

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



EFFECTIVE DATE: 09|01|2015
POLICY LAST UPDATED: 12|17|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 2020 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

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

Corneal Collagen Cross-linking

0402T (Commercial Only)

Discectomy:

Lumbar: 22224, **62380**

Effective 2/1/2020, code 62380 will require authorization for BlueCHiP for Medicare and Commercial Products.

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, **C9757**

Effective 1/1/2020, code 62380 will require authorization for BlueCHiP for Medicare and Commercial Products.

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 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: 0530T, 0531T, 0532T

Neurostimulation System for Posterior Tibial Nerve: 0588T (Commercial Only) (New Code Effective 1/1/2020)

Neurostimulator System for Treatment of Central Sleep Apnea: 0428T, 0429T, 0430T

Occipital Nerve Stimulation: 64570

Permanent Cardiac Contractility System: 0412T, 0413T

Sinus Tarsi Implant: 0510T

Substernal Implantable Defibrillator: 0573T, 0580T (Commercial Only) (New Codes Effective 1/1/2020)

Transperineal Periurethral Balloon Continence Device: 0550T (Commercial Only) (New Code Effective 7/1/2019)

Vagus Nerve Blocking Therapy: 0314T, 0315T

Rhinoplasty:

30410, 30420, 30435, 30450, 30460, 30462

Scoliosis Surgery:

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

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)
Prior Authorization – Cardiology Services
Prostatic Urethral Lift
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

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REFERENCES

Not applicable

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