MDwise
COMMUNITY HEALTH NETWORK

MDwise Community Health Network Hoosier Healthwise Medical Services that Require Prior Authorization

Medical services that require Prior Authorization

Type of Service	Requires PA	Coding
All Out of Network services	Yes	With the exception of ER, Ambulance, Urgent Care Center services, Immunizations, Family planning services, chiropractic services, podiatry, and ologists, except if service is otherwise listed on PA list.
Facility to facility ambulance transport (non-emergent transport)	Yes	A0426 & A0428
Air Ambulance	Yes	A0430, A0431, A0435, A0436
Elective/emergent/urgent medical, surgical inpatient admissions, and skilled nursing facility services	Yes	POS 21, 51, 61, 31 **Maternity stays are notification only and no prior authorization number is issued.**
Inpatient Rehabilitation	Yes	POS 21 or 61 and accommodation codes 024, 931-932 POS 21 or POS 61. Revenue code 024
Subacute admission	Yes	POS 21
Transplants	Yes including the work up/ evaluation for transplant	POS 21 - For outpatient need to have the following: S9975, Solid: Heart/lung: 33930 - 33945 Liver: 47133 - 47147 Pancreas: 48550 - 48556 Bone Marrow: 38240, -38242 Heart valve tissue transplants: 33933, 33944 Stem cell:38204-38215, 38221, 38230, 38231, 38232 Pancreas: 48550-48556 Intestine: 44132-44137, 44715-44721
Bariatric Surgery	Yes	Roux-en-Y:43644, 43846 Gastroplasty: 43842, 43843 Gastric banding sleeve: 43770 - 43774 Gastrectomy: 43644, 43847, 43848, 43886, 46887, 43888 Duodenal switch: 43845 43645, 43775, 43844, 43999
Cochlear Implants surgery (See DME for device)	Yes	69930
General anesthesia for dental procedures	Yes	D9210 - D9248

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Type of Service	Requires PA	Coding
Hysterectomy	Yes	51925, 58150-58294, 58541-58951, 58952-58956
Mastectomy reconstructive surgery	Yes	Same as breast reconstruction below
Maxillofacial surgeries/TMJ -including Arthroplasty, Arthroscopy, Reconstruction, Discectomy (with or without disc replacement), trigger point injections, Arthrocentesis, and mandibular orthopedic repositioning appliances (MORA)	Yes	21010, 21025, 21026, 21050, 21060, 21070, 21073, 21116, 21193-21196, 21240-21249, 21255, 29800, 29804, S8262
Non-cosmetic reconstructive surgery	Yes	11200, 11201, 11920-11922, 11950-11954, 15775, 15776, 15780-15839, 15847, 15876-15879, 17106-17108, 19300, 19316-19396, 21740-21743, 30520, 36468-36471, 37785, 40650-40761, 42200-42281, 54660, 67900-67972, 67730, 67974, 67975, 69300, S2066, S2067,S2068, 19301-19307, 37799
Breast congenital anomaly (i.e. polymastia)	Yes	Included in Breast Reconstruction
Breast enlargement (same as Augmentation)	Yes	Same as Augmentation above
Congenital craniofacial anomaly surgery	Yes	Included in Maxillofacial above
Tonsillectomy & Adenoidectomy	Yes	42820, 42821, 42825, 42826, 42830, 42831, 42835, 42836
Uvulopalatoplasty including laser assisted	Yes	42145
Home health services	Yes	POS 12 with the following codes: G0151, G0152, G0153, G0155, 99600, 99600 TE, 99600 TD, 99601, 99602, 92610, S9349, S9127, 97001, 97003, 92521-24 - Initial evaluation codes for PT, OT, ST in home and all subsequent therapy visits in home requires PA.
Home oxygen	Yes	A4615, A4616, A7046, E0424, E0425, E0426-E0463, E1352-E1392, E1405, E1406, K0738
Hospice (inpatient and outpatient)	Yes	All POS 34, For POS 12, the following should pend: 651, 652, 655 and 656 with HCPCS codes Q5001-Q5010
Nutritionals and Supplements, Enteral/ Parenteral Nutrition and services	Yes, regardless of total claim cost	B4034 -B9998

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Type of Service	Requires PA	Coding
Outpatient ST/OT/PT	The initial evaluation does not require prior auth. Prior authorization is required for services exceeding the 12 visits per discipline within a calendar year	PT - Revenue codes - 420, 421, 422, 423, 429, and 97002, 97004, 97029- 97546, 97750-97762 OT - Revenue codes 430-433, 439 ST - Revenue codes 440,-443, 449, 92507, 92508, 92520, 92521, 92522, 92523, 92524, 92525, 92526
Outpatient Pulmonary rehab	Yes	G0237 - G0239 99 HX G0424 - G0424 99 HX G0237-G0239, 948, G0424
Cochlear Implants (device)	Yes	L8614- L8619
Durable Medical equipment	Yes all DME and supplies >$500 (total claim) including rental or purchase requires prior authorization	ALL DME codes. Please also refer to the orthotics category of this document for other items that may be considered DME that require prior authorization.
Electric breast pump	Yes, rental or purchase of $500 or more per claim	
Hearing Aids	Yes	Left and Right ear- V5030, V5040, V5050, V5060, V5070, V5080, V5095, V5100, V5120, V5130, V5140, V5150, V5170, V5180, V5190, V5210, V5220, V5230, V5242, V5243, V5244, V5245, V5246, V5247, V5248, V5249, V5250, V5251, V5252, V5253, V5254, V5255, V5256, V5257, V5258, V5259, V5260, V5261, V5263, V5267 Bilateral- V5100, V5120, V5130, V5140, V5150, V5248, V5249, V5250, V5251, V5252, V5253, V5258, V5259, V5260, V5261
Orthotics	Yes for orthotics of $250 or more	L0100-L4631
Prosthetics	Yes of $500 or more per claim	L5000–L9900
TENS (see pain management)	Yes	A4556, A4557, A4558, A4595, A4630, E0720, E0730, E0731, A4290
Bone Density study for members under 65 years of age	Yes	G0130 - G0130 99 HX 76977 - 76977 99 CP 77078 - 77086 99 CP 78350 - 78351 99 CP
Botox Injections	Yes	J0585, J0586, J0587, J0588 Please refer to worksheet titled Drugs requiring PA

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Type of Service	Requires PA	Coding
Clinical trials for cancer treatment	Yes	
Dialysis	Yes	Rev codes 082x, 083x, 084x-, 085x
Genetic testing	Yes	81228, 81229, 88230, 88367, 88291, 80502, 88262, 88289, 88230, 72090, 77072
Hyperbaric oxygen	Yes	413 99183 C1300, A4575, E0446
PET Scan- All	Yes	404, G0219,G0220, G0221, G0222, G0223, G0224, G0225, G0226, G0227, G0228, G0229, G0230, G0231, G0232, G0233, G0234, G0235, 78459, 78491, 78492, 78608, 78609, 78811, 78812, 78813, 78813, 78814, 78815, 78816
MRA- ALL	Yes	74185, 73225, 71555, 70544, 70545, 70546, 73725, 70547, 70548, 70549, 72198, 72159 (billed under MRI revenue codes)
MR Spectroscopy	Yes	76390
MRI- Abdomen	Yes	74181, 74182, 74183
MRI - Pelvis	Yes	72195, 72196, 72197
MRI - Lower Extremity	Yes	73718, 73719, 73720, 73721, 73722, 73723
MRI- 3D	Yes	76376-76377
MRI - Brain	Yes	70551, 70552, 70553, 70554, 70555, 70556, 70557, 70558, 70559
MRI - chest	Yes	71550, 71551, 71552, 71555
MRI - Cervical, Thoracic, lumbar spine	Yes	72141, 72142, 72143, 72144, 72145, 72146, 72147, 72148, 72149, 72150, 72151, 72152, 72153, 72154, 72155, 72156, 72157, 72158,
MRI - Breast	Yes	77058 - 77059
CT scan - Cervical, Thoracic, lumbar spine	Yes	72125-72133
CT scan -Thorax	Yes	71250-71275
CT-Scan -Abdomen	Yes	74150 - 74178
CT scan - maxillofacial	Yes	70486, 70487, 70488
CT Scan -Pelvis	Yes	72191, 72192, 72193, 72194
3D CT scans	Yes	77061, 77062, 77063, 76376-76377
Podiatry	Yes after 6 visits	Podiatry visits require prior authorization AFTER the 6th visit. All services rendered during the visit unless otherwise noted on this prior authorization list are included in the visit limit without authorization
Pulse generator	Yes	61885-61886

Type of Service	Requires PA	Coding
The following radiation therapy requires prior auth: IMRT	Yes	77385 and 77386
Vision training therapy	Yes	92065
Routine OB Ultrasounds	Yes, more than 2 OB ultrasounds require prior authorization	76801-76817 with Diagnosis codes Z34.00, Z34.80, Z34.90, Z33.1, O09.00-O09.93, Z36, O00-O99, P05.00-P05.9
PICC line insertion for OB services (i.e. hyperemesis gravidarum)	Yes	36569 with diagnosis of O21-O21.8, O20-O21.9, O44-O47, O67-O6
Pain management- including trigger point injection, facet joint and/or facet joint nerve injection, Epidural steroid injection, transcutaneous electric nerve stimulator	Yes the following require prior authorization (TENS)	A4556,-A4558, A4595, A4630, E0720, E0730, E0731, A4290, 64490-64495, 62310, 62311, 64479-64484, 72275, 77003, 64550,-64581, 61850-61888, 64561, 64581, E0744-E0749, E0762, E0766, L8679-L8695
Sacral nerve, Neuro or Spinal Cord stimulator	Yes	64553, 64454, 64455, 64565 (for implant) 43647, 43881(for electrodes) "
Behavioral Health	Yes	PA requirements as outlined on the following pages.

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Behavioral Health Services that Require PA

MDwise BH contracted providers - outpatient prior authorization requirements for Hoosier Healthwise only.

Service Type	PA Requirements
Psychiatric Diagnostic Interview CPT code 90791 or 90792 (Interactive Interview)	1 unit per member, per billing provider, per rolling 12-months allowed with no PA. 2 units are allowed without PA when member is separately evaluated both by a physician, an advanced practice nurse or HSPP and another mid-level practitioner.
Therapy Services CPT code: 90832 Psytx Office 30 min 90834 Psytx Office 45 min 90837 Psytx off. 60 min 90846 Family medical psychotherapy 90847 Family Psytx conjoint 90853 Group Psychotherapy	No PA is required for contracted providers. Interactive Complexity (CPT code 90785) is an add-on code to this CPT group and does not require a separate authorization.
Medication Management 99201-99205, new patient, office 99211-99215, existing patient, office PA is not required for CPT codes 99201-99203, 99211-99215, 99241-99242, 99244-99245 (contracted providers only)	PA not required for contracted providers. Interactive Complexity (CPT code 90785) is an add-on code to this CPT group and does not require a separate authorization. For non-contracted IHCP phsychiatrists, PA required after 30 visits
Therapy visits with E/M: 90838 Interactive Psytx w/medical EM 60 min	PA is not required for contracted providers.
Multi-Family Group Therapy 90849	PA not required for contracted providers.
Psychoanalysis 90845	Requires PA
Office Patient Visits and Consultations: 99204- 99205 New patient visits 99214-99215 Established patient visits	PA is not required for contracted providers.
Psychological Testing: 96101 Psychological Testing, per hour of the Psychologist or Physicians time, face to face time 96102 Psychological Testing administered by technician, per hour of time face to face 96111 Developmental Test, Extensive 96116 Neurobehavioral Status, 96118 Neurobehavioral Test by Psych 96119 Neuropsychological testing per hour of technician time, face to face	Requires PA Please note: If PA is given for 96101 the PA would also apply to 96102. If PA is given for 96118 the PA would also apply to 96119. CPT Code 96110 – Developmental Test, w/Interpretation & Report does not require a PA.

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Service Type	PA Requirements
Electroconvulsive Therapy ECT - 90870	Requires PA. Anesthesia (CPT code 00104) and outpatient facility (i.e., observation room) may also be provided. If ECT authorized, anesthesia/anesthesia provider and facility service to be authorized.
Health and Behavior Assessment: PA is required for persons with Autism Spectrum Disorder Diagnosis. Authorizations are to be given in accordance with treatment plan which can only be required every 6 months. 96151 Assess health/behavior, subsequent 96152 Intervene health/behavior, initial 96153 Intervene health/behavior, group 96154 Intervene health/behavior, family W/E&M 96155 Health/behavior family, no intervention	Does not require PA except when used with ASD diagnosis for ABA services. PA is required for persons with Autism Spectrum Disorder Diagnosis (ICD-9 codes 299.0, 299.8, ICD-10 codes F84.0 or F84.9). Authorizations are to be given in accordance with treatment plan which can only be required every 6 months.
Cognitive Skills Development - 97532	Requires PA.
Screening & Brief Intervention Services (SBI) - Drug/Alcohol Abuse: 99408 Alcohol &/or SA structured SBI 15-30 min 99409 Alcohol &/or SA SBI greater than 30 min	PA not required for one 99408 or 99409 per member, per contracted billing provider. PA is required for non-contracted providers, except if provided as emergency service. SBI services are not typically billed by behavioral health clinics as screening and interventions are already include in behavioral health assessment/treatment CPT codes.
Partial Hospitalization Services H0035 Partial Hospitalization Services	Requires PA
Smoking Cessation Treatment Services S9075 Smoking Cessation Treatment Services	PA is not required. Benefit maximum - one 12-week course of treatment per member per calendar year.

Non-contracted BH providers - outpatient prior authorization requirements.
*Except for the following self-referral services for any non-contracted IHCP enrolled Psychiatrist, all outpatient BH services provided by non-contracted behavioral health providers require PA. This includes observation stays.

Service Type	PA Requirements
Self-Referral Services for non-contracted IHCP Psychiatrist: 90791 Psychiatric Diagnostic Interview 90792 Interactive Psychiatric Diagnostic Interview 90832-90838 Individual Psychotherapy 90845 Psychoanalysis 90846-90853 Family/Group Psychotherapy 96151-96153 Health/Behavior Assessment Codes	Members may see any non-contracted IHCP enrolled psychiatrist for 20 visits, per rolling 12 months without PA. Per billing provider, this includes (in combination): 90791, 90792, 90832-90838, 90845 –90853, & 96151 – 96153. PA is required for additional visits. See NOTE below for authorization application guideline.

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Behavioral Health Professional Services During Medical/Surgical Stay

Service Type	PA Requirements
Diagnostic Interview CPT codes 90791 or 90792	PA is not required per inpatient episode of care.

Inpatient Services: With the exception of emergency admissions, prior authorization is required for any psychiatric admission stay, including admissions for substance abuse and nursing facility stays.

Please note: For services requiring authorization, authorizations provided for a higher level code may be applied to the claim submitted by that provider with a lower level code, rather than denying the lower level code for no authorization. For example, in the event an authorization is given for a more involved visit, i.e., 90837, but in turn, a claim is submitted with CPT code 90832 or 90834, the claim would be paid on the 90837 authorization rather than denied for no authorization.