

## Service Authorization

Some PrimeWest Health covered services require authorization. The service authorization requirement is used to safeguard against inappropriate and unnecessary use of health care services. Some authorization requirements are governed by state law and federal regulations.

Providers should obtain service authorization prior to providing a service. The service authorization requirements apply when PrimeWest Health is primary, secondary or third payer for the member. Requests for authorization after the service has been provided are subject to the same review criteria as those that are received prior to providing the service. Receiving an approval for a service authorization request does not guarantee payment. Providers must follow PrimeWest Health billing policy guidelines, and the PrimeWest Health member must be eligible at the time the service is rendered.

## Definitions

**Authorization:** The written approval and issuance of an authorization number by a medical review agent under contract with PrimeWest Health

**Fair Hearing:** An administrative proceeding to examine facts concerning the matter in dispute and to advise the Commissioner if the decision to reduce or deny benefits is appropriate.

**Investigative Health Service:** A procedure that has limited human application and trial, and lacks wide recognition as a safe and effective procedure in clinical medicine. A drug or device (identified in the [Food, Drug, and Cosmetic Act](#)) the United States Food and Drug Administration has not yet declared safe and effective for the use prescribed.

**Local Trade Area:** The geographic area surrounding a member's residence commonly used by local residents to obtain similar health care services.

**Medically Necessary or Medical Necessity:** A health service that is consistent with the member's diagnosis or condition and is:

- Recognized as the prevailing medical community standards or current practice by the provider's peer group; and
- Rendered in response to a life-threatening condition or pain; or to treat an injury, illness, or infection; or to treat a condition that could result in physical or mental disability; or to care for the mother and child through the maternity period; or to achieve community standards for diagnosis or condition; or is a preventive health service.

**Out-of-state Provider:** A provider located outside of the State of Minnesota and the member's local trade area.

**Referee:** A person who conducts fair hearings and provides recommendations to the Commissioner.

## PrimeWest Health Authorization Criteria

PrimeWest Health requires service authorization as a condition of PrimeWest Health payment (regardless of PrimeWest Health is primary, secondary or tertiary insurance for the member) if the health service:

- Is of questionable medical necessity;
- Requires monitoring to control the expenditure of PrimeWest Health funds
- A less costly, appropriate alternative health service is available;
- Is investigative or experimental;
- Is newly developed or modified;
- Is of a continuing nature and requires monitoring to prevent its continuation when it ceases to be beneficial;
- Is comparable to a service provided in a skilled nursing facility or hospital but is provided in a member's home;
- May be considered cosmetic; or
- Is mandated by the State of Minnesota.

## Medical Review Agent

The PrimeWest Health Clinical Administration Staff processes requests for service authorization. Medical Administration Staff accept requests for service authorization by fax or over the telephone. Faxed requests for service authorization are accepted on the PrimeWest Health Authorization Form available on the website.

Appropriate documentation for medical necessity is required for all requests. Refer to the appropriate covered services chapter for more information about specific documentation requirements, or contact PrimeWest Health Medical Administration at:

PrimeWest Health  
2209 Jefferson St, Ste 101  
Alexandria, MN 56308  
1-866-431-0803 (toll free)  
1-866-431-0804 (fax)

## Documentation Requirements

The criteria listed below are used by PrimeWest Health Clinical Administration when processing requests for authorization. The service must be:

- Medically necessary, as determined by prevailing medical community standards or customary practice and usage
- Appropriate and effective for the member's medical needs;
- Timely, considering the nature and present medical condition of the member;
- Provided by a provider with appropriate credentials;
- The least expensive, appropriate alternative available; and
- An effective and appropriate use of PrimeWest Health funds.

## Modifiers

If a modifier is required for a particular procedure code, the request for service authorization submitted to PrimeWest Health must include the modifier. Information on the approved

authorization, including the procedure code(s) and the modifier(s), must match claim information for the service, or the claim will be denied.

## Out-of- Plan Providers

Except for emergency services, out-of- plan providers must obtain prior authorization before providing PrimeWest Health covered services. Requests for prior authorization of services provided outside of the PrimeWest Health network or non-contracted providers in or out of State must include documentation establishing medical necessity and the unavailability of that service in Minnesota or in the PrimeWest Health network. PrimeWest Health covered services provided to a Minnesota member by an out-of-state out of plan provider will be covered under the following circumstances:

- The services must be medically necessary;
- The services are provided in response to an emergency while the member is out of the state and the provider is out of plan;
- The services are not available in network or by an out of state contracted provider, and the attending physician has determined medical necessity and obtained prior authorization from PrimeWest Health. (The county is responsible for travel expenses associated with obtaining the out-of- state services) or
- The services are required because the member's health would be endangered if he/she were required to return to Minnesota or to an in plan or in network provider for treatment.

The exception to the service authorization rule for out of plan providers applies only to physician specialists and only for members in the SNBC (Special Needs Basic Care) group and pediatric members ( 21 years old or younger). This exception for these two group of members applies only to clinic or outpatient hospital office visits provided by physician specialists (example: cardiology, pulmonology, pediatric endocrinology, etc) and diagnostic testing or laboratory services ordered by the same physician specialists.

## Notice of Action Taken

PrimeWest Health will notify the provider and member, in writing, of action taken on an authorization request. PrimeWest Health Medical Administration will notify the provider if additional information is needed to decide medical necessity. If a request is denied, the member will receive a notice of member's right to appeal.

## Fair Hearings

If the request is denied or reduced, the member may appeal the decision to PrimeWest Health Appeal and Grievances and/or receive a fair hearing before a referee from DHS. To request a fair hearing, a member must contact the Appeals Unit at DHS.

Providers do not have the right to appeal a denied request under the department's fair hearing process. Providers may submit additional documentation and ask PrimeWest Health for a reconsideration of a decision.

## Authorization List

The following is the current authorization list. The list is not all inclusive. New technology, investigative health services, etc will always require service authorization. In addition all

inpatient admissions to acute level of care, to acute rehabilitation, to long term acute care, to sub acute units, to skilled nursing facilities require certification.

There are medications that require authorization under the Pharmacy benefit that are not listed in this chapter, go to Pharmacy Services, [chapter 22](#) for this information. In this chapter we list medications provided in the clinic during an office visit or in the member's home that need service authorization.

This list applies to in network or in plan providers or facilities. Non-contracted, out of plan, out of network providers and facilities require a service authorization prior to providing any and all services to a PrimeWest Health member (see exception applied for SNBC and pediatric members under Out Of Plan Providers).

As authorized by MS [256B.0625](#), subd. 25, the following list includes all health services that require authorization as a condition of PrimeWest Health payment. The list is presented alphabetically first and then in sections: Dental Services, Vision Care Services, Medical Supplies and Equipment, Prosthetics and Orthotics, Hearing Aids, Medications, Rehabilitative Services, and All Other Services. The criteria used to develop this list are as follows:

- The health service could be considered, under some circumstances, to be of questionable medical necessity.
- Use of the health service needs monitoring to control the expenditure of program funds.
- Less costly, appropriate alternatives to the health service are generally available.
- The health service is investigative.
- The health service is newly developed or modified.
- The health service is of a continuing nature and requires monitoring to prevent its continuation when it ceases to be beneficial.
- The health service is comparable to a service provided in a skilled nursing facility or hospital but is provided in a member's home.
- The health service could be considered cosmetic.

## A

- **Abdominoplasty / Panniculectomy**
- **Acupuncture (beyond 10 treatments)**
- **Air Fluidized Bed**
- **Air ambulance transportation, to or from another State only**
- **Alternative Care /Complimentary Medicine as a benefit exception**
- **Alternating Pressure Mattress**
- **Ambulance, air only (if origination or destination is outside of Minnesota)**
- **Anesthesia for dental cleaning and restorations (8 yrs & older)**
- **Anzemet™ (dolasetron mesylate) (If used for greater than 4 weeks)**
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- **Apnea Monitors (after 6 months rental)**
- **Aprepitant (Emend) (unless accessed through the Pharmacy benefit)**

- **Augmentative Communication Device**
- **Autopsy for IUFD/stillborn or neonatal death (other autopsies not covered)**

**B**

- **Bariatric Surgery**
- **Beds-Manual. Electric, Special**
- **Billights (after 7 days of treatment in the home)**
- **BiPAP (after 3 months rental)**
- **Biofeedback for incontinence**
- **Biofeedback Machines**
- **Blepharoplasty/Ptosis Repair**
- **Blood Glucose Monitor with special features (only)**
- **Bone Marrow Transplant**
- **Bone Growth Stimulators, Electronic & Ultrasonic**
- **Botox (botulinum toxin)**
- **Botulinum toxin (Botox)**
- **Breast Reconstruction Surgery (except if done related to breast cancer)**
- **Breast Reduction Surgery**
- **Breast Pump, heavy duty (only)**
- **Bronchial Drainage Vest and Generator**

**C**

- **Carticel (cultured chondrocyte implants)**
- **Casting/strapping (done by PT or OT)**
- **Chemical Dependency treatment (approved through county assessor)**
- **Chest compression vest**
- **Chiropractic Care (beyond 24 treatments per year)**
- **Cholecystectomy with sphincterotomy**
- **Circumcision**
- **Cochlear Implant analysis (if done by SLP)**
- **Cochlear Device**
- **Contact Lenses**
- **Cosmetic Surgery/Treatments**
- **Cough Stimulator**
- **CPAP/BiPAP after 3 months rental**
- **CPM (Continuous Passive Motion) Devices**
- **Crowns (including Porcelain covered only for SNBC)**
- **Cultured chondrocyte implants (Carticel)**

**D**

- **Defibrillator, automatic external**
- **Dental Procedures:**
  - **Accident Related Dental services**

- Orthodontia
- Porcelain Crowns and Crowns
- Implants
- Fixed Bridge
- TMJ Splints
- Diagnostics – (Genetic testing)
- Disc Replacement – artificial
- Dolasetran mesylate (Anzemet™) (If used for greater than 4 weeks)

**E**

- Electric Stimulators (bone, muscle, cough, etc)
- Emend (aprepitant) (unless accessed through the Pharmacy benefit)
- Enteral therapy, oral ( after 30 days)
- ENT service (done by SLP)
- EROS – sexual dysfunction treatment
- Experimental/Investigational Services

**F**

- Formula/Enteral Nutrition, oral

**G**

- Gait trainer
- Gastric Bypass Surgery
- Genetic Testing (except for advanced maternal age >35 yrs)
- Geri-chair
- Glasses (frames and lenses) (beyond 1 pair every 2 years)
- Granisetron (Kytril™) ( if used for greater than 4 weeks)
- Gynecomastia Surgery

**H**

- Habilitative Services (after reaching DHS threshold, applied annually)
- Hair Prosthesis
- Hearing Aids (if billed amount > \$1000)
- Hearing Aid Systems (in glasses, pocket talker, etc)
- Heart Transplant; Heart-Lung Transplant
- Home Care Services
- Home Health Services
- Hospital Bed (manual, electric, special)
- Hospital Services (inpatient)
- Hospice (If Medicare not covering)

**I**

- Implants/Fixed Bridge, dental

- **Implants (electric stimulator, epidural, intrathecal, neurostimulator, infusion pump)**
- **Infertility Treatment**
- **Insulin Pump**
- **Interferon**
- **Interferential Current Stimulation (IFC)**
- **Intervertebral Disc Replacement (artificial)**
- **Intestine Transplant; Intestine-Liver Transplant**
- **Investigative Services**
- **IRTS (Intensive residential treatment Services)**
- **IPPB**
- **IV Medications provided in the home**

**J**

- **Joint Stimulator**

**K**

- **Kidney Transplant; Pancreas-Kidney Transplant**
- **Kytril™ (granisetron) (if used for greater than 4 weeks)**

**L**

- **LASIK**
- **LAUP**
- **Lap Band Weight Loss Surgery**
- **Laser-Assisted Uvulopalatoplasty (LAUP)**
- **Lesion Destruction (if for Rosacea)**
- **Lift Chair Mechanism**
- **Lift devices (lifts, standers)**
- **Light Therapy (ultraviolet, SAD lights)**
- **Lipectomy**
- **Liver Transplant; Intestine-Liver Transplant**
- **Low Air Loss Bed**
- **Lung Removal (for lung volume reduction)**
- **Lung Transplant; Heart-Lung Transplant**
- **LVAD (Left Ventricular Assist device)**

**M**

- **Mammoplasty**
- **Manual Wheelchair**
- **Mattress, Pressure Reducing (Group 2 and Group 3)**
- **Microair Bed**
- **Mobility Assistive Equipment**
- **Muscle Stimulator**

**N**

- **Natalizumab (Tysabri™)**
- **Nebulizer, ultrasonic (only)**
- **Neuromuscular Electrical Stimulator**
- **New Technology**
- **Non speech generating device (by SLP)**
- **Nutritional Supplements, oral**
- **Nutritional Counseling (beyond 5 sessions)**

**O**

- **OT/PT Rehab (After DHS thresholds exceeded, applied annually)**
- **Occupational Therapy (after thresholds met)**
- **Omalizumab (Xolair™)**
- **Ondansetron (Zofran™) (if used >4 consecutive weeks)**
- **Oral Appliances for Sleep Disorders**
- **Oral Surgery**
- **Organ Transplants**
- **Orthodontia**
- **Orthognathic Surgery**
- **Orthopaedic Shoes (except shoes for Diabetes)**
- **Orthotics (if bill is for >\$3,000 total)**
- **Out of Network services (all except emergency services) (except physician specialists for SNBC and pediatric members)**
- **Out of Plan services (all except emergency services) (except physician specialists for SNBC and pediatric members)**

**P**

- **Palatal Implants for Obstructive Sleep Apnea**
- **Pancreas Transplant; Pancreatic islet cells transplant;**
- **Pancreas kidney Transplant**
- **Panniculectomy**
- **Partial Hospitalization (Mental Health)**
- **Pavalizumab (Synagis™) Injections**
- **PCA Assessment (>2 in a calendar year)**
- **PCA Services**
- **PCA Updated Assessment (>1 a year)**
- **PDN (Private Duty Nursing)**
- **Pelvic Floor Electrical Stimulation for urinary incontinence**
- **Penile Implants**
- **Personal Care Assistant Services**
- **Physical and Occupational Therapy (upon reaching DHS Threshold, applied annually)**
- **Piercing device, skin**
- **Pillar Implant**

- **Pocket Talker**
- **Polarized lenses and Tints**
- **Pool Therapy (if beyond DHS threshold, applied annually)**
- **Porcelain Crowns**
- **Powered Mattress**
- **Power Wheelchair**
- **POV (Power Operated Vehicle)/Scooter**
- **Prosthetics (if bill is for >\$3000 total)**
- **PT/OT, outpatient ( upon reaching DHS threshold, applied annually)**
- **Ptosis Repair**

**R**

- **Reconstructive Surgery**
- **Reduction Mammoplasty**
- **Refractive surgery**
- **Rehabilitation (upon reaching DHS rehab threshold, applied annually)**
- **Residential Treatment**
- **Repairs of DMEPOS**
- **Respiratory Assistive Devices (IPPB, Ventilators)**
- **Rhinoplasty & Septorhinoplasty**
- **RSV prophylaxis/Synagis™ (Pavalizumab)**

**S**

- **Scar revisions**
- **Sclerotherapy for Varicose or spider Vein Treatment**
- **Scooter (POV)**
- **SCS (Spinal Cord Stimulator) insertion**
- **Seat Chair Lift**
- **Second opinion (from non-contracted providers)**
- **Sensory Integration OT modality**
- **Septorhinoplasty & Rhinoplasty**
- **Silicone Implant Removal**
- **SNF (Skilled Nursing Facility) – placement must be communicated to PW in order for claims to pay**
- **Special coating for lenses (only available for SNBC members)**
- **Special Mattress (Group 2 and Group 3)**
- **Speech Generating Device (by SLP)**
- **Speech Therapy (when DHS threshold is met – applied annually)**
- **Spinal Stimulator – External**
- **Staged Laser Surgery**
- **Stimulators (bone growth, cough, muscle, neuromuscular, spinal, etc)**
- **STS (Sympathetic Therapy System)**

- Sympathetic Therapy
- Syngis™ (Pavalizumab) injections

**T**

- Telehomecare
- Telemedicine
- TENS units
- Tints and Polarized lenses
- TMD Surgery (temporomandibular disorder)
- TMJ Treatment
- Transplants, organ
- Tysabri™ (natalizumab)

**U**

- Ultrasonic Bone Stimulator
- Unclassified Drug Code: J3490
- Unspecified antiemetic following chemotherapy
- UPPP (Uvulopalatopharyngoplasty)
- Urinary Incontinence Device
- Uterine Activity Monitoring Services
- Uvulectomy

**V**

- VAD (Ventricular Assist Device)
- Ventilators

**W**

- Weight Loss surgery for Obesity
- Wet stop
- Wheelchair – all
- Wheelchair adaptations / special features
- Wheelchair custom cushion
- Whirlpool
- Wigs/Hair prosthesis
- Wound stimulator
- Wound vac or wound pump

**X**

- Xolair™ (omalizumab)

**Z**

- Zofran™ (ondansetron) (if used >4 consecutive weeks)

**Dental Services**

It is essential that requests submitted for service authorization consideration be accompanied by adequate case information and appropriate diagnostic materials (i.e., radiographs of patient's current dental condition, prosthesis information, teeth to be replaced, prognosis for remaining dentition, complete 6-point periodontal charting for cast metal partials). Refer to Chapter 19 "Dental Services" for coverage guidelines and authorization.

### **Vision Care Services**

Refer to [chapter 20](#) "Eyeglasses and Vision Care Services".

Contact lenses need service authorizations before provided for members without a diagnosis of Aphakia, Aniseikonia, Keratoconus or Bandage Lenses.

Tints and polarized lenses requires service authorization before being provided.

For eyeglasses request service authorization for more than 1 pair in a 24 month period.

Special coating for lenses is only available for SNBC members and requires service authorization before providing this service.

### **Medical Supplies and Equipment; Prostheses and Orthoses**

#### **Medical Equipment/Supplies**

Providers must get authorization for all equipment and supplies listed in [Chapter 23](#)

"Equipment and Supplies, where authorization is indicated, and the following general areas:

- All wheelchairs: When purchased, rented, or for use in nursing facilities.
- Repairs to equipment: Specify who owns the equipment.
- E1399 is the unspecified equipment code. This code is to be used only when no specific, descriptive HCPCS code is assigned.

#### **Prostheses and Orthoses**

Providers must request authorization for prostheses and orthoses (orthotics) when the cumulative cost exceeds \$3,000.

#### **Hearing Aids**

Services in the following categories require authorization:

- Hearing aids billed for more than \$1,000.
- Hearing aid systems regardless of price: hearing aid in glasses, CROS in glasses, BICROS in glasses, Assistive listening device, Pocket talker, Device for use with cochlear implant.
- The provision of more than one hearing aid or hearing aid dispensing fee in a five-year period.
- The purchase of a hearing aid when pure-tone average is less than 25 dB HL in an adult and less than 20 dB HL in a child.

#### **Drugs**

See PrimeWest Health [Chapter 22](#) Pharmacy Services. In Chapter 22 you will see a complete list of medication and pharmacy services provided through the pharmacy that need authorization and how we notify providers if a pharmacy item or medication is added to the service authorization requirement.

The following need service authorization when dispensed during a medical office visit or in the member's home: Botulinum toxin (J0585, J0587); Dolasetran mesylate (J1260, Q0180) if

used for more than 4 consecutive weeks; Granisetron (J1626, Q0166, S0091) if used for more than 4 consecutive weeks; Omalizumab (J2357); Ondansetron, if used for more than 4 consecutive weeks (J2405, Q0179); Cultured Chondrocyte implants (J7330); Aprepitant (J8501); Interferon (J9213, J9214, J9215, J9216); Unspecified oral antiemetic following chemotherapy (Q0181); Natalizumab (Q4079); Unclassified Drug Code (J3490) and Pavilizumab (C9003).

## Rehabilitative Services

See PrimeWest Health [Chapter 17](#) Rehabilitative Services.

## All Other Services

The following health services require authorization:

- All air ambulance transportation that originates from or is to a destination outside of Minnesota **and** is to and/or from an out of network or out of plan provider.
- Investigative health services and procedures that may be considered cosmetic. If staged reconstructive surgery is being proposed for correction of a congenital anomaly the complete plan for future surgeries must be submitted with the first authorization.
- All surgical or behavioral modification services aimed specifically at weight reduction.
- Services provided outside of Minnesota. This requirement for prior authorization does not include, emergency services. A service authorization is still required before providing non-emergent services needed because the member's health would be endangered if the member was required to return to Minnesota or services provided to children placed outside of Minnesota through the subsidized adoption assistance program under MS [256B.055](#), subd. 1 or 2.
- In addition, there are specific procedures and investigative procedures which require authorization. There are two lists: specific procedures with CPT and HCPCS codes and procedures for which no HCPCS codes have been assigned. These procedures are listed in Chapter 5 of the MHCP Provider's Manual.
- From the list of codes and procedures in Chapter 5 of the MHCP Provider Manual, the following are not part of PrimeWest Health service authorization list for our members when provided by a contracted or in network provider: Spinal Fusion ( 22532-22632, 22800-228120; Hysterectomy (58150-58294, 58541-58578); Cesarean Delivery (59510-59622); Tympanostomy tubes (69433-69436); PET scans (78459-78492, 78608, 78609); High tech Imaging (72159-73225, 76390) Mental Health assessment and outpatient mental health services (90801-90875, 90887,96100); Neuropsychology services (97535); Day Treatment (H0012);CTSS (H2014); ARMHS (H2017, H0034, 90882); Vision Therapy (92065) and Preventive medicine codes 99401-99412.

## Legal References

[MS 256B.02](#)

[MS 256B.04](#)

[MS 256B.093](#)

[MS 256B.0625](#)

[MS 256B.0627](#)

Minnesota Rules [9505.0175](#), [9505.0215](#); [9505.0500 to 9505.0540](#)

Minnesota Rules [9505.5000 to 9505.5105](#)

[42 CFR 431.52](#)

[42 CFR 440.230](#)