COVID-19 UPDATE
Please refer to this link: Important Updates Regarding Coronavirus COVID-19, for authorization and coding guidelines related to the COVID-19 Pandemic.

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 01/01/2020: Inpatient detoxification, inpatient rehabilitation and inpatient residential treatment services (Inpatient SUD) provided by facilities in New York State that are licensed, certified or otherwise authorized by OASAS and participating in Fidelis Care’s provider network are not subject to prior authorization review by Fidelis Care. In
addition, Inpatient SUD services are not subject to concurrent utilization review during the first twenty-eight (28) days of the inpatient admission, provided that the facility notifies Fidelis Care of the inpatient admission and the initial treatment plan within two (2) business days of the admission. The facility may fax or email the OASAS Appendix A Notification Form and OASAS LOCADTR Medical Necessity Tool to 646-829-1421 or LOCADTR@fideliscare.org. All Inpatient SUD services require facilities to perform daily clinical review of the patient. This does not require a facility to conduct a LOCADTR concurrent review module every day. In addition, all Inpatient SUD facilities must periodically consult with Fidelis Care starting on or just prior to the fourteenth (14th) day of treatment to ensure that the facilities are using the LOCADTR tool to ensure that the inpatient treatment is medically necessary for the patient. Inpatient SUD services may be subject to utilization review after the 28th day from admission or upon discharge using the LOCADTR clinical review tool. Prior to the member’s discharge, facilities must provide the member and Fidelis Care with a written discharge plan as determined using the LOCADTR clinical review tool. Further, prior to discharge, facilities must indicate to Fidelis Care whether the services included in the discharge plan are secured or determined to be reasonably available. All services may be reviewed retrospectively to assess the clinical necessity of the care.

Facilities that are outside of New York State, facilities that are not licensed, certified or otherwise authorized by OASAS, and facilities that are outside of Fidelis Care’s provider network, continue to be required to request prior authorization review for Inpatient SUD services. All Inpatient SUD services provided by such facilities are subject to concurrent review throughout the admission.

Providers with questions regarding these changes are encouraged to call Fidelis Care, during regular business hours, at 1-888-FIDELIS (1-888-343-3547), extension 16072 for Behavioral Health.

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

G. 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.

H. OMH Licensed Inpatient Mental Health Treatment
Effective 01/01/2020: Inpatient mental health treatment for members under age 18 provided by OMH licensed hospitals in New York State that are participating in Fidelis Care’s provider network are not subject to prior authorization review by Fidelis Care. Fidelis Care will not conduct concurrent utilization review during the first 14 days of
inpatient admissions provided that the facility: i) notifies Fidelis Care of both the admission and the initial treatment plan within two business days of the admission by completing the OMH developed “Two-Day Notification and Initial Treatment Plan” form and submitting it to Fidelis Care by fax (718-896-1784), or by email to Mental_Health_Admission@fideliscare.org; ii) performs daily clinical review of the patient, and iii) participates in periodic consultation with Fidelis Care to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by Fidelis Care which is approved by OMH and appropriate to the age of the patient to ensure medical necessity. All services may be reviewed retrospectively using the clinical review criteria of the plan which is approved by the office of mental health.

Inpatient mental health services provided to members age 18 and older require prior authorization review by Fidelis Care and are subject to concurrent review throughout the admission. Out-of-State and Out-of-Network providers continue to be required to request prior authorization review for inpatient mental health treatment for members of all ages. All inpatient mental health services provided by such facilities are subject to concurrent review throughout the admission. Providers with questions regarding these changes are encouraged to call Fidelis Care, during regular business hours, at 1-888-FIDELIS (1-888-343-3547), extension 16072 for Behavioral Health.

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, 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). 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, 66987-66988, 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, 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, 22867-22870, 62380.
O. Esophageal sphincter augmentation: 43284
P. Certain outpatient orthopedic and spinal surgical procedures 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. Refer to Section II – item # G above. For a list of codes requiring prior authorization, click here.

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.

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
Requests for members under 21 can be made by email chmmc@fideliscare.org, fax, (347) 690-7362 or by calling 1-888-FIDELIS (1-888-343-3547) and following the prompts for Children’s Medicaid.

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.
Requests for members ages 18-20 can be made by email chmmc@fideliscare.org, fax, (347) 690-7362 or by calling 1-888-FIDELIS (1-888-343-3547) and following the prompts for Children’s Medicaid.

H. Personalized Recovery Oriented Services (PROS): H2018, H2019
Requests for members ages 18-20 can be made by email chmmc@fideliscare.org, fax, (347) 690-7362 or by calling 1-888-FIDELIS (1-888-343-3547) and following the prompts for Children’s Medicaid.

I. Assertive Community Treatment (ACT): H0040
Requests for members ages 18-20 can be made by email chmmc@fideliscare.org, fax, (347) 690-7362 or by calling 1-888-FIDELIS (1-888-343-3547) and following the prompts for Children’s Medicaid.

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 adult HealthierLife plan and in conjunction with an evidence based assessment. These services are categorized as adult 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
10. Supported Employment; H2023, H2025
11. Education Support Services; T2013
12. Provider Travel Supplement; A0160

O. Children and Family Treatment & Support Services (CFTSS)
Effective 4/1/2020, utilization management requirements for Children and Family Treatment and Support Services will be discontinued. The CFTSS 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)
4. FPSS- Family Peer Support Services (H0038)
5. YPSS – Youth Peer Supports and Services (H0038)
6. CI – Crisis Intervention (H2001, S9484, S9485) - - no previous authorization requirements

Prior authorization was never required for these services. Concurrent review is no longer required. If there are questions related to these changes, providers may contact Fidelis Care by telephone at 1-888-FIDELIS (1-888-343-3547) and follow the prompts.

P. Children’s BH Carve-In: Effective 7/1/19

<table>
<thead>
<tr>
<th>Name of Service</th>
<th>Authorization Requirement</th>
<th>Age Requirement</th>
<th>Medicaid Benefit Status (New or Previously covered)</th>
<th>Medicaid -SSI Benefit Status (New, Previously covered, Carve-In)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OMH designated Serious Emotional Disturbance (SED) Clinic Services</td>
<td>None</td>
<td>Under 19</td>
<td>New</td>
<td>New</td>
</tr>
<tr>
<td>OMH Outpatient Services</td>
<td>None</td>
<td>Under 21</td>
<td>Previously covered</td>
<td>New</td>
</tr>
<tr>
<td>Psychiatric Services</td>
<td>None</td>
<td>Under 21</td>
<td>Previously covered</td>
<td>New</td>
</tr>
<tr>
<td>Service Type</td>
<td>Under 21 Status</td>
<td>Previously Covered</td>
<td>New Status</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>-----------------</td>
<td>--------------------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>Psychological Services</td>
<td>None</td>
<td>Under 21</td>
<td>Previously covered</td>
<td>New</td>
</tr>
<tr>
<td>Partial Hospitalization Program</td>
<td>Prior Auth, Concurrent Review</td>
<td>Under 21</td>
<td>New</td>
<td>New</td>
</tr>
<tr>
<td>Assertive Community Treatment (ACT)</td>
<td>Prior Auth, Concurrent Review</td>
<td>18-20</td>
<td>New</td>
<td>New</td>
</tr>
<tr>
<td>Continuing Day Treatment</td>
<td>Prior Auth, Concurrent Review</td>
<td>18-20</td>
<td>New</td>
<td>New</td>
</tr>
<tr>
<td>Personalized Recovery Oriented Services (PROS)</td>
<td>Prior Auth, Concurrent Review</td>
<td>18-20</td>
<td>New</td>
<td>New</td>
</tr>
<tr>
<td>Inpatient Psychiatric Services</td>
<td>Prior Auth, Concurrent Review</td>
<td>Under 21</td>
<td>Previously covered</td>
<td>New</td>
</tr>
<tr>
<td>Comprehensive Psychiatric Emergency Program</td>
<td>None</td>
<td>Under 21</td>
<td>Previously covered</td>
<td>New</td>
</tr>
<tr>
<td>Outpatient – Clinic</td>
<td>None</td>
<td>Under 21</td>
<td>New</td>
<td>New</td>
</tr>
<tr>
<td>Outpatient – Rehabilitation Programs</td>
<td>Concurrent</td>
<td>Under 21</td>
<td>New</td>
<td>New</td>
</tr>
<tr>
<td>Opioid Treatment Program Services</td>
<td>Concurrent</td>
<td>Under 21</td>
<td>New</td>
<td>New</td>
</tr>
<tr>
<td>Chemical Dependence Inpatient Rehabilitative Services</td>
<td>Prior, Concurrent</td>
<td>Under 21</td>
<td>Previously covered</td>
<td>New</td>
</tr>
</tbody>
</table>

Requests for services listed above for members under age 21 can be made by email chmmc@fideliscare.org, fax (347) 690-7362 or by calling 1-888-FIDELIS (1-888-343-3547) and following the prompts for Children’s Medicaid.

**Q. Children’s Home and Community Based Services, Effective 10/1/19:**
The following additional services are available to members age 20 and younger, if determined to be HCBS-eligible by a Health Home or the Children and Youth Evaluation Service (C-YES):

1. Community Habilitation
2. Day Habilitation
3. Caregiver/Family Support and Services
4. Community Self Advocacy Training and Support:
5. Prevocational Services - must be age 14 and older
6. Supported Employment - must be age 14 and older
7. Respite Services (Planned Respite and Crisis Respite)
8. Palliative Care
9. Environmental Modifications
10. Vehicle Modifications
11. Adaptive and Assistive Equipment

**Services 1-6**: HCBS eligibility and POC are required for an initial authorization of 96 units or 24 hours (total) of service within 60 days from the time notification is received from an HCBS Provider. Concurrent review is required for continued stay.

Respite Services do not require Prior Authorization. Concurrent review is required after 7 consecutive days of Planned Respite Services. Fidelis Care will conduct concurrent review for Crisis Respite stays that exceed 72 hours.

Palliative Care services require prior authorization and concurrent review.

**Services 9-11** require prior authorization with service limits at $15,000 annually.

Requests for all services listed above for eligible members under age 21 can be made by email SM_Childrens_HCBS@fideliscare.org, fax (347) 690-7362 or by calling 1-888-FIDELIS (1-888-343-3547) and following the prompts for Children’s Medicaid.

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: 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.

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>→</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>
<td></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>
<td></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>
<td></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>
<td></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 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, O09.4-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, O09.7-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. Effective 10/1/2019, Outpatient Therapy, including services rendered in the home: Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST): all services performed by a therapy provider after the initial evaluation will require prior authorization through National Imaging Associates (NIA). Excludes PT, OT, ST performed in an Inpatient setting, Emergency Room, Skilled Nursing Facility, or during an Observation stay.

Services rendered on or after 10/1/2019, require prior authorization*

*PT, OT, and ST initial evaluations do not require a prior authorization. However, all other billed procedure codes, even if performed on the same date as the initial evaluation date, will require authorization prior to billing.

Non-Therapy Providers (MD, DO, DPM, etc.) should request prior authorization for all services after the initial evaluation directly through Fidelis Care.

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, 62370, 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. 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 codes require authorization (with the exception of B4088). Please submit prior authorization requests to our Pharmacy Team electronically via fax (e-fax) to: 1-877-533-2405.

<table>
<thead>
<tr>
<th>C9054</th>
<th>lefamulin (Xenleta)</th>
<th>J0205</th>
<th>alglucerase</th>
<th>J0567</th>
<th>cerliponase alfa (Brineura)</th>
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<tbody>
<tr>
<td>C9047</td>
<td>caplacizumab-yhdp (Cablivi)</td>
<td>J0215</td>
<td>alefacept (Amevive)</td>
<td>J0570</td>
<td>buprenorphimpl (Probuphine)</td>
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<td>C9055</td>
<td>brexanolone,</td>
<td>J0220</td>
<td>alg glucosidase alfa (Myozyme)</td>
<td>J0584</td>
<td>burosumab-twza (Crys vita)</td>
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<td>C9399</td>
<td>unclassified drugs/biologics</td>
<td>J0221</td>
<td>alg glucosidase alfa (Lumizyme)</td>
<td>J0585</td>
<td>onabotulin tox A (Botox)</td>
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<tr>
<td>G0516</td>
<td>insertion of implant</td>
<td>J0222</td>
<td>patsiran (Onpat tro)</td>
<td>J0586</td>
<td>abobotulin tox A (Dysport)</td>
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<td>G0517</td>
<td>removal of implant</td>
<td>J0256</td>
<td>alpha 1-prot inhib NOS</td>
<td>J0587</td>
<td>rimabotulin tox B (Myobloc)</td>
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<td>removal / reinsert implant</td>
<td>J0257</td>
<td>alpha 1-prot inhib (Glassia)</td>
<td>J0588</td>
<td>incobotulinumtoxinA (Xeomin)</td>
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<td>J0129</td>
<td>abatacept (Oencia)</td>
<td>J0270</td>
<td>alprostadil (Prostin VR)</td>
<td>J0593</td>
<td>lanadelumab-flyo (Takhzyro)</td>
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<td>J0135</td>
<td>adalimumab (Humira)</td>
<td>J0275</td>
<td>alprostadil sup (Muse)</td>
<td>J0596</td>
<td>c1 est inhib rec (Ruconest)</td>
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<td>J0178</td>
<td>aflibercept (Eylea)</td>
<td>J0401</td>
<td>aripiprazone ER inj (Abilify Maintena)</td>
<td>J0597</td>
<td>c1 est inhib hum (Berinert)</td>
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<td>J0179</td>
<td>brolicuzumab-dbll</td>
<td>J0490</td>
<td>belimumab (Benlysta)</td>
<td>J0598</td>
<td>c1 est inhib hum (Cinryze)</td>
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<td>algalsidase beta (Fabrazyme)</td>
<td>J0517</td>
<td>benralizumab (Fasenra)</td>
<td>J0599</td>
<td>c1 est inhib hum (Haegarda)</td>
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<td>bezlotoxumab (Zinplava)</td>
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<td>canakinumab (Ilaris)</td>
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<td>J0706</td>
<td>caffeine citrate inj</td>
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</table>
Note:

- **J7318, J7320, J7321, J7322, J7323, J7324, J7325, J7326, J7327, J7328, J7329, J7331, J7332** 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.
- **J9035 (Avastin), J9355 (Herceptin), and J9306 (Perjeta)** are available through the medical benefit without prior authorization (PA). Xolair is available through the medical benefit and requires PA. Clinical criteria for Xolair may be found on the provider portal.

*authorization is not required for oncology indications*
X. All services for “Unlisted” or “Temporary” Codes require authorization