2021 Authorization and Notification Requirements – Medical Services
For the following UCare Plans:

UCare Medicare Plans = Medicare Advantage | **UCare Medicare Plans with M Health Fairview & North Memorial =** Medicare Advantage

I-SNP = Institutional Special Needs Plan

UCare works with delegated organizations to handle the following types of authorizations, so they are not included in this document. Find current guidelines and contact information on the UCare Provider Website.

- Chiropractic care
- Dental care
- Pharmacy

The following medical services require authorization or notification. (Click a topic for details.)

Acute Inpatient Rehabilitation
Back (Spine) Surgery
Bariatric Surgery (Gastric Bypass)
Bone Growth Stimulator
Cosmetic or Reconstructive Procedures
Cranial Nerve Stimulation
Durable Medical Equipment – RENTAL
Durable Medical Equipment – PURCHASE
Genetic Testing for Cancer
Inpatient Hospital, Acute
Long-Term Acute Care (LTAC)
Non-Contracted Provider
Proton Beam Therapy
Skilled Nursing Facility & Swing Bed
Spinal Cord Stimulation
Transplant
Vein Procedures
Wheelchair & Accessories – RENTAL
Wheelchair & Accessories - PURCHASE

Effective 1/1/2021

Important Information regarding Medical Authorization & Notification

- Submit authorization requests 14 calendar days prior to the start of service for non-urgent conditions.
- All Services are subject to member eligibility and benefit coverage.
- For services that require authorization, failing to obtain the authorization in advance may result in a denied claim.
- UCare reserves the right to review and verify medical necessity for all services.
- UCare does not instruct providers on how to bill. The codes listed on the authorization grid are for informational purposes only to assist our providers in the authorization process.
- InterQual Decision Support tool and Medicare National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Local Coverage Articles and MHCP coverage policies are used as appropriate for medical necessity determinations. You may request a copy of the criteria used to make a medical necessity determination.
- Contact UCare Provider Assistance Center (612-676-3000 or 1-888-531-1493) for additional information on thresholds.
- UCare is the authorizing entity for all services, unless noted otherwise.
- Clinical criteria may vary by UCare plan.
- Authorization is not required for orthotics and prosthetics.
- Upon discharge from an observation or an inpatient admission, please provide the discharge date.

Forms Needed – **Medicare Plans** - Please leverage our Medicare Forms under each specialty type on the UCare Provider website, and scroll to *Forms & Information*.

Prescription Drugs –

- Review the list of injectable drugs that require medical prior authorization. (Click the list for UCare's Medicare plans at UCare's Provider's Pharmacy page.) The list explains who to contact for each category of injectable drugs.
- The Formularies page on the UCare Provider Pharmacy Information website shows which drugs are covered on the pharmacy benefit for each UCare Plan, as well as everything you need to request exceptions or prior authorization.
- Any medication, even on the formulary of covered drugs, requires prior authorization if the use is not supported by an FDA-approved indication. Use the exception request form and the contact information that matches the member's UCare plan on our Formularies page.

Authorization and Notification Contacts

Authorizing Entity	Phone	Fax	Website
Fulcrum	1-877-886-4941 (toll free)	N/A	Fulcrum
Delta Dental of Minnesota	**Medicare** 1-855-648-1416 (toll free)	N/A	Delta Dental
Express Scripts, Inc. (ESI)	Medicare Phone line for Prior Authorization 1-877-558-7521 (toll free)	Medicare FAX for Prior Authorization 1-877-251-5896 (toll free)	Express Scripts
Fairview Partners	952-914-1720	612-884-3602	Fairview Partners
Magellan Healthcare	952-225-5700 1-888-660-4705 (toll free)	1-888-656-1952 (toll free)	https://www.hsminc.com/ Magellan Clinical Guidelines
UCare Mental Health and Substance Use Disorder Services	612-676-6533 or 1-833-276-1185 (toll free)	612-884-2033 1-855-260-9710 (toll free)	UCare
UCare Clinical Services	612-676-6705 1-877-447-4384 (toll free)	612-884-2499 1-866-610-7215 (toll free)	

Service Category	Requirements	Codes Requiring Authorization CPT/HCPC Codes	Medical Necessity Criteria
Acute Inpatient Rehabilitation	Obtain authorization before admission. Concurrent Review for additional days. Upon discharge please send discharge summary.	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 Lumbar Spinal Fusion Sacroiliac Joint Fusion	Obtain authorization 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 **Medicare:** • No National Coverage Determination (NCD) or Local Coverage Determination (LCD) for MN
Bariatric Surgery (Gastric Bypass)	Obtain authorization 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)

Service Category	Requirements	Codes Requiring Authorization CPT/HCPC Codes	Medical Necessity Criteria
Bone Growth Stimulator	Obtain authorization prior to purchase or placement.	E0747, E0748, E0749, E0760	**InterQual Medicare Durable Medical Equipment:** • Bone Growth Stimulators, Noninvasive **Medicare:** • National Coverage Determination (NCD) for Osteogenic Stimulators (150.2) • Local Coverage Determination (LCD) Osteogenesis Stimulators (L33796)
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)	Obtain authorization 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, 15879, 15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793, 15876, 15877, 15878, 15819, 15824, 15825, 15826, 15828, 15829, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 17106, 17107, 17108, 17340, 17360, 17380, 19300, 19303, 19316, 19318, 19324, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19366, 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 DME item

Service Category	Requirements	Codes Requiring Authorization CPT/HCPC Codes	Medical Necessity Criteria
Cranial Nerve Stimulation including Vagus Nerve and Hypoglossal Nerve	Obtain authorization prior to service.	0466T, 64553, 64568, 64569	**InterQual Medicare Procedures:** • Hypoglossal Nerve Stimulation for the treatment of Obstructive Sleep Apnea • 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)

Service Category	Requirements	Codes Requiring Authorization CPT/HCPC Codes	Medical Necessity Criteria
Durable Medical Equipment – RENTAL See also: Wheelchairs and accessories UCare reserves the right to determine rental vs. purchase. Repair or replacement of rental equipment is the provider's responsibility. **Authorization is not required for** • Monthly rental of ventilators • Monthly rental of oxygen and equipment. • Prosthetics and orthotic devices/equipment	Authorization is required prior to delivery or dispensing DME items with a per month allowable rental rate over $500. All months must be authorized.	E0193, E0194, E0277, E0302, E0304, E0472, E0482, E0483, E0636, E0652, E0694, E0764, E0766, E0784, E1035, E1036, E1841, E2402, E2510, K0606	**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

Service Category	Requirements	Codes Requiring Authorization CPT/HCPC Codes	Medical Necessity Criteria
Durable Medical Equipment – PURCHASE See also: Wheelchairs and accessories Wheelchairs and wheelchair parts/accessories listed separately at end of document. UCare reserves the right to determine rental vs. purchase. **Authorization is not required for** • Prosthetics and orthotic devices/equipment	Obtain authorization prior to purchase. All DME items over $500 allowable require prior authorization.	Not Applicable	**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 • Ovarian cancer • Colorectal cancer (excluding Fecal DNA test) • Pancreatic cancer • Prostate cancer • And all cancer panels (i.e., gene sequencing, whole genome/exome sequencing).	Obtain authorization 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, 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** **NCCN Guidelines**

Service Category	Requirements	Codes Requiring Authorization CPT/HCPC Codes	Medical Necessity Criteria
Inpatient Hospital, Acute All Hospital Inpatient Level of Care Admissions	Notification required within 24 hours of admission. Concurrent Review for: • Inpatient stays greater than 7 days Upon discharge please send discharge summary.	Not Applicable **Information needed for concurrent review for inpatient stays beyond 7 days and Maternity stays greater than 4 days:** • Admission History and Physical • Current MD notes • Current labs • Diagnostic imaging • PT/OT Progress notes • Discharge Summary upon discharge Please fax this information to 612-884-2499 or 1-866-610-7215 (toll free)	**InterQual: LOC Acute Adult** • Appropriate subset will be chosen based on reason for inpatient admission
Long-Term Acute Care (LTAC)	Obtain authorization before admission. Concurrent Review for additional days. Upon discharge please send discharge summary.	Not Applicable	**InterQual: LOC Long Term Acute Care** • Appropriate subset will be chosen based on reason for LTAC admission
Non-UCare Contracted Provider (Not part of our provider network.)	Obtain authorization prior to service. Only required for procedures and services with authorization requirements listed on this grid.	Not Applicable	Please reference appropriate section of this grid.

Service Category	Requirements	Codes Requiring Authorization CPT/HCPC Codes	Medical Necessity Criteria
Proton Beam Therapy	Obtain authorization 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	**Obtain authorization** within 1 business day of admission Concurrent Review for additional days. Upon discharge please send discharge summary.	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	Obtain authorization 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)

Service Category	Requirements	Codes Requiring Authorization CPT/HCPC Codes	Medical Necessity Criteria
Transplant • Bone marrow • Heart • Heart-lung • Kidney • Liver • Lung • Pancreas • Stem cell	For a Medicare-approved transplant at a UCare-contracted facility: Notify UCare within 24 hours of inpatient hospital admissions. Concurrent Review for: • Inpatient stays greater than 7 days Upon discharge please send discharge summary. For a non-Medicare-approved transplant and/or at a non-UCare-contracted facility: Notify UCare **prior** to referral to a provider or center.	Not Applicable	**InterQual: LOC Acute Adult** • Appropriate subset will be chosen based on reason for inpatient admission
Vein Procedures	Obtain authorization 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)

Service Category	Requirements	Codes Requiring Authorization CPT/HCPC Codes	Medical Necessity Criteria
Wheelchair & Wheelchair Accessories – RENTAL Repair or replacement of rental equipment is the DME provider's responsibility. UCare reserves the right to determine rental vs. purchase.	Authorization is required prior to delivery or dispensing wheelchair and separately billable accessories with a per month allowable rental rate over $500. All months must be authorized.	E0986, E1003, E1004, E1005, E1006, E1007, E1008, E2328, K0011, K0822, K0824,K0825, K0826, K0827, K0828, K0829, 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	**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
Wheelchair & Wheelchair Accessories – PURCHASE UCare reserves the right to determine rental vs. purchase.	Obtain authorization prior to purchase of all wheelchair bases. Wheelchair accessories for purchase, repair and replacement require authorization if over $500 allowable each item.	Not Applicable	**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