2023 Authorization and Notification Requirements – Medical Services

List of Authorization and Notification Requirements

Acute Inpatient Rehabilitation	Durable Medical Equipment	Transplant
Back (Spine) Surgery	Genetic Testing	Vein Procedures
Bariatric Surgery	Inpatient Hospital Acute	Wheelchair Accessories
Bone Growth Stimulator	Long-Term Acute Care (LTAC)	Wheelchair - Rental
Cosmetic or Reconstructive Procedures	Proton Beam Therapy	Wheelchair - Purchase
Cranial Nerve Stimulation	Skilled Nursing Facility (SNF) or Swing Bed Admission	Wound VAC
	Spinal Cord Stimulation	

Important Information

- Allow up to 14 calendar days for a non-urgent authorization decision.
- All services are subject to member eligibility and benefit coverage.
- For services that require an authorization, failing to obtain the authorization in advance may result in a denied claim.
- If you are not able to obtain services in your network, you may submit a prior authorization request prior to services.
- Aspirus Health Plan reserves the right to review and verify medical necessity for all services.
- Inclusion or exclusion of a code listed does not constitute or imply member coverage or provider reimbursement.
- Authorization is not required for prosthetics and/or orthotics.
- Providers may request a copy of the criteria used to make a medical necessity determination on Aspirus Health Plan's website.
- Provider of Service qualifications, eligibility and licensure requirements must be met to provide services and submit claims to Aspirus Health Plan.
- Contact the Provider Assistance Center (PAC) at 715-631-7412 or 1-855-931-4851 toll-free for information on eligibility, benefits and network status.

Forms

- Aspirus Health Plan Authorization and Notification Forms

Prescription Drugs and Medical Injectable Drugs

- The Medical Drug Polices library is a list of medical injectable drugs that require prior authorization and the policies that contain coverage criteria.
- The Formulary webpage indicates which drugs are covered under the Pharmacy Benefit.

Delegated Services

Information on how to request authorization for the following services can be found at https://medicare.aspirushealthplan.com/providers/authorizations/. Aspirus Health Plan is the contract resource for all authorization service requests, concerns and questions, unless noted otherwise within delegated services.

- Acupuncture
- Chiropractic
- Dental
- Pharmacy

Requirement Definitions

APPROVAL AUTHORITY	**Aspirus Health Plan or an organization delegated by Aspirus Health Plan to approve or deny prior authorization requests.**
NOTIFICATION	The process of informing Aspirus Health Plan or delegates of Aspirus Health Plan of a specific medical treatment or services prior to, or within a specified time period after, the start of the treatment or service.
PRE-SERVICE DETERMINATION (PSD)	An enrollee, or a provider acting on behalf of the enrollee, always has the right to request a pre-service determination if there is a question as to whether an item or service will be covered by plan.
PRIOR AUTHORIZATION	An approval by an Approval Authority prior to the delivery of a specific service or treatment. Prior authorization requests require a clinical review by qualified, appropriate professionals to determine if the service or treatment is medically necessary, an eligible expense, appropriate and that other alternatives have been considered.

Contact Information

ASPIRUS HEALTH PLAN CONTACT	SERVICE AREA	PHONE	FAX	WEBSITE/EMAIL
Clinical Services	Medical Authorizations	715-631-7443 or 1-855-931-5265 toll-free	715-787-7316	Aspirus
Mental Health and Substance Use Disorder Services	MH/SUD Authorizations	715-631-7442 or 1-855-931-5264 toll-free	715-787-7314	Aspirus MHSUDservicesMA@aspirushealthplan.com
Clinical Pharmacy Intake	Medical Drug – Non-PAR and MultiPlan Providers	715-787-7340	715-841-4322	Aspirus
Provider Assistance Center (PAC)	Member Eligibility/ Benefits and Network Status	715-631-7412 or 1-855-931-4851 toll-free	N/A	Aspirus
DELEGATE CONTACT	**SERVICE AREA**	**PHONE**	**FAX**	**WEBSITE/EMAIL**
Delta Dental	Dental	1-866-298-5520 toll-free	N/A	Delta Dental
Fulcrum	Chiropractic	1-877-886-4941 toll-free	N/A	Fulcrum
Care Continuum	Medical Drug - PAR Providers	1-866-540-8289 toll-free	1-866-540-8935 toll-free	ExpressPAth
Express Scripts, Inc. (ESI)	Pharmacy Drug Prior Authorizations	1-877-558-7521 toll-free	1-877-251-5896 toll-free	ExpressPAth

SERVICE CATEGORY	REQUIREMENTS	CODE REQUIRING AUTHORIZATION CPT/HCPC CODES	CONTACT APPROVAL OR NOTIFICATION
Acute Inpatient Rehabilitation	Prior authorization required prior to admission. Concurrent review required for additional days. Discharge summary required to be sent upon discharge.	Not applicable	**InterQual LOC Rehabilitation:** - Appropriate subset will be chosen based on reason acute inpatient rehabilitation admission **Medicare Benefit Policy Manual:** - Chapter 1 Inpatient Hospital Services Covered Under Part A
Back (Spine) Surgery	Prior authorization required prior to service. Authorization not required for: - Emergency surgery for trauma - Acute transverse myelopathy - Tumors - Cervical and Thoracic Back Surgery	0200T, 0201T, 0221T, 0222T, 22533, 22534, 22558, 22585, 22586, 22612, 22614, 22630, 22632, 22633, 22634, 22808, 22810, 22812, 22840, 22841, 22842, 22843, 22844, 27279, 27280	**InterQual Medicare Procedures:** - Lumbar Spinal Fusion - Minimally Invasive Sacroiliac (SI) Joint Fusion - Vertebroplasty or Kyphoplasty **Medicare Local Coverage Determination:** - Minimally Invasive Surgical (MIS) Fusion of the Sacroiliac Joint L36406
Bariatric Surgery (Gastric Bypass)	Prior authorization required prior to service.	43644, 43645, 43770, 43773, 43775, 43842, 43843, 43845, 43846, 43847, 43848	**InterQual Medicare Procedures:** - Bariatric Surgery **Medicare:** - National Coverage Determination (NCD) for Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity (100.1)
Bone Growth Stimulator	Prior authorization required prior to purchase or placement.	E0748, E0749	**InterQual Medicare Durable Medical Equipment:** - Osteogenesis Stimulators **Medicare:** - National Coverage Determination (NCD) for Osteogenic Stimulators (150.2)

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			- Local Coverage Determination (LCD) Osteogenesis Stimulators (L33796)
Cosmetic or Reconstructive Procedures Examples include: - Abdominoplasty - Breast reduction surgery - Gynecomastia - Mammoplasty - Panniculectomy - Removal of breastimplant(s)/ Replacement of breast implants - Rhinoplasty /Septorhinoplasty - Skin peel(s)	Prior authorization required prior to service. Authorization not required for: - Blepharoplasty - Breast Reconstructive Surgery following medically necessary mastectomy **Please note:** Photographs are not required to be submitted when requesting authorization for cosmetic/reconstructive surgeries. If Aspirus Health Plan determines photographs are needed, the Utilization Review Specialist will call to request them.	11920, 11921, 11922, 11950, 11951, 11952, 11954, 11960, 15775, 15776, 15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793, 15819, 15824, 15825, 15826, 15828, 15829, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15876, 15877, 15878, 15879, 17106, 17107, 17108, 17340, 17360, 17380, 19300, 19303, 19316, 19318, 19324, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19371, 19380, 21137, 21138, 21139, 21172, 21175, 21179, 21180, 21181, 21182, 21183, 21184, 21208, 21209, 21230, 21235, 21248, 21249, 21255, 21256, 21260, 21261, 21263, 21267, 21268, 21270, 21275, 21295, 21296, 21299, 30120, 30400, 30410, 30420, 30430, 30435, 30450, 30540, 30545, 30560, 30620, 40500, 67900, 67912, 69090, 69300, 69320, G0429, Q2026, Q2028, S2066, S2067, S2068	**InterQual Medicare Procedures:** - Appropriate subset will be chosen based on requested procedure **Medicare:** - Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested procedure
Cranial Nerve Stimulation including Vagus Nerve and Hypoglossal Nerve	Prior authorization required prior to service.	64553, 64568, 64569, 64582	**InterQual Medicare Procedures:** - Hypoglossal Nerve Stimulation for the treatment of Obstructive Sleep Apnea

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			- Vagus Nerve Stimulation **Medicare:** - National Coverage Determination (NCD) for Vagus Nerve Stimulation (VNS) (160.18) - Local Coverage Determination (LCD) Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38387)
Durable Medical Equipment (DME) – **PURCHASE and RENTAL** See also: Wheelchairs and Accessories See also: Wound VAC **Aspirus Health Plan reserves** the right to determine rental vs. purchase. Repair or replacement of rental equipment is the provider's responsibility.	Prior authorization required prior to delivery or dispensing of DME items. All months must be authorized. Authorization is not required for: - Monthly rental of ventilators - Monthly rental of oxygen and equipment - Prosthetics and orthotic devices and equipment	E0483 - High Frequency Chest Wall Oscillation System E0652 - Pneumatic Compression Device E0694 - Ultraviolet Multidirectional Light Therapy E0764 – Functional Neuromuscular Stimulator (this is a Rental only item) E0766 - Electrical Stimulation Device (this is a Rental only item) E2510 - Speech Generating Device	**InterQual Medicare Durable Medical Equipment:** - Appropriate subset will be chosen based on requested DME item **Medicare:** - Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested DME item
Genetic/Molecular Diagnostic tests for the following: - Breast cancer - Colorectal cancer (excluding Fecal DNA test) - Ovarian cancer - Pancreatic cancer - Prostate cancer	Prior authorization required prior to ordering test.	0037U, 81162, 81163, 81164, 81165, 81166, 81167, 81210, 81212, 81215, 81216, 81217, 81288, 81292, 81293, 81294, 81295, 81296, 81297, 81298, 81299, 81300, 81301, 81317, 81318, 81319, 81415, 81416, 81432, 81433, 81435, 81436, 81437, 81438, 81445, 81460, 81479, 81500, 81503, 81504, 81506, 81518, 81520, 81521, 81523,	**InterQual Molecular Diagnostics:** - Appropriate subset will be chosen based on requested genetic testing **Medicare:** - Local Coverage Determination (LCD): Molecular Pathology Procedures (L35000) - Local Coverage Determination (LCD):

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- And all cancer panels (i.e., gene sequencing, whole genome/exome sequencing)		81525, 81535, 81536, 81539, 81540, 81541, 81551, 81599, 84999	Genomic Sequence Analysis Panels in the Treatment of Solid Organ Neoplasms (L37810) - Local Coverage Determination (LCD): Genomic Sequence Analysis Panels in the treatment Hematolymphoid Diseases (L37606) **Medical Policy may be available for select genetic tests** **NCCN Guidelines**
Inpatient Hospital, Acute All Hospital Inpatient Level of Care Admissions	Notification required within 24 hours of admission. Include admission history and physical information with notification. Aspirus Health Plan reserves the right to require a concurrent review for any inpatient hospital stay. Discharge summary required to be sent within 72 hours of discharge.	Not applicable	Not applicable
Long-Term Acute Care (LTAC)	Prior authorization required prior to admission. Concurrent review required for additional days. Discharge summary required to be sent upon discharge.	Not applicable	**InterQual LOC Long Term Acute Care:** - Appropriate subset will be chosen based on reason for LTAC admission

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Proton Beam Therapy	Prior authorization required prior to service.	77520, 77522, 77523, 77525	**InterQual Medicare Procedures:** - Proton Beam Therapy **Medicare:** Local Coverage Determination (LCD): Proton Beam Therapy (L35075)
Skilled Nursing Facility (SNF) or Swing Bed Admission	Prior authorization required within one business day of admission. Concurrent review required for additional days. Discharge summary required to be sent upon discharge.	Not applicable	**InterQual: LOC Subacute / SNF:** - Appropriate subset will be chosen based on reason for SNF admission **Medicare Benefit Policy Manual:** - Chapter 8 – Coverage of Extended Care (SNF) Services Under Hospital Insurance
Spinal Cord Stimulation	Prior authorization required prior to trial and prior to permanent placement.	63650, 63655, 63663, 63664, 63685	**InterQual Medicare Procedures:** - Spinal Cord Stimulator **Medicare:** - National Coverage Determination (NCD) for Electrical Nerve Stimulators (160.7)

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Transplant - Bone marrow - Heart - Heart-lung - Kidney - Liver - Lung - Pancreas - Stem cell	Medicare-approved transplant at an Aspirus Health Plan - contracted facility: Notification required within 24 hours of inpatient hospital admissions. Notification required for transplant consult/evaluation and listing. For a non-Medicare-approved transplant and/or at a non-Aspirus Health Plan contracted facility: Notification is required prior to referral to a provider or center.	Not applicable	Not applicable
Vein Procedures	Prior authorization required prior to service.	36465, 36466, 36468, 36470, 36471, 36473, 36474, 36475, 36476, 36478, 36479, 36482, 36483, 37765, 37766	**InterQual Medicare Procedures:** - Varicose Veins **Medicare:** - Local Coverage Determination (LCD): Varicose Veins of the Lower Extremity, Treatment of (L33575)
Wheelchair Accessories – PURCHASE and RENTAL Repair or replacement of rental equipment is the provider's responsibility. Aspirus Health Plan or our authorizing delegate reserves the right to determine rental vs. purchase.	Prior authorization is required prior to delivery or dispensing billable accessories that are new, replacements or repaired with a per month allowable rental rate or purchase over $1000. All months must be authorized.	E1008, E2204 Please note: This may not be an all-inclusive list. Please review the Medicare or DHS fee schedule to determine if the item you are requesting would be over $1000 per month to purchase or rent.	**InterQual Medicare Durable Medical Equipment:** - Appropriate subset will be chosen based on requested wheelchair item **Medicare:** - Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested wheelchair item

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Wheelchair - RENTAL Aspirus Health Plan or our authorizing delegate reserves the right to determine rental vs. purchase.	Prior authorization is required prior to delivery or dispensing power operated vehicles and power wheelchairs.	K0800, K0801, K0802, K0806, K0807, K0808, K0812, K0813, K0814, K0815, K0816, K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0830, K0831, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, K0864, K0890, K0891	**InterQual Medicare Durable Medical Equipment:** - Appropriate subset will be chosen based on requested wheelchair item **Medicare:** - Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested wheelchair item
Wheelchair - PURCHASE Aspirus Health Plan or our authorizing delegate reserves the right to determine rental vs. purchase.	Prior authorization required prior to purchase of **all** wheelchair bases. See Wheelchair Accessories for purchase, repair, and replacement authorization requirements.	**All** Manual Wheelchairs, Power Operated Vehicles, and Power Wheelchairs.	**InterQual Medicare Durable Medical Equipment:** - Appropriate subset will be chosen based on requested wheelchair item **Medicare:** - Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested wheelchair item
Wound VAC	Prior authorization required prior to the 4th month of rental.	E2402	**InterQual Medicare Durable Medical Equipment:** - Negative Pressure Wound Therapy Pumps **Medicare:** - Local Coverage Determination for Negative Pressure Wound Therapy Pumps (L33821)