Medical Coverage Policy | Preauthorization via Web-Based Tool for Procedures

EFFECTIVE DATE: 10|01|2015
POLICY LAST UPDATED: 12|01|2016

OVERVIEW
This policy documents the prior authorization request process for certain medical procedures, using the BCBSRI online prior authorization tool. Therapies such as PT/OT, speech and 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 4/1/2017, the services identified in blue will require preauthorization.
Effective 4/1/2017, the services identified in purple will no longer require preauthorization.

Effective 5/1/2017, the services identified in red will no longer require preauthorization.

Effective 6/1/2017, the services identified in brown will no longer require preauthorization.

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

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)

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

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

Endoscopic Antireflux Procedures:
43235

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

Enhanced External Counterpulsation (EECP):
G0166 (Medicare only))

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, 33262, 33263, 33264

Subcutaneous Implantable Cardioverter Defibrillator (S-ICD): (Medicare Only) 33270, 33271, 33273
Effective 4/1/2017, Subcutaneous Implantable Cardioverter Defibrillator (S-ICD) will require preauthorization for both 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

Injectable Clostridial Collagenase for Fibroproliferative Disorders:
20527, J0775

Intensity Modulated Radiotherapy: 77301, 77385, 77386, 77338, 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

Posterior Tibial Nerve Stimulation (PTNS) for Urinary Dysfunction:
64566 (Medicare 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, Total Joint Replacement (TJR):
Hip: 27132, 27134, 27137, 27138
Knee: 27486, 27487
Shoulder: 23470, 23472, 23473, 23474

Removal of Non-Covered Implantable Devices
Aortic Counterpulsation Ventricular Assist System and components: 0455T, 0456T, 0457T, 0458T
Artificial Intervertebral Disc: 22865
Bone Conduction Hearing Device: 69711
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
Subcutaneous Implantable Cardioverter Defibrillator: 33272 (Commercial Only)

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.

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

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

Upper Gastrointestinal Endoscopy:
43191, 43192, 43197, 43235

Uvulopalatopharyngoplasty (UPPP):
42145

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

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

RELATED POLICIES

Anastomosis of Extracranial-Intracranial Arteries
Autologous Chondrocyte Implantation
Cardiac Hemodynamic Monitoring

Enhanced External Counterpulsation (EECP)
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: Cancer of the Head, Neck or Thyroid
Intensity Modulated Radiotherapy: Central Nervous System Tumors
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
Posterior Tibial Nerve Stimulation (PTNS) for Urinary Dysfunction
Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors
Removal of Non-Covered Implantable Devices
Stereotactic Body Radiation Therapy
Varicose Vein Treatment

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REFERENCES

Not applicable