Service	Medical Records Used for Reviews
Light and Laser Therapy	Medical notes documenting the following, when applicable: 1. History of medical conditions requiring treatment or surgical intervention which includes all the following: a. Specific location and size of the lesion b. To prove medical necessity, a well-defined physical/physiologic abnormality resulting in a medical condition that requires treatment c. Recurrent or persistent functional impairment caused by the abnormality 2. Treatments tried, failed, contraindicated or on-going; include the dates, duration, and reason for discontinuation 3. Clinical studies/tests addressing the physical/physiologic abnormality confirming its presence and degree to which it causes impairment 4. High-quality color photograph(s); all photos must be labeled with the date taken and the applicable case number obtained at time of notification, or member's name and ID number on the photograph(s) a. Date taken b. Applicable case number obtained at time of notification, or member's name and ID number on the photograph(s) Submission of color image(s) are required and can be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 5. Physician plan of care with proposed procedures and whether this request is part of a staged procedure. Indicate how the procedure will improve and/or restore function
Liposuction for Lipedema	Medical notes documenting the following, when applicable: 1. Diagnosis 2. Specific procedure requested and treatment plan, including post-operative plan of care 3. History of the medical condition(s) requiring treatment 4. Level of functional impairment 5. Physical exam including evidence of lipedema 6. Upon request we may require high-quality color photographs. All photographs must be labeled with: a. The date taken b. The applicable case number obtained at time of notification or member's name and ID number on the photograph(s) NOTE: Submission of color photographs can be submitted via the external portal at www.uhcprovider.com/paan; faxes of color photographs will not be accepted 7. Relevant medical history 8. Treatments tried, failed, or contraindicated. Include the dates, duration and reason for discontinuation 9. Relevant surgical history, including dates 10. Assessment of the cause of functional impairment by primary care provider or specialist in vascular conditions other than treating surgeon
Lower Extremity Endovascular Procedures	Medical notes documenting the following, when applicable: 1. Diagnosis 2. Relevant history and physical to include member symptoms and pertinent findings due ischemia 3. Treatments tried, failed, and/or contraindicated, including structured exercise program, pharmacologic therapy, and smoking cessation, if applicable 4. Details of functional disability(ies) interfering with work or activities of daily living (ADL) 5. Documentation of ischemic peripheral artery disease including Ankle-brachial index (ABI) 6. Diagnostic images (e.g., duplex ultrasound, computed tomography angiography [CTA], magnetic resonance angiography [MRA], or invasive angiography) documenting the location and severity of occlusion