HIGHLINE MEDICAL SERVICES ORGANIZATION

2020 Prior Authorization Requirements- effective 3/01/2020

For questions phone 206-724-0868 (outpatient) or 206-724-0866 (IP, HH, SNF)

Fax authorization requests to: **206 878 1539**

REQUIRES PA:

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

Out-of-HMSO network provider office visits **do** require prior authorization for the following provider type: **Allergy, Cardiology, Dermatology, Nephrology, Neurology, Ophthalmology, Orthopedics, Otolaryngology, Physiatry/Pain Medicine, Plastic & Reconstructive Surgery, Podiatry, Urology and Vascular Surgery.**

The **medical care and procedures below require prior authorization in all settings unless stated below**.

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, L81.9
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	0001U-0118U, 0129U-0138U, 0152U-0162U, 0004M-0013M, 81105-81479, 81507, 81518-81599, 87480-87482, 87505-87512, 87623, 87652, 87660-87661, 87797-87801, S3870

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

Prior Authorization is NOT REQUIRED for the following:

- **OBSERVATION** status in acute care facilities.
- **Routine Obstetric** delivery admissions for mother and baby

- **Radiology/Ultrasound-**

Routine x-rays and ultrasound by any contracted Health Plan facility.

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

- **Specialist Authorizations-**

For office visits with specialist that are **NOT Allergy, Cardiology, Dermatology, Nephrology, Neurology, Ophthalmology, Orthopedics, Otolaryngology, Physiatry/Pain Medicine, Plastic & Reconstructive Surgery, Podiatry, Urology and Vascular Surgery.** HMSO does not require an out of network prior authorization as long as the Specialists selected are contracted with the Health Plan and have a PCP referral on record. PCP's submit a referral directly to the Specialists.

- **Highline Medical Hospital**

No PA required for any HMSO contracted Specialists for office visits or procedures they provide at Highline Medical Center.

- **Maintenance Supplies**

Ostomy supplies, catheter supplies, wound care supplies, disposable tubing/filters for approved equipment, diabetic supplies including dispensed by a retail pharmacy.

- **Colonoscopy,** screening/diagnostic by any Health Plan contracted provider/facility.

- **Women's Health Care** procedures at any Health Plan contracted facility(ex. Tubal Ligation, IUD, D&C, All OB related services)

- **Routine lab**

- **Chiropractic Services-** Note: some members have benefit limits or supplemental coverage managed by the health plan for routine chiropractic services. Verify coverage, benefits and responsible payer with the Health Plan.

Utilization Management Processes

HMSO will accept authorization requests for additional services/procedures **directly** from Specialists as long as there is a PCP referral and or a previous HMSO authorization on file.

SECONDARY REFERRAL: Health Plan Specialists requesting for patient to be seen by an additional Specialists must refer patient back to their PCP with request/recommendations for additional consults or studies.

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.

CMS defines an expedited/urgent request as "an expedited/urgent request for a determination is a request in which waiting for a decision under the standard time frame could place the member's life, health or ability to regain maximum function in seriously jeopardy." Submit requests in accordance with CMS guidelines to allow for organization determinations within the standard turnaround time, unless the member urgently needs care based on the CMS definition of an expedited/urgent request. (WAC 284-43-410).

Specialists consult reports and test results are to be faxed or mailed to HMSO PCP timely.

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