EssentiaCare
Essentia Health + UCare

2023 Authorization and Notification Requirements - Medical Services

EssentiaCare (Essentia Health + UCare)

List of Authorization and Notification Requirements

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

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.
- UCare 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 UCare's website.
- Provider of service qualifications, eligibility and licensure requirements must be met to provide services and submit claims to UCare.
- Contact the UCare Provider Assistance Center (612-676-3300 or 1-888-531-1493) for information on eligibility, benefits and network status.

Forms

- **UCare Authorization and Notifications Forms**

Prescription Drugs and Medical Injectable Drugs

- The Medical Drug Policies library is a list of medical injectable drugs that require prior authorization and the policies that contain coverage criteria.
- The formulary page, located on ucare.org/providers, 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: ucare.org/providers. UCare 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	UCare, or an organization delegated by UCare, to approve or deny prior authorization requests.
Notification	The process of informing UCare, or delegates of UCare, of a specific medical treatment or service 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 at pre-service determination if there is a question as to whether an item or service will be covered by the 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. This is to determine if the service or treatment is medically necessary, an eligible, appropriate, expense and that other alternatives have been considered.

Contact Information

UCare Contact	Service Area	Phone	Fax	Website/Email
Clinical Services	Medical Authorizations	612-676-6705 1-877-447-4384 toll-free	612-884-2499	UCare
Clinical Pharmacy Intake	Medical Drug - Non-PAR and MultiPlan Providers	612-676-6504	612-617-3948	UCare® - Pharmacy
Mental Health and Substance Use Disorder Services	MH/SUD Authorizations	612-676-6533 1-833-276-1185 toll-free	612-884-2033 1-855-260-9710 toll-free	UCare MHSUDservices@ucare.org
Provider Assistance Center (PAC)	Member Eligibility/Benefits and Network Status	612-676-3300 1-888-531-1493 toll-free	N/A	UCare
Delegate Contact	**Service Area**	**Phone**	**Fax**	**Website**
Delta Dental	Dental	1-866-298-5520 toll-free	N/A	Delta Dental
Fulcrum	Acupuncture	1-877-886-4941 toll-free	763-204-8572	Fulcrum
Fulcrum	Chiropractic	1-877-886-4941 toll-free	N/A	Fulcrum
Care Continuum	Medical Drug - PAR Providers	1-800-818-6747 toll-free	1-877-266-1871 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	Essentia Health Provider Requirements	Other EssentiaCare Network Providers	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
Acute Inpatient Rehabilitation	Prior authorization required prior to admission. Concurrent review required for additional days. Discharge summary required to be sent upon discharge.	Prior authorization required prior to admission. Concurrent review required for additional days. Discharge summary required to be sent upon discharge.	N/A	**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
	Contact UCare for authorization or notification.			
Back (Spine) Surgery Lumbar Spinal Fusion Sacroiliac Joint Fusion	No authorization or notification requirements.*	Prior authorization required prior to service. Authorization not required for: - Emergency surgery for trauma - Acute transverse myelopathy - Tumors - Cervical & 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 0200T, 0201T **Medicare Local Coverage Determination:** - Minimally-invasive Surgical (MIS) Fusion of the Sacroiliac Joint L36406
	Contact UCare for authorization or notification.			
Bariatric Surgery (Gastric Bypass)	No authorization or notification requirements.*	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)
	Contact UCare for authorization or notification.			

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Bone Growth Stimulator	Prior authorization required prior to purchase or placement.	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) - Local Coverage Determination (LCD) Osteogenesis Stimulators
	Contact UCare for authorization or notification.			
Cosmetic or Reconstructive Procedures Examples include: - Abdominoplasty - Breast reduction surgery - Gynecomastia - Mammoplasty - Panniculectomy - Removal of breast - Implant(s)/ Replacement of breast implants - Rhinoplasty/ Septorhinoplasty - Skin peel(s)	No authorization or notification requirements.* Please note: Photographs are not required to be submitted when requesting authorization for cosmetic/reconstructive surgeries. If UCare determines photographs are needed the Utilization Review Specialist will call to request them.	Prior authorization required prior to service. Authorization **not** required for: - Blepharoplasty - Breast Reconstructive Surgery following medically necessary Mastectomy	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, 19366, 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
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Cranial Nerve Stimulation including Vagus Nerve and Hypoglossal Nerve	No authorization or notification requirements.*	Prior authorization required prior to service.	64553, 64568, 64569, 64582	**InterQual Medicare Procedures:** - Hypoglossal Nerve Stimulation for the treatment of Obstructive Sleep Apnea- Vagus Nerve Stimulation **Medicare:** - Local Coverage Determination (LCD) Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38387) - National Coverage Determination (NCD) for Vagus Nerve Stimulation (VNS) (160.18)
	Contact UCare for authorization or notification.			
Durable Medical Equipment - PURCHASE & RENTAL See also: Wheelchair Accessories See also: Wound VAC UCare reserves the right to determine rental vs. purchase. Repair or replacement of rental equipment is the provider's responsibility.	Prior authorization is required prior to deliver or dispending of DME items. All months must be authorized.	Prior authorization is required prior to deliver or dispending 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/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
	Contact UCare for authorization or notification.			

Service Category	Essentia Health Provider Requirements	Other EssentiaCare Network Providers	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
Genetic/Molecular Diagnostic Tests for the following: - Breast cancer - Colorectal cancer (excluding Fecal) - Ovarian cancer - Pancreatic cancer - Prostate cancer - And all cancer panels (i.e., gene sequencing, whole genome/exome sequencing)	No authorization or notification requirements.*	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, 81525, 81535, 81536, 81539, 81540, 81541, 81551, 81599, 84999	**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): 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**
	Contact UCare for authorization or notification.			

Service Category	Essentia Health Provider Requirements	Other EssentiaCare Network Providers	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
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. UCare reserves the right to require a concurrent review for any inpatient hospital stay. Discharge summary required to be sent within 72 hours of discharge.	Notification required within 24 hours of admission. Include admission history and physical information with notification. UCare reserves the right to require a concurrent review for any inpatient hospital stay. Discharge summary required to be sent within 72 hours of discharge.	N/A	
	Contact UCare for authorization or notification.			
Long-Term Acute Care Hospitalization (LTAC)	Prior authorization required prior to admission. Concurrent review required for additional days. Discharge summary required to be sent upon discharge.	Prior authorization required prior to admission. Concurrent review required for additional days. Discharge summary required to be sent upon discharge.	N/A	**InterQual LOC Long Term Acute Care:** - Appropriate subset will be chosen based on reason for LTAC admission
	Contact UCare for authorization or notification.			
Proton Beam Therapy	Prior authorization required prior to service.	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)
	Contact UCare for authorization or notification.			

Service Category	Essentia Health Provider Requirements	Other EssentiaCare Network Providers	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
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.	Prior authorization required within one business day of admission. Concurrent review required for additional days. Discharge summary required to be sent upon discharge.	N/A	**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
	Contact UCare for authorization or notification.			
Spinal Cord Stimulation	Prior authorization required prior to trial and prior to permanent placement.	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)
	Contact UCare for authorization or notification.			
Transplant - Bone marrow - Heart - Heart-lung - Kidney - Liver - Lung - Pancreas - Stem cell	Step 1: notification required for transplant consult/evaluation. Step 2: notification required for transplant listing. Step 3: notification required within 24 hours of inpatient hospital admissions.	Step 1: notification required for transplant consult/evaluation. Step 2: notification required for transplant listing. Step 3: notification required within 24 hours of inpatient hospital admissions.	N/A	
	Contact UCare for authorization or notification.			

Service Category	Essentia Health Provider Requirements	Other EssentiaCare Network Providers	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
Vein Procedures	No authorization or notification requirements.*	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)
	Contact UCare for authorization or notification.			
Wheelchair Accessories - PURCHASE & RENTAL Repair or replacement of rental equipment is the DME provider's responsibility. UCare reserves the right to determine rental vs. purchase**.**	Prior authorization is required prior to delivery or dispensing billable accessories with a per month allowable rental rate or purchase over $1,000. All months must be authorized. No authorization required for repair of purchased wheelchair accessories under $1,000.	Prior authorization is required prior to delivery or dispensing billable accessories with a per month allowable rental rate or purchase over $1,000. All months must be authorized. No authorization required for repair of purchased wheelchair accessories under $1,000.	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 $1,000 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
	Contact UCare for authorization or notification.			

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Wheelchair - RENTAL UCare reserves the right to determine rental vs. purchase.	Authorization is required prior to delivery or dispensing power operated vehicles and power wheelchair. All months must be authorized.	Authorization is required prior to delivery or dispensing power operated vehicles and power wheelchair. All months must be authorized.	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
	Contact UCare for authorization or notification.			
Wheelchair - PURCHASE UCare 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.	Prior authorization required prior to purchase of **all** wheelchair bases.	**All** Manual Wheelchairs, Power Operated Vehicles, and Power Wheelchairs require prior authorization when purchased.	**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
	Contact UCare for authorization or notification.			
Wound VAC	Prior authorization required prior to the fourth month of rental.	Prior authorization required prior to the fourth 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)**
	Contact UCare for authorization or notification.			