2022 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.)

Effective 1/1/2022

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 and Medical Injectable Drugs –

- Review the list of medical injectable drugs that require prior authorization and the policies that contain coverage criteria in the Medical Drug Policies library.
- The Formulary pages on the UCare Provider's Pharmacy website show which drugs are covered on the pharmacy benefit for each UCare Plan, as well as everything you need to request exceptions or prior authorization.

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
Care Continuum	1-800-818-6747 (toll free)	1-877-266-1871 (toll free)	ExpressPAth
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)	ExpressPAth
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 • Vertebroplasty or Kyphoplasty **Medicare Local Coverage Determination:** • Minimally Invasive Surgical (MIS) Fusion of the Sacroiliac Joint L36406
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.	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 (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, 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, 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

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.	64553, 64568, 64569, 64582	**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 – PURCHASE and RENTAL See also: Wheelchairs and 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. **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. All months must be authorized.	**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

Service Category	Requirements	Codes Requiring Authorization CPT/HCPC Codes	Medical Necessity Criteria
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, 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** **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 required for non-UCare contracted provider over the course of the hospital stay. ➡	Not Applicable **Information needed for concurrent review for inpatient for non-UCare contracted hospital stays** • 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. For a non-Medicare-approved transplant and/or at a non-UCare-contracted facility: Notify UCare **prior** to referral to a provider or center. Concurrent review required for **non-UCare contracted provider** over the course of the hospital stay. ➡	Not Applicable **Concurrent review for inpatient for non-UCare contracted hospital stays** • 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
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)

Prior Authorization / Notification Forms

Service Category	Requirements	Codes Requiring Authorization CPT/HCPC Codes	Medical Necessity Criteria
Wheelchair Accessories – PURCHASE and 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 separately billable accessories with a per month allowable rental rate or purchase over $1000 per item. All months must be authorized.	Rental allowable over $1000 per month requiring authorization: E1008 K0108*** if over $1000 per item Purchase allowable over $1000 per month requiring authorization: E2204 K0108*** if over $1000 per item ***Effective 2-15-22 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
Wheelchair RENTAL UCare reserves the right to determine rental vs. purchase.	Authorization is required prior to delivery or dispensing power operated vehicles and power wheelchairs. For wheelchair accessories please see the wheelchair accessories auth section above	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, K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886, K0890, K0891, K0898	**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

Service Category	Requirements	Codes Requiring Authorization CPT/HCPC Codes	Medical Necessity Criteria
Wheelchair – PURCHASE UCare reserves the right to determine rental vs. purchase.	Obtain authorization prior to purchase of **all** wheelchair bases. For wheelchair accessories please see the wheelchair accessories auth section above wheelchair accessories please see the wheelchair accessories auth section above	**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
Wound VAC	Obtain authorization prior to the 4th month of rental.	E2402	**InterQual Medicare Durable Medical Equipment:** • Negative Pressure Wound Therapy Pumps **Medicare:** • Medicare Local Coverage Determination for Negative Pressure Wound Therapy Pumps (L33821)