# 2023 Authorization and Notification Requirements - Medical Services

**UCare Medicare Plans | UCare Your Choice | UCare Medicare Plans with M Health Fairview & North Memorial | Institutional Special Needs Plans (I-SNP)**

## List of Authorization and Notification Requirements

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|---|---|---|
| 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.
- 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 additional 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

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| **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 a 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<br>1-877-447-4384 toll-free | 612-884-2499 | UCare |
| **Mental Health and Substance Use Disorder Services** | MH/SUD Authorizations | 612-676-6533<br>1-833-276-1185 toll-free | 612-884-2033<br>1-855-260-9710 toll-free | UCare<br>MHSUDservices@ucare.org |
| **Provider Assistance Center (PAC)** | Member Eligibility/ Benefits and Network Status | 612-676-3300<br>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** | Chiropractic | 1-877-886-4941 toll-free | N/A | Fulcrum |
| **Care Continuum** | Pharmacy | 1-800-818-6747 toll-free | 1-877-266-1871 toll-free | ExpressPAth |
| **Express Scripts, Inc. (ESI)** | Pharmacy | 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.<br><br>Concurrent review required for additional days.<br><br>Discharge summary required to be sent upon discharge. | N/A | **InterQual LOC Rehabilitation:**<br>- Appropriate subset will be chosen based on reason acute inpatient rehabilitation admission<br><br>**Medicare Benefit Policy Manual:**<br>- Chapter 1 - Inpatient Hospital Services Covered Under Part A |
| **Back (Spine) Surgery** | Prior authorization required prior to service. Authorization not required for:<br>- Emergency surgery for trauma<br>- Acute transverse myelopathy<br>- Tumors<br>- 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:**<br>- Lumbar Spinal Fusion<br>- Minimally Invasive Sacroiliac (SI) Joint Fusion<br>- Vertebroplasty or Kyphoplasty<br><br>**Medicare Local Coverage Determination:**<br>- 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:**<br>- Bariatric Surgery<br><br>**Medicare:**<br>- National Coverage Determination (NCD) for Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity (100.1) |

| Service Category | Requirements | Codes Requiring Authorization CPT/HCPTC Codes | Medical Necessity Criteria |
|---|---|---|---|
| **Bone Growth Stimulator** | Prior authorization required prior to purchase or placement. | E0748, E0749 | **InterQual Medicare Durable Medical Equipment:**<br>- Osteogenesis Stimulators<br><br>**Medicare:**<br>- National Coverage Determination (NCD) for Osteogenic Stimulators (150.2)<br>- Local Coverage Determination (LCD) Osteogenesis Stimulators (L33796) |
| **Cosmetic or Reconstructive Procedures**<br>Examples include:<br>- Abdominoplasty<br>- Breast reduction surgery<br>- Gynecomastia<br>- Mammoplasty<br>- Panniculectomy<br>- Removal of breast implant(s)/ Replacement of breast implants<br>- Rhinoplasty/Septorhinoplasty<br>- Skin peel(s) | Prior authorization required prior to service. Authorization **not** required for:<br>- Blepharoplasty<br>- Breast Reconstructive Surgery following medically necessary mastectomy<br><br>**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, 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:**<br>- Appropriate subset will be chosen based on requested procedure<br><br>**Medicare:**<br>- Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested procedure |

| Service Category | Requirements | Codes Requiring Authorization CPT/HCPTC Codes | Medical Necessity Criteria |
|---|---|---|---|
| **Cranial Nerve Stimulation including Vagus Nerve and Hypoglossal Nerve** | Prior authorization required prior to service. | 64553, 64568, 64569, 64582 | **InterQual Medicare Procedures:**<br>- Hypoglossal Nerve Stimulation for the treatment of Obstructive Sleep Apnea<br>- Vagus Nerve Stimulation<br><br>**Medicare:**<br>- National Coverage Determination (NCD) for Vagus Nerve Stimulation (VNS) (160.18)<br>- Local Coverage Determination (LCD) Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38387) |
| **Durable Medical Equipment – PURCHASE and RENTAL**<br><br>See also: Wheelchairs and accessories<br><br>See also: Wound VAC<br><br>UCare reserves the right to determine rental vs. purchase.<br><br>Repair or replacement of rental equipment is the provider's responsibility. | Prior authorization required prior to delivery or dispensing of DME items.<br><br>All months must be authorized.<br><br>**Authorization is not required for:**<br>- Monthly rental of ventilators<br>- Monthly rental of oxygen and equipment.<br>- Prosthetics and orthotic devices/equipment | E0483 - High Frequency Chest Wall Oscillation System<br><br>E0652 - Pneumatic Compression Device<br><br>E0694 - Ultraviolet Multidirectional Light Therapy<br><br>E0764 - Functional Neuromuscular Stimulator (this is a Rental Only item)<br><br>E0766 - Electrical Stimulation Device (this is a Rental Only item)<br><br>E2510 - Speech Generating Device | **InterQual Medicare Durable Medical Equipment:**<br>- Appropriate subset will be chosen based on requested DME item<br><br>**Medicare:**<br>- Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested DME item |

| Service Category | Requirements | Codes Requiring Authorization CPT/HCPTC Codes | Medical Necessity Criteria |
|---|---|---|---|
| **Genetic/Molecular Diagnostic Tests**<br>for the following:<br>- Breast cancer<br>- Ovarian cancer<br>- Colorectal cancer (excluding Fecal DNA test)<br>- Pancreatic cancer<br>- Prostate cancer<br>- And all cancer panels<br>(i.e., gene sequencing, whole genome/exome sequencing) | 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:**<br>- Appropriate subset will be chosen based on requested genetic testing<br><br>**Medicare:**<br>- Local Coverage Determination (LCD): Molecular Pathology Procedures (L35000)<br>- Local Coverage Determination (LCD): Genomic Sequence Analysis Panels in the Treatment of Solid Organ Neoplasms (L37810)<br>- Local Coverage Determination (LCD): Genomic Sequence Analysis Panels in the treatment Hematolymphoid Diseases (L37606)<br><br>**Medical Policy may be available for select genetic tests**<br><br>**NCCN Guidelines** |
| **Inpatient Hospital, Acute**<br><br>All Hospital Inpatient Level of Care Admissions | Notification required within 24 hours of admission. Include admission history and physical information with notification.<br><br>UCare reserves the right to require a concurrent review for any inpatient hospital stay.<br><br>Discharge summary required to be sent within 72 hours of discharge. | N/A | **InterQual LOC Acute Adult:**<br>- Appropriate subset will be chosen based on reason for inpatient admission |

| Service Category | Requirements | Codes Requiring Authorization CPT/HCPTC Codes | Medical Necessity Criteria |
|---|---|---|---|
| **Long-Term Acute Care (LTAC)** | Prior authorization required prior to admission.<br><br>Concurrent review required for additional days.<br><br>Discharge summary required to be sent upon discharge. | N/A | **InterQual LOC Long Term Acute Care:**<br>- Appropriate subset will be chosen based on reason for LTAC admission |
| **Proton Beam Therapy** | Prior authorization required prior to service. | 77520, 77522, 77523, 77525 | **InterQual Medicare Procedures:**<br>- Proton Beam Therapy<br><br>**Medicare:**<br>- 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.<br><br>Concurrent review required for additional days.<br><br>Discharge summary required to be sent upon discharge. | N/A | **InterQual LOC Subacute/SNF:**<br>- Appropriate subset will be chosen based on reason for SNF admission<br><br>**Medicare Benefit Policy Manual:**<br>- Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance |

| Service Category | Requirements | Codes Requiring Authorization CPT/HCPTC Codes | Medical Necessity Criteria |
|---|---|---|---|
| **Spinal Cord Stimulation** | Prior authorization required prior to trial and prior to permanent placement. | 63650, 63655, 63663, 63664, 63685 | **InterQual Medicare Procedures:**<br>- Spinal Cord Stimulator<br><br>**Medicare:**<br>- National Coverage Determination (NCD) for Electrical Nerve Stimulators (160.7) |
| **Transplant**<br>- Bone marrow<br>- Heart<br>- Heart-lung<br>- Kidney<br>- Liver<br>- Lung<br>- Pancreas<br>- Stem cell | Step one: Notification required for transplant consult/evaluation.<br><br>Step two: Notification required for transplant listing.<br><br>Step three: Notification required within 24 hours of inpatient hospital admissions. | N/A | **InterQual LOC Acute Adult:**<br>- 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, 37766 | **InterQual Medicare Procedures:**<br>- Varicose Veins<br><br>**Medicare:**<br>- Local Coverage Determination (LCD): Varicose Veins of the Lower Extremity, Treatment of (L33575) |

| Service Category | Requirements | Codes Requiring Authorization CPT/HCPTC Codes | Medical Necessity Criteria |
|---|---|---|---|
| **Wheelchair Accessories - PURCHASE and RENTAL**<br><br>Repair or replacement of rental equipment is the DME provider's responsibility.<br><br>UCare 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 $1,000.<br><br>All months must be authorized. | E1008, E2204<br><br>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:**<br>- Appropriate subset will be chosen based on requested wheelchair item<br><br>**Medicare:**<br>- Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested wheelchair item |
| **Wheelchair - RENTAL**<br><br>UCare 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:**<br>- Appropriate subset will be chosen based on requested wheelchair item<br><br>**Medicare:**<br>- Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested wheelchair item |
| **Wheelchair - PURCHASE**<br><br>UCare reserves the right to determine rental vs. purchase. | Prior authorization required prior to purchase of **all** wheelchair bases.<br><br>See **Wheelchair Accessories** for purchase, repair and replacement authorization requirements. | **All** Manual Wheelchairs, Power Operated Vehicles and Power Wheelchairs. | **InterQual Medicare Durable Medical Equipment:**<br>- Appropriate subset will be chosen based on requested wheelchair item<br><br>**Medicare:**<br>- Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested wheelchair item |

| Service Category | Requirements | Codes Requiring Authorization CPT/HCPTC Codes | Medical Necessity Criteria |
|---|---|---|---|
| **Wound VAC** | Prior authorization required prior to the 4th month of rental. | E2402 | **InterQual Medicare Durable Medical Equipment:**<br>- Negative Pressure Wound Therapy Pumps<br><br>**Medicare:**<br>- Medicare Local Coverage Determination for Negative Pressure Wound Therapy Pumps (L33821) |