

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



EFFECTIVE DATE: 02|01|2023
POLICY LAST UPDATED: 10|19|2022

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.

MEDICAL CRITERIA

Generally, InterQual criteria, is used to determine medical necessity and is found in the online authorization tool. Medical necessity criteria from Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations (NCD/LCD) is used when applicable for Medicare Advantage Members to determine medical necessity of services 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 Medicare Advantage Plans 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

Medicare Advantage Plans 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.bcsri.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 2023 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

Balloon Dilation of the Eustachian Tube
69705, 69706

Balloon Ostial Dilation
31295, 31296, 31297, 31298

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
Revisonal Procedure: 43771, 43772, 43773, 43774, 43848
Roux-en-Y Gastric Bypass (RYGB): 43644, 43645, 43846, 43847
Sleeve Gastrectomy: 43775

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

19371 Effective 8/2/2021 Exception for code 19371: 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

Breast Reconstruction:

11920, 11921, 19316, 19324, 19325, 19340, 19342, 19350, 19357, 19361, 19364, 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

Cryosurgical Ablation of Miscellaneous Solid Tumors other than Renal, Liver and Prostate

32994

Discectomy:

Lumbar: 22224, 62380

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, C9757

High-Intensity Focused Ultrasound (HIFU) Treatment in Prostate Cancer

55880 (Medicare Advantage Only, Effective 8/01/2022)

Implantable Continuous Glucose Monitor (I-CGM)

0446T, G0308 (Medicare Advantage Only) - Effective 1/01/2023

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, Pelvis and Chest
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

Magnetic Resonance Imaging-Guided Focused Ultrasound

0398T (Effective 11/1/2021)

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)

Prostatic Urethral Lift

52441, 52442

C9739, C9740 (For Institutional Providers Only)

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

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

Removal and Replacement Joint Replacement (TJR):
Hip: 27132, 27134, 27137, 27138
Knee: 27486, 27487
Shoulder: 23470, 23472, 23473, 23474

Removal of Implantable Devices

Anterior Segment Intraocular Nonbiodegradable Drug-eluting System: 0661T

Aortic Counterpulsation Ventricular Assist System and components: 0455T, 0456T, 0457T, 0458T (Codes Deleted 12/31/2021)

Artificial Intervertebral Disc: 22865

Carotid Sinus Baroflex Activation Device: 0269T, 0270T, 0271T

Chest Wall Respiratory Sensor Electrode: ~~64584~~, 0468T (Code Deleted 12/31/2021)

Esophageal Sphincter Augmentation Device: 43285

Implantable Bone-Conduction and Bone-Anchored Hearing Aids: 69726, 69727

Interstitial Glucose Sensor: 0447T, 0448T, G0309 (New code effective 7/01/2022)

Intracardiac Ischemia Monitoring System: 0530T, 0531T, 0532T

Permanent Cardiac Contractility System: 0412T, 0413T, 0414T

Sinus Tarsi Implant: 0510T, 0511T

Stimulator Removal: 43648, 43882, 61880, 61888, 64570, 64584, 64595, 0314T, 0315T, 0428T, 0429T, 0430T, 0431T, 0588T, 0679T, 0682T

Substernal Implantable Defibrillator: 0573T, 0580T

Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome: 64584

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.

Stereotactic Radiation:
32701, 77373, 77435

Stimulator Insertion

Deep Brain Stimulation: 61885, 61886

Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea: 64582, 64583, Effective 8/01/2022). Refer to Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome in the Related Policies section for Commercial Products medical criteria. For Medicare Advantage Plans, please refer to the online authorization tool for medical criteria.

Percutaneous Tibial Nerve Stimulation (PTNS): 64566

Spinal Cord Stimulator (SCS): 63650, 63655, 63663, 63685

Stereotactic Introduction, Subcortical or Cortical Electrodes: 61885, 61886

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

Surgical and Debulking Treatments for Lymphedema
38999

15878, 15879 (with diagnosis code I89.0 or I97.2) (Effective 10/1/2021)

Total Joint Replacement (TJR):

Ankle: 27702

Hip: 27130, 27132

Knee: 27447

Ablative or Transarterial Therapy, Liver:

37242, 37243

Note: Effective 1/01/2023, when the CPT codes are being used for benign prostate hypertrophy treatment, refer to the Related Policies section below.

Exception: Prior Authorization for CPT code 37243 is 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)

Transurethral Water Vapor Thermal Therapy:

Medicare Advantage Only

53854 (Effective 7/1/2021)

Transurethral Water Jet Ablation (Aquablation):

(Medicare Advantage Only)

0421T (Effective 10/1/2021)

Tumor Treatment Fields Therapy

E0766

Unicondylar Knee Replacement:

27446

Uvulopalatopharyngoplasty (UPPP):

42145

Varicose Vein Treatment:
 36465, 36466, 36470, 36471, 36475, 36478, 36482, 37500, 37700, 37718, 37722, 37735, 37760, 37761, 37765, 37766, 37780, 37785, S2202
 36473 Medicare Advantage Only

RELATED POLICIES

Medicare Advantage Plans and Commercial Products

Anastomosis of Extracranial-Intracranial Arteries

Autologous Chondrocyte Implantation

Balloon Dilation of the Eustachian Tube

Cryosurgical Ablation of Miscellaneous Solid Tumors other than Renal, Liver and Prostate

Glucose Monitoring - Continuous

Implantation of Intrastromal Corneal Ring Segments

Infertility Services

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 Tibial Nerve Stimulation (PTNS)

Prostatic Artery Embolization (PAE) for Benign Prostatic Hyperplasia

Prostatic Urethral Lift

Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors

Removal of Non-Covered Implantable Devices

Stereotactic Body Radiation Therapy

Surgical and Debulking Treatments for Lymphedema

Tumor Treatment Fields Therapy

Varicose Vein Treatment

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Provider Update, June/December 2022

Provider Update, March, June 2021

Provider Update, March 2020

Provider Update, April 2019

REFERENCES:

Not applicable

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