

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



EFFECTIVE DATE: 10|01|2015
POLICY LAST UPDATED: 09|01|2015

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. 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

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>

Medical Procedures are considered medically necessary when the criteria in the BCBSRI online prior authorization tool has been met.

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:

NOTE: Effective February 15, 2016, the services identified in blue font below will require prior authorization through the BCBSRI online prior authorization tool.

Anastomosis of Extracranial-Intracranial Arteries:
61711

Angioplasty and Stent, Carotid:
35475, 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

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.
62310, 62311, 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

Implantation of Intrastromal Corneal Ring Segments (Code Effective January 1, 2016):
65785

Injectable Clostridial Collagenase for Fibroproliferative Disorders:
20527, J0775

Integumentary Reconstruction:

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

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

Interspinous Process Decompression:
0171T (Medicare Only)

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

Lid Reconstruction:
67961, 67966, 67971, 67973, 67974, 67975

Non-Contact, Non-thermal Ultrasound Treatment for Wounds:
97610 (Medicare only)

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

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
Artificial Intervertebral Disc: 22864, 22865
Bone Conduction Hearing Device: 69711

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

Esophageal Sphincter Augmentation Device: 0393T

Gastric Electrical Stimulation: 43648, 43882, 64595

Neurostimulator System for Treatment of Central Sleep Apnea (Codes Effective January 1, 2016): 0428T, 0429T, 0430T

Occipital Nerve Stimulation: 64570

Peripheral Subcutaneous Field Stimulator: 0284T

Permanent Cardiac Contractility System (Codes Effective January 1, 2016): 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

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:

Echosclerotherapy: S2202

Endovenous Ablation: 36475, 36478

Ligation/Excision with or without Stripping: 37700, 37718, 37722, 37735, 37760, 37761, 37780, 37785

Sclerotherapy: 36470, 36471

Stab Phlebectomy: 37765, 37766

Vascular Endoscopy: 37500

RELATED POLICIES

Anastomosis of Extracranial-Intracranial Arteries

Autologous Chondrocyte Implantation

Cardiac Hemodynamic Monitoring

Enhanced External Counterpulsation (EECP)

Hyperbaric Oxygen Therapy (HBO)

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

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

PUBLISHED

Provider Update, November 2015

Provider Update, September 2014

REFERENCES

Not applicable

CLICK THE ENVELOPE ICON BELOW TO SUBMIT COMMENTS

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

