

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



**EFFECTIVE DATE:** 09|01|2015  
**POLICY LAST UPDATED:** 04|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

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)

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  
Exception: See separate policy "Hyperbaric Oxygen Therapy (HBO)" for diagnosis codes that do not 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

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

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

33340 **(Commercial Only)**

Percutaneous Tibial Nerve Stimulation (PTNS)  
64566

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

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: 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) 0388T (Code Deleted Effective 12/31/2018)**

**Sinus Tarsi Implant: 0510T (New Code Effective 1/1/2019)**

Vagus Nerve Blocking Therapy: 0314T, 0315T

**Wireless Cardiac Stimulation System for Left Ventricular Pacing: 0518T (New Code Effective 1/1/2019)**

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  
Percutaneous Tibial Nerve Stimulation (PTNS)  
Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors  
Removal of Non-Covered Implantable Devices  
Stereotactic Body Radiation Therapy  
Varicose Vein Treatment

### **BlueCHiP for Medicare Only**

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

## **PUBLISHED**

Provider Update, April 2019  
Provider Update, February 2019

Provider Update, February 2018  
Provider Update, February 2017  
Provider Update, November 2015

## REFERENCES

Not applicable

## FOR INTERNAL USE ONLY

### 2017 Preauthorization Requirement Changes

#### Angioplasty and Stent, Carotid

Effective 1/1/2017 – Code 35475 deleted (code deleted as of 12/31/2016)

#### Artificial Disc Replacement, Cervical

Effective 2/1/2017 – Preauth requirement added

#### Corneal Collagen Cross-linking

Effective 8/15/2017 – Preauth requirement added to Commercial products only

#### Endoscopic Antireflux Procedures

Effective 5/1/2017 – Preauth requirement removed

#### Enhanced External Counterpulsation (EECP)

Effective 5/1/2017 – Preauth requirement removed

#### Epidural Injections

Effective 1/1/2017

Codes 62310 and 62311 deleted (codes deleted as of 12/31/2016)

Codes 62321, 62323, 62325, 62327 added (new codes as of 1/1/2017)

Codes 62320, 62322, 62324, 62326 added (new codes as of 1/1/2017)

#### Implantable Cardioverter Defibrillator (ICD) Insertion

Effective 10/1/2017 - Preauth requirement removed from only: 33262, 33263, 33264

#### Interspinous Process Decompression

Effective 1/1/2017 – Preauth requirement removed

#### Mastectomy for Gynecomastia

Effective 1/1/2017 - Preauth requirement added, upon group renewal

#### Non-Contact, Non-Thermal Ultrasound Treatment for Wounds

Effective 3/1/2017 – Preauth requirement removed

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

Effective 1/1/2017

Code 0281T deleted (code deleted as of 12/31/2016)



Code 33340 added (new code as of 1/1/2017)

#### Removal of Non-Covered Implantable Devices

Aortic Counterpulsation Ventricular Assist System and components

Effective 1/1/2017 – Preauth requirement added

Artificial Intervertebral Disc

Effective 2/1/2017 – Preauth requirement removed only from code 22864

Bone Conduction Hearing Device

Effective 6/1/2017 – Preauth requirement removed

Chest Wall Respiratory Sensor Electrode

Effective 1/1/2017 – Preauth requirement added

Esophageal Sphincter Augmentation Device

Effective 1/1/2017

Code 0393T deleted (code deleted as of 12/31/2016)

Code 43285 added (new code as of 1/1/2017)

Interstitial Glucose Sensor

Effective 1/1/2017 – Preauth requirement added

Peripheral Subcutaneous Field Stimulator

Effective 1/1/2017 – Preauth requirement removed

Subcutaneous Implantable Cardioverter Defibrillator

Effective 4/1/2017 – Preauth requirement removed

Vagus Nerve Blocking Therapy

Effective 10/1/2017 - Preauth requirement added

Subcutaneous Implantable Cardioverter Defibrillator

Effective 4/1/2017 – Preauth requirement added to codes 33270, 33271, 33273 - for COMMERCIAL Products

Upper Gastrointestinal Endoscopy

Effective 5/1/2017 – Preauth requirement removed

#### 2018 Preauthorization Requirement Changes

Varicose Vein Treatment

Effective 1/1/2018 - Preauth requirement added to codes 36465, 36466, 36482 (new codes effective 1/1/18)

Radiofrequency Ablation of Misc Solid Tumors

Effective 1/1/2018 - Preauth requirement added to code 32994 for Medicare only (new code effective 1/1/18)

Injectable Clostridial Collagenase for Fibroproliferative Disorders

Effective 6/1/2018 - Preauth requirement for J0775 for Commercial moved to Prime.

Effective 6/1/2018 - Preauth requirement for 20527 for Commercial removed.

Effective 6/1/2018 - Preauth requirement for J0775 for Medicare moved to UM/Traditional method.

Effective 6/1/2018 - Preauth requirement for 20527 for Medicare removed.

Percutaneous Tibial Nerve Stimulation

Effective 9/1/2018 – Preauth requirement added to Commercial Products.

Transcatheter Mitral Valve Repair

Effective 11/1/2018 – Preauth requirement added to Commercial Products only.

### 2019 Preauthorization Requirement Changes

Removal of Non-Covered Implantable Devices

Permanent Leadless Pacemaker, Ventricular

Effective 1/1/2019

Code 0388T deleted (code deleted as of 12/31/2018)

Code 33275 added to Commercial Only (new code as of 1/1/2019)

Intracardiac Ischemia Monitoring System

Effective 1/1/2019 – Preauth requirement added

Sinus Tarsi Implant

Effective 1/1/2019 – Preauth requirement added

Wireless Cardiac Stimulation System for Left Ventricular Pacing

Effective 1/1/2019 – Preauth requirement added

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

Effective 2/1/2019 – Preauth requirement removed from Medicare

Capsule Endoscopy

Effective 1/1/2019 – Preauth requirement removed

Sacroiliac (SI) Joint Injection

Effective 1/1/2019 – Preauth requirement removed

Septoplasty

Effective 1/1/2019 – Preauth requirement removed

Skin Repair/Reconstruction

Effective 1/1/2019 – Preauth requirement removed

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