Evidence of Coverage pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. …Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 38. Genetic testing, counseling or services;	No	No

2337377	PCP	Outpatient	Home Health	F80.1, G40.909, P94.2, R62.0	As stated in the 2020 Sendero Evidence of Coverage pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. If a claim is denied as being Experimental or Investigational, you have the right to seek an Independent Federal External Review. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 7. Services exceeding the amount of benefits available for a particular service; Additionally, the 2020 Summary of Benefits and Coverage for IdealCare Expanded Bronze On Exchange indicates that home health care visits are limited to 60 visits per year. Coverage period is 1/1/2020 through 12/31/2020.	No	No
9399585	PCP	Outpatient	Imaging	M54.5, M54.6	The requested lumbar and thoracic MRI does not meet medical necessity as required by Sendero 2020 Evidence of Coverage page 76, “Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient's condition; • Performed in the most cost effective setting required by the patient's condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational.” The clinical basis for this decision is: After reviewing April 2020 InterQual CP: Imaging Subset: Imaging, Spine, Lumbar guidelines we are unable to authorize the lumbar MRI request at this time. The reason we are denying this request is that based on the information provided, you have nonspecific low back pain with no documented neurological deficits. Lumbar MRI is not recommended for this condition. You did not have suspected lumbar disc herniation or foraminal stenosis (unilateral symptoms), you did not have radiculopathy post herniated disc surgery, you did not have suspected cauda equina syndrome, you did not have suspected lumbar spinal stenosis (bilateral symptoms), you did not have known lumbar spine fracture or suspected cord injury, you did not have spinal tumor, you did not have suspected bone metastasis, you did not have osteomyelitis, you did not have suspected disc space infection, you did not have epidural abscess, you did not have ankylosing spondylitis (AS), you did not have suspected nonunion after spinal fusion (pseudoarthrosis), you did not have preoperative planning for degenerative disc disease, and you did not have scoliosis by physical examination. After reviewing April 2020 InterQual CP: Imaging Subset: Imaging, Spine, Thoracic guidelines we are unable to authorize the thoracic MRI request at this time. The reason we are denying this request is that based on the information provided, you did not have suspected thoracic disc herniation or foraminal stenosis, you did not have myelopathy, you did not have suspected or known thoracic spine fracture or suspected cord injury, you did not have suspected nonunion after spinal fusion (pseudoarthrosis), you did not have spinal tumor, you did not have suspected bone metastasis, this is not for follow up after bone metastasis treatment, you did not have osteomyelitis, you did not have suspected disc space infection, you did not have epidural abscess, scoliosis by physical examination and you do not have multiple sclerosis (MS).	No	No

9556030	PCP	Outpatient	Imaging	M54.16, M54.6	The requested lumbar and thoracic MRI does not meet medical necessity as required by Sendero 2020 Evidence of Coverage page 76, “Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient's condition; • Performed in the most cost effective setting required by the patient's condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational.” The clinical basis for this decision is: After reviewing April 2020 InterQual CP: Imaging Subset: Imaging, Spine, Lumbar guidelines we are unable to authorize the lumbar MRI request at this time. The reason we are denying this request is that based on the information provided, you have nonspecific low back pain with no documented neurological deficits. Lumbar MRI is not recommended for this condition. You did not have suspected lumbar disc herniation or foraminal stenosis (unilateral symptoms), you did not have radiculopathy post herniated disc surgery, you did not have suspected cauda equina syndrome, you did not have suspected lumbar spinal stenosis (bilateral symptoms), you did not have known lumbar spine fracture or suspected cord injury, you did not have spinal tumor, you did not have suspected bone metastasis, you did not have osteomyelitis, you did not have suspected disc space infection, you did not have epidural abscess, you did not have ankylosing spondylitis (AS), you did not have suspected nonunion after spinal fusion (pseudoarthrosis), you did not have preoperative planning for degenerative disc disease, and you did not have scoliosis by physical examination. After reviewing April 2020 InterQual CP: Imaging Subset: Imaging, Spine, Thoracic guidelines we are unable to authorize the thoracic MRI request at this time. The reason we are denying this request is that based on the information provided, you did not have suspected thoracic disc herniation or foraminal stenosis, you did not have myelopathy, you did not have suspected or known thoracic spine fracture or suspected cord injury, you did not have suspected nonunion after spinal fusion (pseudoarthrosis), you did not have spinal tumor, you did not have suspected bone metastasis, this is not for follow up after bone metastasis treatment, you did not have osteomyelitis, you did not have suspected disc space infection, you did not have epidural abscess, scoliosis by physical examination and you do not have multiple sclerosis (MS).	No	No
1758130	Neuro Oncology	Inpatient	Inpatient Rehabilitation	C71.7, G96.9	The requested inpatient rehabilitation does not meet medical necessity as required by Sendero 2020 Evidence of Coverage page 76, “Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient's condition; • Performed in the most cost effective setting required by the patient's condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational.” The clinical basis for this decision is: After reviewing April 2020 InterQual CP: LOC: Rehabilitation, Subset: CNS / TBI (Acute Rehab) guidelines we are unable to authorize inpatient rehabilitation at this time. The reason we are denying this request is that based on the information provided you did not have an injury, illness or surgery within the last 30 days.	No	No

8236566	Rheumatology	Outpatient	Injection	M17.11	The requested Synvisc One injection to the right knee does not meet medical necessity as required by Sendero 2020 Evidence of Coverage page 76, “Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be: • In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use; • Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration; • Not primarily for the convenience of the patient or Healthcare Practitioner; • Clearly substantiated and supported by the medical records and documentation concerning the patient's condition; • Performed in the most cost effective setting required by the patient's condition; • Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and • Not Experimental or Investigational.” The clinical basis for this decision is: After reviewing April 2020 InterQual CP: Specialty Rx Non-Oncology Subset: Synvisc One (Hylan G-F 20) guidelines we are unable to authorize the Synvisc One injection at this time. The reason we are denying this request is that based on the information provided, you did not have home exercise or physical therapy for at least 4 weeks, you did not have activity modification for at least 4 weeks and you did not have Non-steroidal anti-inflammatory drugs (NSAIDS) or acetaminophen for at least 3 weeks.	No	No
8404618	Pain Management	Outpatient	Injection	M43.06	As stated in the Sendero Provider Manual effective 8/2020, page 4, section 1.0 – “Prior Authorization List” for Medical effective 7/27/2020 specifically states that pain management procedures including but not limited to, external implanted infusion pumps or stimulator devices, epidural steroid injections require prior authorization. Page 40 section 6.4 Prior Authorization “Sendero requires that all services described on the prior authorization list be authorized prior to services being rendered.”	No	No
9565629	Surgery	Inpatient	Elective Inpatient Surgery	M79.609, R10.2	As stated in the 2020 Sendero EOC pages 37-41: General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. If a claim is denied as being Experimental or Investigational, you have the right to seek an Independent Federal External Review. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 5. Services which are Experimental or Investigational, or related to such, whether incurred prior to, in connection with, or subsequent to the service which is Experimental or Investigational except as expressly provided in this Contract.	Yes	No

3391352	OB/Gyn	Outpatient	Imaging	Z01.419	As stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), Page 9: “Unless preauthorized by Sendero or part of covered Emergency Care, Out-of-Network Benefits are considered Excluded Services and are not Covered Services by Sendero. You are responsible for the full cost of Excluded Services. Covered Services are Medically Necessary, appropriate, preauthorized by Sendero and/or included in your benefits. Excluded Services do not count toward your deductible, copayment and Maximum Out of Pocket amounts. If Medically Necessary, covered services are not available through an In-Network Provider, Your Primary Care Provider (PCP) may request a Preauthorization for You to see an Out-of-Network Provider.” IdealCare has contracted in-network providers that can provide the requested service. Additionally, as stated in the 2020 Sendero IdealCare Evidence of Coverage (EOC 20190814), pages 37-41: “General Exclusions and Limitations Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us. … Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: 1. Services provided by a non-participating provider, except when: a) Authorized by Sendero; or b) The following services are Medically Necessary to render Emergency Care: • Professional ambulance service; or • Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;”	No	No