Medical Coverage Policy | Prior Authorization via Web-Based Tool for Procedures

EFFECTIVE DATE: 09|01|2015
POLICY LAST UPDATED: 08|09|2019

OVERVIEW
This policy documents the prior authorization request process for certain medical procedures, using the BCBSRI online prior authorization tool. Therapies such as pulmonary rehab and certain drugs such as Belimumab will not be authorized by this system. Please refer to the individual policies on the web.

There is no change to the prior authorization process for specialty pharmacy drugs.

MEDICAL CRITERIA
Generally InterQual criteria is used to determine medical necessity and is found in the online authorization tool. However, for those policies specifically listed in the Related Policies section of this policy, BCBSRI medical criteria is used.

PRIOR AUTHORIZATION
Prior authorization is required for BlueCHiP for Medicare and recommended for Commercial products.

If a service that requires prior authorization is performed on an urgent basis, a retrospective authorization must be obtained through the online tool.

If the complexity of a procedure is unknown prior to the service, a retrospective authorization must still be obtained.

POLICY STATEMENT
BlueCHiP for Medicare and Commercial Products

Medical Procedures are considered medically necessary when the criteria in the BCBSRI online prior authorization tool has been met.

Requests for medical procedures should be obtained via the BCBSRI online prior authorization tool, which is available only to participating providers. All other providers should fax the request to Utilization Management at 401-272-8885 to complete the prior authorization process. Please see reference to the procedures requiring prior authorization through the online tool below.

https://www.bcbsri.com/BCBSRIWeb/Login.do?redirectTo=/providers/preauth/preauthProviderOverview.jsp

COVERAGE
Benefits may vary between groups/contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage, or Subscriber Agreement for applicable coverage for surgery.

BACKGROUND
Not applicable

CODING

The following CPT and HCPCS codes require prior authorization:

Please see 2019 updates in bold in the list below.

Anastomosis of Extracranial-Intracranial Arteries:
61711

Angioplasty and Stent, Carotid:
37215, 37217

Antireflux Surgery or Hiatal Hernia Repair:
43280, 43281, 43282, 43325, 43327, 43328, 43332, 43333, 43334, 43335, 43336, 43337

Aortic Valvuloplasty, Percutaneous Balloon:
92986
Effective 10/1/2019 this service will no longer require prior authorization.

Arthroplasty, Temporomandibular Joint (TMJ):
21010, 21240, 21242, 21243

Arthroscopically Assisted Knee Surgery:
29855, 29856, 29882, 29883, 29888, 29889

Arthroscopy, Temporomandibular Joint (TMJ):
29804

Artificial Disc Replacement, Cervical:
22856

Autologous Chondrocyte Implantation:
27412, J7330

Bariatric Surgery (Adolescent)
Adjustable Gastric Banding: 43770
Roux-en-Y Gastric Bypass (RYGB): 43644, 43645, 43846, 43847
Sleeve Gastrectomy: 43775

Bariatric Surgery (Adult) *
Adjustable Gastric Banding: 43770
Biliopancreatic Diversion with Duodenal Switch: 43845, 43847
Revisional Procedure: 43771, 43772, 43773, 43774, 43848
Roux-en-Y Gastric Bypass (RYGB): 43644, 43645, 43846, 43847
Sleeve Gastrectomy: 43775
* For BlueCHiP for Medicare, see Bariatric Surgery policy in Related Policies section below

Blepharoplasty:
15820, 15821, 15822, 15823

Bone Marrow Transplant:
Members with FEP coverage requiring a bone marrow transplant require prior authorization.

Brachytherapy, Prostate:

55875, 55876

Breast Implant Removal:
11971, 19328, 19330

Breast Reconstruction:
11920, 11921, 19316, 19324, 19325, 19340, 19342, 19350, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380, 19396
Exception: Prior Authorization not required for services related to reconstruction due to cancer, represented by ICD-10 diagnosis codes C50.011-C50.929; C79.81; D05.00-D05.92; Z42.1; Z85.3

Capsule Endoscopy:
91110, 91111
Effective 1/1/2019 this service will no longer require prior authorization.

Cardiac Hemodynamic Monitoring:
93701 (Medicare Only)
Effective 10/1/2019 this service will no longer require prior authorization.

Corneal Collagen Cross-linking
0402T (Commercial Only)

Discectomy:
Lumbar: 22224
Temporomandibular Joint (TMJ): 21060

Discectomy and Fusion, Anterior Cervical:
22220, 22551, 22554, 63075

Epidural Injection, For Pain Management Only
The following codes would not be used for maternity delivery or as an anesthetic for surgical procedures.
62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327, 64479, 64483

Facet Joint Injection:
64490, 64493
For BlueCHiP for Medicare, refer to: CMS Local Coverage Determination for medical criteria: "Facet Joint Injections, Medial Branch Blocks, And Facet Joint Radiofrequency Neurotomy"

Fusion:
Cervical Spine: 22548, 22551, 22554, 22590, 22595, 22600
Lumbar Spine: 22533, 22558, 22612, 22630, 22633, 22800, 22804, 22810, 22812
Thoracic Spine: 22532, 22556, 22610

Hemilaminectomy:
Cervical: 63020, 63040, 63045, 63075
Lumbar: 63030, 63042, 63047, 63056

Hyperbaric Oxygen Therapy (HBO):
99183, G0277
Exception: See separate policy "Hyperbaric Oxygen Therapy (HBO)" for diagnosis codes that do not require prior authorization.
Effective 10/1/2019 this service will no longer require prior authorization.

Implantable Cardioverter Defibrillator (ICD) Insertion:
33202, 33203, 33216, 33217, 33224, 33230, 33231, 33240, 33241, 33249
Subcutaneous Implantable Cardioverter Defibrillator (S-ICD): 33270, 33271, 33273
NOTE: Effective 10/1/2019, the highlighted codes will no longer require prior authorization. All other codes will require prior authorization through the Radiology Vendor. Please see the Prior Authorization – Cardiology Services policy for more information.

Implantation of Intrastromal Corneal Ring Segments:
65785

Infertility Services:
58970, 58974, 58976, 76948, 89250, 89251, 89253, 89254, 89280, 89281, 89255, 89268, 89272, S4011, S4013, S4014, S4015, S4016, S4017, S4018, S4020, S4021, S4022, S4023, S4025, S4042

Intensity Modulated Radiotherapy: 77301, 77338, 77385, 77386, G6015, G6016
For more detail, see each of the individual policies as referenced in the Related Policies section below.
Abdomen and Pelvis
Breast and Lung
Central Nervous System
Head and Neck or Thyroid
Prostate

Joint Replacement:
Elbow: 24360, 24361, 24362, 24363
Shoulder: 23470, 23472
Wrist: 25441, 25442, 25443, 25444, 25445, 25446

Keratoplasty:
65710, 65730, 65750, 65755, 65756

Kyphoplasty or Vertebroplasty:
22510, 22511, 22513, 22514
For BlueCHiP for Medicare, see Kyphoplasty or Vertebroplasty policy in Related Policies section below

Laminectomy:
Cervical, with or without Fusion: 22590, 22595, 22600, 63001, 63015, 63020, 63045, 63050, 63051
Lumbar, with or without Fusion: 22612, 22630, 63005, 63012, 63017, 63047
Thoracic, with or without Fusion: 22206, 22610, 63003, 63016, 63046, 63077

Laser Treatment for Proliferative Vascular Lesions:
17106, 17107, 17108

Lid Lesion Excision with or without Reconstruction:
67800, 67801, 67805, 67808, 67810, 67840, 67961, 67966, 67971, 67973, 67974, 67975

Mastectomy for Gynecomastia
19300

Orthognathic Surgery:

(Commercial Only) 21141, 21142, 21143, 21145, 21146, 21147, 21150, 21151, 21154, 21155, 21159, 21160, 21188, 21193, 21194, 21195, 21196, 21198, 21199, 21206, 21208, 21209

Panniculectomy, Abdominal:
15830

Percutaneous Coronary Interventions (PCI):
92920, 92924, 92928, 92933, 92937, 92941, 92943
Effective 10/1/2019 this service will no longer require prior authorization.

Percutaneous Left Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation
33340 **(Commercial Only)**

Percutaneous Tibial Nerve Stimulation (PTNS)
64566

Prostatic Urethral Lift
52441, 52442
C9739, C9740 (For Institutional Providers Only)

Proton Beam Radiotherapy (PBRT):
77520, 77522, 77523, 77525
For BlueCHiP for Medicare, refer to: CMS Local Coverage Determination for medical criteria: "Proton Beam Therapy"

Ptosis Repair:
67900, 67901, 67902, 67903, 67904, 67906, 67908, 67909, 67911

Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors
20982, 32998
32994 BlueCHiP for Medicare only

Radiofrequency Ablation (RFA), Liver:
47370, 47380, 47382

Radiofrequency Ablation (RFA) or Cryoablation, Renal:
50250, 50542, 50592, 50593

Reconstruction, Temporomandibular Joint (TMJ):
21050, 21070, 21244, 21245, 21247, 21255

Reduction Mammoplasty:
19318
For BlueCHiP for Medicare, refer to: CMS Local Coverage Determination for Reduction Mammoplasty for medical criteria

Removal and Replacement, Total Joint Replacement (TJR):
Hip *: 27132, 27134, 27137, 27138
Knee *: 27486, 27487
Shoulder: 23470, 23472, 23473, 23474
* For BlueCHiP for Medicare, see Total Joint Arthroplasty – Hip and Knee policy in Related Policies section below

Removal of Non-Covered Implantable Devices
Aortic Counterpulsation Ventricular Assist System and components: 0455T, 0456T, 0457T, 0458T
Artificial Intervertebral Disc: 22865
Carotid Sinus Baroflex Activation Device: 0269T, 0270T, 0271T
Chest Wall Respiratory Sensor Electrode: 0468T
Esophageal Sphincter Augmentation Device: 43285
Gastric Electrical Stimulation: 43648, 43882, 64595
Interstitial Glucose Sensor: 0447T
Intracardiac Ischemia Monitoring System: (Effective 9/1/19 for Commercial Only) 0530T, 0531T, 0532T (New Codes Effective 1/1/2019)
Neurostimulator System for Treatment of Central Sleep Apnea: 0428T, 0429T, 0430T
Occipital Nerve Stimulation: 64570
Permanent Cardiac Contractility System: 0412T, 0413T
Permanent Leadless Pacemaker, Ventricular: 33275 Commercial Only (New Code Effective 1/1/2019) NOTE: Effective 10/1/2019, this service will require prior authorization through the Radiology Vendor. Please see the Prior Authorization – Cardiology Services policy for more information.
Sinus Tarsi Implant: 0510T (New Code Effective 1/1/2019)
Transperineal Periurethral Balloon Continence Device: 0550T (Commercial Only) (New Code Effective 7/1/2019)
Vagus Nerve Blocking Therapy: 0314T, 0315T
Wireless Cardiac Stimulation System for Left Ventricular Pacing: 0518T (New Code Effective 1/1/2019) Effective 9/1/2019 this service will no longer require prior authorization.

Rhinoplasty:
30410, 30420, 30435, 30450, 30460, 30462

Sacroiliac (SI) Joint Injection:
27096
Effective 1/1/2019 this service will no longer require prior authorization.

Scoliosis Surgery:
22800, 22802, 22804, 22808, 22810, 22812, 22818, 22819, 22849, 22850

Septoplasty:
30520
Effective 1/1/2019 this service will no longer require prior authorization.

Skin Repair/Reconstruction:
13151, 13152, 14060, 14061, 15120, 15260, 15576, 15630
Effective 1/1/2019 this service will no longer require prior authorization.

Sleep Studies
Multiple Sleep Latency Test (MSLT): 95805
Polysomnogram (PSG), Facility Based Only: 95808, 95810, 95811
Note: Home Sleep Studies are covered without preauthorization requirement.
Effective April 1, 2010 for labs:

- *All sleep laboratories must be accredited by the American Academy of Sleep Medicine (AASM).*
- *All sleep laboratory providers performing sleep testing services must participate and be in good standing with Medicare*

Effective April 1, 2010 for physicians:

All physicians reading or supervising sleep tests must be board-certified in sleep medicine or have completed the necessary training requirements to take the exam in sleep medicine.

Spinal Cord Stimulator (SCS) Insertion:
63650, 63655, 63663, 63685
For BlueCHiP for Medicare, refer to: CMS National Coverage Determinations for medical criteria: "Treatment of Motor Function Disorders with Electrical Nerve Stimulation" and "Electrical Nerve Stimulators"

Stereotactic Radiation:
32701, 77373, 77435

Total Joint Replacement (TJR):
Ankle: 27702
Hip *: 27130, 27132
Knee *: 27447
* For BlueCHiP for Medicare, see Total Joint Arthroplasty – Hip and Knee policy in Related Policies section below

Transarterial Chemoembolization (TACE), Liver:
37242, 37243
Exception: Prior Authorization not required for services related to uterine fibroids, represented by ICD-10 diagnosis codes D25.0-D25.9 and O72.0-O72.2.

Transcatheter Aortic-Valve Implantation for Aortic Stenosis:
33361, 33362, 33363, 33364, 33365, 33366 (Commercial Only)

Unicondylar Knee Replacement:
27446

Uvulopalatopharyngoplasty (UPPP):
42145

Vagal Nerve Stimulator:
61885, 61886, 64553, 64568, 64575

Varicose Vein Treatment:
36465, 36466, 36470, 36471, 36475, 36478, 36482, 37500, 37700, 37718, 37722, 37735, 37760, 37761, 37765, 37766, 37780, 37785, S2202

RELATED POLICIES

BlueCHiP for Medicare and Commercial Products
Anastomosis of Extracranial-Intracranial Arteries
Autologous Chondrocyte Implantation
Epidural Injections for Pain Management
Hyperbaric Oxygen Therapy (HBO)
Implantation of Intrastromal Corneal Ring Segments
Intensity Modulated Radiotherapy of the Abdomen and Pelvis
Intensity Modulated Radiotherapy of the Breast and Lung
Intensity Modulated Radiotherapy: Central Nervous System Tumors
Intensity Modulated Radiotherapy: Cancer of the Head, Neck or Thyroid
Intensity Modulated Radiotherapy of the Prostate
Laser Treatment for Proliferative Vascular Lesions

Percutaneous Left Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation
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Bariatric Surgery
Cardiac Hemodynamic Monitoring
Kyphoplasty or Vertebroplasty
Total Joint Arthroplasty – Hip and Knee

Commercial Products Only
Corneal Collagen Cross-linking
Orthognathic Surgery
Percutaneous Left Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation

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REFERENCES
Not applicable