Essential Plan Authorization Grid
FIDELIS CARE AUTHORIZATION REQUIREMENTS
Benefit/Service Detail
SERVICES AND PROCEDURES WHICH REQUIRE AUTHORIZATION
EFFECTIVE 6/1/2019

I. **Out of Network:** There are no OON benefits. However for any medically necessary service not available in network, authorization will be provided

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**

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 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. The link provides a list of inpatient only procedures

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:
   There is no auth requirement for many skin surgery treatments and repairs when performed in the office or outpatient facility (POS 11 and 22). The following codes require authorization if completed as ambulatory surgery (POS 24): 10040, 11300-11313, 11400 - 11471, 11721
   Only the following codes require authorization for any place of service: 11200-11201, 11719, 15775-15829, 17340-17999
E. Services for the following codes performed in free standing ambulatory surgery centers billing with bill type 0831 require an authorization (10060, 11100, 11900 and 17000, 20600, 20605, and 20610) M17.0, M17.10-M17.12, M17.2, M17.30-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, septroplasty, rhinoplasty: 21120-21296, 30400-30450, 30460, 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
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)
   Revenue code 912, 913, 944, and 945; HCPCS code H0035

E. Intensive Outpatient Treatment
   Revenue code 905 or 912, CPT code 90899, S9480, HCPCS code H2013

F. Autism Spectrum Disorder (ASD):
   The State has expanded benefits for members with ASD to include increased case management services, certain DME items to assist speech performance, and Applied Behavior Analysis (ABA), a form of enhanced behavioral modification.
   1. Authorization is required for DME speech generation equipment.
   2. Authorization is required from Behavioral Health for Applied Behavior Analysis.
   3. Attestation of the diagnosis of ASD must be provided, at the time of request, by a licensed physician or psychologist.

G. Residential Treatment
   CPT codes: 1001 and 1002 residential treatment
   HCPCS codes: H0017-H0019, H2036

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
   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/Supplies:
   1. Orthotics are not covered
   2. These DME codes that do not require an authorization:
   3. Other DME codes require an authorization.
   4. Supplies requiring authorization:
      a. Compression garments/compression gradient stockings
      b. Electric breast pumps
      c. Electric heat pads and hot water bottles
      d. Surgical stockings
      e. Protective helmets
      f. Wigs
      g. Insulin pumps
      h. Insulin infusion pumps
   5. Codes for blood glucose monitors and testing supplies (A4253, A9275, E0607, E2100, and E2101) are covered through the member’s prescription drug benefit.
C. **Home Health Care:** Home care approvals are based on the medical need for skilled services. The benefit maximum is 40 visits per plan year.

D. **Hospice Care:** Hospice care must be provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. When medically necessary, coverage is available for up to 210 days.

E. **Imaging Studies:** The following services require authorization:

1. The first 4 OB ultrasounds for a normal pregnancy can be performed without an authorization. Five or more ultrasounds for a normal pregnancy (dx code Z32.01, 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).

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 do require authorization, including swallow function and therapy.

1. **Rehabilitation:** The benefit is limited to 60 visits per condition per plan year. The visit limit applies to all therapies combined.

2. **Habilitation:** The benefit is limited to 60 visits per condition per plan year. The visit limit applies to all therapies combined.

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 will continue to require authorization. Podiatrists will continue to require authorization for all DME codes that are supplied in the office, regardless of member diagnosis. Routine foot care for non-diabetics is not covered.

H. **Therapeutic Services:**

1. Phototherapy (96567, 96573-96574, 96900, 96910, 96912, 96913, 96920)

2. Hyperbaric Oxygen Therapy (99183 and C1300)

3. Pain Management Codes (i.e. injections, TENS, therapeutic services):


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.


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. Chiropractic Services:
The following codes require prior authorization: 98940-98943, rev code 0940.

J. 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 12 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. Education and Training for patient self-management: 98960

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

VIII. Services provided by outside vendors
A. Orthodontic and Major Dental services require prior authorization by DentaQuest 1-800-516-9615.

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

C. Transportation:
   a. Non-emergency ambulance transportation by a licensed provider may be covered between Facilities when the transport is any of the following:
      • From a Non-Participating Hospital to a Participating Hospital
      • To a Hospital that provides a higher level of care that was not available at the original Hospital.
      • To a more cost-effective acute care Facility.
      • From an acute Facility to a sub-acute setting.
   b. Emergency transportation by air/water ambulance are reviewed for medical necessity.

IX. Pharmacy
For monthly 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. Nutritional supplements (formulas) for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.

2. Non-prescription enteral formulas for home use for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastrosophageal reflux with failure to thrive; gastrosophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies.

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.


*authorization is not required for oncology indications

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