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. All facility admissions are reviewed for medical necessity.

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

B. Inpatient Rehabilitation Services: (acute, sub acute and skilled nursing rehabilitation) require prior authorization.
   1. Medical rehabilitation can be completed at an acute or sub acute level of care
   2. Inpatient substance abuse rehabilitation requires prior authorization.

C. Out of Network: Any service provided by a non-participating provider/facility/physician requires authorization.

D. 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, 38230-38242, 44133-44136, 47133-47147, 48160, 48550-48556, 50300-50380, 50547, 65710-65757.

E. Elective Surgical Procedures:
   Many surgical and medical procedures which are completed within 24 hours will not be approved at an inpatient level of care. These same services when billed as an outpatient 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. Outpatient surgery: The following services require prior authorization:
A. Obstetrical procedure: 58340
B. Bariatric surgery: 43770-43774, S2083
C. Blepharoplasty: 15820-15823
D. Breast reconstruction: 11920-11971, 19300, 19316-19342, 19355, 19370-19396
E. Skin surgery and other dermatological procedures:
There is no authorization requirement for many skin surgery treatments and repairs if performed in the office or outpatient facility (POS 11 and 22). The following codes will require authorization if completed as ambulatory surgery (POS 24): 10040, 11300-11313, 11400 - 11471, 11721

**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). Note: cpt code 20610 is non-covered when billed with one of the following diagnosis codes: M17.0, M17.10-M17.12, M17.2, M17.20-M17.32, M17.4, M17.5, M17.9

**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, seotoplasty, rhinoplasty: 21120-21296, 30400-30450, 30465-30520, 30620-30802, 30999

**L.** Vascular procedures i.e. vein stripping, ligation, ablation and sclerotherapy: 36468-36479, 37718-37785, 36011, and 37204.

### III. Behavioral Health - Outpatient services

There is no authorization requirement for the majority of outpatient behavioral health services **except the following, which will require authorization:**

**A. Psychological/Neuropsychological Testing:**
96101, 96102, 96103, 96116, 96119, 96120, 96125. All 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 H2013

**E. Intensive Outpatient Treatment**
Revenue code 905 or 912, CPT code 90899, HCPCS code H2013

**F. Day Treatment and Continuing Day Treatment:**
H2012

**G. Assertive Community Treatment (ACT):**
H0040

**H. Personalized Recovery Oriented Services (PROS):**
H0002, H2019,T1015, H2018, H2025, H2019

**I. OMH Licensed Community Residences:**
H2018

**J. OASAS Residential Treatment Services:**
H2034 and H2036

### IV. Outpatient and DME Services: The following 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)

B. Durable Medical Equipment and Supplies:
   1. These DME codes do not require an authorization:
   2. These orthotic codes do not require an authorization:
   3. Other DME and orthotic codes require an authorization.
   4. Compression stockings are covered with authorization when medically necessary.
   5. Footwear benefit: Prescription footwear means orthopedic shoes, shoe modifications and shoe additions. These are covered with authorization when medically necessary.
   6. The following codes for incontinence supplies require authorization (*effective 4/1/16): A4335, A4554, T4521-T4524, T4529, T4530, T4533, T4535, T4537, T4539, T4540, T4543 (*note this authorization requirement is effective 4/1/16)

C. Home Health Care: Home care approvals are based on the medical need for skilled services.
   1. Personal Care Services:
      All services require authorization and use of the following codes:
      T1001-for a nursing assessment (not for nurse supervision)
      T1019-Personal Care Level I- 15 minute intervals, maximum of 8 hours a week.
      T1020-Personal Care Level II-hourly intervals, up to 24 hours a day
      G0162 - Nursing Supervision of Personal Care Providers is applicable to bill for services outside of New York City.
   2. Personal Emergency Response System (PERS) is a FIDA benefit and requires an authorization.
   3. Consumer Directed Personal Assistance services (CDPAS) is a benefit for FIDA and requires authorization.

D. Hospice care is covered through original Medicare. For more information:
E. Imaging Studies: The following services below require authorization:
   1. The first 4 OB ultrasounds can be performed without an authorization. Five or more ultrasounds require authorization.
   2. The authorization requirement for PET scans (CPT codes 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-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 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.

G. Podiatry Services:
Authorization is not 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 Codes (i.e. injections, TENS, therapeutic services): 20526, 20550-20553, 21073, 27096, 62263-62264, 62273, 62280-62282, 62310-62311, 62318-62319, 62360-63262, 62365, 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 facet joint steroid injections in the lumbar and sacral regions with or without CT fluoroscopic image guidance;
      c. Therapeutic injections of steroids into intervertebral discs; and
      d. Continuous or intermittent traction.
   6. Topical oxygen requires prior authorization.

I. Long Term Home Health Care Services
Medical Social Services (S9127) and Home Delivered Meals (S5170) are covered with an authorization for Medicaid Managed Care enrollees who have transitioned from the Medicaid Fee-for-Services Long Term Home Health Care Program (LTHHCP) and were in receipt of these services at the time of transition into Medicaid Managed Care.
J. Adult Day Health Care/AIDS Adult Day Health Care (ADHC/AADHC)
Authorization is required for any new ADHC/AADHC patient.

K. DME and pharmaceutical treatment for Erectile Dysfunction (note: these items and services are not covered for registered sex offenders): 54360, 54400-54402, 54405, L7900

V. Counseling Services

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 based on medical necessity.

VII. Services provided by outside vendors
A. Dental Services: Prior authorizations are completed by DentaQuest 1-800-516-9615.
B. Vision: Prior authorizations by Davis Vision 1-800-601-3383
C. Transportation Link:


VIII. Pharmacy: As per formulary for FIDA.

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

B. These injectable codes require authorization.

IX. All services for “Unlisted” codes require authorization.