



2023 Authorization and Notification Requirements - Medical Services

UCare Medicare Plans | UCare Your Choice | UCare Medicare Plans with M Health Fairview & North Memorial | Institutional Special Needs Plans (I-SNP)

List of Authorization and Notification Requirements

Acute Inpatient Rehabilitation	Durable Medical Equipment	Transplant
Back (Spine) Surgery	Genetic Testing	Vein Procedures
Bariatric Surgery	Inpatient Hospital Acute	Wheelchair Accessories
Bone Growth Stimulator	Long-Term Acute Care (LTAC)	Wheelchair - Rental
Cosmetic or Reconstructive Procedures	Proton Beam Therapy	Wheelchair - Purchase
Cranial Nerve Stimulation	Skilled Nursing Facility (SNF) or Swing Bed Admission	Wound VAC
Spinal Cord Stimulation		

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 an 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.
- Authorization is not required for prosthetics and/or orthotics.
- 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 additional information on eligibility, benefits and network status.

Forms

- [UCare Authorization and Notifications 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 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. UCare is the contract resource for all authorization service requests, concerns and questions, unless noted otherwise within delegated services.

- Acupuncture
- Chiropractic
- Dental
- Pharmacy

Requirement Definitions

Approval Authority	UCare, or an organization delegated by UCare, to approve or deny prior authorization requests.
Notification	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.
Pre-Service Determination (PSD)	An enrollee, or a provider acting on behalf of the enrollee, always has the right to request a pre-service determination if there is a question as to whether an item or service will be covered by the plan.
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, appropriate, expense and that other alternatives have been considered.

Contact Information

UCare Contact	Service Area	Phone	Fax	Website/Email
Clinical Services	Medical Authorizations	612-676-6705 1-877-447-4384 toll-free	612-884-2499	UCare
Clinical Pharmacy Intake	Medical Drug - Non-PAR and MultiPlan Providers	612-676-6504	612-617-3948	UCare® - Pharmacy
Mental Health and Substance Use Disorder Services	MH/SUD Authorizations	612-676-6533 1-833-276-1185 toll-free	612-884-2033 1-855-260-9710 toll-free	UCare MHSUDservices@ucare.org
Provider Assistance Center (PAC)	Member Eligibility/Benefits and Network Status	612-676-3300 1-888-531-1493 toll-free	N/A	UCare
Delegate Contact	Service Area	Phone	Fax	Website
Delta Dental	Dental	1-866-298-5520 toll-free	N/A	Delta Dental
Fulcrum	Acupuncture	1-877-886-4941 toll-free	763-204-8572	Fulcrum
Fulcrum	Chiropractic	1-877-886-4941 toll-free	N/A	Fulcrum
Care Continuum	Medical Drug - PAR Providers	1-800-818-6747 toll-free	1-877-266-1871 toll-free	ExpressPath
Express Scripts, Inc. (ESI)	Pharmacy Drug Prior Authorizations	1-877-558-7521 toll-free	1-877-251-5896 toll-free	ExpressPath

Service Category	Requirements	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
Acute Inpatient Rehabilitation	<p>Prior authorization required prior to admission.</p> <p>Concurrent review required for additional days.</p> <p>Discharge summary required to be sent upon discharge.</p>	N/A	<p>InterQual LOC Rehabilitation:</p> <ul style="list-style-type: none"> - Appropriate subset will be chosen based on reason acute inpatient rehabilitation admission <p>Medicare Benefit Policy Manual:</p> <ul style="list-style-type: none"> - Chapter 1 - Inpatient Hospital Services Covered Under Part A
Back (Spine) Surgery	<p>Prior authorization required prior to service. Authorization not required for:</p> <ul style="list-style-type: none"> - Emergency surgery for trauma - Acute transverse myelopathy - Tumors - Cervical and Thoracic Back Surgery 	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>InterQual Medicare Procedures:</p> <ul style="list-style-type: none"> - Lumbar Spinal Fusion - Minimally Invasive Sacroiliac (SI) Joint Fusion - Vertebroplasty or Kyphoplasty <p>Medicare Local Coverage Determination:</p> <ul style="list-style-type: none"> - Minimally Invasive Surgical (MIS) Fusion of the Sacroiliac Joint L36406
Bariatric Surgery (Gastric Bypass)	<p>Prior authorization required prior to service.</p>	43644, 43645, 43770, 43773, 43775, 43842, 43843, 43845, 43846, 43847, 43848	<p>InterQual Medicare Procedures:</p> <ul style="list-style-type: none"> - Bariatric Surgery <p>Medicare:</p> <ul style="list-style-type: none"> - National Coverage Determination (NCD) for Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity (100.1)

Service Category	Requirements	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
Bone Growth Stimulator	Prior authorization required prior to purchase or placement.	E0748, E0749	InterQual Medicare Durable Medical Equipment: - Osteogenesis Stimulators Medicare: - National Coverage Determination (NCD) for Osteogenic Stimulators (150.2) - Local Coverage Determination (LCD) Osteogenesis Stimulators (L33796)
Cosmetic or Reconstructive Procedures Examples include: - Abdominoplasty - Breast reduction surgery - Gynecomastia - Mammoplasty - Panniculectomy - Removal of breast implant(s)/ Replacement of breast implants - Rhinoplasty/Septorhinoplasty - Skin peel(s)	Prior authorization required prior to service. Authorization not required for: - Blepharoplasty - Breast Reconstructive Surgery following medically necessary mastectomy Please note: Photographs are not required to be submitted when requesting authorization for cosmetic/reconstructive surgeries. If UCare determines photographs are needed the Utilization Review Specialist will call to request them.	11920, 11921, 11922, 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, 19303, 19316, 19318, 19324, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19366, 19371, 19380, 21137, 21138, 21139, 21172, 21175, 21179, 21180, 21181, 21182, 21183, 21184, 21208, 21209, 21230, 21235, 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, G0429, Q2026, Q2028, S2066, S2067, S2068	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	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
<p>Cranial Nerve Stimulation including Vagus Nerve and Hypoglossal Nerve</p>	<p>Prior authorization required prior to service.</p>	<p>64553, 64568, 64569, 64582</p>	<p>InterQual Medicare Procedures:</p> <ul style="list-style-type: none"> - Hypoglossal Nerve Stimulation for the treatment of Obstructive Sleep Apnea - Vagus Nerve Stimulation <p>Medicare:</p> <ul style="list-style-type: none"> - National Coverage Determination (NCD) for Vagus Nerve Stimulation (VNS) (160.18) - Local Coverage Determination (LCD) Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38387)
<p>Durable Medical Equipment – PURCHASE and RENTAL</p> <p>See also: Wheelchairs and accessories</p> <p>See also: Wound VAC</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.</p> <p>All months must be authorized.</p> <p>Authorization is not required for:</p> <ul style="list-style-type: none"> - Monthly rental of ventilators - Monthly rental of oxygen and equipment. - Prosthetics and orthotic devices/equipment 	<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 (this is a Rental Only item)</p> <p>E0766 - Electrical Stimulation Device (this is a Rental Only item)</p> <p>E2510 - Speech Generating Device</p>	<p>InterQual Medicare Durable Medical Equipment:</p> <ul style="list-style-type: none"> - Appropriate subset will be chosen based on requested DME item <p>Medicare:</p> <ul style="list-style-type: none"> - Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested DME item

Service Category	Requirements	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
<p>Genetic/Molecular Diagnostic Tests for the following:</p> <ul style="list-style-type: none"> - Breast cancer - Ovarian cancer - Colorectal cancer (excluding Fecal DNA test) - Pancreatic cancer - Prostate cancer - And all cancer panels (i.e., gene sequencing, whole genome/exome sequencing) 	<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>InterQual Molecular Diagnostics: - Appropriate subset will be chosen based on requested genetic testing</p> <p>Medicare: - Local Coverage Determination (LCD): Molecular Pathology Procedures (L35000) - Local Coverage Determination (LCD): Genomic Sequence Analysis Panels in the Treatment of Solid Organ Neoplasms (L37810) - Local Coverage Determination (LCD): Genomic Sequence Analysis Panels in the treatment Hematolymphoid Diseases (L37606)</p> <p>Medical Policy may be available for select genetic tests</p> <p>NCCN Guidelines</p>
<p>Inpatient Hospital, Acute</p> <p>All Hospital Inpatient Level of Care Admissions</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>	<p>N/A</p>	<p>InterQual LOC Acute Adult: - Appropriate subset will be chosen based on reason for inpatient admission</p>

Service Category	Requirements	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
Long-Term Acute Care (LTAC)	<p>Prior authorization required prior to admission.</p> <p>Concurrent review required for additional days.</p> <p>Discharge summary required to be sent upon discharge.</p>	N/A	<p>InterQual LOC Long Term Acute Care:</p> <ul style="list-style-type: none"> - Appropriate subset will be chosen based on reason for LTAC admission
Proton Beam Therapy	Prior authorization required prior to service.	77520, 77522, 77523, 77525	<p>InterQual Medicare Procedures:</p> <ul style="list-style-type: none"> - Proton Beam Therapy <p>Medicare:</p> <ul style="list-style-type: none"> - Local Coverage Determination (LCD): Proton Beam Therapy (L35075)
Skilled Nursing Facility (SNF) or Swing Bed Admission	<p>Prior authorization required within one business day of admission.</p> <p>Concurrent review required for additional days.</p> <p>Discharge summary required to be sent upon discharge.</p>	N/A	<p>InterQual LOC Subacute/SNF:</p> <ul style="list-style-type: none"> - Appropriate subset will be chosen based on reason for SNF admission <p>Medicare Benefit Policy Manual:</p> <ul style="list-style-type: none"> - Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Service Category	Requirements	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
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)
Transplant - Bone marrow - Heart - Heart-lung - Kidney - Liver - Lung - Pancreas - Stem cell	Step one: Notification required for transplant consult/evaluation. Step two: Notification required for transplant listing. Step three: Notification required within 24 hours of inpatient hospital admissions.	N/A	InterQual LOC Acute Adult: - Appropriate subset will be chosen based on reason for inpatient admission
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)

Service Category	Requirements	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
<p>Wheelchair Accessories - PURCHASE and RENTAL</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 prior to delivery or dispensing billable accessories that are new, replacements or repaired with a per month allowable rental rate or purchase over \$1,000.</p> <p>All months must be authorized.</p>	<p>E1008, E2204</p> <p>Please note: This may not be an all-inclusive list. Please review the Medicare or DHS fee schedule to determine if the item you are requesting would be over \$1,000 per month to purchase or rent.</p>	<p>InterQual Medicare Durable Medical Equipment:</p> <ul style="list-style-type: none"> - Appropriate subset will be chosen based on requested wheelchair item <p>Medicare:</p> <ul style="list-style-type: none"> - Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested wheelchair item
<p>Wheelchair - RENTAL</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.</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>InterQual Medicare Durable Medical Equipment:</p> <ul style="list-style-type: none"> - Appropriate subset will be chosen based on requested wheelchair item <p>Medicare:</p> <ul style="list-style-type: none"> - Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested wheelchair item
<p>Wheelchair - PURCHASE</p> <p>UCare reserves the right to determine rental vs. purchase.</p>	<p>Prior authorization required prior to purchase of all wheelchair bases.</p> <p>See Wheelchair Accessories for purchase, repair and replacement authorization requirements.</p>	<p>All Manual Wheelchairs, Power Operated Vehicles and Power Wheelchairs.</p>	<p>InterQual Medicare Durable Medical Equipment:</p> <ul style="list-style-type: none"> - Appropriate subset will be chosen based on requested wheelchair item <p>Medicare:</p> <ul style="list-style-type: none"> - Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) will be chosen based on the requested wheelchair item

Service Category	Requirements	Codes Requiring Authorization CPT/HCPTC Codes	Medical Necessity Criteria
Wound VAC	Prior authorization required prior to the 4th month of rental.	E2402	<p>InterQual Medicare Durable Medical Equipment: - Negative Pressure Wound Therapy Pumps</p> <p>Medicare: - Medicare Local Coverage Determination for Negative Pressure Wound Therapy Pumps (L33821)</p>