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CHAPTER I
PRIOR AUTHORIZATION AND SECOND SURGICAL OPINION REQUIREMENTS

This bulletin clarifies requirements associated with the prior authorization process, lists the health services for which prior authorization must be obtained, and implements the Second Surgical Opinion Program. The information in this bulletin is effective April 1, 1985.

I. Prior Authorization

A. Conditions Under Which MA or GAMC Reimbursement Will Be Denied:

In order to receive reimbursement from the Medical Assistance (MA) or General Assistance Medical Care (GAMC) Programs for health services listed in Attachment 1, providers must obtain prior authorization. Failure to comply with the prior authorization requirement will result in denial of reimbursement for all costs associated with providing the service. Once prior authorization is obtained, MA or GAMC reimbursement is guaranteed only if all other applicable requirements are met and the health service is provided to a person eligible for MA or GAMC on the date of the service.

B. Prohibition From Seeking Reimbursement From Recipients:

A physician, hospital, or other provider who is denied MA or GAMC reimbursement because of failure to comply with the prior authorization requirement is prohibited from seeking or accepting payment from the recipient, and the recipient shall not be held liable for payment of the service for which reimbursement is denied.

C. Retroactive Authorizations

A required authorization can be requested after a health service is provided to a recipient under the following conditions:

1. The health service was required to treat an emergency, i.e., a medical condition that, if not immediately diagnosed and treated, could cause a recipient serious physical or mental disability, continuation of severe pain, or death.

   Authorization will be considered if the provider submits the Prior Authorization Request Form, DPW-1855, no later than three (3) working days after giving the initial service. The provider must include documentation to substantitate the emergency such as reports, progress notes, admission histories, etc.

2. The health service was provided on or after the date on which the recipient's eligibility began, but before the date on which the recipient was notified that the case was opened.

   Authorization will be considered if form DPW-1855 is submitted within 20 working days of the date the recipient was notified that the case was opened.

3. Medicare reimbursement for the health service has been denied.

   Authorization requests must be submitted on the Prior Authorization Request Form, DPW-1855, within 20 working days of notification of the denial of Medicare reimbursement. A copy of the notification of denial must be attached to the DPW-1855.

Retroactive authorization requests will be evaluated according to the same criteria applied to prior authorization requests.

D. Prior Authorization Process:

If a health service is specified in Attachment I as requiring prior authorization, the following procedures must be followed:

1. Complete the Prior Authorization Request form, DPW 1855, according to the instructions outlined in the applicable Provider Handbook. NOTE: Prior authorization requests for dental services must be submitted on form DPW-1856.

2. Make certain that the enrolled provider personally signs the Prior Authorization Request form and other attachments. If services are being provided under the enrolled provider's supervision, then that individual must sign the supporting, attached documentation and list his/her credentials/degrees.

3. All requests for prior authorization must contain enough information/documentation to address the following criteria:

   a. The request must demonstrate the medical necessity for the requested health service.

   b. The request must demonstrate that the health service for which prior authorization is being sought is appropriate as to quality, timeliness and effectiveness.

   c. The request must demonstrate that less expensive appropriate health services have been tried and did not prove satisfactory or are judged to be unsuitable or are contraindicated.

   d. The request must demonstrate that provision of the requested service would be an appropriate expenditure of program funds.

   The provider bears the burden of establishing compliance with the above criteria, both for emergency and non-emergency situations. Failure to submit sufficient information to support a prior authorization request will result in the return of the prior authorization and other documentation submitted to support it. The reason for the return will be designated by a numerical code under the Service Name Box, Box #14 etc. Refer to the list marked Pending Code Reason List located in Attachment III for an

explanation of additional information needed or clarification of existing information needed. Provide such information and mark it "Additional Information as Requested", and return it with the original Prior Authorization Request form. If the Prior Authorization Request form is not resubmitted within 15 working days of the postmarked date on which it was returned, the prior authorization request will be denied.

If a request is denied, the recipient will receive a notice of denial, and the provider will receive a copy of the denied prior authorization, with a numerical code under the service name Box, #'s 14,24 etc. indicating the denial reason(s). Refer to the DENIAL REASON CODE LIST (Attachment II). If a P.A. contains multiple requests, some approved and some placed on pending because further information is needed, it will be processed and you will have to submit a (1) new prior authorization for the pended items, (2) a copy of the original prior authorization and documentation originally submitted, and (3) the additional information or clarification requested as indicated by the PENDING CODE REASON LIST.

If a request presents sufficient information with which to render a determination, then the Department shall either approve or deny the request within 15 working days of its receipt. The Department retains the right to keep all information/photographs submitted in support of the prior authorization request.

Recipients will be notified by the Department of any denial of a prior authorization request submitted on his/her behalf and the reasons. They will also be informed of their right to appeal a denial and who they contact to do so.

E. Fair Hearings

Any recipient who disagrees with the department's action to deny or reduce benefits has the right to appeal. Recipients who want to request a fair hearing to appeal the denial of benefits should contact their County Agency, or the Appeals Unit of the Department of Human Services by writing to:

Appeals Unit
Department of Human Services
4th Floor - Space Center
444 Lafayette Road
St. Paul, MN 55101

This appeal right is only available to MA or GAMC recipients, and does not extend to providers.

Second Surgical Opinion Program

The legislature has directed the Department to implement a Second Surgical Opinion Program. Effective March 1, 1985, a second opinion which confirms the initial recommendation that surgery be performed must be obtained as a condition of MA or GAMC reimbursement for the following surgical procedures:

Hernia Repair
Cholecystectomy
Hysterectomy
Tonsillectomy and/or Adenoidectomy
(Appropriate procedure codes will be listed following each surgical procedure - See attachment IV.

The second surgical opinion requirement for the procedures listed above will be waived when any of the following circumstances exist:

1. Reimbursement for the surgical procedure will be made by Medicare.

2. The surgical procedure is a customary and accepted practice as an incident to, or a consequence of, a more major surgical procedure.

3. The surgical procedure is an emergency. (An emergency means a medical condition that, if not immediately diagnosed and treated, could cause a recipient serious physical or mental disability, continuation of severe pain, or death.)

4. A visit to another practitioner to obtain a second opinion would require travel outside the local trade area. (The local trade area is the geographic area surrounding the recipient's residence which the local welfare agency identifies as commonly used by other persons in the same area to obtain necessary goods and services.)

5. The recipient has good cause for not obtaining a second opinion. (Good cause refers to circumstances beyond the recipient's control. Examples are illness of the recipient, illness of a family member requiring the presence of the recipient, or the unavailability of transportation, or weather conditions which cause travel to be unsafe. The Department retains the right to require documentation in support of exemptions for good cause.

In order for the second surgical opinion requirement to be waived, the provider must submit documentation with the claim for payment which substantiates that one of the circumstances listed above exists. If a provider wishes to obtain advance approval for the waiver of the second surgical opinion requirement, the provider must submit to the department a properly completed prior authorization form and attach to the form documentation to substantiate the reason for the waiver. If approval is granted, an authorization number will be assigned. Entering the authorization number on the claim for payment will insure that the second surgical opinion requirement is waived.

Process

The physician who initially recommends surgery shall provide to the recipient the names of at least two other physicians who are qualified to render a second or third opinion, or the name of an appropriate medical referral resource service. When a second surgical opinion fails to substantiate the initial surgical opinion, a third surgical opinion can be obtained if the recipient still wants the surgery.

NOTE: The Department will consider a maximum of three opinions in determining whether or not a requested surgical procedure will be approved. The cost of an opinion beyond the third opinion will not be reimbursed under either the MA or GAMC Program.

The physician who provides a second or third opinion shall indicate his or her approval or disapproval of the requested surgical procedure on the Second Surgical Opinion Form, DHS 2698. The form shall be properly completed and personally signed by each physician providing an opinion concerning the surgery. The form must be attached to a prior authorization form (DPW-1855) and submitted to the Professional Services Section of the Department. The prior authorization form must be completed according to instructions in the Physician's Handbook, except that information concerning medical necessity is not required. Prior authorization forms may be obtained by sending a forms requisition to: Welfare Forms Supply DHS, B-20, Centennial Office Building, St. Paul, MN 55156. A copy of the Second Surgical Opinion form is attached. Additional forms may be obtained from Welfare Forms Supply at the address listed above.

If two physicians concur that the requested surgical procedure is appropriate, the Department will certify that the second surgical opinion requirement has been met and assign an authorization number. The Department will assign the number within 15 working days of the Department's receipt of the necessary information and forms.

NOTE: It is the responsibility of the physician offering the surgical service to insure that the second opinion and, when required, the third opinion are obtained.

The second surgical opinion must be obtained within 90 days of the date of the initial opinion. If a third opinion is necessary, it must be obtained with 45 days of the initial opinion. Approved surgical procedures must be performed within 180 days of the initial opinion. If any of these time limits are not met, the second surgical opinion process must be repeated.

Denial of Reimbursement

Failure to obtain an authorization number certifying that the second surgical opinion requirement has been met will result in denial of MA or GAMC reimbursement for any costs, direct and indirect, associated with the surgery, including costs attributable to other providers and hospitals except for the providers who rendered the second or third opinion.

Even when the physician who is requesting authorization to perform the surgery is unable to secure the required second or third opinion to support the surgical procedure, the second surgical opinion form, DHS 2698, must be submitted within 135 days of the date of the first opinion. This is necessary so the Department can compile statistics concerning the second surgical opinion requirement. Failure to submit the form when the first opinion is not confirmed by a second or third opinion may result in the physician who initially recommended surgery being terminated from participation in the MA and GAMC Programs. When a physician who provides a second or third opinion also performs the surgery in question, reimbursement for the surgery will be denied.

Prohibition Against Seeking Reimbursement from a Recipient

A physician, hospital, or other provider who is denied reimbursement because of failure to comply with the second surgical opinion requirement is prohibited from seeking payment from the recipient of the service for which reimbursement was denied.

Fair Hearings

Any recipient who disagrees with the Department's action to deny benefits has the right to appeal the denial. Recipient's who wish to request a fair hearing to appeal the denial of benefits should contact their County Agency, or the Appeals Unit of the Department of Human Services by writing to:

Appeals Unit
Department of Human Services
4th Floor-Space Center
444 Lafayette Road
St. Paul, MN 55101

MINNESOTA MEDICAL ASSISTANCE/GENERAL ASSISTANCE MEDICAL CARE
SECOND SURGICAL OPINION

MAIL TO: DEPARTMENT OF HUMAN SERVICES
SECOND SURGICAL OPINION PROGRAM
PROFESSIONAL SERVICES SECTION
2ND FLOOR - SPACE CENTER
444 LAFAYETTE ROAD
ST. PAUL, MINNESOTA 55101

RECIPIENT PLEASE NOTE

IF YOU FAIL TO GET A SECOND OR THIRD SURGICAL OPINION, THE SURGERY WHICH IS CHECKED BELOW WILL NOT BE PAID FOR BY MA OR GAMC. THERE ARE EXCEPTIONS TO THIS RULE SUCH AS GOOD CAUSE, MEDICARE REIMBURSEMENT, EMERGENCIES, LONG TRAVEL TIME, ETC. SPEAK WITH YOUR PHYSICIAN ABOUT WHETHER OR NOT ONE OF THE EXCEPTIONS APPLY TO YOU, OR CALL YOUR LOCAL WELFARE AGENCY OR THE DEPARTMENT OF HUMAN SERVICES.

REFERRING PHYSICIAN/RECIPIENT

PRIMARY/REFERRING PHYSICIAN		RECIPIENT	
NAME	PROVIDER NUMBER	NAME	MA/GAMC NUMBER
STREET		STREET	
CITY AND STATE	ZIP	CITY AND STATE	ZIP

DATE OF RECOMMENDATION FOR SURGERY _____

PROPOSED PROCEDURE (check one)

- ☐ TONSILLECTOMY AND/OR ADENOIDECTOMY
- ☐ HERNIA REPAIR
- ☐ CHOLECYSTECTOMY
- ☐ HYSTERECTOMY

SECOND OPINION

PHYSICIAN GIVING SECOND OPINION

NAME	PROVIDER NUMBER
STREET	
CITY AND STATE	ZIP

I HAVE EXAMINED THE ABOVE-NAMED PATIENT, AND IN MY OPINION, THE PROPOSED SURGERY:

- ☐ IS APPROPRIATE
- ☐ IS NOT APPROPRIATE BECAUSE:
  - ☐ NO PATHOLOGY IS EVIDENT.
  - ☐ SYMPTOMS ARE NOT SEVERE ENOUGH TO WARRANT SURGERY.
  - ☐ SURGERY SHOULD BE DEFERRED, PENDING MEDICAL TESTS (DESCRIBE BELOW).
  - ☐ MEDICAL TREATMENT IS PREFERABLE (DESCRIBE BELOW).
  - ☐ ALTERNATE PROCEDURE IS RECOMMENDED (DESCRIBE BELOW).
  - ☐ OTHER (SPECIFY BELOW).

COMMENTS:

PHYSICIAN'S SIGNATURE _____ DATE _____

THIRD OPINION (If necessary)

PHYSICIAN GIVING THIRD OPINION

NAME	PROVIDER NUMBER

STREET

CITY AND STATE	ZIP

I HAVE EXAMINED THE ABOVE-NAMED PATIENT, AND IN MY OPINION, THE PROPOSED SURGERY:

- ☐ IS APPROPRIATE
- ☐ IS NOT APPROPRIATE BECAUSE:
  - ☐ NO PATHOLOGY IS EVIDENT.
  - ☐ SYMPTOMS ARE NOT SEVERE ENOUGH TO WARRANT SURGERY.
  - ☐ SURGERY SHOULD BE DEFFERED, PENDING MEDICAL TESTS (DESCRIBE BELOW).
  - ☐ MEDICAL TREATMENT IS PREFERABLE (DESCRIBE BELOW).
  - ☐ ALTERNATE PROCEDURE IS RECOMMENDED (DESCRIBE BELOW).
  - ☐ OTHER (SPECIFY BELOW).

COMMENTS:

PHYSICIAN'S SIGNATURE _____ DATE _____

INSTRUCTIONS and ADDITIONAL INFORMATION

THE PHYSICIAN WHO FIRST RECOMMENDS SURGERY MUST COMPLETE THE REFERRING PHYSICIAN/RECIPIENT SECTION OF THIS FORM AND PROVIDE THE RECIPIENT WITH THE NAMES OF AT LEAST TWO OTHER PHYSICIANS WHO ARE QUALIFIED TO GIVE A SECOND OPINION, OR THE NAME OF AN APPROPRIATE MEDICAL REFERRAL SERVICE. THE RECIPIENT MUST MAKE AN APPOINTMENT WITH A PHYSICIAN TO GET A SECOND OPINION. THE SECOND OPINION MUST BE OBTAINED WITHIN 90 DAYS OF THE REFERRING PHYSICIAN'S RECOMMENDATION THAT SURGERY BE PERFORMED. THE RECIPIENT MUST PRESENT THIS FORM TO THE SECOND PHYSICIAN. THE SECOND OPINION SECTION OF THIS FORM MUST BE COMPLETED AND PERSONALLY SIGNED BY THE PHYSICIAN GIVING A SECOND OPINION.

IF A SECOND OPINION FAILS TO CONFIRM THE REFERRING PHYSICIAN'S RECOMMENDATION, THE RECIPIENT CAN OBTAIN, IF HE OR SHE WISHES, THE OPINION OF A THIRD PHYSICIAN. THIRD OPINIONS MUST BE OBTAINED WITHIN 45 DAYS OF THE SECOND OPINION. THE RECIPIENT MUST PRESENT THIS FORM TO THE THIRD PHYSICIAN. THE PHYSICIAN WHO GIVES THE THIRD OPINION MUST COMPLETE AND PERSONALLY SIGN THE THIRD OPINION SECTION OF THIS FORM.

ONCE THE SECOND AND, IF NECESSARY, THIRD OPINIONS ARE OBTAINED, THE RECIPIENT MUST RETURN THIS FORM TO THE PHYSICIAN WHO FIRST RECOMMENDED SURGERY. THE PHYSICIAN MUST SUBMIT THIS FORM TO DHS, EVEN IF A CONFIRMING OPINION IS NOT OBTAINED. DHS WILL AUTHORIZE PAYMENT FOR THE SURGICAL PROCEDURE IF, IN THE OPINION OF THE SECOND OR THIRD PHYSICIAN, THE PROCEDURE IS APPROPRIATE, UNLESS THE DHS COMMISSIONER ORDERS AN INDEPENDENT PHYSICIAN EVALUATION AND THE EVALUATION INDICATES THE PROCEDURE IS NOT APPROPRIATE.

THE SURGICAL PROCEDURE MUST BE PERFORMED WITHIN 180 DAYS OF THE INITIAL RECOMMENDATION.

WHEN DHS DOES NOT GRANT AUTHORIZATION FOR PAYMENT OF A SURGICAL PROCEDURE, THE RECIPIENT HAS THE RIGHT TO REQUEST A FAIR HEARING. INFORMATION ABOUT FAIR HEARINGS CAN BE OBTAINED BY CONTACTING THE DHS APPEALS UNIT AT 612/296-5764.

DATA PRIVACY

THE INFORMATION ON THIS FORM IS NEEDED TO COMPLY WITH MINNESOTA STATUTES §256B.02, SUBDIVISION 8, WHICH REQUIRES A SECOND SURGICAL OPINION FOR ELECTIVE SURGERIES. THE INFORMATION WILL BE USED TO DETERMINE THE NEED FOR SURGERY. IF THIS FORM IS NOT COMPLETED AND SENT TO THE DEPARTMENT OF HUMAN SERVICES, PAYMENT FOR THE SURGERY WILL NOT BE AUTHORIZED. THE INFORMATION ON THIS FORM IS PRIVATE AND WILL ONLY BE SHARED WITH LOCAL, STATE OR FEDERAL EMPLOYEES WHO REQUIRE THE DATA TO AUDIT THE APPROPRIATENESS OF MEDICAL ASSISTANCE OR GENERAL ASSISTANCE MEDICAL CARE BENEFITS A RECIPIENT REQUESTS OR RECEIVES.

CHAPTER II

PSYCHIATRIC AND PSYCHOLOGICAL SERVICES

DEFINITIONS, FORMAT OF PRIOR AUTHORIZATION REQUESTS, DOCUMENTATION REQUIRED

Psychotherapy - Psychotherapy means treatment of a person or persons who have cognitive, emotional, behavioral or social dysfunctions through psychological or interpersonal methods. The treatment is a planned and structured program which is based on information from a complete diagnostic examination and which is directed at the accomplishment of specified goals. Examples of treatment goals are alleviating existing symptoms, mediating disturbed patterns of behavior, and promoting positive personal growth and development by enhancing the ability of the individual to adapt to and cope with, internal and external stresses.

Differential Diagnostic Examination - "Differential Diagnostic examination" means a face-to-face examination, assessment and diagnosis of the person's emotional, behavioral, and social functioning which shall include two or more of the following: diagnostic interview, mental status examination, neurologic studies, psychological testing and psycho-social assessment of the recipient's functioning.

When prior authorization is being requested for continued individual psychotherapy services (since prior authorization is unnecessary for the first ten visits of the calendar year), a detailed summary of the diagnostic examination should be included. This summary should list the components of the diagnostic examination. It should indicate the nature and severity of the mental illness and/or symptoms of psychological emotional and social dysfunction. It should also include a statement about the necessity for psychotherapy and the expected outcome. A copy of the treatment plan, which should relate the findings of the diagnostic examination to specific behavioral and personality changes which are being sought and how these changes will be achieved, should be included. Frequency of sessions and total duration of treatment should be estimated.

When prior authorization for ongoing individual psychotherapy is requested, the recipient will already have completed some sessions (usually about 7 of the 10 to which he/she is automatically entitled). Therefore, you must satisfactorily document the progress achieved so far in reaching the treatment goals and indicate how additional individual psychotherapy at the intensity requested rather than group or/family psychotherapy would be more effective in attaining these goals. We would like to have you organize this information into the following outline: (1) Diagnosis based on ICD-9-CM or DSM III; (2) Brief history; (3) Description of symptoms, problems, living and working situation; (4) Nature of the therapy being provided; (5) Treatment plan; and strategies for achieving; (6) Response of the recipient to treatment to date; (7) Prognosis; (8) Duration and intensity of treatment.

General Guidelines Relating to Prior Authorization of Individual Psychotherapy 90841, 90843 and 90844 beyond (10) ten visits per calendar year.

The Department of Human Services has formulated the following general guidelines with respect to the provision of individual psychotherapy. It is the expectation of the MA/GAMC Programs that alternate therapeutic modalities i.e. group, family be utilized in lieu of individual psychotherapy in all cases where such modalities would be appropriate. The following categories refer to those listed in DSM III.

1. Mental Retardation - Individual psychotherapy is not a covered service for persons with a primary diagnosis of mental retardation except when the individual has psychological problems that necessitate psychotherapeutic intervention and it has been demonstrated that the individual is able to participate in, and benefit from, such treatment. When a recipient who is mentally retarded is being treated for a psychiatric/psychological disorder, this disorder should be listed as the primary diagnosis and mental retardation as the secondary diagnosis.

   NOTE: Individual psychotherapy does not constitute training or instruction of ICF staff with respect to modifying the behavior of recipients who are difficult to manage and/or have other behavior problems stemming from their mental retardation. Funding for such services should be sought from other sources.

2. Organic Mental Disorders - Appropriate outpatient treatment is usually supportive individual or group therapy. As in the case of mental retardation, the primary diagnosis should reflect the psychiatric/psychological disorder being treated with psychotherapy. In most cases, one-half hour per week of individual therapy would be the maximum amount authorized.

3. Substance Use Disorders - In most cases, recipients with a primary diagnosis of substance use disorder should be referred to treatment programs specifically designed for such treatment. In a minority of cases, individual, group or family psychotherapy may be appropriate as follow-up to the treatment program or to prepare individuals for the treatment program. Such psychotherapy, especially individual, should be limited, and the ten sessions to which recipients are automatically entitled should be sufficient for these purposes.

4. Affective Disorders - Individual and/or group and family psychotherapy may be appropriate. Many individuals with affective disorders should be on psycho tropic medication regime prescribed and supervised by physicians. Chemotherapy management should thus be a part of many persons' treatment plan. Information about the chemotherapy regime should always be included in the prior authorization request.

   Recipients who are residents of nursing homes and are depressed have access to personnel and activity programs within the home and thus should not require extended individual psychotherapy.

5. Anxiety Disorders - Individual and/or group and family psychotherapy may be appropriate . For persons with phobic disorders, group therapy programs designed to treat phobias may be most effective. Information about medication regimes prescribed for some recipients to lower their anxiety should be included in the prior authorization request.

6. Somatoform Disorders - Individual and/or group and family psychotherapy may be appropriate. For many persons with these disorders, it is especially important for them to have a complete physical examination and to be associated with a physician. In many cases, psychotherapy should be coordinated with the plans and goals of the physician. For those recipients who are chronically fixated on organic symptomotology, psychotherapy should be limited.

7. Dissociative Disorders - Individual and/or group and family psychotherapy may be appropriate. In some cases, hypnosis may be the treatment of choice.

8. Psychosexual Disorders - Individual and/or group and family psychotherapy may be appropriate. For those recipients who "act out" in a destructive way, psychotherapy should in most cases not be provided unless these persons are in a secure environment.

9. Adjustment Disorders - Individual and/or group and family psychotherapy may be appropriate. Individual psychotherapy can often be of short duration and the recipient treated with group psychotherapy.

10. Personality Disorder - Individual and/or group and family psychotherapy may be appropriate. Persons with paranoid and schizoid personality disorders may not be responsive to psychotherapy, and in those cases individual psychotherapy should be limited. Recipients with anti-social personality disorders typically do not respond to individual psychotherapy and prior authorization requests for ongoing psychotherapy with these persons will usually be denied.

11. Schizophrenic Disorders - Individual and/or group and family psychotherapy may be appropriate. Many individuals with schizophrenic disorders should be on psychotropic medication regimes prescribed and supervised by psychiatrists. Chemotherapy management should then be a part of the treatment plan. Information about the chemotherapy regime should always be included in the prior authorization request. Many persons with schizophrenic disorders live in residences where there is staff available to them. They should, therefore, have less need for individual psychotherapy. Also, in many cases, the prognosis is poor even with extended psychotherapy. In these cases, weekly sessions of individual psychotherapy will not be authorized.

12. Psychological Factors Affecting Physical Condition - Individual and/or group and family psychotherapy may be appropriate. Individual psychotherapy can be denoted in part to helping individuals understand their illness, including etiology, and in managing their symptoms and medical treatments. Such psychotherapy can often be short-term.

Individual Psychotherapy 90841, 90843, 90844 in excess of 20 visits per calendar year will be closely scrutinized and denied/reduced when appropriate alternative modalities of treatment i.e. group or family, would be therapeutically appropriate.

CLARIFICATION OF SERVICE COVERAGE

The preceeding guidelines are presented in order to provide sufficient information to enable a provider to evaluate whether or not an individual would be an appropriate candidate for continued individual psychotherapy authorized through the prior authorization process. Please bear in mind that if your patient does not fit within these general guidelines, extenuating circumstances may provide the necessary medical justification for approving individual psychotherapy. Also note that the limits on group therapy 90853 have been increased to 30-2 hour sessions per calendar year. Additional sessions beyond this limitation may be prior authorized. You should also consider using family therapy where appropriate in lieu of individual psychotherapy. In appropriate cases, group and family therapy should be utilized in lieu of individual psychotherapy.

Furthermore, in the event that more than one type of therapy is being provided i.e. family and individual, individual and group, these therapies should generally not be provided during the same week except in exceptional circumstances.

Individuals utilizing Day treatment MI X0691 may receive concurrently, up to one half hour/week of individual psychotherapy (90843), if indicated and prior authorization requirements have been met.

All MI services, must be provided under the direct, on site supervision of the enrolled provider under whose provider number services are being billed. Direct, on site means that the enrolled provider is on the premises at all times that services to be billed under his/her number are to be performed.

Invoices for psychiatric services must use ICD codes only. DSM III codes on invoices cannot be processed.

CHANGES IN PRIOR AUTHORIZATION REQUIREMENTS

1. X0690, outpatient chemical dependency services will no longer require prior authorization as of 10/29/84. A recipient will be entitled to 30 days (up to 3 clinical units a day--90 units maximum) per calendar year. There will now be post payment review of outpatient chemical dependency services. Post payment review is conducted by the Surveillance Unit and consists of review of charts and other documentation after a service has been provided, to insure its appropriateness.

2. Inpatient physician visits are no longer subjected to the 30 day limitation without prior authorization requirement for mental illness diagnoses. The 902 series codes, physician visits, when provided to an inpatient recipient with a primary MI diagnosis only need now insure that certification has been obtained, even if the recipient has had more than 30 inpatient hospital days during the calendar year. The present requirement regarding inpatient CD(90240) still applies i.e. P.A. is required after first episode in calendar year.

3. 90853, Group therapy, now raised to 30-2 hour sessions per calendar year. This service also may now be prior authorized for services in excess of this amount.

4. Apnea Monitors, 2016 - 2018 no longer require prior authorization.

5. X0691, Day Treatment MI no longer requires prior authorization.

6. Oxygen and equipment, E0410, E0415, E0650, Z0401-Z0407, 800-0610, 900-2400 to 900-2412, 900-2424 to 900-2427; no longer requires PA. NOTE: The provision of this service is limited to state authorized contractors.

7. Catheters, 800-0610, 800-0612, 800-0615, 900-0626 to 900-0633, 900-0634, 900-0635 no longer require prior authorization.

8. Hearing Aids, V5030-V5299, and X5270 and X5271, no longer require prior authorization. NOTE: The provision of this service is limited to state authorized contract vendors.

THE ABOVE P.A. CHANGES ARE EFFECTIVE 4/1/85.

DAY TREATMENT AND OTHER PROGRAMS

Please note that all chemical dependency, mental illness, (X0690, X0691) and MI/CD Day Treatment Programs must receive DHS approval before you may be reimbursed for services. Similarily, such programs as pain control, weight control, cardiac rehab, and other similar structured treatment programs must receive approval.

If you have any questions regarding this bulletin, please call:

	TOLL FREE WATS #	METRO AREA
MA Policy	1-800-652-9747, ext. 6-8822	612/296-8822

ATTACHMENT 1 - Prior Authorization List

As required by the Rules of the Department of Human Services, Section 9505.5020, Subp. 4, the following list includes all health services that require prior authorization as a condition of Medical Assistance or General Assistance Medical Care reimbursement. The list is presented in five sections: dental services, vision care services, medical supplies and durable medical equipment, hearing aids, and all other services.

I. Dental Services

In addition to the specific services and procedures listed below, the following dental services always require prior authorization:

1. Hospitalization for dental treatment.
2. Surgical services except emergencies and alveolectomies.
3. All removable prothesis.
4. All root canal therapy.

PLEASE NOTE: It is essential that as you submit requests for prior authorization consideration they be accompanied by adequate case information and appropriate diagnostic materials (i.e., x-rays, prosthesis information, teeth to be replaced, etc.).

Service Code	Service Description
D2960	Labial veneer (laminate)
D4365	Athletic mouthguard fabrication
D5213	Upper-cast chrome base, with acrylic saddles, excluding clasps
D5214	Lower cast chrome base, with acrylic saddles, excluding clasps
D5934	Mandibular resection (flange) prosthesis
D5935	Mandibular resection (denture) prosthesis
D5454	Superimposed prosthesis
D5955	Palatal lift prosthesis
D5956	Obturator
D5957	Speech bulb
D5971	Simple implant
D5972	Complex implant
D5973	Subperiosteal implant
D5974	Endosseous implant (in the bone)
D5975	Endodontic - endosseous pin (through root and into bone)
D5981	Splint - per arch
D5982	Surgical stent
D5986	Flouride applicator - per arch
D5987	Trismus appliance
D5988	Infant orthopedic appliance
D5989	Maxillary included plane and/or maxillary occlusal table
D5990	Mandibular guide flange
D6545	Cast metal retainer (for acid etch bridge) to be used to report each abutment tooth. The appropriate code from the 06200 series, bridge pontics, is to be used to report the pontic

Service Code	Service Description
D7941	Osteotomy, ramus, closed
D7942	Osteotomy, ramus, open
D7943	Osteotomy, ramus, open with bone graft
D7944	Segmented or subapical per sextant or quadrant
D7945	Osteotomy, body of mandible
D7946	Maxilla, total (Le-Fort I)
D7947	Maxilla, segmented
D7948	Osteoplasty of maxilla and/or other facial bones for midface hypoplasia or retrusion (Le Fort II and III) without bone graft.
D7949	Same as above except with bone graft
D7991	Coronoidectomy
D7992	Emindectomy
D7993	Alloplastic implant to maxilla and other facial bones
D7994	Implant, chin, homologous, heterologous, or all-aplastic
00321	TMJ - x-rays left and right
00901	Prosthetic eye inc. services & mat.
01110	Adult Prophylaxis*
01120	Child Prophylaxis*
02410	Gold foil - 1 surface
02420	" " - 2 surfaces
02430	" " - 3 surfaces
02710	Plastic acrylic
03310	One canal (excludes final restoration)
03311	Root canal, anterior, sargenti type
03320	Two canals (excludes final restoration)
03321	Root canal, bicuspid, sargenti type
03330	Three canals (excludes final restoration)
03331	Root canal, molar, sargenti type
03340	Four canals (excludes final restoration)
03350	Apexification
03460	Endosseous implants
03960	Bleaching
04210	Gingivectomy or gingivoplasty
04220	Gingival curettage
04240	Gingival flap procedure
04250	Muco - ging surg - per quad
04260	Osseous surg. incl. flap
04261	Osseous graft - single site
04262	Osseous graft
04270	Pedicle soft tissue grafts
04271	Free soft tissue grafts
04272	Vestibuloplasty
04280	Peridontal pulpal procedures
04320	Provisional splinting - entracoronal
04321	Provisional splinting - extracoronal
04330	Occlusal adjustment (limited)
04331	" " (complete)
04340	Periodontal scale & root plane - entire mouth
04341	Periodontal scale & root plane - fewer than 12 teeth

*Prior authorization required only if service performed more than once in a six-month period.

Service Code	Service Description
04350	Tooth movement for periodontal purposes
04360	Special periodontal appliance
04500	Type I gingivitis
04600	Type II early periodontitis
04700	Type III moderate periodontitis
04800	Type IV advanced periodontitis
04910	Preventive periodontic procedures
05110	Complete upper denture
05120	Complete lower denture
05130	Immediate upper denture
05140	Immediate lower denture
05210	Upper or lower w/o clasps acrylic base
05211	Upper w/o clasps - acrylic
05212	Lower w/o clasps - acrylic
05215	Upper w/ gold clasps - acrylic
05216	Upper w/ two chrome clasps - acrylic
05217	Lower w/ two gold clasps - acrylic
05218	Lower w/ two chrome clasps - acrylic
05220	Upper or lower w/ two gold or chrome clasps
05230	Lower w/ gold lining bar-2 clasps - acrylic
05231	Lower w/ chrome lining bar-2 clasps - acrylic
05240	Lower w/ gold lining bar-2 clasps - cast base
05241	Lower w/ gold lining bar-2 clasps - cast base
05250	Upper w/ gold palatal base-2 clasps - acrylic
05251	Upper w/ chrome palatal bar-2 clasps - acrylic
05260	Upper w/ gold palatal bar-2 clasps - cast base
05261	Upper w/ chrome palatal bar-2 clasps - cast base
05280	Remove uni-lat partial denture - 1 pc gold
05281	Remove uni-lat partial denture - 1 pc chrome
05291	Upper full-cast partial w/ two gold clasps
05292	Upper full-cast partial w/ two gold clasps
05293	Lower full-cast partial w/ two gold clasps
05294	Lower full-cast partial w/ two chrome clasps
05310	Each additional clasp
05320	Each additional tooth
05810	Dent-temp-complete upper
05811	Dent-temp-complete lower
05820	Dent-temp-stay-plate upper
05821	Dent-temp-stay-plate lower
05830	Hing. phar. sec. inc. hin. (PR/PST Clef. Pal)
05840	Solid clear pharyngeal section
05860	Over denture parital
07210	Extraction of tooth, erupted
07220	Extraction of tooth, soft tissue
07230	Extraction of tooth partial bony impaction
07240	Extraction tooth complete bony impaction
07241	Impaction - presents unusual diff
07270	Tooth replantation
07271	Tooth implantation
07272	Tooth transplantation

Service Code	Service Description
07280	Surg expos impact unerupt tooth
07281	Surg expos - imp aid erupt
07290	Surgical repositioning of tooth
07340	Per arch, uncomplicated
07350	Per arch, comp - inc. soft tissue graft ridext
07470	Removal exostotis max or mand
07480	Part. ostect. (guttering saucerization)
07490	Radical resection mandible bone graft
07940	Osteop
07950	Osteop, pertost cart graft
07955	Repair max - fac soft htd tissue defects
07970	Excision of hyperplas
07980	Sialolthotomy
07981	Excision of salivary gland
07982	Sialodochoplasty
08020	Full orthodont case study
08110	Removable
08120	Fixed or cemented
08210	Removable
08220	Fixed or cemented
08360	Removable appliance therapy
08370	Fixed appliance therapy
08460	Class 1 malocclusion
08470	Class 2 malocclusion
08480	Class 3 malocclusion
08560	Class 1 malocclusion
08570	Class 2 malocclusion
08580	Class 3 malocclusion
08650	Trt. of atypical or extended skel. case
08750	Post trt. stabilization
21010	Arthrotomy, temporomandibular joint; unilateral
21011	Bilateral
21050	Arthrectomy, temporomandibular joint; unilateral
21051	Bilateral
21060	Meniscectomy, temporomandibular joint; unilateral
21061	Bilateral
21240	Arthroplasty, temporomandibular joint
21242	Arthroplasty, temporomandibular joint, with alloplastic material
21462	Open treatment of closed or open mandibular fracture; with interdental fixation
21480	Uncomplicated treatment of temporomandibular dislocation; initial or subsequent
21485	Complicated manipulative treatment of temporomandibular diso-lation
21490	Open treatment of temporomandibular dislocation
70328	Radiologic examination; temporomandibular joint, open and closed mouth
70330	Bilateral
70332	Temporomandibular joint arthrotomogrophy; supervision and interpretation only
70333	Complete procedure

II. Vision Care Services

Service Code	Service Description
V0280*	Dispensing fee, bifocal lens
V0320	Dispensing fee, single vision contact lens
V0350	Dispensing fee, bifocal contact lens
V0490*	Dispensing fee, single vision lens
V2020*	Frames, purchases
V2118	Aniseikonic lens, single vision
V2218	Aniseikonic, per lens, bifocal
V2219	Bifocal seg width over 28mm
V2299	Speciality bifocal (by report)
V2318	Aniseikonic lens, trifold
V2319	Trifocal seg width over 28mm
V2399	Specialty trifocal (by report)
V2500	Contact lens, PMMA, spherical, per lens
V2501	Contact lens, PMMA, toric or prism ballast, per lens
V2502	Contact lens, PMMA, bifocal, per lens
V2510	Contact lens, gas permeable, spherical, per lens
V2511	Contact lens, gas permeable, toric, prism ballast, per lens
V2512	Contact lens, gas permeable, bifocal, per lens
V2513	Contact lens, gas permeable, extended wear, per lens
V2520	Contact lens, hydrophilic, sperical, per lens
V2521	Contact lens, hydrophilic, toric, or prism ballast, per lens
V2522	Contact lens, hydrophlic, extended wear, per lens
V2523	Contact lens, hydrophilic, extended wear, per lens
V2530	Contact lens, scleral, per lens (for contact lens modification, See 92325)
V2599	Not otherwise classified, contact lens
V2600	Hand held low vision aids and other nonspectacle mounted aids
V2610	Single lens spectacle mounted low vision aids
V2615	Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system
V2622	Prosthetic, eye, glass, custom
V2623	Prosthetic eye, plastic, custom
V2629	Not otherwise classified, prosthetic eye
V2718	Press on lens, fresnell prism, per lens
V2744	Tint, photochromatic, per lens
V2750	Anti-reflective coating, per lens
V2755	U-V lens, per lens
V2760	Scratch resistant coating, per lens
V2780	Oversized lens, per lens
V2799	Not otherwise classified
X0101*	Eye exam with complete visual fields included by optometrist
X0103*	Eye refraction only
X0108	Orthoptic eval by optometrist
X0109	Orthoptic re-eval by optometrist
X0111	Orthoptic and/or pleoptic trng
92354	Fitting low vision aid, single element
92355	Fitting low vision aid, telescopic
92392	Supply of low vision aid, materials

*Prior authorization necessary only if service has been utilized by recipient within the past 12 months.

III. Medical Supplies and Durable Medical Equipment, Including Prosthetic and Orthotic Items

In addition to the specific supplies and equipment listed below, items in the following general categories always require prior authorization:

1. Durable medical equipment when the purchase or projected cumulative rental cost exceeds $250.

2. Nondurable medical supplies when the cost exceeds $150.

3. Prostheses and orthoses when the purchase or projected cumulative rental cost exceeds $1,000.

4.

5.

6. Repairs to durable medical equipment, prostheses, and orthoses when the cost exceeds $200. If a repair involves items on the following list, but is under the $200 limit, prior authorization is not required.

Supply Code	Supply Description
E0155	Sitz type bath, portable, fits comm st. faucet
E0179	Bathroom equipment; rails, seats, stools, bench
E0190	Decubitus care matt, inc float or gel mat
E0260	Hospital bed, semi-electric with mattress
E0265	Hosp bed, tot elec hd, ft. ht adj. w/mattress
E0270	Hospital bed; oscil, circ, stryker
E0300	Mattress, replc, med. nec. bed owned by pat.
E0690	Ultraviolet cabinet, approp home use
E0720	TENS, 2 lead
E0730	TENS, 4 lead
E0745	Neuromuscular stimulator
E0747	Osteogenesis stimulator, noninvasive
E0749	Osteogenesis stimulator, implanted
E1000	W/c access: tray, back rest, loops any type
E1050-E1297	Wheelchairs, all types
E1300	Whirlpool, portable overtub type
E1310	Whirlpool, nonportable built-in type
E1350	Repair (breaking down seal com-requirs)
E1399	Durable medical equip not otherwise clas including Clinitron beds, etc.
Y4635*[1]	Blood glucose monitor
Y4950	Enteral therapy, entire system
Y4959*	Enteral pump

Supply Code	Supply Description
800-4032	Headwings for tiny tot
800-4033	Buckle lock strap
800-4034	Velcro lock strap
800-4035	Luggage rack - bolt on
800-4036	Hook-on headrest
800-4037	Headrest
800-4038	Zipper back upholstery for chairs
800-4039	Back upholstery
800-4040	Detach back upholstery
800-4041	Back upholstery
800-4042	Solid insert back for chairs
800-4043	Bolt on headrest w/headwings
800-4044	Slack back upholstery chairs
800-4045	Ortho backrest to correct posture
800-4046	Crutch or cane holder
800-4047	Carrying pocket detach/ea
800-4048	Solid insert back for chairs w/recliners
800-4049	Ortho backrest for chairs w/recliners
800-4050	IV hanger
800-4051	Telescopic IV hanger
800-4052	Back upholstery
800-4053	Arm slings - "Rancho"
800-4054	Arm slings
800-4070	Footrest and legrest
800-4071	Anti-tipping outrigger
800-4072	Toe loops w/buckle
800-4073	Heel rest, metal
800-4074	Heel loops
800-4075	Heel loops and ankle straps
800-4076	Pop up footrest assembly
800-4078	Heel strap, 2" laeatherette w/buckle
800-4080	Heel strap, 3" hook-on
800-4081	Heal strap, 4" hook-on
800-4082	Evalating legrest
800-4083	Footplate angle adjustment
800-4084	Web heel strap
800-4085	Heel strap, web, H-type
800-4086	Plastic coated footplates
800-4087-800-4091	Footrest assembly
800-4092	Legrest panel
800-4093	Anti-tipping
800-4094	Quad release
800-4120	Wheels & casters
800-4121	Handrims
800-4122	Handrims
800-4123	Snap-on handrim covers
800-4124	Handrims
800-4125-800-4130	Hand rims
800-4131	Amputee adapter
800-4132	8" caster wheels

Service Code	Service Description
Y4962*	Liquid diet for catheter administration
Y5269*	Parenteral Pump
800-0206	Sitz type bath, port w/faucet attachment
800-0320	Hospital beds
800-0321	Hospital beds
800-0322	Hospital beds
800-0350	Mattress hospital bed (replacement only)
800-0815	Ultra-Violet light
800-0917	Air flotation pad (E-G roho)
800-0918	Water flotation pad (E-G bard)
800-0919	Flotation pad, leveling mattress
800-1220	TPN
800-1230	Chair, Lumex, 6-position recliner
800-1231	Chairs, mobile lounge w/ arms
800-1232	Chair, bath
800-1300	Drainage apparatus/ea
800-1405	Electric muscle stimulator
800-1410	Electric nerve stimulator, ea, dual
800-1411	Electric nerve stimulator, ea, single
800-1500	Parenteral administration/ea
800-1800	Hydroptherapy apparatus/ea
800-2200	Diabetic equipment (nec)
800-2201	Diabetic equipment
800-2220*1	Blood glucose analyzer
800-3800	Wheelchairs/ea
800-3805	Wheelchair, standard folding/ea
800-3810	Wheelchair, standard, folding w/swing footrsts/ea
800-3863	Rollabout chair with arms
800-3880	Wheelchair, accessories/ea
800-3885	Wheelchair cushions
800-3902	Special height seat
800-3903	Special height back
800-3904	Sectional back
800-4000	Arm of chair, adj HT/FI lngth/detch arm
800-4001	Adj Ht dsk length detachable arms/pr.
800-4002	Full ht side panels to arm bend/pr.
800-4003	Side panel, stainless steel, spcl ht
800-4004	Heavy duty side panel, stainless steel, P
800-4005	Heavy duty side panel, stainless steel, sh
800-4006	Tray mate, adult, fits seat widths of 14
800-4007	Tray mate, child
800-4008	Adjusto tray w/rim
800-4009	Adjusto tray w/rim
800-4010	Adjusto tray w/rim
800-4011	Adjusto tray w/rim
800-4102	Chair caddie/ea
800-4013	Body pos. adult - chairs w/standard bk
800-4014	Body positioner, child for chairs w/standard
800-4015	Body positioner, adult chairs w/reclining
800-4016	Body positioner child, chairs w/reclining
800-4030	Back of chair/anti-tipping device
800-4031	Anti-tipping device

Supply Code	Supply Description
800-4133	8" x 2" preumatic caster wheels
800-4134	Preumatic caster wheels
800-4135	Rubber bumpers
800-4136	Wheels x/24" x 1-3/4" preumatic tires
800-4161	Lever extension
800-4162	Attendant operated locks
800-4180	Seat accessories
800-4181	Seat widened & lowered by uphols
800-4182	Seat & back reinforced
800-4183	Anti-folding device
800-4184	Commode attachment for wheelchairs
800-4185	Seat upholstery
800-4186	Reduce-a-width
800-4187	Anti-folding device
800-4210	1-arm-drive-fx
800-4211	Fixed/detach arm - right-hand drive
900-1500	Parenteral administration
900-2200	Diabetic supplies
900-2201	Diabetic supplies
900-9998	His only: Non-DME non-covered item
900-9999	His only: Non-DME miscellaneous

*Due to the nature of the use of and similar equipment, these items may be provided to a recipient for a period of 30 days while you are awaiting necessary documentation and/or a response to your prior authorization request. (See Documentation Required outlined elsewhere in this bulletin.) If medical necessity is established, this one month period will be approved even though no prior authorization was submitted before providing the service. This 30-day retroactive application applies only to new patients, not patients for whom you are seeking a continuing or a renewal prior authorization.

*Prior authorization only if for individual who is not an insulin dependent diabetic.

IV. All Other Services

The following types of health services require prior authorization:

1. Procedures performed outside of Minnesota, unless within the recipients local trade area, and the procedure is contained on this list. If not within the local trade area, prior authorization is required for all out of state health services.

2. Investigative.

3. Elective plastic and reconstructive procedures.

4. In addition, the following specific procedures require prior authorization.

Service Code	Service Description
T2031	Bone marrow transplant
T5035	Renal transplant
X2010*[1]	Manual manipulation of the spine by a chriopractor, initial treatment
X2020*[1]	Manual manipulation of the spine by a chiropractor, subsequent treatment
X4020*[2]	Private duty nursing by RN
X4021*[2]	Private duty nursing by LPN
X7003	DAC services - special needs
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin
11921	6.0 to 20.0 sq cm
11922	each additional 20.0 sq cm
11950	Subcutaneous injection of "filling" material
11951	1 to 5 cc
11952	5 to 10 cc
11954	over 10 cc
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	more than 15 punch grafts
15780	Abrasion of skin
15781	less than total face
15782	regional
15786	Abrasion; single lesion
15787	each additional four lesions or less
15790	Superficial chemical peel
15791	regional, face, hand, or elsewhere
15810	Salabrasion
15811	20 sq cm and over
15820	Blepharoplaty, lower eyelid
15821	with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	with excessive skin weighting down lid
15824	Rhytidectomy; forehead
15826	glabellar frown lines
15828	cheek, chin and neck

Service Code	Service Description
15831	Excision, excessive skin and subcutaneous tissue, abdomen
15832	thigh
15333	leg
15834	hip
15835	buttock
15836	arm
15837	forearm or hand
15838	submental fat pad
17110	Destruction of warts
17360	Chemical exfoliation for acne
17380	Electrolysis epilation
19316	Mastopexy
19318	Reduction mannaplasty
19324	Mammaplasty, augmentation without prosthetic implant
19325	with prosthetic implant
19350	Nipple/areola recontruction
21010	Arthrotomy, temporomandibular joint; unilateral
21011	bilateral
21050	Arthrectomy, temporomandibular joint, unilateral
21051	bilateral
21060	Meniscectomy, temporomandibular
21061	Joint, unilateral, bilateral
21070	Coronoidectomy; unilateral
21071	bilateral
21116	Injection procedure for temporomandibular arthrotomography
21200	Osteoplasty; mandibule, total or horizontal
21202	mandible, segmental
21204	maxilla, total
21206	maxilla, segmental
21239	Chin implant
21240	Arthroplasty, temporomandibular joint
21250	Osteoplasty of maxiilla and/or other facial bones
21254	with bone graft
21260	Periorbital osteotomies for orbital hypertelorism
21261	combined intra and extracranial approach
21263	with forehead advancement
21267	Orbit repositioning
21268	combined intra and extracranial approach
21270	Reconstruction for Treacher Collins Syndrome
21275	Secondary revision of orbitocraniofacial reconstruction
21462	Open treatment of closed or open mandibular fracture, with inter dental fixation
21480	Uncomplicated treatment of temporomandibular dislocation, initial or subsequent
21485	Complicated manipulative treatment of temporomandibular dislocation
21490	Open treatment of temporomandibular dislocation
30120	Excision or surgical planing of skin of nose
30400	Rhinoplasty, primary
30410	complete
30420	including major septal repair
30430	Rhinoplasty, secondary
30435	intermediate
30450	major revision

Service Code	Service Description
33950	Cardiac transplantation
40650	Repair lip, full thickness, vermilion only
40652	up to half vertical height
40654	over one half vertical height, or complex
40700	Plastic repair of cleft lip
40701	primary bilateral, one stage
40702	primary bilateral, one of two stages
40720	secondary, unilateral
40740	secondary, bilateral
42001*9	Home health visit, speech
42200	Palato plasty for cleft palate
42205	Palatoplasty for cleft palate
42210	with bone graft to alveolar ridge
42215	Palatoplasty for cleft palate
42220	secondary lengthening procedure
42225	attachment pharyngeal flap
43001*9	Home health visit, OT
43620	Gastrectomy, total
43625	with repair by intestinal transplant
43630	Hemigastrectomy
43635	with vagotomy, any type
43638	Hemigastrectomy, thorocic or abdominal approach
43810	Gastroduodenostomy
43820	Gastrojejunostomy
43825	with vagotomy, any type
43844	Gastric bypass for morbid obesity
43845	Gastric stapling for morbid obesity
43846	Gastric bypass with Roux-en-Y gastroenterostomy
43850	Revision of gastroduodenal anastomosis with reconstruction; without vagotomy
43855	with vagotomy
43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction; without vagotomy
43865	with vagotomy
44001*9	Home health visit, PT
44120	Entereonterostomy
44125	with double barrel enterostomy
44130	Enteroenterostomy
44131	intestinal bypass for morbid obesity
46001-46003*9	Home health visit, RN, extended RN, HHA
47135	Liver transplantation
48160	Pancreas transplantation
50300	Donor nephrectomy, with preparation and maintenance of homograft, from cadaver donor, unilateral or bilateral
50320	from living donor, unilateral
50340	Recipient nephrectomy; unilateral
50341	bilateral
50360	Renal homotransplantation, implantation of graft; excluding donor and recipient nephrectomy
50365	with unilateral recipient nephrectomy
50366	with bilateral recipient nephrectomy
54400	Plastic operation for insertion of penile prosthesis
54405	Plastic operation for insertion of inflatable penile prosthesis

Service Code	Service Description
54660	Insertion of testicular prosthesis, penile prosthesis, unilateral
54661	bilaternal
55200	Vastomy cannulization
55400	Vasovasostomy, vasovasorrhaphy; unilateral
55401	bilateral
55970	Intersex surgery; male to female
55980	female to male
61850	Twist drill or burr hole(s) for implantation of neurostimulator electrodes; cortical
61855	subcortical
61860	Craniectomy or craniotomy for implanation of neurostimulator electrodes, cerebral; cortical
61865	subcortical
61870	Craniectomy for implantation of neurostimulator electrodes; cerebellar; cortical
61875	subcortical
61880	Revision or removal of intracranial neurostimulator electrodes
61885	Incision for subcutaneous placement of neurostimulator receiver, direct or inductive coupling
61888	Revision or removal of intracranial neurostimulator receiver
63650	Percutancous implantation of neurostimulator electrodes
63652	intradural (spinal cord)
63655	Laminectomy for implantation of neurostimulater electrodes
63656	endodural
63657	subdural
63658	spinal cord (dorsal or ventral)
63660	Revision or removal of spinal neurostimulator electrodes
63685	Incision for subcutaneous placement of neurostimulator receiver
63688	Revision or removal of spinal neurostimulator receiver
64550	Application of surface (transcutaneous) neurostimulator
64553	Percutaneous implantation of neurostimulator electrodes; cranial nerve
64555	peripheral nerve
64560	autonomic nerve
64565	neuromuscular
64573	Incision for implantation of neurostimulator electrodes; cranial nerve
64575	peripheral nerve
64577	autonomic nerve
64580	neuromuscular
64585	Revision or removal of peripheral neurostimulator electrodes
64590	Incision for subcutaneous placement of neurostimulator receiver, direct or inductive coupling
64595	Revision or removal of peripheral neurostimulator receiver
67901	Repair blepharoptosis, frontails muscle techniques with suture
67902	frontalis muscle technique with fascial sling
67903	(tarso) levator resection, internal approach
67904	(tarso) levator resection, external approach
67906	superior rectus technique with fascial sling
67907	superior rectus tendon transplant

Service Code	Service Description
67909	Reduction of overcorrection of ptosis
67911	Correction of lid retraction
69090	Ear piercing
69300	Otoplasty, protruding ear
69301	bilateral
70328	Radiologic examination, temporomandibular joint open and closed mouth, unilateral
70330	bilateral
70332	Temporomandibular joint arthrotomography; supervision and interpretation only
70333	complete procedure
85120	Bone marrow transplant
88260	Chromosome analysis; lymphocytes, count 1-4 cells, screening
88261	count 1-4 cells, 1 daryotype
88262	count 1-20 cells for mosaicism, 2 karyotypes
88265	Chromosome analysis; myeloid cells, 2 karyotypes (Philadelphia chromosome)
88267	amniotic fluid, count 1-4 cells, 1 karyotype
88268	skin, count 1-4 cells, 1 karyotype
88270	other tissue cells, count 1-4 cells, 1 karyotype
88280	additional karyotyping
88285	additional cells counted
88299	Unlisted cytogenetic study
90000-90080*[3]	Office medical services
90100-90160*[3]	Home medical services
90200-90280*[4]	Hospital medical services
90300-90370*[5]	Skilled nursing, intermediate care and long-term care
90400-90470*[5]	Nursing home, boarding home, domiciliary, or custodial care medical services
90841-90844*[6]	Psychotherapy
90853*[7]	Group medical psychotherapy
90899*[8]	Unlisted psychiatric service or procedure
Code to be announced	Treatment of TMJ disorder

*[1]Prior authorization is required for treatments in excess of 6 per month and 24 per calendar year.

*[2]Prior authorization is required for private duty nursing services in excess of 50 hours per month.

*[3]Prior authorization is only required for podiatry services in excess of three visits per month and 12 visits per calendar year.

*[4]Prior authorization is only required for inpatient chemical dependency treatment (90240), for inpatient pain programs (90260), and for podiatry services in excess of three visits per month and 12 visits per calendar year.

*[5]Prior authorization is only required for podiatry services in excess of three visits per month and 12 visits per calendar year.

*[6]Prior authorization is required for clinical units in excess of 10 per calendar year.

*[7]Prior authorization is required for group therapy in excess of 30 two hour sessions per calendar year.

*[8]Prior authorization is required for weight reduction/control programs, partial hospitalization programs, pain clinic programs, cardiac rehabilitation, and other structured inpatient and outpatient programs.

*[9]Home health agency visits in excess of four per seven-day period.

ATTACHMENT II

CODE LIST FOR MA/GAMC DENIAL REASONS

Following you will find a list of code numbers, followed by a denial reason. When you receive a prior authorization back that has been denied, you will find a code number under the service name box on the P.A. You should refer to this list to ascertain the denial reason(s).

Denial Reasons

1. DHS must safeguard the inappropriate expenditure of Program funds 9505.5020 Supb.6 B.

2. DHS must insure the quality and timeliness of the health services 9505.5020 supb.6 C.

3. DHS has determined that less expensive appropriate health service is available.
   9505.5020 Subp.6 D.

4. DHS must promote the most effective and appropriate use of available health services.
   9505.5020 Subp. 6 E

5. This service has not been documented to be medically necessary.
   9505.5020 Subp. 6A

6. This health service has been paid for directly by recipient.
   9500.1060A

7. This medication dispensed by a physician could reasonably be obtained from a licensed pharmacy. 9500.1060B.

8. Prior authorization was not obtained before providing services.
   9500.1060C., 9505.5020 Subp. 1

9. MA/GAMC does not pay for telephone calls, other non face-to-face communications, or routine reports, billing charges, mileage.
   9500.1060F,G.

10. This procedure is considered to be investigational and not covered.
    9500.1060H.

11. Artifical insemination is not a covered service.
    9500.1060J.

12. This procedure is a cosmetic surgery aimed at beautification only.
    9500.1060M.

13. MA/GAMC does not pay for reversal of voluntary sterilization procedures.
    9500.1060(O.)

14. MA/GAMC do not pay for duplication of services by more than one provider without appropriate medical referrals.
9500.1060(S.)

15. The requested item(s) is required to be provided as part of the per diem rate.
M. S. 256B.02, 9500.1070 Subp. 10 E.S

16. This requested item(s) should be provided as a part of the per diem rate. Item is standard equipment and not necessary for the continuous and exclusive use of recipient to meet an unusual medical need.
9500.1070 Subp.10 E(5)

17. This is an item not primarily and customarily used for a medical purpose.
9500.1070 Subp.10F.(1)

18. This is a comfort and convience item.
9500.1070 Subp. 10F.(2)

19. This is a stock orthopedic shoe--it must be attached to a leg brace or it is not eligible for MA/GAMC reimburse.
9500-1070 Subp. 10F(3)

20. This item is not durable medical equipment or prosthetic/orthotic
9500.1070 Subp 10B,c.

21. You have failed to provide sufficient documentation to support your prior authorization request.
9505.5020 Subp. 4

22. Provision of this item can only be made according to the time frame and criteria listed in rules DHS 9505.5020 Subp. 4. You have not met these requirements.

23. You are required to bill Medicare first. Present evidence of review and appeal hearing upon resubmission of prior authorization
9500.1080 Subp.2.(2)

24. You have failed to obtain the required two signatures supporting the requested surgery.
9505.5030 Subp. 11.

25. You have failed to adequately document the requested exemption
9505.5030 Subp. 12

26. You have exceeded the three day period allowed for emergencies.
DHS 9505.5020 Subp. 2A

27. You have exceeded the 20 day period for authorizations in cases of retroactive eligibilities.
DHS 9505.5020 Subp. 2B

28. PA is not required for this health service
9505.5020 Subp. 4

29. Recipient has not yet exhausted entitlement level necessitating a prior authorization for further services.

30. PA is not permitted for service beyond the levels established in 9505.5020 and 9500.1070.

31. Other, see attached or written reason, on P.A.

DENIAL REASONS PARTICULAR TO DENTAL SERVICES

32. The Medical Assistance program has requested consideration of an alternative procedure which meets the criteria of a basic, medically necessary oral health need.
9500.1070 Subp. 16

33. The prosthetic (Denture) services are provided only once during a (5) year period, except in special circumstances.
9500.1070 Subp. 16, B.(2)

34. Adequate justification for removal of third molar (wisdom teeth) has not been documented to be medically necessary.
9500.1070 Subp. 16.

ORTHODONTIC DENIAL REASONS

35. Orthodontic Consideration has been denied as not being medically necessary for the following reasons:
9500.1070 Subp. 16, 9505.5020 Subp. 6, A-F.

36. _____a. The anterior and facial esthetics is within acceptable limits.

_____b. The overall function is within acceptable limits.

_____c. The anterior spacing is within acceptable limits.

_____d. The overall tooth alignment is within acceptable limits.

_____e. The overbite is within acceptable limits.

_____f. The anterior protrusion is within acceptable limits.

_____g. Treatment is not indicated at this time.

_____h. The overall orthodontic problem is not severe.

_____i. Other:_____
_____
_____
_____

PENDING REASON CODES, OTHER SERVICES

Following you will find a list of code numbers followed by a pending reason, for both general information, and information particular to an item of medical equipment or speciality. When you receive the PA form back and any other information submitted with it, you will find a code number under the service name Box. If no code has yet been assigned with respect to an item of missing information, then a handwritten response will be present in this area. Refer to this list to ascertain what additional information is required to evaluate your request. When you have secured such additional information, make the notation, "Additional Information Requested" prominently on the face of the document that is now being submitted for the first time. Submit the original prior authorization and other documentation that you originally submitted, along with this new documentation. Otherwise we may be unable to honor its effective date properly. Failure to submit the requested information within 15 working days may result in the denial of the request.

PSYCHOTHERAPY

You have failed to provide:

130 Diagnosis based on ICD-9-CM or DSM III

131 Brief History

132 Description of symptoms, problems, living and working situation

133 Nature of therapy being provided

134 Treatment plan, goals, and strategies for achieving them

135 Response of the recipient to treatment to date

136 Prognosis

137 Summary of the previous prior authorization request immediately preceeding this one.

138 Estimated duration and frequency of treatment

139 Dates of previous hospitalizations

CHIROPRACTIC

You have failed to provide:

140 Diagnosis

141 Specific spinal subluxation site

142 (A) Date and history of onset (B) Dates of any exacerbation of the condition

143 Subjective complaints

144 Description of therapy

145 Prognosis

146 Extenuating circumstances

147 Record of previous chiropractic care
(A) Present calendar year
(B) Previous calendar year

148 Frequency of visits being requested

149 Duration of care anticipated and schedule of declining frequency of visits.

GENERAL

You have failed to provide:

160 Current, complete M.D. order

161 Complete and Appropriate Diagnosis

163 Sufficient information to support your request.

164 Name and credentials of individual delivering service

165 Photographs or x-rays necessary to process your request.

166 The recipients MA/GAMC #.

167 The dates for which you are seeking P.A.

168 The date of MA/GAMC application, date of County Board action, date of retroactive eligibility.

169a PA and all its attachments which are personally signed by the enrolled provider and individual delivering services.

170 An appropriate or correct procedure code.

171 A product description or explanation

ATTACHMENT III

DURABLE MEDICAL EQUIPMENT

NOTE: The following documentation is required for all durable medical equipment (DME) that requires prior authorization. From time to time, there will be more specific criteria published with respect to specific items of durable medical equipment. the information published regarding specific DME shall be provided in addition to that requested by 1-4 below. Note the appropriate pending code assigned to each item of information.

GENERAL REQUIREMENTS

You have failed to Provide:

Pending Reason Code #	
100	A current MD order for the requested item(s) including any special adaptations. Current is defined as signed and dated within the past two months.
101	A physician's satement to justify medical necessity to include:
101a.	All Diagnoses
101b.	A list of the functional deficit(s) which indicate a need for the requested equipment. The assessment may be made by either an M.D. or R.P.T.
101c.	Reasons why use of the requested piece of equipment in the home is not contraindicated. It is required that contraindications are addressed when requesting such items as patient lifts, wheelchairs, hospital beds, respiratory equipment i.e. large, heavy and/or bulky equipment which might create space and/or mobility problems,
101d.	A description of the patient's present functional status and the anticipated functional status with the use of this equipment.
101e.	Justification that this equipment is necessary for the continuous and exclusive use of the recipient to meet an unusual medical need. This item applies to long term care facilities operating under a per diem.
101f.	A plan to instruct the patient and caretakers to safely and competently use and care for the equipment.

Pending Reason
Code #

101g. A statement of the estimated length of time the equipment will be necessary.

101h. Documentation that all less costly alternatives to the requested equipment have been tried or considered and why they are not satisfactory.

Information to be submitted by the vendor to include:

102 A determination of whether or not the recipient is eligible for Part B Medicare or payment from any other third parties. If Part B Medicare billing has been denied, a copy of the review request and final Medicare appeal determination must be provided.

102a. An equipment purchase and rental history of all durable medical equipment that the reicpient has used in the past five years including repairs, dates rental/purchase, nature of repairs and costs of such.

103 Dates for which you are seeking prior authorization
NOTE: In most cases, if the equipment which is the subject of the prior authorization request has been rented in the past, the cumulative rental shall not exceed the MA allowable purchase price. Any rental already paid shall be deducted from the allowable pruchase price.

HOSPITAL BEDS

Hospital Beds (Standard)

You have failed to provide:

The following pending reasons are specific to the item they are listed under. Provide this information in addition to 100-103 above if the DME you are requesting P.A. for is one of the following:

104 A statement that patient's condition requires positioning of the body and reasons therefore. Prescription must establish medical necessity and include a description of the medical condition e.g. cardiac disease, chronic obstructive lung disease, quadriplegia or paraplegia, and also the severity and frequency of the symptoms of the condition that necessitates a hospital bed for positioning, and,

104a or that the required attachments cannot be fixed and used on an ordinary bed.

Semi-Electric And Total Bed (Head & Foot Adjustment)

Pending Reason Code #		
105	a.	The above criteria for Standard Bed, and
105a	b.	A statement that the patient's need for position changes are frequent and/or immediate so that the patient must be able to effect these changes him/herself as no delay can be tolerated. Exceptions may be made to this last requirement in cases of spinal cord injury and brain damaged patients, severe respiratory or circulatory problems.

Total Electric Bed (Head, Foot Height Adjustment)

106	a.	Meets requirement of Hosptial Bed Standard 1 and 2 or 1 and 3.
106	b.	Covered for one of the following conditions:
106b(1)	1.	Severe arthritis and other injuries to lower extremities, e.g., fractured hip. The condition requires the variable height feature to assist the patient to ambulate by enabling the patient to place his or her feet on the floor while sitting on the edge of the bed.
106b(2)	2.	Severe cardiac conditions. For those cardiac patients who are able to leave bed, but who must avoid the strain of "jumping" up or down.

PATIENT LIFT (frequently Hoyer Lift)

107	Documentation concerning training of caretakers (family and others including Personal Care Attendant) in patient transfers and why this method is not feasible.
107a	The weight (can be estimated) and height of the patient and height, weight, general strength and age of primary caretaker(s).
107b	Documentation that the patient and caretakers have used the lift together and handle it satisfactorily.
107c	A statement that the residence has been carefully assessed to determine that a lift can be used in those areas where it is needed, i.e., from bed to chair, from chair to lavatory, etc.

MOBILITY DEVICES

WHEELCHAIRS - SPECIALIZED OR MOTORIZED

Pending Reason Code #

108 A. A current M.D. order for the requsted ,specially designed or motorized wheelchair, including all diagnoses. The order must include a complete list of any modifications or accessories needed, and the medical rationale. NOTE: when a recipient is younger than 15, the M.D. must provide a signed statement that this person possesses sufficient maturity and responsibility to handle the machine safely with respect to himself and others. Also, if a non contract wheelchair is being requested written M.D. justification must be provided as to why the requested chair is superior in meeting the needs of the patient over and above the contract version.

B. A functional evaluation of the recipient by the physician or a qualified physical therapist is submitted. Including:

108B(1) 1) Evidence that the prescribed item can be operated by the recipient and is effective. NOTE: When the request is a first time purchase of an electric wheelchair there must be documentation that the client has tried the requsted machine, or one very similiar, and has beginning skills in manuvering it.

108B(2) 2) Muscle strength and coordination to push a wheelchair.

108B(3) 3) Tolerance for the use of a wheelchair over an extended period to time.

108B(4) 4) Sitting balance.

108B(5) 5) Range of motion.

108B(6) 6) Spasticity level.

108B(7) 7) Pain tolerance

C. A statement from a social worker, Registered Nurse or Physical Therapist to include:

Pending Reason Code #		
108C		Present wheelchair activity, including means of getting around in.
108C(1)	1)	Means of accomplishing transfers.
108C(2)	2)	Means of dressing, bathing and accomplishing personal care.
108C(3)	3)	Other special needs.

OXYGEN

Please refer to Attachment I for information concerning the Prior Authorization requirements. NOTE: There have been substantial changes in this requirement.

M.D Prescription to include:

112(1)	1)	Diagnoses
112(2)	2)	Liter flow/concentration of O2 both at rest and ambulatory when applicable.
112(3)	3)	Frequency and length of time/adminstration
112(4)	4)	Mode of administration i.e. cannula, mask
112(5)	5)	Estimated duration/use
112(6)	6)	Order for self administration if applicable
112(7)	7)	PAO2 and oxygen saturation
113		Care plan to demonstrate and document the need for supplemental O2.
114		Justification concerning why the particular form of O2 has been selected over and above others. (Supplier or M.D.)

NOTE: The need for O2 must be reevaluated at intervals not to exceed 4,8 and 12 months.

APNEA MONITORS

Due to the nature of this item, this item may be provided to a new patient for a period of 30 days while you are awaiting necessary documentation and/or a response to your prior authorization reuqest. If medical necessity is established, this one month period will be approved even though no prior authorization was submitted before providing the monitor. The following criteria must be met in order to receive approval either for the one month "No PA Requirement" period or continuation after the first month. This retroactive approval only applies to new patients and not to continuing or renewal prior authorization requests.

115	Documentation the recipient has experienced an apparent life-threatening event, characterized by cessation of breathing, bradycardia, color changes or a change in state of consciousness.
116	Documentation that the infant was premature with a history of apnea or bradycardia, or has a significant family history of SIDS (Sudden Infant Death Syndrome).
117	A statement that provision has been made for adequate family instruction, an organized support system, and follow up.
118	A physician's statement including the following:
118(1)	(1) Diagnosis
118(2)	(2) Clinical history
118(3)	(3) Pneumogram result (including good component of sleep)
118(4)	(4) Evaluation of results following each authorized period of payment.
118(5)	(5) Provisions which have been made for discontinuance of the apena monitor and the criteria to be utilized in determing when discontinuance is appropriate.

ATTACHMENT IV

Service Name	CPT-4---1984 Version Codes
1. Tonsillectomy and/or adenoidectomy	42820, 42821, 42825, 42826, 42830, 42831, 42835, 42836 42860, 42870
2. Hysterectomy	58150, 58152, 58180, 58260, 58265, 58267, 58270, 58275, 58280, 58285
3. Hernia repair	49500, 49505, 49510, 49515, 49520, 49525, 49540, 49550, 49552, 49555, 49560, 49565, 49570, 49575, 49580, 49581, 49590, 49600, 49605, 49606, 49610, 49611
4. Cholecystectomy	47600, 47605, 47610, 47620, (47610 with 47550)