Service	Medical Records Used for Reviews
	2. Comprehensive history of the medical condition(s) requiring treatment or surgical intervention; including: a. A well-defined physical and/or physiological abnormality (e.g., congenital abnormality, functional or skeletal impairments) resulting in a medical condition that has required or requires treatment; and b. The physical and/or physiological abnormality has resulted in a functional deficit; and c. The functional deficit is recurrent or persistent in nature 3. Reports of all recent imaging studies and applicable diagnostic tests, including: a. Cephalometric tracings and analysis addressing the physical and/or physiological abnormality that confirm its presence and the degree to which it is causing impairment, with appropriate measurements, when applicable b. Radiologic image interpretations including lateral cephalometric radiograph, AP radiograph and panoramic radiograph 4. All related, supporting imaging (color photographs, radiologic images including lateral cephalometric radiograph, AP radiograph, and panoramic radiograph) must be diagnostic quality NOTE: All images must be labeled with the: a. Date taken b. Applicable case number obtained at time of notification, or member's name and ID number Submission of images can be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted 5. Treating physician's plan of care including surgical treatment objectives, which must include the expected outcome for the improvement of the functional deficit
Outpatient Surgical Procedures – Site of Service for Commercial Plans	If the location being requested is an outpatient hospital provide medical notes documenting the following, when applicable: 1. History 2. Physical examination including patient weight and co-morbidities 3. Surgical plan 4. Physician privileging information related to the need for the use of the hospital outpatient department 5. American Society of Anesthesiologists (ASA) score, as applicable 6. Specific criteria (see coverage rationale) that qualifies the individual for the site of service requested
Panniculectomy and Body Contouring Procedures	Medical notes documenting the following, when applicable: 1. Primary complaint, history of complaint, and physical exam, including: a. Grade of panniculus b. Body mass index (BMI) c. History of recent weight loss in lbs/kgs d. History of weight stability and duration e. History of dermatologic complications 2. Diagnosis of dermatologic complications (e.g., skin infection, ulcers, maceration, skin breakdown, etc.) 3. Treatments (e.g., antibiotic, corticosteroid, antifungal) for dermatologic complications tried, failed, or contraindicated; include the dates, duration of treatment, and reason for discontinuation 4. Details of functional limitations due to pannus interfering with activities of daily living (ADL) 5. Relevant surgical history, including dates 6. Physician treatment plan, including specific and associated procedures 7. Upon request we may require high-quality color photographs a. For panniculectomy, photographs of a full-frontal view of the hanging pannus, a full-frontal view of pannus elevated that allows for the evaluation of any skin damage, and a full lateral view of the hanging pannus

Service	Medical Records Used for Reviews
	b. All photographs 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) 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
Patient Lifts	Medical notes documenting the following, when applicable: 1. Documentation of most recent face-to-face encounter with prescribing physician, when applicable 2. Current prescription (written order) from physician, when applicable including: a. Initial or replacement b. Rental or purchase c. Specific HCPCS code(s) for item and each accessory requested d. Equipment make, model and price quotation e. If replacement, current device used, date of initial acquisition, status of warranty and reason for replacement 3. Medical notes documenting the following, when applicable: a. Diagnosis b. Member's weight c. Inability to safely make transfers between bed and a chair, wheelchair, or commode without the use of a lift d. Requirement for supine positioning e. Proper use and continued benefit
Pectus Deformity Repair	Medical notes documenting the following, when applicable: 1. Diagnosis 2. History of the medical condition(s) requiring treatment or surgical intervention 3. Documentation of functional limitation/impairment 4. Results of all recent imaging studies and applicable diagnostics, including results of: a. CT scan including Haller Index or Correction Index calculation b. Pulmonary function test – total lung capacity c. Echocardiogram including ejection fraction d. Exercise stress test including cardiopulmonary function values 5. Treatments tried, failed, or contraindicated. Include the dates, duration of treatment and reason for discontinuation 6. Physician treatment plan
Percutaneous Neuroablation for Pancreatic Cancer Pain, Severe Cancer Pain, and Trigeminal Neuralgia	Medical notes documenting the following, when applicable: 1. Diagnosis 2. History of the medical condition(s) requiring treatment or surgical intervention 3. Documentation of signs and symptoms; including onset, duration, and frequency 4. Physical exam 5. Relevant medical history 6. Treatments tried, failed, or contraindicated. Include the dates and reason for discontinuation
Percutaneous Patent Foramen Ovale (PFO) Closure	Medical notes documenting the following, when applicable: 1. History and co-morbid medical condition(s) 2. Documentation of member's symptoms 3. Complete report(s) of diagnostic imaging (MRI, CT Scan, X-rays) 4. Results of diagnostic testing performed to rule out other causes including, but not limited to, carotid disease, hypercoagulable states or atrial fibrillation; and