MetroPlus Health Plan Authorization Requirements
Managed Medicaid, Child Health Plus and MetroPlus Gold

Benefit/Service Detail
SERVICES AND PROCEDURES WHICH REQUIRE AUTHORIZATION

REVISED 07/01/15

I. Out of Network:

Any Medicaid, CHP and MetroPlus Gold service provided by a non-participating provider/facility/physician requires authorization ex. Outpatient radiation therapy.

II. Inpatient Admissions-All inpatient admissions require an authorization.

MetroPlus Health Plan does not require authorization of emergency room services or any emergent service required to provide stabilization of an emergent condition. MetroPlus Health Plan 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) Inpatient Services include but are not limited to:

- Elective surgical and non-surgical inpatient admissions
- Acute rehabilitation admissions
- Inpatient hospice admissions
- Long term acute care (LTAC) facility admissions
- Skilled nursing facility admissions
- Residential nursing facility admissions.

b) Elective Surgical Procedures:

Many surgical and medical procedures which are completed within 24 hours will not be approved at an in-patient level of care. Requests for Ambulatory Surgery procedures level
of care does not require authorization if performed within the MetroPlus Health Plan network (HHC Facilities) or Contracted Facilities except procedures that are potentially cosmetic. Ambulatory Surgery for non-participating hospitals and free standing ambulatory surgery facilities continue to require prior authorization. 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.

c) Transplants:

All solid organ and bone marrow/tissue transplants require authorization at the time of transplant evaluation. [Place of Service Guide]

III. Outpatient surgery: The following services require prior authorization:

A. Percutaneous Transcathether Placement- 92928, 92929
B. Osteochondral allograft and autograft transplantations- 27415
C. Cochlear implant surgery and associated supplies/bone anchored-69930, 69949
D. Uvulopalatopharyngoplasty (UPPP) including laser assisted-42145
E. Obesity/Bariatric Surgery-43886, 43887, 43888
F. Obstetrical procedure-56810
G. Blepharoplasty-67916, 67917, 67923, 67924
H. Breast Reconstruction (potentially cosmetic)- 19357, 19366,
IV. Reconstructive procedures and potentially cosmetic procedures. The following codes continue to require authorization for any place of service.

A. Ptosis repair-67900
B. Bone graft, genioplasty and mentoplasty-21120, 21121, 21122, 21123
C. Breast: reconstruction, reduction, augmentation, mammoplasty, mastopexy, insertion and removal of breast implants-19316, 19318, 19324, 19325, 19328, 19330, 19340, 19340, 19342, 19350, 19357, 19361, 19364, 19366. 19367, 19368, 19369
D. Canthopexy/canthoplasty-21280, 21282, 67950
E. Cervicoplasty-15819
F. Chemical peel-15788, 15797, 15793
G. Dermabrasion-15789
H. Excision of excessive skin and or subcutaneous tissue-15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839
I. Hair Transplant-15775, 15776
J. Injectable dermal fillers-15780
K. Keloid removal-11400, 11446
L. Lipectomy, liposuction or any excess fat removal procedure-15830, 15832, 15833, 15834, 15835, 15836, 15838
M. Otoplasty-69300, 69301
N. Rhinoplasty-30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462
O. Rhytidectomy-15824, 15825, 15826, 15828, 15829
P. Scar revision-25929, 11400, 11446
Q. Skin closures including:
   - Skin grafts-15100, 15120
   - Skin flaps-26560, 26561
   - Tissue grafts-20926

R. Sex reassignment surgery

S. Surgery for varicose veins, including perforators and sclerotherapy

Any procedure, device or service that may potentially be considered experimental or investigational including:
   - New emerging technology/procedures, as well as existing technology and procedures applied for new uses and treatments.

V. Outpatient Services:
   A. Elective (non-emergency) ground, air and sea ambulance transportation.
   A. Outpatient private duty nursing
   B. Day rehabilitation programs
   C. All home-care services (including infusion therapy in the home)

VI. Durable Medical Equipment:

DME coverage information is available in the Medicaid DME Program Manual at:

https://www.emedny.org/ProviderManuals/DME/index.aspx

   A. For Medicaid, supplies and disposable items are covered by MetroPlus Health Plan.
   B. Section 4.1 (Medical Surgical Supplies) in the DME Manual describes specific codes for Supplies that are covered and do not require authorization.
   C. DME items for which MetroPlus Health Plan requires authorization are but not limited to:
- Bone growth stimulators
- Bone anchoring hearing aids
- Continuous positive airways pressure (CPAP) devices, bi-level (Bi-PAP) devices, and all supplies.
- Dynamic adjustable and static progressive stretching devices (excludes CPMs)
- Electric, power and motorized wheelchairs including custom accessories
- External defibrillator and associated accessories
- High frequency chest wall oscillation generator system
- Manual wheelchairs with the exception of those that are rented
- Negative pressure wound therapy
- Neuromuscular stimulators
- Power operated vehicles (POV)
- Pressure reducing support surfaces including:
  - Air fluid bed
  - Non powered advanced pressure reducing mattress
  - Powered air flotation bed (low air loss therapy)
  - Powered pressure reducing mattress
  - Push rim activated power assist devices
- Repair or replacement of all DME items, as well as orthoses and prosthetics that require precertification.
- Speech generating devices. Prosthetics/Orthotics including:
  - Custom ankle foot orthoses
  - Custom knee-ankle-foot orthoses
  - Custom knee braces
• Custom limb prosthetics including accessories/components

D. DME and pharmaceutical treatment for Erectile Dysfunction

(note: these items and services prior to authorization may require screening through the Department of Health).

Benefit limits as defined in the Medicaid DME Program Manual apply.

https://www.emedny.org/ProviderManuals/DME/index.aspx

VII. The following Therapeutic Services require authorization:

A. Hyperbaric Oxygen Therapy
B. Topical Oxygen Therapy
C. Proton Beam Therapy
D. Sleep Studies (facility based)
E. All Transplant procedures

VIII. Services for the following benefits can be referred to Beacon:

Mental health/Serious Mental Illness/Substance Abuse

A. Mental health and serious mental illness treatment (inpatient/partial hospitalization programs/intensive outpatient programs).
B. Repetitive transcranial magnetic stimulation (RTMS)
C. Substance abuse treatment (inpatient/partial hospitalization programs/intensive outpatient programs)
D. Autism behavioral analysis. www.beaconhealthstrategies.com
IX. **Home Health Care:**

Home Care approvals are based on the medical need for skilled services. There are different limitations based on the line of business. Skilled visits at home maybe limited based on the line of business.

Personal Care Services for Medicaid require authorization for the following:

A. Completion and submission of a current and valid M11Q.

B. Nursing Assessment Visit

C. Personal Care Level I- 15 minute (House-keeping and Home Assessment).

D. Personal Care Level II-hourly (Home Attendant) based on Nurse Assessment and completion of M11Q.

X. **Hospice:**

A. Effective 10/1/12, Medicaid Hospice services are covered if a member has a life expectancy of 12 months or less (instead of 6 months or less) CHP and MetroPlus Gold life expectancy 6 months or less.

B. Authorization periods run: 1st period 90 days; 2nd period 90 days; 3rd period and all subsequent periods 60 days regardless of setting.

XI. **Imaging Studies:**

The following radiology/high tech services require authorization: CT Scan, MRI, Pet and Nuclear studies. To determine if other additional services require authorization, refer to the link below: www.medsolutionsonline.com
XII. Pre-Natal Services:

A. Sonograms, non-stress test (NST’s) and Ancillary services are covered under the pre-natal authorization if billed by the same facility. Otherwise it requires authorization.

B. Genetic counseling in Participating facility/Participating MD- does not require authorization. Not to confuse with Genetic testing which regardless requires an authorization.

C. Requests for DME Breast Pumps, must meet criteria.

XIII. Outpatient Therapy: Physical, Occupational, Speech Therapy:

A. The first 20 visits do not require authorization, including swallow function and therapy.

B. The Medicaid, MetroPlus Gold and MLTC benefit is limited to 20 visits per member for each service per calendar year.

C. There is no visit limit for CHP.

XIV. Adult Day Health Care/AIDS Adult Day Health Care (ADHC/AADHC)

A. For initial authorization, MD referral is required.

B. Prior authorization is required for all services

C. Authorization requests for continuity of care should be submitted by participating and contracted providers.

XV. For Dental authorizations and services refer to: www.healthplex.com

XVI. Pharmacy: As per formulary for Managed Medicaid, CHP and MetroPlus Gold

www.caremark.com
Enteral Therapy:

A. Codes for Enteral Feeding and Supplies will require an authorization for both par and non-par providers.

B. The enteral feed solution must go through CVS/Caremark but the pump and other supplies have to be authorized by MetroPlus.

C. These codes are as follows: B4034, B4035, B4081, B4082, B4083, B4087 and B4088.

Benefit Coverage Criteria is limited to:

A. Beneficiaries who are fed via nasogastric, gastrostomy or jejunostomy tube.

B. Beneficiaries with inborn metabolic disorders.

C. Children up to 21 years of age, who require liquid or nutritional therapy when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or metabolized.

D. Adults with a diagnosis of HIV infection, AIDS, or HIV-related illness or other disease or condition, who are oral-fed, and who:

- Require supplemental nutrition, demonstrate documented compliance with an appropriate medical and nutritional plan of care, and have a body mass index (BMI) under 18.5 as defined by the Centers for Disease Control, up to 1,000 calories per day; OR

- Require supplemental nutrition, demonstrate documented compliance with an appropriate medical and nutritional plan of care, and have a body mass index (BMI) under 22 as defined by the Centers for Disease Control, and a documented, unintentional weight loss of 5 percent or more within the previous 6 month period, up to 1,000 calories per day;
• Require total nutritional support, have a permanent structural limitation that prevents the chewing of food, and placement of a feeding tube is medically contraindicated.