Medicare Authorization Grid
FIDELIS CARE AUTHORIZATION REQUIREMENTS
Benefit/Service Detail
SERVICES AND PROCEDURES WHICH REQUIRE AUTHORIZATION
EFFECTIVE 01/01/2020

I. 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 inpatient facility services - Medical, Substance Abuse, and Behavioral Health admissions require authorization.

B. Inpatient Rehabilitation Services: Acute, sub-acute and skilled nursing rehabilitation require authorization.
   1. Acute and sub-acute rehabilitation are authorized, as long as skilled services are provided.
   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. Elective Surgical Procedures:
Many surgical and medical procedures which are completed within 24 hours will not be approved as an in-patient level of care. These 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 for Medicare:
List of inpatient only procedures for Medicare

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. Orthopedic Surgical Procedures and Spinal Surgical Procedures, performed in both inpatient and outpatient settings, require prior authorization for dates of service beginning 10/1/2019. Effective for dates of service rendered on or after 12/23/19, prior authorization has been delegated to TurningPoint Healthcare Solutions, LLC. For a list of codes requiring prior authorization, click here.

II. Outpatient surgery: The following services require prior authorization:
A. Bariatric surgery: 43770-43888, 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).
   1. The following codes will continue to require authorization if completed as ambulatory surgery (POS 24): 10040, 11300-11313, 11400 - 11471, 11721
   2. Dermal injections for the treatment of Facial Lipodystrophy Syndrome (LDS) require authorization. Coverage for these services is limited to individuals diagnosed with HIV who have a secondary diagnosis of depression. Codes that may be covered with authorization are Q2026, Q2027, and G0429.

Only the following codes continue to require authorization for any place of service: 11200-11201, 11719, 15769-15829, 17340-17999.
E. Services for the following codes performed in freestanding ambulatory surgery centers billing with bill type 0831 require an authorization (10060, 11100, 11900 and 17000, 20600, 20605, and 20610).
F. Ear repair and ear piercing 69300 and 69090
G. Eyelid & ocular surgery 65760-65771, 65772-65775, 66987-66988, 67900-67911
H. Abdominoplasty, lipectomy, panniculectomy 15830-15839, 15847, 15876-15879
I. Reduction mammoplasty 19300, 19318
J. Facial cosmetic, septrhaphalplasty, 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, 37241-37244, and 37718-37785
L. Sinuplasty 31295, 31296, 31297
M. Spinal Surgery: 20932, 20933, 20934, 22867-22870, 62380.
N. Esophageal sphincter augmentation: 43284
O. Certain outpatient orthopedic and spinal surgical procedures require prior authorization for dates service beginning 10/1/2019. Effective for dates of service rendered on or after 12/23/19, prior authorization has been delegated to TurningPoint Healthcare Solutions, LLC. Refer to Section I – item # F above. For a list of codes requiring prior authorization, click here.
III. Behavioral Health-Outpatient:
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)
Revenue code 912, 913, 944 and 945. HCPCS code H0035

E. Intensive Outpatient Treatment
Bill type 131, Revenue code 905 or 912, CPT code 90899, S9480, HCPCS code H2013

IV. Outpatient and DME Services: These services require prior authorization:

A. Diagnostic Testing:
1. Sleep Studies, including Home Sleep Studies
2. Breast Cancer testing (BRCA) and other Genetic Testing (Note: Authorization is not required for CPT 81220, 81329 and 81336. CPT 81220 has a lifetime limit of 1. CPT 81329 and 81336 have a combined limit of 1 per lifetime.)
3. Wireless Capsule Endoscopy (91110, 91111)
4. Gastroenterology Procedures – The following procedures require authorization if performed in POS 19 and 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
5. Infectious Agent detection by DNA or RNA: 87483

B. Durable Medical Equipment:
1. The following DME codes do not require an authorization:
2. The following orthotic codes do not require an authorization:
3. Other DME and orthotic codes require an authorization.
C. Home Health Care

D. Hospice care is covered through original Medicare. For more information: http://www.medicare.gov/coverage/hospice-and-respite-care.html

E. Imaging Studies:
   1. The first 4 OB ultrasounds 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.

F. Outpatient Therapy:
Physical, Occupational, Speech Therapy - The initial evaluation does not require prior authorization. All visits require authorization, including swallow function and therapy. Members enrolled in Fidelis Dual Advantage Flex (Plan 017) have a separate $2,010 annual dollar limit for Physical and Speech Therapy combined and $2,010 annual dollar limit for Occupational Therapy.

G. Podiatry Services:
Authorization is no longer 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 and orthotic codes that are supplied in the office, regardless of member diagnosis.

H. Therapeutic Services:
   1. Phototherapy (96567, 96573-96574, 96900, 96910, 96912, 96913, 96920)
   2. Chiropractic Services
   3. Hyperbaric Oxygen Therapy
   4. Pain Management Codes (ie. injections, TENS, therapeutic services)
      20526, 20550-20553, 21073, 27096, 62263-62264, 62273, 62280-62282, 62290, 62310-62311, 62318-62319, 62320-62327, 62370, 64400-64530, 64553-64595, 64600-64640, C1823, C9752, C9753. (for non-orthopedists only).
   5. The following services are not covered for members with a diagnosis of Low Back Pain:
      a. Prolotherapy;
      b. Therapeutic injections of steroids into intervertebral discs
   6. Topical oxygen is not a covered service.
   7. 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. Telehealth
Authorization is required for G2010 and G2012.

V. Counseling Services Authorization requirements are indicated. Please read carefully.
A. Medical Nutrition Therapy (MNT)

B. 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.

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

VII. Services provided by outside vendors
A. Vision: Prior authorizations by Davis Vision 1-800-601-3383
B. Transportation Provider Manual

VIII. Pharmacy:
For monthly updates to the formulary, please check the website at
https://www.fideliscare.org/Member/Medicare-Information/Prescription-Drug-Information
All covered Medicare Part D drugs must be prescribed for medically accepted indications, which are the FDA approved indications or the use of which is supported by one or more Medicare approved compendia. The Medicare approved compendia include: DRUGDEX (Micromedex), AHFS (American Hospital Formulary Service). Additional consideration of anticancer chemotherapeutic regimen can be researched in DRUGDEX (Micromedex), AHFS (American Hospital Formulary Service), Clinical
Pharmacology, NCCN (National Comprehensive Cancer Network), PubMed and in the Medicare approved peer-reviewed literature.

The Fidelis Website provides further details on Formulary Drug List, Prior Authorization Criteria, Step Therapy Criteria, Coverage Determination process, Redetermination process.

https://www.fideliscare.org/Member/Medicare-Information/Prescription-Drug-Information

A. Enteral Therapy-HCPCS codes B4034-B4162 describe the available enteral formulas or disposable items that require authorization. Benefit applies to Part B services.

B. These injectable codes require authorization. **Please submit prior authorization requests to our Pharmacy Team electronically via fax (e-fax) to: 1-877-882-5892.**

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<th>Code</th>
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authorization is not required for oncology indications
IX. **Out-of-network:**
Out-of-network services are covered with an authorization for the Medicare Advantage Flex Plan (003) and the Medicare Advantage without RX (001) but additional co-pays and deductibles may apply.

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