I. **Inpatient Admissions** - All inpatient admissions require an authorization.
Fidelis Care does not require authorization of emergency room services or any emergent service required to provide stabilization of an emergent condition. Fidelis Care does require authorization of post stabilization services and inpatient admissions, after emergency room services are completed. All facility admissions are reviewed for medical necessity.

A. **All inpatient facility services** - Medical, Substance Abuse, and Behavioral Health admissions require authorization.

B. **Inpatient Rehabilitation Services**: Acute, sub acute and skilled nursing rehabilitation require authorization.
   1. Acute and sub acute rehabilitation are authorized, as long as skilled services are provided.
   2. Inpatient substance abuse rehabilitation requires prior authorization.

C. **Transplants**:  
All solid organ and bone marrow / tissue transplants require authorization at the time of the transplant evaluation.  
Includes but not limited to: 32850-32856, 33930-33945, 38204-38215, 38220-38221, 38230-38242, 41133-41136, 47133-47147, 48160, 48550-48556, 50300-50380, 50547, 65710-65757.

D. **Elective Surgical Procedures**:  
Many surgical and medical procedures which are completed within 24 hours will not be approved as an in-patient level of care. These services, when billed as an out-patient level of care, do not require authorization if performed within the Fidelis Care network. Such procedures include, but are not limited to, cardiac catheterization and stenting, laparoscopic procedures, and thyroid surgery if completed within 24 hours from the onset of surgery.

The link provides a list of inpatient only procedures for Medicare:  

II. **Out-patient Surgery**: The following services require prior authorization:
A. Obstetrical procedures: 58340
B. Bariatric surgery: 43770-43888, S2083
C. Blepharoplasty: 15820-15823
D. Breast reconstruction: 11920-11971, 19300, 19316-19342, 19355, 19370-19396
E. Skin surgery and other dermatological procedures: The auth requirement for many skin surgery treatments and repairs has been removed if performed in the office or outpatient facility (POS 11 and 22).

1. The following codes will continue to require authorization if completed as ambulatory surgery (POS 24): 10040, 11300-11313, 11400 - 11471,11721
2. Dermal injections for the treatment of Facial Lipodystrophy Syndrome (LDS) require authorization. Coverage for these services is limited to individuals diagnosed with HIV who have a secondary diagnosis of depression. Codes that may be covered with authorization are Q2026, Q2027, and G0429.

Only the following codes continue to require authorization for any place of service: 11200-11201, 11719, 15775-15829, 17340-17999.

F. Services for the following codes performed in free standing ambulatory surgery centers billing with bill type 0831 require an authorization (10060, 11100, 11900 and 17000, 20600, 20605, and 20610).

G. Ear repair and ear piercing 69300 and 69090

H. Eyelid & ocular surgery 65760-65771, 65772-65775, 67900-67911

I. Abdominoplasty, lipectomy, panniculectomy 15830-15839, 15847, 15876-15879

J. Reduction mammoplasty 19300, 19318

K. Facial cosmetic, septrhino, rhinoplasty 21120-21296, 30400-30450, 30465-30520, 30620-30802, 30999, Q2028

L. Vascular procedures i.e. vein stripping, ligation, ablation and sclerotherapy 36468-36479, 37241-37244, and 37718-37785,

III. Behavioral Health-Outpatient:
The authorization requirement has been removed from all outpatient behavioral health services except the following, which will continue to require authorization:

A. Psychological/Neuropsychological Testing:
96101, 96102, 96103, 96116, 96118, 96119, 96120, 96125. Authorization requests should be submitted on the Neuropsychological testing form.

B. Developmental Pediatric Testing:
96105, 96111 Note: 96110 is a non-covered service

C. Outpatient ECT
90870

D. Partial Hospitalization (Mental Health and/or Substance Abuse)
Revenue code 912, 913,944 and 945. HCPCS code H0035

E. Intensive Outpatient Treatment
Bill type 131, Revenue code 905 or 912, CPT code 90899, HCPCS code H2013

IV. Outpatient and DME Services: These services require prior authorization:

A. Diagnostic Testing:
1. Sleep Studies
2. Breast Cancer testing (BRCA) and other Genetic Testing (note cpt 81220 does not require authorization)
3. Wireless Capsule Endoscopy (91110, 91111)
4. HIV Resistance Testing
   i. Prior authorization is required for 87900, 87903, and 87904
   ii. 87901 – up to 2 per calendar year permitted without prior authorization; 3 or more in a calendar year require authorization
   iii. 87906 – up to 1 per calendar year permitted without prior authorization; 2 or more in a calendar year require authorization
iv. 87999 – prior authorization required for trofile testing (i.e. when accompanied by dx code B20 or Z21)

5. Gastroenterology Procedures – The following procedures require authorization if performed in POS 22 when there is an office-based or ambulatory surgery center available to provide the service: 43239, 45378, 45380, 45384, and 45385. Authorization is not required for these services when performed in POS 11 or 24

B. Durable Medical Equipment:
1. The following DME codes do not require an authorization:
2. The following orthotic codes do not require an authorization:
3. Other DME and orthotic codes require an authorization.

C. Home Health Care

D. Hospice care is covered through original Medicare. For more information: http://www.medicare.gov/coverage/hospice-and-respite-care.html

E. Imaging Studies:
1. The first 4 OB ultrasounds can be performed without an authorization. Four or more ultrasounds for a normal pregnancy (dx code V22.x) require authorization. OB ultrasounds for a high risk pregnancy (dx code V23.x) do not require authorization.
2. The authorization requirement for PET scans (CPT codes 78492, 78608 and 78811-78816) with a cancer diagnosis (ICD 10 codes C7A.019-C7B.8, C00.0-C04.9, C06.0-C08.9, C09.8-C11.9, C13.0-C14.8, C15.3-C17.9, C18.3-C21.8, C22-C26.9, C30.0-C34.92, C37-C49.9, C50.019-C50.919, C50.029-C50.929, C52-C58, C60.0-C68.9, C69.4-C69.92, C71.0-C78.89, C79.00-C80.2, C81.79-C81.98, C82.00-C96.Z, D00.00, D18.81, D21.0-D36.9, D37.030-D38.6, D39.0-D41.8, D44.3-D43.9, D48.0-D49.9, R68.84) has been removed. All other diagnosis codes continue to require authorization.
3. Low Dose CT Lung Cancer Screening (S8032) – coverage is limited to asymptomatic adults age 55-80 who have a 30 pack per year smoking history and currently smoke or have quit smoking within the past 15 years.

F. Outpatient Therapy:
Physical, Occupational, Speech Therapy - The initial evaluation does not require prior authorization. Additional visits require authorization, including swallow function and therapy. Members enrolled in Fidelis Dual Advantage Flex (Plan 017) have a separate $1,880 annual dollar limit for Physical and Speech Therapy combined and $1,880 annual dollar limit for Occupational Therapy.

G. Podiatry Services:
Authorization is no longer required for podiatric services rendered to members with a confirmed diagnosis of Diabetes Mellitus. The Diabetes diagnosis must be included on the claim when services are billed. Podiatric services to members without a diagnosis of diabetes will continue to require authorization. Podiatrists will continue to require authorization for all DME and orthotic codes that are supplied in the office, regardless of member diagnosis.

H. Therapeutic Services:
1. Phototherapy (96567, 96900, 96910, 96912, 96913, 96920)
2. Chiropractic Services
3. Hyperbaric Oxygen Therapy
4. Pain management authorization is required for the codes below and the requirement applies to all providers.
   20526, 20550-20553, 21073, 27096, 62263-62264, 62273, 62280-62282, 62290, 62310-62311, 62318-62319, 62360-62362, 62365, 62367-62368, 62370, 63650-63688, 64400-64530, 64550-64595, 64600-64640. (for non-orthopedists only)
5. The following services are not covered for members with a diagnosis of Low Back Pain:
   a. Prolotherapy;
   b. Therapeutic injections of steroids into intervertebral discs
6. Topical oxygen is not a covered service.

V. Counseling Services Authorization requirements are indicated. Please read carefully.
A. Medical Nutrition Therapy (MNT)

**B. Diabetes Self Management Training (DSMT)**
Members are allowed 10 hours/20 units in a continuous 12 month period. These services must be provided by certified providers and no longer require authorization. Services are covered when billed with codes G0108 and G0109.

**VI. New Technology/Experimental Treatment: Prior authorization is required and approval is based on medical necessity.**

**VII. Services provided by outside vendors**

A. Vision: Prior authorizations by Davis Vision 1-800-601-3383

B. Transportation


**VIII. Pharmacy: As per the Medicare Part D Formulary (see Website) for Medicare Plan members**

All covered Medicare Part D drugs must be prescribed for medically accepted indications, which are the FDA approved indications or the use of which is supported by one or more Medicare approved compendia. The Medicare approved compendia include: DRUGDEX (Micromedex), AHFS (American Hospital Formulary Service). Additional consideration of anticancer chemotherapeutic regimen can be researched in DRUGDEX (Micromedex), AHFS (American Hospital Formulary Service), Clinical Pharmacology, NCCN (National Comprehensive Cancer Network), PubMed and in the Medicare approved peer-reviewed literature.

The Fidelis Website provides further details on Formulary Drug List, Prior Authorization Criteria, Step Therapy Criteria, Coverage Determination process, Redetermination process.


and


A. Enteral Therapy-HCPCS codes B4034-B4162 describe the available enteral formulas or disposable items that require authorization. Benefit applies to Part B services.

B. These injectable codes for all lines of business require authorization:

IX. **Out-of-network:**
Out-of-network services are covered with an authorization for the Medicare Advantage Flex Plan (003) and the Medicare Advantage without RX (001) but additional co-pays and deductibles may apply.

X. **All services for “Unlisted” codes require authorization**