Authorization and Notification Requirements – Effective June 1, 2025

Authorization and Notification Requirements

Aspirus Health Plan requires that providers obtain prior authorization/notification for the services addressed below. This list contains prior authorization (PA) and notification requirements for inpatient and outpatient services, as referenced in the Aspirus Health Plan Provider Manual. PA does not guarantee payment. To request PA or to submit a notification, complete the appropriate request form with supporting clinical documentation as needed and submit by fax or e-mail to Aspirus Health Plan according to the return information noted on each form.

Upcoming changes to PA requirements are published in the quarterly Provider Newsletters, which are part of the Aspirus Health Plan Provider News Library.

The CPT/HCPCS codes listed are included for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.

Important Information

- Allow up to 14 calendar days for a non-urgent authorization decision.
- All services are subject to member eligibility and benefit coverage.
- For services that require authorization, failing to obtain the authorization in advance may result in a denied claim.
- If you are not able to obtain services in your network, you may submit a network exception request prior to services.
- Inclusion or exclusion of a code listed does not constitute or imply member coverage or provider reimbursement.
- Providers may request a copy of the criteria used to make a medical necessity determination on Aspirus Health Plan's Authorization page.
- Provider of Service qualifications, eligibility and licensure requirements must be met to provide services and submit claims to Aspirus Health Plan.
- Not all plans offer out-of-network benefits. Call the Aspirus Provider Assistance Center at 715.631.7412 or 855.931.4851 toll-free for questions related to member eligibility, benefits and network status.

Authorization and Notification Forms

- Aspirus Health Plan Authorization and Notification Forms

Prescription Drugs and Medical Injectable Drugs

- The Medical Drug Policy library is a list of medical injectable drugs that require prior authorization and the policies that contain coverage criteria.
- The formulary indicates drugs that are covered under the pharmacy benefit. Formularies are available on the Formulary page.

Delegated Services

Aspirus Health Plan's Authorization page provides information on how to request authorization for the following services. Unless otherwise noted within delegated services, Aspirus Health Plan is the contract resource for all authorization service requests, concerns and questions.

- Chiropractic
- Dental
- Pharmacy

Requirement Definitions

APPROVAL AUTHORITY	Aspirus Health Plan, or an organization delegated by Aspirus Health Plan, to approve or deny prior authorization requests.
NOTIFICATION	The process of informing Aspirus Health Plan, or delegates of Aspirus Health Plan, of a specific medical treatment or services prior to, or within a specified time period after, the start of the treatment or service.
PRIOR AUTHORIZATION	An approval by an approval authority prior to the delivery of a specific service or treatment. Prior authorization requests require a clinical review by qualified, appropriate professionals. This is to determine if the service or treatment is medically necessary, an eligible expense, appropriate and that other alternatives have been considered.

Notification Only Requirements

SERVICE CATEGORY	REQUIREMENTS
Inpatient Hospital Notifications: - Acute Inpatient Medical Admissions - Inpatient Mental Health Admissions - Inpatient Substance Use Disorder Admissions	- Notification within 24 hours of admission. - Discharge summary to be sent within 72 hours of discharge. - Fax information for Acute Inpatient Medical Admissions to 715.787.7316. - Fax information for Inpatient Mental Health Admissions and Inpatient Substance Use Disorder Admissions to 715.787.7314.

Authorization Requirements

SERVICE CATEGORY	REQUIREMENTS	CODE REQUIRING AUTHORIZATION CPT OR HCPC CODES	MEDICAL NECESSITY CRITERIA
Acute Inpatient Rehabilitation	Notification required within 24 hours of admission. Concurrent review required for additional days. Discharge summary required to be sent upon discharge.	N/A	**InterQual LOC Rehabilitation:** Appropriate subset will be chosen based on the reason and diagnosis for acute inpatient rehabilitation admission **Medicare Benefit Policy Manual:** Chapter 1 Inpatient Hospital Services Covered Under Part A
Back (Spine) Surgery	Prior authorization required prior to service. **Authorization is not required for:** - Emergency surgery for trauma - Acute transverse myelopathy - Tumors - Cervical and Thoracic Back Surgery	22533, 22534, 22558, 22585, 22586, 22612, 22614, 22630, 22632, 22633, 22634, 22808, 22810, 22812, 22840, 22841, 22842, 22843, 22844, 27279, 27280, 64628, 64629	**InterQual Medicare Procedures:** Minimally Invasive Sacroiliac (SI) Joint Fusion **InterQual Care Plan (CP) Procedures:** Lumbar Spinal Fusion Decompression +/- Fusion, Lumbar Neuroblation, Percutaneous **Medicare Local Coverage Determination (LCD):** Minimally invasive Surgical (MIS) Fusion of the Sacroiliac Joint L36406
Bariatric Surgery (Gastric Bypass)	Prior authorization required prior to service.	43644, 43645, 43770, 43773, 43775, 43842, 43845, 43846, 43847, 43848	**InterQual Medicare Procedures:** Bariatric Surgery **Medicare National Coverage Determination (NCD)**: Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity (100.1)

SERVICE CATEGORY	REQUIREMENTS	CODE REQUIRING AUTHORIZATION CPT OR HCPC CODES	MEDICAL NECESSITY CRITERIA
Cosmetic Procedures Examples include: • Abdominoplasty • Blepharoplasty/ Blepharoptosis • Breast reduction surgery • Gynecomastia • Mammoplasty • Panniculectomy • Removal of breast implant(s) or replacement of breast implants • Rhinoplasty or Septorhinoplasty • Skin peel(s) See also: Orthognathic surgery	Prior authorization required prior to service. **Note:** Photographs are not required to be submitted when requesting authorization for cosmetic/reconstructive surgeries. If Aspirus Health Plan determines photographs are needed, the Utilization Review Specialist will call to request them. **Authorization is not required for** breast reconstruction associated with breast cancer	11960, 15780, 15781, 15782, 15783, 15786, 15787, 15820, 15821, 15822, 15823, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15877, 15878, 15879, 17106, 17107, 17108, 17340, 17360, 17380, 19300, 19316, 19318, 19325, 19328, 21137, 21138, 21139, 21172, 21175, 21179, 21180, 21181, 21182, 21183, 21184, 21208, 21209, 21230, 21248, 21249, 21255, 21256, 21260, 21261, 21263, 21267, 21268, 21270, 21275, 21295, 21296, 30120, 30400, 30410, 30420, 30430, 30435, 30450, 30540, 30545, 30560, 30620, 40500, 67900, 67901, 67902, 67903, 67904, 67906, 67908, 67912, 69090, 69300, 69320	**InterQual Medicare Procedures:** Appropriate subset will be chosen based on requested procedure **Medicare:** Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested procedure

SERVICE CATEGORY	REQUIREMENTS	CODE REQUIRING AUTHORIZATION CPT OR HCPC CODES	MEDICAL NECESSITY CRITERIA
Cranial Nerve Stimulation including Vagus Nerve and Hypoglossal Nerve	Prior authorization required prior to service. Vagus Nerve Stimulation mental health diagnosis, send to Mental Health and Substance Use Disorders fax line.	64553, 64568, 64569, 64582	**InterQual Medicare Procedures:** Hypoglossal Nerve Stimulation for the treatment of Obstructive Sleep Apnea Vagus Nerve Stimulation Peripheral Nerve Stimulation Deep Brain Stimulation (DBS) **InterQual CP or BH Procedures:** Vagus Nerve Stimulation **Medicare National Coverage Determination (NCD)** Vagus Nerve Stimulation (VNS) (160.18) Deep Brain Stimulation for Essential Tremor and Parkinson's Disease (160.24) Stereotaxic Depth Electrode Implantation (160.5) **Medicare Local Coverage Determination (LCD)** Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38387)

SERVICE CATEGORY	REQUIREMENTS	CODE REQUIRING AUTHORIZATION CPT OR HCPC CODES	MEDICAL NECESSITY CRITERIA
Durable Medical Equipment (DME) See also: *Wheelchairs and Accessories* Aspirus Health Plan reserves the right to determine rental vs. purchase. Repair or replacement of rental equipment is the provider's responsibility.	Prior authorization required prior to delivery or dispensing of DME items that require authorization. **Miscellaneous code E1399 requires authorization if billed charges are greater than $1500.**	E0483 - High Frequency Chest Wall Oscillation System E0652 - Pneumatic Compression Device E0748 - Osteogenesis stimulator, electrical, non-invasive, spinal applications E0749- Osteogenesis stimulator, electrical, surgically implanted E0764 – Functional Neuromuscular Stimulator (rental only item) E0766 - Electrical Stimulation Device (rental only item) E1399 – Miscellaneous	**InterQual Medicare Durable Medical Equipment:** Appropriate subset will be chosen based on requested DME item **Medicare:** Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested DME item
Formula or Nutritional Services	Prior authorization required prior to service. **Authorization is not required** if administered through a feeding tube.	B4102, B4103, B4105, B4149, B4150, B4152, B4153, B4154, B4155, B4157, B4158, B4159, B4160, B4161, B4162	**InterQual Medicare:** Enteral Nutrition

SERVICE CATEGORY	REQUIREMENTS	CODE REQUIRING AUTHORIZATION CPT OR HCPC CODES	MEDICAL NECESSITY CRITERIA
Genetic or Molecular Diagnostic tests for the following: - Breast cancer - Colorectal cancer (excluding Fecal DNA test) - Ovarian cancer - Pancreatic cancer - Prostate cancer - All cancer panels (i.e., gene sequencing, whole genome or exome sequencing)	Prior authorization required prior to ordering test.	0037U, 81162, 81163, 81164, 81165, 81166, 81167, 81210, 81212, 81215, 81216, 81217, 81288, 81292, 81293, 81294, 81295, 81296, 81297, 81298, 81299, 81300, 81301, 81317, 81318, 81319, 81415, 81416, 81432, 81433, 81435, 81436, 81437, 81438, 81445, 81460, 81500, 81503, 81504, 81506, 81518, 81520, 81521, 81523, 81525, 81535, 81536, 81539, 81540, 81541, 81551	**InterQual Molecular Diagnostics:** Appropriate subset will be chosen based on requested genetic testing **Medicare:** Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested service
Long-Term Acute Care (LTAC)	Prior authorization is required prior to admission. Concurrent review required for additional days. Discharge summary required to be sent upon discharge.	N/A	**InterQual LOC Long Term Acute Care:** Appropriate subset will be chosen based on reason for LTAC admission
Microprocessor Controlled Lower Limb Prosthesis	Prior authorization required prior to service.	L5856, L5857, L5858, L5859, L5930, L5961	**InterQual Medicare Procedures:** Lower Limb Prostheses

SERVICE CATEGORY	REQUIREMENTS	CODE REQUIRING AUTHORIZATION CPT OR HCPC CODES	MEDICAL NECESSITY CRITERIA
Orthognathic Surgery	Prior authorization required prior to service. **Authorization is not required** for emergency surgery for trauma.	21121, 21141, 21142, 21143, 21145, 21146, 21147, 21193, 21194, 21195, 21196, 21198	**InterQual Care Plan (CP) Procedures:** Osteotomy, Anterior Segment, Mandibles Maxillomandibular Advancement Osteotomy, LeFort I Osteotomy Sagittal Split, Mandible Ramus Reconstruction, Temporomandibular Joint (TMJ) Bone Augmentation, Mandible
Proton Beam Therapy	Prior authorization required prior to service.	77520, 77522, 77523, 77525	**InterQual Medicare Procedures:** Proton Beam Therapy **Medicare:** Local Coverage Determination (LCD): Proton Beam Therapy (L35075)
Skilled Nursing Facility (SNF) or Swing Bed Admission	Notification required within 24 hours of admission. Concurrent review required for additional days. Discharge summary required to be sent upon discharge.	N/A	**InterQual: LOC Subacute/SNF:** Appropriate subset will be chosen based on reason for SNF admission **Medicare Benefit Policy Manual:** Chapter 8 – Coverage of Extended Care (SNF) Services Under Hospital Insurance
Spinal Cord Stimulation	Prior authorization required prior to trial and prior to permanent placement.	63650, 63655, 63663, 63664, 63685	**InterQual Medicare Procedures:** Spinal Cord Stimulator **Medicare:**National Coverage Determination (NCD) for Electrical Nerve Stimulators (160.7)

SERVICE CATEGORY	REQUIREMENTS	CODE REQUIRING AUTHORIZATION CPT OR HCPC CODES	MEDICAL NECESSITY CRITERIA
Transcranial Magnetic Stimulation	Prior authorization required prior to service.	90867, 90868, 90869	**InterQual BH:** Behavioral Health Services Transcranial Magnetic Stimulation (TMS)
Transplant Procedures Heart Heart/Lung Hematopoietic Stem Cell Liver Lung Pancreas Pancreas/Kidney Pancreatic Islet Cell Small Bowel Small Bowel/Liver Multivisceral	Prior Authorization required prior to: - Evaluation - Listing Notification required within 24 hours of admission for transplant procedure.	Heart: 33945 Heart/Lung: 33935 Hematopoietic Stem Cell: 38240, 38241 Liver: 47135 Lung – 32851, 32852, 32853, 32854 Pancreas and Pancreas/Kidney: 48554, 50360, 50365 Pancreatic Islet Cell: 48160 Small Bowel, Small Bowel/Liver, Multivisceral: 44136	**InterQual Medicare Procedures:** Intestinal and multi-visceral Allogeneic Hematopoietic Cell Transplantation Adult Liver Transplantation

SERVICE CATEGORY	REQUIREMENTS	CODE REQUIRING AUTHORIZATION CPT OR HCPC CODES	MEDICAL NECESSITY CRITERIA
Vein Procedures	Prior authorization required prior to service.	36465, 36466, 36468, 36470, 36471, 36473, 36474, 36475, 36476, 36478, 36479, 36482, 36483, 37765, 37766	**InterQual Medicare Procedures:** Varicose Veins **Medicare:** **Local Coverage Determination (LCD):** Varicose Veins of the Lower Extremity, Treatment of (L33575)
Wheelchair Accessories – Purchase and Rental Repair or replacement of rental equipment is the DME provider's responsibility. Aspirus Health Plan or our authorizing delegate reserves the right to determine rental vs. purchase.	Prior authorization is required before delivering or dispensing accessories or items that require authorization, including new, replacement or repaired accessories. **Miscellaneous codes K0108 and K0669 require authorization if billed charges are greater than $1500.**	E0986, E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1009, E1010, E1012, E1030, E2204, E2227, E2228, E2298, E2301, E2310, E2311, E2312, E2321, E2322, E2325, E2327, E2328, E2329, E2330, E2331, E2376, E2609, E2617, E0986, E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1009, E1010, E1012, E2204, E2227, E2301, E2310, E2311, E2312, E2321, E2325, E2327, E2328, E2329, E2330, E2331, E2376, E2609, E2617, K0108, K0669	**InterQual Medicare Durable Medical Equipment:** Appropriate subset will be chosen based on requested wheelchair item **Medicare:** Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested wheelchair item

SERVICE CATEGORY	REQUIREMENTS	CODE REQUIRING AUTHORIZATION CPT OR HCPC CODES	MEDICAL NECESSITY CRITERIA
Wheelchair - Rental Aspirus Health Plan or our authorizing delegate reserves the right to determine rental vs. purchase.	Prior authorization is required prior to delivery or dispensing power operated vehicles and power wheelchairs for items that require authorization. All months must be authorized.	K0800, K0801, K0802, K0806, K0807, K0808, K0812, K0813, K0814, K0815, K0816, K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0830, K0831, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, K0864, K0890, K0891	**InterQual Medicare Durable Medical Equipment:** Appropriate subset will be chosen based on requested wheelchair item **Medicare:** Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested wheelchair item
Wheelchair - Purchase Aspirus Health Plan or our authorizing delegate reserves the right to determine rental vs. purchase.	Prior authorization is required prior to purchase K0005 - K0007, E1161, all power-operated vehicles and power wheelchairs.	K0005 - K0007, E1161, all power-operated vehicles and power wheelchairs	**InterQual Medicare Durable Medical Equipment:** Appropriate subset will be chosen based on requested wheelchair item **Medicare:** Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested wheelchair item

Contact Information

ASPIRUS HEALTH PLAN CONTACT	SERVICE AREA	PHONE	FAX	WEBSITE OR EMAIL
Medical Services	Medical Authorizations	715.631.7443 or 855.931.5265 toll-free	715.787.7316	Aspirus Health Plan medicaldrugauthMA@aspirushealthplan.com
Clinical Pharmacy Intake	Medical Drug – Non-PAR and MultiPlan Providers	715.787.7340	715.841.4322	Aspirus Health Plan
Mental Health and Substance Use Disorder Services	Mental Health and Substance Use Disorder Authorizations	715.631.7442 or 855.931.5264 toll-free	715.787.7314	Aspirus Health Plan MHSUDservicesMA@aspirushealthplan.com
Provider Assistance Center (PAC)	Member Eligibility or Benefits and Network Status	715.631.7412 or 855.931.4851 toll-free	N/A	Aspirus Health Plan
DELEGATE CONTACT	**SERVICE AREA**	**PHONE**	**FAX**	**WEBSITE**
DentaQuest	Dental	855.453.5287	N/A	DentaQuest
Fulcrum Health	Chiropractic	1.877.886.4941 toll-free	N/A	Fulcrum
Navitus	Pharmacy Drug Prior Authorizations	833.837.4300	855.668.8552	CoverMyMeds Surescripts