

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



EFFECTIVE DATE: 09|01|2015
POLICY LAST UPDATED: 12|19|2017

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 Clear Coverage 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:

Effective 2018, the services identified in red will require prior authorization according to the effective date of the group's renewal.

Please see additional 2018 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, 43330, 43333, 43334, 43335, 43336, 43337

Aortic Valvuloplasty, Percutaneous Balloon:
92986

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: for conditions other than part of reconstruction due to cancer
11920, 11921, 19316, 19324, 19325, 19340, 19342, 19350, 19357, 19361, 19364, 19366, 19367, 19368, 19369,
19370, 19371, 19380, 19396

Capsule Endoscopy:
91110, 91111

Cardiac Hemodynamic Monitoring:
93701 (Medicare Only)

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

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

Implantable Cardioverter Defibrillator (ICD) Insertion:
33202, 33203, 33216, 33217, 33224, 33230, 33231, 33240, 33241, 33249
Subcutaneous Implantable Cardioverter Defibrillator (S-ICD): 33270, 33271, 33273

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

Injectable Clostridial Collagenase for Fibroproliferative Disorders:

20527, J0775

Effective 6/1/2018: Prior Authorization requirement removed from CPT code 20527.

See separate policy, Xiaflex (Clostridial Collagenase), for Prior Authorization requirements for HCPCS code J0775.

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

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

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

Percutaneous Left Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation

33340

Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary Dysfunction:
64566

Effective 9/1/2018: Prior Authorization requirement added to Commercial Products.

Proton Beam Radiotherapy (PBRT):
77520, 77522, 77523, 77525

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

**Mastectomy for Gynecomastia - Effective 1/1/2018, upon group renewal
19300**

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

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: 0388T

Vagus Nerve Blocking Therapy: 0314T, 0315T

Rhinoplasty:

30410, 30420, 30435, 30450, 30460, 30462

Sacroiliac (SI) Joint Injection:

27096

Scoliosis Surgery:

22800, 22802, 22804, 22808, 22810, 22812, 22818, 22819, 22849, 22850

Septoplasty:

30520

Skin Repair/Reconstruction:

13151, 13152, 14060, 14061, 15120, 15260, 15576, 15630

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

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

Transcatheter Aortic-Valve Implantation for Aortic Stenosis:

33361, 33362, 33363, 33364, 33365, 33366 (Commercial Only)

Unicondylar Knee Replacement:

27446

Uterine Artery Embolization

37243

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

Cardiac Hemodynamic Monitoring

Corneal Collagen Cross-linking

Epidural Injections for Pain Management

Hyperbaric Oxygen Therapy (HBO)

Implantation of Intrastromal Corneal Ring Segments

Injectable Clostridial Collagenase for Fibroproliferative Disorders

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

Non-Contact, Non-thermal Ultrasound Treatment for Wounds

Orthognathic Surgery

Percutaneous Left Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation

Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary Dysfunction

Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors

Removal of Non-Covered Implantable Devices

Sacroiliac Joint Injection

Stereotactic Body Radiation Therapy

Varicose Vein Treatment

BlueCHiP for Medicare Only

Bariatric Surgery

Total Joint Arthroplasty – Hip and Knee

Vertebroplasty and Vertebral Augmentation (e.g. Kyphoplasty)

Xiaflex (Clostridial Collagenase)

The following policies follow Medicare Guidelines

Local Coverage Determination for Reduction Mammoplasty

PUBLISHED

Provider Update, February 2018

Provider Update, February 2017

Provider Update, November 2015

Provider Update, September 2014

REFERENCES

Not applicable

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