



<b>UM-22 Prior Authorization Code List</b>	
<b>Department:</b> Utilization Management	<b>Original Issue Date:</b> 12/02/2021
<b>Approver:</b> UM Committee <b>Date Approved:</b> 07/01/2024	<b>X</b> <b>Date Last Reviewed / Revised</b> <u>06/25/2024</u> <b>OR</b> <b>Date Last Reviewed / No Revisions</b> <b>OR</b> <b>New Requirements</b>
<b>Dependencies:</b> • <i>Claims</i>	<b>Original Effective Date:</b> 01/01/2023 <b>Revised Effective Date:</b> 07/01/2024

**I. GENERAL INFORMATION**

This list provides prior authorization guidance for providers who participate in the Mass Advantage Medicare PPO, HMO Basic, and HMO Plus plans.

- To request prior authorization, please complete and submit the [Inpatient Authorization Request Form](#) or [Outpatient Authorization Request Form](#) via fax, or call 888-656-7783.
- Member eligibility and benefit coverage can be verified by contacting Provider Services or electronically on the secure Provider website.
- Prior Authorization is not required for emergency or urgent care, but inpatient stays require notice of admission (NOA) within 24 hours.
- Obtaining a prior authorization is not a guarantee of payment. In addition, while some providers may not be directly responsible for obtaining prior authorization, in some instances as a condition for payment, you may need to make sure that prior authorization has been obtained.
- New CPT/HCPCS codes approved by AMA that are like existing services listed below will automatically require prior authorization prior to policy update.
- As a Medicare Advantage plan, Mass Advantage is required to make coverage determinations for services through the Centers for Medicare and Medicaid Services (CMS) National Coverage Determination (NCD) policies and Medicare Administrative Contractors (MACs) Local Coverage Determination (LCD) policies. When cited by CMS, NCDs, LCDs, and Original Medicare guidance in Medicare manuals are utilized for decision making. When CMS citations are unavailable, we will follow a Hierarchy of Evidence for Medical Necessity Decisions, including, but not limited to, MCG guidelines.

**II. PRIOR AUTHORIZATION IS REQUIRED FOR SOME ITEMS WITHIN THE SERVICE CATEGORIES BELOW.**

1. Scheduled Inpatient Hospitalizations for Medical or Psychiatric stays; Rehabilitation, Skilled Nursing Facility stays
2. Transplants
3. Hospital Outpatient Services: Observation Stay.
4. Hospital Outpatient Services: Outpatient Surgery
5. Rehabilitation: Cardiac/Pulmonary, Occupational Therapy
6. Medicare Part B Prescription Drugs
7. Outpatient Diagnostic Procedures and Tests
8. Ambulance Services: Land, Air, Water
9. Prosthetics and Orthotics: Medicare allowable exceeding \$500
10. DME: Medicare allowable exceeding \$500

<b>Inpatient Hospitalizations for Acute, Psychiatric, Rehabilitation, and Skilled Nursing Facility stays and Partial Hospitalization Stays</b>	
<b>Services</b>	<b>Requirement</b>

<i>Inpatient Acute Hospitalization and Acute Psychiatric Hospitalization</i>	<ul style="list-style-type: none"> <li>All Non-Emergent/Urgent Stays require Prior Authorization</li> <li>Emergent/Urgent stays require Notice of Admission within 24 hours of admission.</li> </ul>
<i>Long Term Acute Care Hospitalization (LTACH)</i>	All Stays require Prior Authorization
<i>Partial Hospitalization</i>	All Stays require Prior Authorization
<i>Skilled Nursing Facility</i>	All Stays require Prior Authorization
<i>Inpatient Rehabilitation Hospitalization</i>	All Stays require Prior Authorization
<b>Transplants</b>	
<b>Services</b>	<b>Requirement</b>
<i>Transplant Inpatient Hospitalization</i>	Prior Authorization required at the time of transplant listing
<b>Outpatient Hospital Services - Observation</b>	
<b>Services</b>	<b>Requirement</b>
<i>Observation Stay</i>	<ul style="list-style-type: none"> <li>All Stays require Prior Authorization, may be requested via Notice of Admission (NOA) within 24 hours.</li> <li>Stay may be denied if NOA not received within 24 hours</li> </ul>
<b>Outpatient Hospital Services – Outpatient Procedures</b>	
<b>Services - Outpatient Surgery and Procedures</b>	<b>Requirement – Procedure CPT/HCPCS and description*</b>
<i>Hip /Knee /Shoulder Arthroplasty</i>	23472, 23473, 23474, 27125, 27130, 27132, 27134, 27137, 27138, 27437, 27438, 27440, 27441, 27442, 27443, 27444, 27445, 27446, 27447, 27486, 27487
<i>Sleep Apnea Procedures</i>	21685, 41512, 41530, 41599, 42145
<i>Attended Sleep Testing Procedures</i>	95806, 95807, 95808, 95810, 95811
<i>Blepharoplasty</i>	15820, 15821, 15822, 15823, 67900, 67901, 67902, 67903, 67904, 67906, 67908, 67909, 67911, 67914, 67915, 67916, 67917, 67921, 67922, 67923, 67924, 67930, 67935, 67938, 67950, 37961, 37966, 37971, 37973, 37974, 37975, 60799
<i>Abdominoplasty</i>	15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15847, 15876, 15877, 15878, 15879, 17999, 15877
<i>Aortic, Implants, etc.</i>	33875, 33877, 33880, 33881, 33883, 33886, 34701, 34702, 34703, 34704, 34705, 34706, 34830, 34831, 34832, 34841, 34842, 34843, 34845, 34846, 34847, 34848
<i>Bunionectomy/Hammertoe</i>	28296, 28297, 28298, 28299, 28306, 28308, 28310, 28740, 28750, L8641, 26535, 26536, 28110, 28240, 28285, 28289, 28291, 28292, 28295
<i>Rhinoplasty, Septoplasty</i>	30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, 30468, 20912, 21210, 30465, 30520, 30620

	20999, 22100, 22101, 22102, 22103, 22116, 22206, 22207, 22208, 22210, 22212, 22214, 22216, 22222, 22226, 22510, 22511, 22512, 22513, 22514, 22515, 22526, 22527, 22532, 22533, 22534, 22548, 22551, 22552, 22554, 22556, 22558, 22585, 22586, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22633, 22634, 22800, 22802, 22804, 22808, 22810, 22812, 22818, 22819, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 22853, 22854, 22856, 22857, 22858, 22859, 22861, 22862, 22867, 22868, 22869, 22870, 22899, 27279, 27280, 62287, 62380, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63050, 63051, 63052, 63053, 63054, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102, 63103, 63170, 63172, 63173, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200, 63250, 63251, 63252, 63265, 63266, 63267, 63268, 63270, 63271, 63272, 63273, 63275, 63276, 63277, 63278, 63280, 63281, 63282, 63283, 63285, 63286, 63287, 63290, 63295, 63300, 63301, 63302, 63303, 63304, 63305, 63306, 63307, 63308, 0095T, 0098T, 0163T, 0164T, 0165T, 0202T, 0219T, 0220T, 0221T, 0222T, 0274T, 0275T, 0656T, 0657T, C1821, C2614, C9757, S2348, S2350, S2351
<i>Spinal Fusion, Kyphoplasty, Decompression, Vertebroplasty</i>	
<i>Varicose Veins</i>	36465, 36466, 36468, 36470, 36471, 36473, 36474, 36475, 36476, 36478, 36479, 36482, 36483, 37500, 37700, 37718, 37722, 37735, 37760, 37761, 37765, 37766, 37780, 37785, 0524T, S2202
<i>Bariatric Surgery/Gastric restrictive procedures</i>	43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43775, 43845, 43846, 43847, 43848, 43886, 43887, 43888
<i>Dermabrasion</i>	15780, 15781, 15782, 15783
<i>Chemical peel</i>	15788, 15789, 15790, 15791, 15792, 15793
<i>Laser treatment</i>	96920, 96921, 96900, 96910, 96567
<i>Temporomandibular joint arthroplasty, reconstruction, prosthesis</i>	21010, 21050, 21060, 21073, 21085, 21089, 21116, 21240, 21242, 21243, 21480, 21485, 21490, 29800, 29804
<i>Botox (botulism injection) for head/face and migraine</i>	64612, 64615
<i>Cervical fusion with disc removal</i>	22551, 22552
<i>Implanted spinal neurostimulator</i>	63650, 63655, 63661, 63662, 63663, 63664
<i>Any other implanted stimulator (deep brain, sleep apnea, gastric, sacral nerve, vagus nerve)</i>	Gastric: 64590, 64595 Deep brain: 61880 Sleep apnea hypoglossal: 64568 Sacral nerve: 64561, 64581 Others: 61885, 64553, 64555, 64569, 64570, 64575, 64585, 64999
<i>Cochlear implant</i>	69930, 69949
<b>Rehabilitation: Cardiac/Pulmonary</b>	
<b>Services</b>	<b>Requirement</b>
<i>Cardiac/Pulmonary Services</i>	G0422, G0423, G0433, 93668 (SET), 93737, 93798, 94625, 94626
<b>Medicare Part B Prescription Drugs</b>	
<b>Services</b>	<b>Requirement</b>
<i>Part B Prescription Drugs</i>	C9166, C9167, C9168  J0129, J0172, J0174, J0177, J0179, J0185, J0178, J0490, J0517, J0585, J0717, J0881 (non-ESRD use), J0885 (non-ESRD use), J0586, J0587, J0897, J0588, J0589, J0596, J0597, J0598, J1202, J1203, J1290, J1300, J1302, J1303,

	J1323, J1439, J1459, J1561, J1568, J1569, J1602, J1745, J2277, J2323, J2327, J2350, J2356, J2357, J2469, J2506, J2777, J2778, J2782, J3032, J3055, J3111, J3262, J3358, J3380, J3396, J3489, J7170, J7320, J7321, J7322, J7323, J7324, J7325, J7326, J7327, J7328, J9022, J9034, J9035, J9041, J9144; J9145 (IV), J9173, J9217, J9228, J9248, J9249, J9264, J9271, J9299, J9305, J9306, J9312, J9355, J9376,  Q5101, Q5103, Q5104, Q5108, Q5111, Q5103, Q5106 (non-ESRD use), Q5107, Q5112, Q5113, Q5114, Q5115, Q5116, Q5117, Q5118, Q5119, Q5121, Q5124, Q5126, Q5128, Q5129
<b>Outpatient Diagnostic Procedures and Tests:</b>	
<b>Services</b>	<b>Requirement</b>
<i>Genetic Testing</i>	All Services require Prior Authorization
<i>Molecular Pathology</i>	All Services require Prior Authorization
<i>Transthoracic Echocardiogram</i>	93303, 93304, 93305, 93307,93308, 93320, 93321, 93322
<i>Heart Catheterization</i>	93452, 93454, 93455, 93456,93457, 93458, 93459, 93460, 93461, 93462, 93463, 93464, 93465, 93466, 93467, 93468, 93453
<i>Stress Echocardiogram</i>	93350, 93351, 93320, 93321, 93325, 93352
<i>CTA Coronary Arteries</i>	75574
<i>Cardiac Resynchronization Therapy</i>	33221, 33224, 33225, 33231
<b>Ambulance Services: Land, Air, Water</b>	
<b>Services</b>	<b>Requirement</b>
<i>Emergent Transport</i>	No Prior Authorization required.
<i>Non-Emergent Transport</i>	No Prior Auth required for non-emergent facility-to-facility transport less than 50 miles with origin/destinations: EH, HE, EN, NE, HH, HN, NH, SH Prior Auth required for all other Non-Emergent Transports including Facility to Facility over fifty (50) miles.
<b>Prosthetics and Orthotics</b>	
<b>Services</b>	<b>Requirement</b>
<i>Prosthetics and Orthotics</i>	Requires Prior Authorization for any single item with a Medicare allowable amount of over \$500
<b>Durable Medical Equipment (DME)</b>	
<b>Services</b>	<b>Requirement</b>
<i>Durable Medical Equipment</i>	Requires Prior Authorization for any single item with a Medicare allowable amount of over \$500

## VIII. VERSION AND REVIEW HISTORY:

<b>Version #</b>	<b>Action (Original Issue, Reviewed, Revised)</b>	<b>Date Action Taken</b>	<b>Brief Summary of Revision, if applicable</b>	<b>Individual Taking Action</b>	<b>Effective Date</b>	<b>Date Approved and By Whom</b>
1	Original Issue	10/01/2023	NA	Melissa Whitley	01/01/2024	UM Committee 10/01/2023
2	Revised	04/01/2024	New codes added for quarterly code release.	Melissa Heath, RN	04/01/2024	UM Committee 04/01/2024
3	Revised	07/01/2024	Removed home health and dialysis prior authorization requirements.	Melissa Heath, RN	07/01/2024	UM Committee 07/01/2024
4	Revised	07/31/2024	Removed home infusion prior authorization requirements.	Melissa Heath, RN		