2023 Authorization and Notification Requirements - Medical Services

UCare Individual & Family Plans (IFP) | UCare Individual & Family Plans with M Health Fairview

List of Authorization and Notification Requirements

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

Important Information

- Allow up to five business 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

Term	Definition
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	Requirements	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.	N/A	**InterQual LOC Rehabilitation:** - Appropriate subset will be chosen based on reason acute inpatient rehabilitation admission
Back (Spine) Surgery - Lumbar Spinal Fusion - Sacroiliac Joint Fusion	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
Bone Growth Stimulator	Prior authorization required prior to purchase or placement.	E0748, E0749	**InterQual CP Durable Medical Equipment:** - Bone Growth Stimulators, Noninvasive

Service Category	Requirements	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
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)	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 UCare 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, 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 CP Procedures:** - Appropriate subset will be chosen based on 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 - Vagus Nerve Stimulation

Service Category	Requirements	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
Durable Medical Equipment - RENTAL See also: Wheelchairs & Accessories UCare reserves the right to determine rental vs. purchase. Repair or replacement of rental equipment is the provider's responsibility. **Authorization not required for:** - Apnea monitors - Enteral feeding pump - Hospital Grade Breast Pumps - Insulin pump - IV pump & pole - Nebulizer - Oximeters - Oxygen (equipment) - Prosthetics and orthotic devices/equipment - TENS units - Ventilator	Prior authorization required prior to 5th month of rental. Refer to Pharmacy Authorization Requirements for Glucose Monitoring.	N/A	**InterQual CP Durable Medical Equipment:** - Appropriate subset will be chosen based on requested DME item

Service Category	Requirements	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
Durable Medical Equipment - PURCHASE See also: Wheelchairs & Accessories UCare reserves the right to determine rental vs. purchase. Authorization is not required for: - Baclofen pump - Enteral feeding pump - Implantable pain pumps - Insulin pump & pole - Orthotics - Oxygen (contents only) - Prosthetics and orthotic devices/equipment - TENS units	Prior authorization is required prior to the purchase of DME items over $1,000. For continuous glucose monitors please refer to the Pharmacy prior authorization grid.		**InterQual CP Durable Medical Equipment:** - Appropriate subset will be chosen based on requested DME item
Genetic/Molecular Diagnostic tests for the following: - Breast cancer - Colorectal cancer (excluding Fecal DNA test) - Ovarian cancer - Pancreatic cancer - Prostate cancer - And all cancer panels (i.e., gene sequencing, whole genome/exome sequencing)	Prior authorization is 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 **Medical Policy may be available for select genetic tests** **NCCN Guidelines**

Service Category	Requirements	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
Inpatient Hospital, Acute	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. Please fax information to 612-884-2499 or 1-866-610-7215 toll-free.	N/A	**InterQual LOC Acute Adult:** - Appropriate subset will be chosen based on reason for inpatient admission **InterQual LOC Acute Pediatric:** - Appropriate subset will be chosen based on reason for inpatient admission
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.	N/A	**InterQual LOC Long Term Acute Care:** - Appropriate subset will be chosen based on reason for LTAC admission

Service Category	Requirements	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
Proton Beam Therapy	Prior authorization required prior to service.	77520, 77522, 77523, 77525	**InterQual CP Procedures:** - Proton Beam Therapy (PBRT)
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.	Post-acute treatment and rehabilitative care of illness or injury following a hospital stay.	**InterQual LOC Subacute/SNF:** - Appropriate subset will be chosen based on reason for SNF admission
Spinal Cord Stimulation	Prior authorization required prior to trial and prior to permanent placement.	63650, 63655, 63663, 63664, 63685	**InterQual CP Procedures:** - Spinal Cord Stimulator (SCS) Insertion

Service Category	Requirements	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
Transplant - Bone marrow - Heart - Heart-lung - Kidney - Liver - Lung - Pancreas - Stem cell	Step one: Notification required for transplant consult/evaluation. Step two: Notification required for transplant listing. Step three: Notification required within 24 hours of inpatient hospital admissions.	N/A	**InterQual LOC Acute Adult:** - Appropriate subset will be chosen based on reason for inpatient admission **InterQual LOC Acute Pediatric:** - Appropriate subset will be chosen based on reason for inpatient admission
Vein Procedures	Prior authorization required prior to service.	36465, 36466, 36468, 36470, 36471, 36473, 36474, 36475, 36476, 36478, 36479, 36482, 36483, 37765	**InterQual CP Procedures:** - Ablation, Endovenous Varicose Vein - Ambulatory Phlebectomy, Varicose Veins - Sclerotherapy, Varicose Veins **InterQual Medicare Procedures:** - Varicose Veins

Service Category	Requirements	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
Wheelchair & Accessories - RENTAL Repair or replacement of rental equipment is the provider's responsibility. UCare or our authorizing delegate reserves the right to determine rental vs. purchase.	Prior authorization required prior to 5th month of rental.	N/A	**InterQual CP Durable Medical Equipment:** - Appropriate subset will be chosen based on requested DME item

Service Category	Requirements	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
Wheelchair & Accessories - PURCHASE UCare or our authorizing delegate reserves the right to determine rental vs. purchase.	Prior authorization required prior to purchase. Prior authorization is required for repair or replacement of member owned equipment or accessories.	**All** Manual Wheelchairs, Power Operated Vehicles and Power Wheelchairs (standard and complex rehab), including separately payable accessories.	**InterQual CP Durable Medical Equipment:** - Appropriate subset will be chosen based on requested DME item