



## Authorization and Notification Requirements – Effective August 1, 2025

### EssentiaCare

#### General information

UCare requires that providers obtain prior authorization or notification for the services addressed below. This list contains prior authorization (PA) and notification requirements for inpatient and outpatient services, as referenced in the [UCare Provider Manual](#). PA does not guarantee payment. To provide PA or notification, complete the appropriate request form with supporting clinical documentation as needed and submit by fax or email to UCare according to the return information noted on each form.

Upcoming changes to PA requirements are published in the monthly *Health Lines* provider newsletters, which are part of the [UCare Provider News Library](#). The CPT or 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

- **Essentia Health Providers - for services that state “no authorization or notification requirements,” contact Essentia Health Managed Care Support Services. For services that require prior authorization for Essentia Health providers and other EssentiaCare Network Providers, contact UCare.**
- 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 [UCare’s Authorizations page](#).
- Provider of service qualifications, eligibility and licensure requirements must be met to provide services and submit claims to UCare.
- Not all plans offer out of network benefits. Call the UCare Provider Assistance Center at 612-676-3300 or 1-888-531-1493 toll-free for questions related to member eligibility, benefits and network status.

#### Authorization and notification forms

- [Medical Authorization and Notification Forms](#)
- [Mental Health and Substance Use Disorder 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 which drugs are covered under the pharmacy benefit. Formularies are available by clicking the product name on the [Pharmacy page](#).

## Delegated services

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

- Chiropractic
- Dental
- Pharmacy
- Genetic Testing

## Requirement definitions

<b>Approval authority</b>	UCare, or an organization delegated by UCare, to approve or deny prior authorization requests.
<b>Notification</b>	The process of informing UCare, or delegates of UCare, of a specific medical treatment or service prior to, or within a specified time period after, the start of the treatment or service.
<b>Prior authorization</b>	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, appropriate, expense and that other alternatives have been considered.

## Notification only requirements

Service category	Requirements
<b>Inpatient Hospital Notifications:</b> Acute Inpatient Medical Admissions  Inpatient Mental Health Admissions	<p><i>If you are an enrolled provider with the UCare Encounter Alert System (EAS), notification of Inpatient Hospital Admissions is not required.</i></p> <ul style="list-style-type: none"> <li>- Notification within 24 hours of admission if you are not enrolled with the UCare EAS system.</li> <li>- Discharge summary to be sent within 72 hours of discharge.</li> <li>- Fax information for Acute Inpatient Medical Admissions to 612-884-2499 or 1-866-610-7215 toll-free.</li> <li>- Fax information for Inpatient Mental Health Admissions to 612-884-2033 or 1-855-260-9710 toll-free.</li> </ul>
<b>Inpatient Substance Use Disorder Admission</b>	<ul style="list-style-type: none"> <li>- Notification within 24 hours of admission.</li> <li>- Discharge summary to be sent within 72 hours of discharge.</li> <li>- Fax information to 612-884-2033 or 1-855-260-9710 toll-free.</li> </ul>

## Authorization Requirements

Service category	EssentiaHealth provider requirements	Other EssentiaCare network providers	Codes requiring authorization CPT/HCPTC codes	Medical necessity criteria
<b>Air Ambulance Non-Emergent (fixed wing)</b>	No authorization or notification requirements.*	Prior authorization required prior to service.  <b>Authorization is not required for emergent air transport.</b>	A0430, A0435	<b>Medicare Benefit Policy Manual:</b> Chapter 10
<b>Acute Inpatient Hospitalization</b> (Medical, Mental Health, Substance Use Disorder)	UCare will contact facilities when a concurrent review is required.  Discharge summary required to be sent upon discharge.	UCare will contact facilities when a concurrent review is required.  Discharge summary required to be sent upon discharge.	Not applicable	<b>InterQual LOC: Acute Adult or LOC: Acute Pediatric:</b> Appropriate subset will be chosen based on the reason and diagnosis for acute inpatient rehabilitation admission
<b>Acute Inpatient Rehabilitation</b>	Prior authorization is required prior to admission.  Concurrent review required for additional days.  Discharge summary required to be sent upon discharge.	Prior authorization is required prior to admission.  Concurrent review required for additional days.  Discharge summary required to be sent upon discharge.	Not applicable	<b>InterQual LOC Rehabilitation:</b> Appropriate subset will be chosen based on reason acute inpatient rehabilitation admission  <b>Medicare Benefit Policy Manual:</b> Chapter 1 Inpatient Hospital Services Covered Under Part A

Service category	EssentiaHealth provider requirements	Other EssentiaCare network providers	Codes requiring authorization CPT/HCPTC codes	Medical necessity criteria
<b>Artificial Disc</b>	No authorization or notification requirements.*	Prior authorization required prior to service.	22856, 22857, 22858	<b>InterQual CP: Procedures:</b> Artificial Disc Replacement, Cervical
<b>Back (Spine) Surgery</b>  - Lumbar Spinal Fusion - Sacroiliac Joint Fusion - Intracept	No authorization or notification requirements.*	Prior authorization required prior to service.  <b>Authorization not required for:</b> - 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	<b>InterQual: Medicare Procedures:</b> Minimally Invasive Sacroiliac (SI) Joint Fusion  <b>InterQual: Care Plan (CP) Procedures</b> Lumbar Spinal Fusion Decompression +/- Fusion, Lumbar Neuroablation, Percutaneous  <b>Medicare Local Coverage Determination:</b> Minimally invasive Surgical (MIS) Fusion of the Sacroiliac Joint L36406
<b>Bariatric Surgery (Gastric Bypass)</b>	No authorization or notification requirements.*	Prior authorization required prior to service.	43644, 43645, 43770, 43773, 43775, 43842, 43845, 43846, 43847, 43848	<b>InterQual Medicare Procedures:</b> Bariatric Surgery  <b>Medicare National Coverage Determination (NCD):</b> Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity (100.1)

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<p><b>Cosmetic Procedures</b> Examples include:</p> <ul style="list-style-type: none"> <li>- Abdominoplasty</li> <li>- Blepharoplasty/Blepharoptosis</li> <li>- Breast reduction surgery</li> <li>- Gynecomastia</li> <li>- Mammoplasty</li> <li>- Panniculectomy</li> <li>- Removal of breast implant(s) or replacement of breast implants</li> <li>- Rhinoplasty or Septorhinoplasty</li> <li>- Skin peel(s)</li> </ul> <p>See also: <i>Orthognathic surgery</i></p>	<p>No authorization or notification requirements.*</p>	<p>Prior authorization required prior to service.</p> <p><b>Authorization not required for</b> breast reconstruction associated with breast cancer.</p> <p><b>Note:</b> Photographs are not required to be submitted when requesting authorization for cosmetic or reconstructive surgeries. If UCare determines photographs are needed the Utilization Review Specialist will call to request them.</p>	<p>11960, 15775, 15776, 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</p>	<p><b>InterQual Medicare Procedures:</b> Appropriate subset will be chosen based on requested procedure</p> <p><b>Medicare:</b> Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested procedure</p>

Service category	EssentiaHealth provider requirements	Other EssentiaCare network providers	Codes requiring authorization CPT/HCPTC codes	Medical necessity criteria
<b>Cranial Nerve Stimulation including Vagus Nerve and Hypoglossal Nerve</b>	<p>Prior authorization required prior to service.</p> <p>Vagus Nerve Stimulation mental health diagnosis, send to Mental Health and Substance Use Disorders fax line.</p>	<p>Prior authorization required prior to service.</p> <p>Vagus Nerve Stimulation mental health diagnosis, send to Mental Health and Substance Use Disorder fax line.</p>	<p>64553, 64568, 64569, 64582</p>	<p><b>InterQual Medicare Procedures:</b>  Hypoglossal Nerve Stimulation for the treatment of Obstructive Sleep Apnea  Vagus Nerve Stimulation  Peripheral Nerve Stimulation  Deep Brain Stimulation (DBS)</p> <p><b>Medicare: National Coverage Determination (NCD):</b>  Vagus Nerve Stimulation (VNS) (160.18)  Deep Brain Stimulation for Essential Tremor and Parkinson's Disease (160.24)  Stereotaxic Depth Electrode Implantation (160.5)</p> <p><b>Local Coverage Determination (LCD):</b>  Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38387)</p> <p><b>InterQual Critical Points (CP) or Behavioral Health (BH) Procedures:</b>  Vagus Nerve Stimulation</p>

Service category	EssentiaHealth provider requirements	Other EssentiaCare network providers	Codes requiring authorization CPT/HCPTC codes	Medical necessity criteria
<p><b>Durable Medical Equipment (DME)</b></p> <p>See also: <i>Wheelchair and Accessories</i></p> <p>UCare reserves the right to determine rental vs. purchase.</p> <p>Repair or replacement of rental equipment is the provider's responsibility.</p>	<p>Prior authorization required prior to delivery or dispensing of DME items that require authorization.</p> <p>All months must be authorized.</p> <p><b>Miscellaneous code E1399 requires authorization if billed charges are greater than \$1500.</b></p>	<p>Prior authorization required prior to delivery or dispensing of DME items that require authorization.</p> <p>All months must be authorized.</p> <p><b>Miscellaneous code E1399 requires authorization if billed charges are greater than \$1500.</b></p>	<p>E0483 - High Frequency Chest Wall Oscillation System</p> <p>E0652 - Pneumatic Compression Device</p> <p>E0748 - Osteogenesis stimulator, electrical, non-invasive, spinal applications</p> <p>E0749 - Osteogenesis stimulator, electrical, surgically implanted</p> <p>E0764 - Functional Neuromuscular Stimulator (rental only item)</p> <p>E0766 - Electrical Stimulation Device (rental only item)</p> <p>E1399 - Miscellaneous</p>	<p><b>InterQual Medicare Durable Medical Equipment:</b> Appropriate subset will be chosen based on requested DME item</p> <p><b>Medicare:</b> Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested DME item</p>

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<b>Formula or Nutritional Services</b>	<p>Prior authorization required prior to service.</p> <p><b>Authorization is not required</b> if administered through a feeding tube.</p>	<p>Prior authorization required prior to service.</p> <p><b>Authorization is not required</b> if administered through a feeding tube.</p>	<p>B4102, B4103, B4105, B4149, B4150, B4152, B4153, B4154, B4155, B4157, B4158, B4159, B4160, B4161, B4162</p>	<p><b>InterQual Medicare:</b> Enteral Nutrition</p>
<b>Long-Term Acute Care (LTAC)</b>	<p>Prior authorization is required prior to admission.</p> <p>Concurrent review required for additional days.</p> <p>Discharge summary required to be sent upon discharge.</p>	<p>Prior authorization is required prior to admission.</p> <p>Concurrent review required for additional days.</p> <p>Discharge summary required to be sent upon discharge.</p>	<p>Not applicable</p>	<p><b>InterQual LOC Long Term Acute Care:</b> Appropriate subset will be chosen based on reason for LTAC admission</p>
<b>Microprocessor Controlled Lower Limb Prosthesis</b>	<p>Prior authorization required prior to service.</p>	<p>Prior authorization required prior to service.</p>	<p>L5856, L5857, L5858, L5859, L5930, L5961</p>	<p><b>InterQual Medicare:</b> Lower Limb Protheses</p>

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<b>Orthognathic Surgery</b>	No authorization or notification requirements.*	Prior authorization required prior to service.	21121, 21141, 21142, 21143, 21145, 21146, 21147, 21193, 21194, 21195, 21196, 21198	<b>InterQual Care Plan (CP): Procedures:</b> Appropriate subset will be chosen based on procedure
<b>Proton Beam Therapy</b>	Prior authorization required prior to service.	Prior authorization required prior to service.	77520, 77522, 77523, 77525	<b>InterQual Medicare Procedures:</b> Proton Beam Therapy  <b>Medicare: Local Coverage Determination (LCD):</b> Proton Beam Therapy (L35075)
<b>Skilled Nursing Facility (SNF) or Swing Bed Admission</b>  Medicare-covered Skilled Nursing Facility coverage for members who have their Medicare coverage through UCare.	Prior authorization is required prior to admission.  Concurrent review required for additional days.  Discharge summary required to be sent upon discharge.	Prior authorization is required prior to admission.  Concurrent review required for additional days.  Discharge summary required to be sent upon discharge.	Not applicable	<b>InterQual LOC Subacute or SNF:</b> Appropriate subset will be chosen based on reason for SNF admission  <b>Medicare Benefit Policy Manual:</b> Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance
<b>Spinal Cord Stimulation</b>	Prior authorization required prior to trial and prior to permanent placement.	Prior authorization required prior to trial and prior to permanent placement.	63650, 63655, 63663, 63664, 63685	<b>InterQual Medicare Procedures:</b> Spinal Cord Stimulator  <b>Medicare:</b> National Coverage Determination (NCD) for Electrical Nerve Stimulators (160.7)

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<b>Transcranial Magnetic Stimulation</b>	Prior authorization required prior to service.	Prior authorization required prior to service.	90867, 90868, 90869	<b>InterQual BH:</b> Behavioral Health Services Transcranial Magnetic Stimulation (TMS)
<b>Transplant</b> 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.	Prior Authorization required prior to: - Evaluation - Listing  Notification required within 24 hours of admission for transplant procedure.	<b>Heart:</b> 33945 <b>Heart/Lung:</b> 33935  <b>Hematopoietic Stem Cell:</b> 38240, 38241  <b>Liver:</b> 47135  <b>Lung –</b> 32851, 32852, 32853, 32854  <b>Pancreas and Pancreas/Kidney:</b> 48554, 50360, 50365  <b>Pancreatic Islet Cell:</b> 48160  <b>Small Bowel, Small Bowel/Liver, Multivisceral:</b> 44136	<b>InterQual Medicare:</b> Appropriate subset will be chosen based on transplant type  <b>Medicare:</b> Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested transplant

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<p><b>Vein Procedures</b></p>	<p>No authorization or notification requirements.*</p>	<p>Prior authorization required prior to service.</p>	<p>36465, 36466, 36468, 36470, 36471, 36473, 36474, 36475, 36476, 36478, 36479, 36482, 36483, 37765, 37766</p>	<p><b>InterQual Medicare Procedures:</b> Varicose Veins</p> <p><b>Medicare Local Coverage Determination (LCD):</b> Varicose Veins of the Lower Extremity, Treatment of (L33575)</p>
<p><b>Wheelchair Accessories - Purchase and Rental</b></p> <p>Repair or replacement of rental equipment is the DME provider’s responsibility.</p> <p>UCare reserves the right to determine rental vs. purchase.</p>	<p>Prior authorization is required before delivering or dispensing accessories or items that require authorization, including new, replacement or repaired accessories.</p> <p><b>Miscellaneous codes K0108 and K0669 require authorization if billed charges are greater than \$1500.</b></p>	<p>Prior authorization is required before delivering or dispensing accessories or items that require authorization, including new, replacement or repaired accessories.</p> <p><b>Miscellaneous codes K0108 and K0669 require authorization if billed charges are greater than \$1500.</b></p>	<p>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, K0108, K0669</p>	<p><b>InterQual Medicare Durable Medical Equipment:</b> Appropriate subset will be chosen based on requested wheelchair item</p> <p><b>Medicare:</b> Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested wheelchair item</p>

Service category	EssentiaHealth provider requirements	Other EssentiaCare network providers	Codes requiring authorization CPT/HCPTC codes	Medical necessity criteria
<p><b>Wheelchair – Rental</b></p> <p>UCare reserves the right to determine rental vs. purchase.</p>	<p>Prior authorization is required prior to delivery or dispensing power operated vehicles and power wheelchairs for items that require authorization.</p> <p>All months must be authorized.</p>	<p>Prior authorization is required prior to delivery or dispensing power operated vehicles and power wheelchairs for items that require authorization.</p> <p>All months must be authorized.</p>	<p>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</p>	<p><b>InterQual Medicare Durable Medical Equipment:</b> Appropriate subset will be chosen based on requested wheelchair</p> <p><b>Medicare:</b> Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested wheelchair</p>
<p><b>Wheelchair – Purchase</b></p> <p>UCare reserves the right to determine rental vs. purchase.</p>	<p>Prior authorization is required prior to purchase K0005 - K0007, E1161, all power-operated vehicles and power wheelchairs.</p> <p>See <i>Wheelchair Accessories</i> for purchase, repair and replacement authorization requirements.</p>	<p>K0005 - K0007, E1161, all power-operated vehicles and power wheelchairs</p>	<p>Manual wheelchairs, power operated vehicles and power wheelchairs, excludes K0001.</p>	<p><b>InterQual Medicare Durable Medical Equipment:</b> Appropriate subset will be chosen based on requested wheelchair</p> <p><b>Medicare:</b> Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested wheelchair</p>

## Contact information

UCare contact	Service area	Phone	Fax	Website or email
<b>Medical Services</b>	Medical Authorizations	1-877-447-4384 toll-free 612-676-6705	612-884-2499	<a href="#">UCare's Medical Services Authorizations page</a>
<b>Clinical Pharmacy Intake</b>	Medical Drug - Non-PAR and MultiPlan Providers	612-676-6504	612-617-3948	<a href="#">UCare's Pharmacy page</a>
<b>Mental Health and Substance Use Disorder Services</b>	Mental Health and Substance Use Disorder Authorizations	1-833-276-1185 toll-free 612-676-6533	1-855-260-9710 toll-free 612-884-2033	<a href="#">UCare's Mental Health and Substance Use Disorder Services Authorizations page</a>  <a href="mailto:MHSUDservices@ucare.org">MHSUDservices@ucare.org</a>
<b>Provider Assistance Center (PAC)</b>	Member Eligibility or Benefits and Network Status	1-888-531-1493 toll-free 612-676-3300	N/A	<a href="#">UCare's Provider home page</a>
Delegate contact	Service area	Phone	Fax	Website
<b>Carelon</b>	Genetic Testing	1-833-821-1954	1-844-425-3736	<a href="#">Carelon</a>
<b>DentaQuest</b>	Dental	1-888-260-5152	N/A	<a href="#">DentaQuest</a>
<b>Fulcrum Health</b>	Chiropractic	1-877-886-4941 toll-free	N/A	<a href="#">Fulcrum Health</a>
<b>Navitus</b>	Pharmacy Drug Prior Authorizations	1-833-837-4300 toll-free	1-855-668-8552 toll-free	<a href="#">CoverMyMeds Surescripts</a>