Medicaid, Child Health Plus and HealthierLife (HARP) Authorization Grid
FIDELIS CARE AUTHORIZATION REQUIREMENTS
Benefit/Service Detail
SERVICES AND PROCEDURES WHICH REQUIRE AUTHORIZATION
EFFECTIVE 2/1/2019

I. Out of Network: Any Medicaid, CHP and HealthierLife service provided by a non-participating provider/facility/physician requires authorization.

II. Inpatient Admissions: All inpatient admissions require an authorization.
Fidelis Care does not require authorization of emergency room services or any emergent service required to provide stabilization of an emergent condition. Fidelis Care does require authorization of post stabilization services and inpatient admissions after emergency room services are completed. All facility admissions are reviewed for medical necessity.

A. All acute inpatient facility services - benefits are unlimited when medically necessary.

B. Inpatient Rehabilitation Services: (acute, sub-acute and skilled nursing rehabilitation) require prior authorization.
   1. Medical rehabilitation can be completed at an acute or sub-acute level of care.
   2. Inpatient substance abuse rehabilitation requires prior authorization.

C. Transplants: All solid organ and bone marrow / tissue transplants require authorization at the time of the transplant evaluation.
Includes but not limited to: 32850-32856, 33930-33945, 38204-38215, 38230-38242, 44133-44136, 47133-47147, 48160, 48550-48556, 50300-50380, 50547, 65710-65757.

D. Breast Cancer Surgery Centers:
Fidelis Care Medicaid members must receive mastectomy and lumpectomy procedure associated with a breast cancer diagnosis, at high volume facilities. This link provides information regarding New York State policies.

E. OASAS Licensed Inpatient Substance Use Disorder Treatment:
Effective 01/01/2017, Fidelis Care will not conduct prior authorization review for the initial 14 days of OASAS licensed Inpatient Detoxification, Inpatient Rehabilitation or Inpatient Residential treatment services. Providers are required to notify Fidelis Care of each admission within 48 hours by faxing or emailing the OASAS Appendix A Notification Form and OASAS LOCADTR Medical Necessity Tool to 646-829-1421 or LOCADTR@fideliscare.org
All services require periodic consultation between the providers and the plan during the initial 14 days and may be subject to utilization review after the 14th day from admission or upon discharge. Out-of-State and Out-of-Network providers continue to be required to request prior authorization for inpatient substance use disorder treatment. Providers with questions regarding these changes are encouraged to call Fidelis Care, during regular business hours, at 1-888-FIDELIS (1-888-343-3547) and follow the prompts.

**F. Elective Surgical Procedures:**
Many surgical and medical procedures which are completed within 24 hours will not be approved at an in-patient level of care. These same services when billed as an out-patient level of care do not require authorization if performed within the Fidelis Care network. Such procedures include, but are not limited to, laparoscopic procedures, and thyroid surgery if completed within 24 hours from the onset of surgery.

[List of inpatient only procedures]

**III. Outpatient surgery:** The following services require prior authorization:

**A. Bariatric surgery:** 43770-43775, S2083

**B. Blepharoplasty:** 15820-15823

**C. Breast reconstruction:** 11920-11971, 19300, 19316-19342, 19355, 19370-19396

**D. Skin surgery and other dermatological procedures:**
The auth requirement for many skin surgery treatments and repairs has been removed if performed in the office or outpatient facility (POS 11 and 22). The following codes will continue to require authorization if completed as ambulatory surgery (POS 24): 10040, 11300-11313, 11400-11471, 11721

**Only the following codes continue to require authorization for any place of service:**
11200-11201, 11719, 15775-15829, 17340-17999

**E. Services for the following codes performed in freestanding ambulatory surgery centers billing with bill type 0831 require an authorization:**
Note: CPT code 20610 is non-covered when billed with one of the following diagnosis codes: M17.0, M17.10-M17.12, M17.2, M17.20-M17.32, M17.4, M17.5, M17.9

**F. Ear repair and ear piercing:** 69300 and 69090

**G. Eyelid & ocular surgery:** 65760-65771, 65772-65775, 67900-67911

**H. Abdominoplasty, lipectomy, panniculectomy:** 15830-15839, 15847, 15876-15879

**I. Reduction mammoplasty:** 19300, 19318

**J. Facial cosmetic, septoplasty, rhinoplasty:** 21120-21296, 30400-30450, 30465-30520, 30620-30802, 30999, 31298, C9749, Q2028

**K. Vascular procedures i.e. vein stripping, ligation, ablation and sclerotherapy:** 36465-36466, 36468-36479, 36482-36483, 37718-37785, and 37241-37244.

**L. Gender reassignment surgery:** 55970, 55980

**M. Sinuplasty:** 31295, 31296, 31297

**N. Spinal Surgery:** 20932, 20933, 20934, 22510, 22511, 22512, 22513, 22514, 22515, 22853, 22854, 22859, 22867-22870, 62380.

**O. Esophageal sphincter augmentation:** 43284
IV. Behavioral Health - Outpatient services

The authorization requirement has been removed from all outpatient behavioral health services except the following, which will continue to require authorization:

A. Psychological/Neuropsychological Testing:

96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146.

Authorization is required: All requests should be submitted on the Psychological/Neuropsychological testing request form.

B. Developmental Pediatric Testing:

96112, 96113. Authorization is required. Note: 96110 is a non-covered service

C. Outpatient ECT: 90870

D. Partial Hospitalization (Mental Health and/or Substance Abuse)

Rate Codes 4349, 4350, 4351, 4352, 4353, 4354, 4355, 4356, 4357, 4358, 4359, 4360, 4361, 4362, 4363, Revenue code 912, 913. HCPCS code H0035 and S9484

E. Intensive Outpatient Treatment

No prior authorization needed for first seven days of service; additional service days do require authorization Revenue code 905, 906, or 912, CPT code 90899, S9480, HCPCS code H2013

F. Autism Spectrum Disorder (ASD):

The State has expanded benefits for CHP members with ASD to include increased case management services, certain DME items to assist speech performance, and Applied Behavioral Analysis, a form of enhanced behavioral modification.

1. Authorization is required for DME speech generation equipment.
2. Authorization is required from Behavioral Health for Applied Behavioral Analysis.

Attestation of the diagnosis of ASD must be provided, at the time of request, by a licensed physician or psychologist.

G. Mental Health Continuing Day Treatment (H2012): the first 7 service days do not require authorization; additional service days do require authorization.

H. Personalized Recovery Oriented Services (PROS): H2018, H2019

I. Assertive Community Treatment (ACT): H0040

J. Intensive Psychiatric Rehabilitation Treatment (IPRT): H2012

K. Substance Use Disorder Intensive Outpatient Treatment: S9480 no prior authorization needed for first seven days of service; additional service days do require authorization.

L. Opioid Treatment Program Services: the first 30 service days do not require authorization; additional service days do require authorization

M. Outpatient Substance Use disorder Rehabilitation Services: the first 14 service days do not require authorization; additional service days do require authorization.

N. The following additional services are available if determined to be eligible through enrollment in the HealthierLife plan and in conjunction with an evidence based assessment. These services are categorized as Home and Community Based Services HCBS:

1. Psychosocial Rehabilitation; H2017
2. Community Psychiatric Support and Treatment (CPST); H0036
3. Habilitation and Residential Support Services; T2017
4. Empowerment Services (Peer Supports); H0038
5. Short Term Crisis Respite; (No prior auth required for access; auth required before 72 hours of stay); H0045
6. Intensive Crisis Respite; H0045
7. Family Support and Training; H2014
8. Pre-Vocational Services: T2015
9. Transitional Employment; T2019
O. Children and Family Treatment & Support Services (CFTS)
Effective 1/1/2019, three Children and Family Treatment and Support Services will be available to Medicaid recipients under age 21 who meet medical necessity criteria. The three services are as follows:

1. **OLP - Other Licensed Practitioner** (90791, H0004, H2011, 90882)
2. **CPST – Community Psychiatric Supports and Treatment** (H0036)
3. **PSR - Psychosocial Rehabilitation** (H2017)

Fidelis Care will not conduct prior authorization review for the first 3 CFTS visits, however, concurrent review is required prior to the 4th visit. Providers must notify Fidelis Care before providing services by telephone at 1-888-FIDELIS (1-888-343-3547) and follow the prompts or email chmmc@fideliscare.org NYS SDOH is finalizing a Standardized Authorization Form for CFTS and that will be uploaded once made available.

V. Outpatient and DME Services: The following services require prior authorization:

A. Diagnostic testing
   1. Sleep Studies, including Home Sleep Studies
   2. Breast Cancer testing (BRCA) and other Genetic Testing (note CPT 81220 does not require authorization)
   3. Wireless Capsule Endoscopy (91110, 91111)
   4. Gastroenterology Procedures – The following procedures require authorization if performed in POS 22 when there is an office-based or ambulatory surgery center available to provide the service: 43235, 43239, 43248, 45378, 45380, 45384, 45385, 46255, 46260, and 46270.
   Authorization is not required for these services when performed in POS 11 or 24.

B. Durable Medical Equipment:
DME coverage information is available in the Medicaid DME Program Manual at:
https://www.emedny.org/ProviderManuals/DME/index.aspx

   1. For Medicaid, supplies and disposable items are covered by Fidelis Care. Disposable items and supplies are not covered by Fidelis Care CHP lines of business. Sections 4.1 to 4.3 in the DME Manual describe the specific codes for Supplies that are covered and do not require authorization. For MLTC members only, the following supply codes require authorization: A4335, A4554, T4521-T4524, T4529, T4530, T4533, T4535, T4537, T4539, T4540, T4543
(*note this authorization requirement is effective 4/1/16)
DME items for which Fidelis Care requires authorization
Benefit limits as defined in the Medicaid DME Program Manual apply.

C. Home Health Care: Home care approvals are based on the medical need for skilled services.
   1. Personal Care Services for Medicaid and Managed Long Term Care (MLTC-Fidelis Care at Home and MAP). All services require authorization and use of the following codes:
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Previous HCPCS Code</th>
<th>Previous Service Billing Units</th>
<th>New HCPCS Code</th>
<th>New Service Billing Units</th>
<th>Contract Note Regarding Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Assessment including PRI &amp; Intense cases</td>
<td>T1001</td>
<td>Per Visit</td>
<td>T1001</td>
<td>Per Visit</td>
<td>No code or rate change</td>
</tr>
<tr>
<td>Level I (housekeeping)</td>
<td>T1019</td>
<td>Per 15 mins</td>
<td>S5130U1</td>
<td>Per 15 mins</td>
<td>Code change only</td>
</tr>
<tr>
<td>Level II</td>
<td>T1020</td>
<td>Hourly Code</td>
<td>T1019U1</td>
<td>Per 15 mins</td>
<td>Code and unit change</td>
</tr>
<tr>
<td>Nursing Supervision</td>
<td>G0162</td>
<td>One per visit</td>
<td>G0162</td>
<td>One per visit</td>
<td>No code or rate change</td>
</tr>
</tbody>
</table>

2. Personal Emergency Response System (PERS) is a Medicaid and MLTC benefit and requires an authorization.

3. Consumer Directed Personal Assistance services (CDPAS) is a benefit for Medicaid and Medicare and requires authorization.

D. Hospice: Effective October 1, 2013, Hospice requests for Medicaid members should be submitted to Fidelis Care. CHP requests also should continue to be submitted to Fidelis Care. For Medicaid members enrolled in Hospice prior to October 1, 2013, the services will be covered by Medicaid FFS until member is no longer enrolled in Hospice.

E. Imaging Studies: The services below require authorization:

1. The first 4 OB ultrasounds can be performed without an authorization. Five or more ultrasounds for a normal pregnancy (dx code Z33.1, Z34.00-Z34.03, Z34.80-Z34.83, Z34.9-Z34.93) require authorization. OB ultrasounds for a high risk pregnancy (dx code O09.00-O09.03, O09.1-O09.13, O09.211-O09.213, O09.219, O09.291-O09.293-O09.299-O09.33, O09.40-O09.43, O09.511-O09.513, O09.519, O09.521-O09.523, O09.529, O09.611-O09.613, O09.619, O09.621-O09.623, O09.629, O09.70-O09.73, O09.811-O09.813, O09.819, O09.821-O09.823, O09.829, O09.891-O09.893, O09.899-O09.93, O36.80X0-O36.80X5, O36.80X9) do not require authorization.

2. Radiology services require prior authorization through eviCore healthcare. A full list of CPT codes can be found at [https://www.evicore.com/healthplan/fideliscare](https://www.evicore.com/healthplan/fideliscare).

3. DXA Scans:
   - Authorization is **not** required when the following services are billed:
     a. Women age ≥ 65: one 77080 or 77081 every two years when accompanied by diagnosis code Z13.820
     b. Men age ≥ 70: one 77080 or 77081 every two years when accompanied by diagnosis code: Z13.820
     c. Women age 51-64 years: one 77080 or 77081 every two years when accompanied by any of the diagnosis codes on the attached list.
d. Men age 51-69 years: one 77080 or 77081 every two years when accompanied by any of the diagnosis codes on the attached list: Requests for either CPT code for any other age group or any other diagnosis will require authorization.

F. Outpatient Therapy: Physical, Occupational, Speech Therapy:
The initial evaluation and the first 10 visits of each therapy type do not require prior authorization. Additional visits beyond the first 10 require authorization, including swallow function and therapy. The Medicaid and MLTC benefit is limited to 20 visits per member for Occupational and Speech Therapy per calendar year, and effective 7/1/18, 40 visits for Physical therapy beginning with the calendar year 2018. There is no visit limit for CHP. Services received at home are not included in this restriction.

G. Podiatry Services:
Authorization is not required for podiatric services rendered to members with a confirmed diagnosis of Diabetes Mellitus. The Diabetes diagnosis must be included on the claim when services are billed. Podiatric services to members without a diagnosis of diabetes do require authorization. For DME and orthotic codes in which authorization is required, Podiatrists will require authorization even when supplied in the office, regardless of member diagnosis.

H. Therapeutic Services:
1. Phototherapy (96567, 96573-96574, 96900, 96910, 96912, 96913, 96920)
2. Hyperbaric Oxygen Therapy
3. Pain Management Codes (i.e. injections, TENS, therapeutic services):
   20526, 20550-20553, 21073, 27096, 62263-62264, 62273, 62280-62282, 62290, 62310-62311, 62318-62319, 62320-62327, 62360-62362, 62365, 62367 – 62368, 62370, 63650-63688, 64400-64530, 64553 - 64595, 64600-64640, C1823, C9752, C9753 (for non-orthopedists only).
4. The following services are not covered for members with a diagnosis of Low Back Pain:
   a. Prolotherapy;
   b. Therapeutic facet joint steroid injections in the lumbar and sacral regions with or without CT fluoroscopic image guidance;
   c. Therapeutic injections of steroids into intervertebral discs; and
   d. Continuous or intermittent traction.
5. Topical oxygen requires prior authorization.
6. Radiation Therapy services require prior authorization through eviCore healthcare. A full list of CPT codes can be found at https://www.evicore.com/healthplan/fideliscare.

I. Long Term Home Health Care Services
Medical Social Services (S9127) and Home Delivered Meals (S5170) are covered with an authorization for Medicaid Managed Care enrollees who have transitioned from the Medicaid Fee-for-Services Long Term Home Health Care Program (LTHHCP) and were in receipt of these services at the time of transition into Medicaid Managed Care.
J. **Adult Day Health Care/AIDS Adult Day Health Care (ADHC/AADHC)**

Authorization is required for any new ADHC/AADHC patient. Prior authorization is also required for the initial assessment, up to two visits. Members already enrolled in an ADHC/AADHC program as of 8/1/13 may remain in their current care plan for up to 90 days. Requests for continuation of services beyond that time period will be reviewed for medical necessity.

K. **DME and pharmaceutical treatment for Erectile Dysfunction** (note: these items and services are not covered for registered sex offenders): 54360, 54400-54402, 54405, L7900

L. Telehealth

Authorization is required for G2010 and G2012.

VI. **Counseling Services**

A. **Diabetes Self-Management Training (DSMT)**

Members are allowed 10 hours/20 units in a continuous 6-month period. These services must be provided by certified providers and no longer require authorization. Services are covered when billed with codes G0108 and G0109

B. **Asthma Self-Management Training (ASMT):**

Asthma self-management training services may be provided in individual sessions, or in group sessions of no more than eight patients. Authorization is not required for codes S9441, S9445, S9446, 98960-98962 when billed with diagnosis codes J45x

Members, including pregnant women, with newly diagnosed asthma or with asthma and a medically complex condition (such as an exacerbation of asthma, poor asthma control, diagnosis of a complication, etc.) will be allowed up to ten (10) hours of ASMT during a continuous six-month period. Members with asthma who are medically stable may receive up to one (1) hour of ASMT during a continuous six-month period.

C. **Smoking Cessation Counseling (SCC):**

Billing for Medicaid members must meet the following criteria. No authorization is required.

1. Smoking cessation counseling will be reimbursed for up to 8 visits per calendar year using the sum of codes 99406 and 99407, and billed ONLY with DX code F17.200, F17.201, F17.210, F17.211, F17.220, F17.221, F17.290, F17.291.

VII. **New Technology/Experimental Treatment:** Prior authorization is required and based on medical necessity.

VIII. **Services provided by outside vendors**

A. **Dental and fluoride varnish treatment- Medicaid and CHP members up to and including age 6 can receive fluoride varnish treatments.**

Prior authorizations are completed by DentaQuest 1-800-516-9615.

Fluoride varnish treatment (D1206, 99188) is authorized by DentaQuest.

Pediatricians, Family and Nurse Practitioners can also obtain authorization through DentaQuest to provide these treatments.

Orthodontic services are available for Medicaid members under age 21. Services require prior authorization by DentaQuest 1-800-516-9615.

B. **Vision: Prior authorizations by Davis Vision 1-800-601-3383**

C. **Transportation Provider Manual** (PDF)
IX. Pharmacy:
For quarterly updates to the formulary please check the website at: https://www.fideliscare.org/Provider/Provider-Resources/Pharmacy-Services

A. Enteral Therapy-HCPCS codes B4034-B4162 describe the available enteral formulas or disposable items that require authorization. Benefit applies to:
1) Tube-fed individuals who can only obtain nutrition through a tube, 2) Individuals with inborn metabolic disorders requiring specific nutritional formulas not available through any other means, 3) Children under age 21 who require medical formulas due to mitigating growth and development factors. 4) Adults with a diagnosis of HIV infection, AIDS, or HIV-related illness, or other disease or condition, who are oral-fed, and who
   • (a) require supplemental nutrition, demonstrate documented compliance with an appropriate medical and nutritional plan of care, and have a body mass index (BMI) under 18.5 as defined by the Centers for Disease Control, up to 1,000 calories per day; or
   • (b) require supplemental nutrition, demonstrate documented compliance with an appropriate medical and nutritional plan of care, and have a body mass index under 22 as defined by the Centers for Disease Control and a documented, unintentional weight loss of 5 percent or more within the previous 6 month period, up to 1,000 calories per day; or
   • (c) require total nutritional support, have a permanent structural limitation that prevents the chewing of food, and the placement of a feeding tube is medically contraindicated.
Pharmacy supplies do not require an authorization (supplies not covered for CHP, please refer to benefit plan).

B. These injectable codes require authorization. Please submit prior authorization requests to our Pharmacy Team electronically via fax (e-fax) to: 1-877-533-2405.

J8700, J8999, J9022, J9023, J9057, J9173, J9203, J9217, J9225, J9226, J9228, J9229, J9302, J9311*, J9312*, Q2041, Q2042, Q4101, Q4105, Q4113, Q5102, Q5103, Q5104, Q5109, Q9991, Q9992, S0122, S0126, S0128
*authorization is not required for oncology indications

Note: J7318, J7320, J7321, J7322, J7323, J7324, J7325, J7326 J7327, J7328, J7329 are non-covered when billed with CPT code 20610 or 20611 or any of the following diagnosis: M17.0, M17.10-M17.12, M17.2, M17.20-M17.32, M17.4, M17.5, M17.

X. All services for “Unlisted” or “Temporary” Codes require authorization