HIGHLINE MEDICAL SERVICES ORGANIZATION

2019 Prior Authorization Guide effective 5/1/19

Office visits/Evaluations with Health Plan contracted specialists require a PCP referral but do not require a HMSO prior authorization/notification EXCEPT for the following specialties:
Allergy, Cardiology, Dermatology, Nephrology, Neurology, Ophthalmology, Orthopedics, Otolaryngology, Physiatry/Pain Medicine, Plastic & Reconstructive Surgery, Podiatry, Urology and Vascular Surgery.

Requests for authorization for additional services/procedures can be submitted directly to HMSO by the Specialist. The Specialist must have a PCP referral and/or HMSO authorization (based on PA guidelines detailed in this guide) on file to submit for additional services/procedure authorization.

Except for services in this guide, prior authorization/notification is not required for services provided by The Center for Diagnostic Imaging (CDI) when referred by a HMSO PCP or Specialist.

All additional services (Surgery, Radiology, etc.) outside of the HMSO network REQUIRE PRIOR AUTHORIZATION/notification UNLESS OTHERWISE NOTED.

The **medical care and procedures below require prior authorization in all settings unless stated below**. If you have a question contact 206-878-1827(phone) or **206 878 1539 (fax)***
*Please Note: CHANGE OF FAX NUMBER EFFECTIVE 1/1/19

Cosmetic and Reconstructive Procedures	**Codes**
Blepharoplasty,	15820-15823
Brow Ptosis Repair	67900-67909
Breast Reduction/augmentation	19316-19499 L8600
Panniculectomy,	15830 15839 15847
Gynecomastia	19300
Rhinoplasty,	30400-30450
Vein Procedures	37700-37785 36470-36479
Botox injections	J0585 J0586 J0587 J0588

Dermatology Conditions	
Vitiligo	L80, L81-L81.6
Hair loss	L65-L65.9, L63-L63.9
Keloids	L91.0-91.9, L73.0-L73.9

Moles/Lesions	D22-D22.9, D23-D23.9, L98.9
Skin Excisions/Revisions	11400-11446, 11200-11201, 17106-17108, 17999, 14000-14350 (except if billed with ICD10 D01-D09 or "C" codes)
Skin Cancer Screening **without** history of CA	Z12.83

Gene testing

Molecular and Genetic	81211, 81213-81214, 81292, 81294, 81300, 81479, 81317

Spinal Procedures

Vertebroplasty, Kyphoplasty	22510-22515

Nutrition Education/Counseling

Medicaid PA required for ages 21 & older **Medicare**-PA required **NOTE**: Open to Health Plan's provider network	

Physical, Occupational, Speech Therapy

Medicaid PA required for ages 21 & older AFTER 6 hours per modality per calendar year. **Medicare**-Pa required AFTER 12 visits. **NOTE**: Open to Health Plan's therapy agencies. Plan contracted Women's health Care Providers and HMSO Orthopedic, Physiatrist, Podiatry and Otolaryngology Specialists may refer directly for therapy.	

Prosthetics/Orthotics:

All prosthetic & orthotic devices require PA **except if provided by Pacific Prosthetics & Orthotics** and purchase cost are less than $500 retail purchase or cumulative rental cost per device -**do not require PA.**

PET scan

All non-oncological require PA

Therapeutic Radiology Simulation/Treatment

77280, 77285, 77290, 77299

Hyperbaric Therapy

99183-99184

New Technology

All require PA

Experimental or Investigational (all therapies)

All require PA

Durable Medical Equipment (DME):

Medicaid-all require PA except if <$300 retail purchase or cumulative rental cost and provided by Performance Home Medical

Medicare-The following codes do not require PA if provided by Performance Home Medical. All other require PA except if <$300 total retail purchase or cumulative rental cost and provided by Performance Home Medical.

Medicare exempt DME by Performance Home Medicals	**Codes**
Manual Wheelchairs	K0001-K0006, K0195, E1226,
Walkers	E0143, E0135
Commode	E0162-E0165, E0168-E0171
Oxygen	E1390, E1392, E0424, E0431-E0444, K0738
CPAP	E0601, A4604, A7027-A7046, E0561, E0562
Nebulizers	E0570
Hospital Bed	E0260, E0261

Note: NO PA REQUIRED for maintenance supplies such as ostomy supplies, catheter supplies, wound care supplies, disposable tubing/filters for approved equipment.

Diabetic Supplies: No PA required and can be dispensed by a retail pharmacy.

Note: Please DO NOT mark an authorization request as urgent or expedited unless they meet the following definition:
URGENT or EXPEDITED REQUEST DEFINITION - care or treatment where the passage of time could seriously jeopardize the life or health of the patient, seriously jeopardize the patient's ability to regain maximum function, or in the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without care or treatment or lack of timely treatment may result in an emergency visit or emergency admission, that is the subject of request (WAC 284-43-410).
If prior authorization is required and member has an appointment scheduled for services within 5 calendar day, mark the prior authorization with "appointment scheduled" along with date and HMSO goal is to process within 24 business hours of receipt.

Inclusion of items/services on this list DOES NOT indicate benefit coverage. Please verify benefits prior to requesting authorization.