



## 2024 Authorization and Notification Requirements

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 appropriate and submit by fax or e-mail to UCare according to the return information noted on each form.

Upcoming changes to PA requirements can be found in the monthly *Health Lines* Provider Newsletters published at [ucare.org/providers/provider-news](https://ucare.org/providers/provider-news). 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” please contact Essentia Health Managed Care Support Services. For services that have a prior authorization requirement for Essentia Health providers and Other EssentiaCare Network Providers, please 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 prior authorization request prior to services.
- UCare reserves the right to review and verify medical necessity for all 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 website](#).
- Provider of service qualifications, eligibility and licensure requirements must be met to provide services and submit claims to UCare.
- Contact the UCare Provider Assistance Center (612-676-3300 or 1-888-531-1493) for information on eligibility, benefits, and network status.

## Authorization and Notification Forms

- [Medical Authorization and Notification Forms](#)
- [Mental Health & SUD Authorization and Notification Forms](#)

## Prescription Drugs and Medical Injectable Drugs

- The [Medical Drug Policies](#) library is a list of medical injectable drugs that require prior authorization and the policies that contain coverage criteria.
- The formulary page, located on [ucare.org/providers](https://ucare.org/providers), indicates which drugs are covered under the pharmacy benefit.

## Delegated Services

Information on how to request authorization for the following services can be found at: [ucare.org/providers](https://ucare.org/providers). UCare is the contract resource for all authorization service requests, concerns, and questions, unless noted otherwise within delegated services.

- Chiropractic
- Dental
- Pharmacy

## 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.

Service Category	Essentia Health Provider Requirements	Other EssentiaCare Network Providers	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
<b>Acute Inpatient Rehabilitation</b>	<p>Notification within 24 hours of admission.</p> <p>Concurrent review required for additional days.</p> <p>Discharge summary required to be sent upon discharge.</p>	<p>Notification within 24 hours of admission.</p> <p>Concurrent review required for additional days.</p> <p>Discharge summary required to be sent upon discharge.</p>	N/A	<p><b>InterQual: LOC Rehabilitation:</b></p> <ul style="list-style-type: none"> <li>- Appropriate subset will be chosen based on reason acute inpatient rehabilitation admission</li> </ul> <p><b>Medicare Benefit Policy Manual:</b></p> <ul style="list-style-type: none"> <li>- Chapter 1 Inpatient Hospital Services Covered Under Part A</li> </ul>
<p><b>Back (Spine) Surgery</b></p> <p>Lumbar Spinal Fusion</p> <p>Sacroiliac Joint Fusion</p>	No authorization or notification requirements.*	<p>Prior authorization required prior to service.</p> <p><b>Authorization not required for:</b></p> <ul style="list-style-type: none"> <li>- Emergency surgery for trauma</li> <li>- Acute transverse myelopathy</li> <li>- Tumors</li> <li>- Cervical and Thoracic back surgery</li> </ul>	0200T, 0201T, 0221T, 0222T, 22533, 22534, 22558, 22585, 22586, 22612, 22614, 22630, 22632, 22633, 22634, 22808, 22810, 22812, 22840, 22841, 22842, 22843, 22844, 27279, 27280	<p><b>InterQual Medicare Procedures:</b></p> <ul style="list-style-type: none"> <li>- Lumbar Spinal Fusion</li> <li>- Minimally Invasive Sacroiliac (SI) Joint Fusion</li> <li>- Vertebroplasty or Kyphoplasty 0200T, 0201T</li> </ul> <p><b>Medicare Local Coverage Determination:</b></p> <ul style="list-style-type: none"> <li>- Minimally-invasive Surgical (MIS) Fusion of the Sacroiliac Joint L36406</li> </ul>
<b>Bariatric Surgery (Gastric Bypass)</b>	No authorization or notification requirements.*	Prior authorization required prior to service.	43644, 43645, 43770, 43773, 43775, 43842, 43843, 43845, 43846, 43847, 43848	<p><b>InterQual Medicare Procedures:</b></p> <ul style="list-style-type: none"> <li>- Bariatric Surgery</li> </ul> <p><b>Medicare:</b></p> <ul style="list-style-type: none"> <li>- National Coverage Determination (NCD) for Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity (100.1)</li> </ul>

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<p><b>Cosmetic Procedures</b></p> <p>Examples include:</p> <ul style="list-style-type: none"> <li>- Abdominoplasty</li> <li>- Breast reduction surgery</li> <li>- Gynecomastia</li> <li>- Mammoplasty</li> <li>- Panniculectomy</li> <li>- Removal of breast</li> <li>- Implant(s) or replacement of breast implants</li> <li>- Rhinoplasty or Septorhinoplasty</li> <li>- Skin peel(s)</li> </ul>	<p>No authorization or notification requirements.*</p> <p>Note: 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>Prior authorization required prior to service.</p> <p><b>Authorization not required for:</b></p> <ul style="list-style-type: none"> <li>- Blepharoplasty</li> <li>- Breast reconstruction associated with breast cancer</li> <li>- Ear cartilage graft</li> <li>- HIV related indications for G0429, Q2026, and Q2028</li> </ul>	<p>11950, 11951, 11952, 11954, 11960, 15775, 15776, 15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793, 15819, 15824, 15825, 15826, 15828, 15829, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15876, 15877, 15878, 15879, 17106, 17107, 17108, 17340, 17360, 17380, 19300, 19316, 19318, 19324, 19325, 19328, 19355, 19366, 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, 21299, 30120, 30400, 30410, 30420, 30430, 30435, 30450, 30540, 30545, 30560, 30620, 40500, 67900, 67912, 69090, 69300, 69320, S2066, S2067, S2068</p>	<p><b>InterQual Medicare Procedures:</b></p> <ul style="list-style-type: none"> <li>- Appropriate subset will be chosen based on requested procedure</li> </ul> <p><b>Medicare:</b></p> <ul style="list-style-type: none"> <li>- Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested procedure</li> </ul>

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<b>Cranial Nerve Stimulation including Vagus Nerve and Hypoglossal Nerve</b>	No authorization or notification requirements.*	<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>	64553, 64568, 64569, 64582	<p><b>InterQual Medicare Procedures:</b></p> <ul style="list-style-type: none"> <li>- Hypoglossal Nerve Stimulation for the treatment of Obstructive Sleep Apnea</li> <li>- Vagus Nerve Stimulation</li> </ul> <p><b>InterQual Critical Points (CP) or Behavioral Health (BH) Procedures:</b></p> <ul style="list-style-type: none"> <li>- Vagus Nerve Stimulation</li> </ul> <p><b>Medicare:</b></p> <ul style="list-style-type: none"> <li>- Local Coverage Determination (LCD) Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38387) - National Coverage Determination (NCD) for Vagus Nerve Stimulation (VNS) (160.18)</li> </ul>

Service Category	Essentia Health Provider Requirements	Other EssentiaCare Network Providers	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
<p><b>Durable Medical Equipment (DME) - Purchase and Rental</b></p> <p>See also: <i>Wheelchair Accessories</i> <i>Wound VAC</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 is required prior to deliver or dispensing of DME items <b>that require authorization.</b></p> <p>All months must be authorized.</p>	<p>Prior authorization is required prior to deliver or dispensing of DME items <b>that require authorization.</b></p> <p>All months must be authorized.</p> <p><b>Authorization not required for:</b></p> <ul style="list-style-type: none"> <li>- Monthly rental of ventilators</li> <li>- Monthly rental of oxygen and equipment</li> <li>- Prosthetics and orthotic devices or equipment</li> </ul>	<p>E0483 - High Frequency Chest Wall Oscillation System</p> <p>E0652 - Pneumatic Compression Device</p> <p>E0694 - Ultraviolet Multidirectional Light Therapy</p> <p>E0764 - Functional Neuromuscular Stimulator (rental only item)</p> <p>E0766 - Electrical Stimulation Device (rental only item)</p> <p>E2510 - Speech Generating Device</p> <p>E0748 - Osteogenesis stimulator, electrical, non-invasive, spinal applications</p> <p>E0749 - Osteogenesis stimulator, electrical, surgically implanted</p>	<p><b>InterQual Medicare Durable Medical Equipment:</b></p> <ul style="list-style-type: none"> <li>- Appropriate subset will be chosen based on requested DME item</li> </ul> <p><b>Medicare:</b></p> <ul style="list-style-type: none"> <li>- Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested DME item</li> </ul>

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<p><b>Genetic or Molecular Diagnostic Tests for the following:</b></p> <ul style="list-style-type: none"> <li>- Breast cancer</li> <li>- Colorectal cancer (excluding fecal)</li> <li>- Ovarian cancer</li> <li>- Pancreatic cancer</li> <li>- Prostate cancer</li> <li>- And all cancer panels (i.e., gene sequencing, whole genome or exome sequencing)</li> </ul>	<p>No authorization or notification requirements.*</p>	<p>Prior authorization required prior to ordering test.</p>	<p>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, 81479, 81500, 81503, 81504, 81506, 81518, 81520, 81521, 81523, 81525, 81535, 81536, 81539, 81540, 81541, 81551, 81599, 84999</p>	<p><b>InterQual Molecular Diagnostics:</b></p> <ul style="list-style-type: none"> <li>- Appropriate subset will be chosen based on requested genetic testing</li> </ul> <p><b>Medicare:</b></p> <ul style="list-style-type: none"> <li>- Local Coverage Determination (LCD): Molecular Pathology Procedures (L35000)</li> <li>- Local Coverage Determination (LCD): Genomic Sequence Analysis Panels in the Treatment of Solid Organ Neoplasms (L37810)</li> <li>- Local Coverage Determination (LCD): Genomic Sequence Analysis Panels in the treatment Hematolymphoid Diseases (L37606)</li> </ul> <p><b>Medical Policy may be available for select genetic tests</b></p>

Service Category	Essentia Health Provider Requirements	Other EssentiaCare Network Providers	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
<b>Inpatient Hospital, Acute</b> All Hospital Inpatient Level of Care Admissions	<p>Notification required within 24 hours of admission. Include admission history and physical information with notification.</p> <p>UCare reserves the right to require a concurrent review for any inpatient hospital stay.</p> <p>Discharge summary required to be sent within 72 hours of discharge.</p>	<p>Notification required within 24 hours of admission. Include admission history and physical information with notification.</p> <p>UCare reserves the right to require a concurrent review for any inpatient hospital stay. Discharge summary required to be sent within 72 hours of discharge.</p>	N/A	N/A
<b>Inpatient Mental Health Admission</b>	<p>Notification required within 24 hours of admission.</p> <p>Include admission history and physical information with notification.</p> <p>UCare reserves the right to require a concurrent review for any inpatient hospital stay.</p> <p>Discharge summary required to be sent within 72 hours of discharge.</p>	<p>Notification required within 24 hours of admission. Include admission history and physical information with notification.</p> <p>UCare reserves the right to require a concurrent review for any inpatient hospital stay.</p> <p>Discharge summary required to be sent within 72 hours of discharge.</p>	N/A	<b>InterQual Adult and Geriatric Psychiatry:</b> - Inpatient



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<b>Inpatient Substance Use Disorder Admission</b>	<p>Notification required within 24 hours of admission.</p> <p>Include admission history and physical information with notification.</p> <p>UCare reserves the right to require a concurrent review for any inpatient hospital stay.</p> <p>Discharge summary required to be sent within 72 hours of discharge.</p>	<p>Notification required within 24 hours of admission. Include admission history and physical information with notification.</p> <p>UCare reserves the right to require a concurrent review for any inpatient hospital stay.</p> <p>Discharge summary required to be sent within 72 hours of discharge.</p>	N/A	<b>InterQual: American Society of Addiction Medicine</b>
<b>Long-Term Acute Care (LTAC)</b>	<p>Notification within 24 hours of admission.</p> <p>Concurrent review required for additional days.</p> <p>Discharge summary required to be sent upon discharge.</p>	<p>Notification within 24 hours of admission.</p> <p>Concurrent review required for additional days.</p> <p>Discharge summary required to be sent upon discharge.</p>	N/A	<b>InterQual LOC Long Term Acute Care:</b> - Appropriate subset will be chosen based on reason for LTAC admission
<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:</b> - Local Coverage Determination (LCD): Proton Beam Therapy (L35075)

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<b>Skilled Nursing Facility (SNF) or Swing Bed Admission</b>	<p>Notification within 24 hours of admission.</p> <p>Concurrent review required for additional days.</p> <p>Discharge summary required to be sent upon discharge.</p>	<p>Notification within 24 hours of admission.</p> <p>Concurrent review required for additional days.</p> <p>Discharge summary required to be sent upon discharge.</p>	N/A	<p><b>InterQual LOC Subacute or SNF:</b> - Appropriate subset will be chosen based on reason for SNF admission</p> <p><b>Medicare Benefit Policy Manual:</b> - Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance</p>
<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	<p><b>InterQual Medicare Procedures:</b> - Spinal Cord Stimulator</p> <p><b>Medicare:</b> - National Coverage Determination (NCD) for Electrical Nerve Stimulators (160.7)</p>
<b>Transcranial Magnetic Stimulation</b>	Prior authorization required prior to service.	Prior authorization required prior to service.	90867, 90868, 90869	<p><b>InterQual BH:</b> - Behavioral Health Services Transcranial Magnetic Stimulation (TMS)</p>
<p><b>Transplant</b></p> <ul style="list-style-type: none"> <li>- Bone marrow</li> <li>- Heart</li> <li>- Heart-lung</li> <li>- Kidney</li> <li>- Liver</li> <li>- Lung</li> <li>- Pancreas</li> <li>- Stem cell</li> </ul>	<p>Step 1: notification required for transplant consult or evaluation.</p> <p>Step 2: notification required for transplant listing.</p> <p>Step 3: notification required within 24 hours of inpatient hospital admissions.</p>	<p>Step 1: notification required for transplant consult or evaluation.</p> <p>Step 2: notification required for transplant listing.</p> <p>Step 3: notification required within 24 hours of inpatient hospital admissions.</p>	N/A	N/A

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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:</b> - Local Coverage Determination (LCD): 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>All months must be authorized.</p>	<p>Prior authorization is required before delivering or dispensing accessories or items that require authorization, including new, replacement or repaired accessories.</p> <p>All months must be authorized.</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</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>

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<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></p> <ul style="list-style-type: none"> <li>- Appropriate subset will be chosen based on requested wheelchair item</li> </ul> <p><b>Medicare:</b></p> <ul style="list-style-type: none"> <li>- Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested wheelchair item</li> </ul>
<p><b>Wheelchair - Purchase</b></p> <p>UCare reserves the right to determine rental vs. purchase.</p>	<p>Prior authorization required prior to purchase of manual wheelchairs, power operated vehicles and power wheelchairs, excludes K0001.</p> <p>See <i>Wheelchair Accessories</i> for purchase, repair and replacement authorization requirements.</p>	<p>Manual wheelchairs, power operated vehicles and power wheelchairs, excludes K0001.</p>	<p>Manual wheelchairs, power operated vehicles and power wheelchairs, excludes K0001.</p>	<p><b>InterQual Medicare Durable Medical Equipment:</b></p> <ul style="list-style-type: none"> <li>- Appropriate subset will be chosen based on requested wheelchair item</li> </ul> <p><b>Medicare:</b></p> <ul style="list-style-type: none"> <li>- Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested wheelchair item</li> </ul>

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<b>Wound VAC</b>	Prior authorization required prior to the fourth month of rental.	Prior authorization required prior to the fourth month of rental.	E2402	<b>InterQual Medicare Durable Medical Equipment:</b> - Negative Pressure Wound Therapy Pumps  <b>Medicare Local Coverage Determination for Negative Pressure Wound Therapy Pumps (L33821)</b>

## Contact Information

UCare Contact	Service Area	Phone	Fax	Website or Email
<b>Clinical Services</b>	Medical Authorizations	1-877-447-4384 toll-free 612-676-6705	612-884-2499	<a href="#">UCare</a>
<b>Clinical Pharmacy Intake</b>	Medical Drug - Non-PAR and MultiPlan Providers	612-676-6504	612-617-3948	<a href="#">UCare - Pharmacy</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</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</a>
Delegate Contact	Service Area	Phone	Fax	Website
<b>Delta Dental</b>	Dental	1-855-648-1416 toll-free 651-768-1416	N/A	<a href="#">Delta Dental</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	833-837-4300	855-668-8552	<a href="#">CoverMyMeds</a> <a href="#">Surescripts</a> <a href="#">Express-PAth</a> (for dates of service prior to Jan. 1, 2024)