



CMO Guidelines for Obtaining Authorization

The Medical Management Department at CMO should be notified at least 72 hours in advance when services require authorization. The CMO Precertification List is included in this document. Approval will be determined based on medical necessity. Payment for services also depends on whether the member was eligible at the time of service and if the requested procedure is covered under the member's benefit.

Emergent Services:

In a situation where a provider believes services that generally require authorization need to be provided on an urgent/emergent basis, the service should be provided and CMO must be contacted by the next business day.

How to submit a precertification request:

Post-N-Track:

Providers that have access to Post-N-Track should submit their requests for authorization electronically. Once submitted, a provider can view the status of a submitted authorization request using the "Authorization History" tab on the Post-N-Track Portal. Approval and denial letters are also mailed to the member, primary care physician and the specialist. If services are denied, the denial letter will include instruction for the filing of an appeal and will be mailed to the member and the provider.

Phone:

If you do not have access to Post-N-Track, please contact CMO Provider Relations as soon as possible at 914-377-4477, for instructions on account set up. You can also email CMOProviderRelations@montefiore.org and a representative will contact you regarding set-up. Until your account is set up, you can submit your requests for authorization by calling CMO Customer Service at 914-377-4400 or toll free 888-MONTE-CMO.

Fax:

You can also submit your requests for authorization by fax. The main fax number for Medical Management is 914-377-4798 and the Medical Management fax number for Radiology authorization is 914-457-9509.

**ALL PROVIDERS ARE STRONGLY ENCOURAGED TO
OBTAIN AND REVIEW AUTHORIZATIONS THROUGH POST-N-TRACK.**

CMO Precertification List Overview

Precertification Phone Lines: 914-377-4400 · 888-MONTE-CMO

Precertification Fax Line: 914-377-4798 Radiology Precertification Fax: 914-457-9509

<p>1. Inpatient Admissions</p> <ul style="list-style-type: none"> • Elective Admission require prior authorization at least 5 days prior to admission • Urgent/Emergent Admissions require notification within 24 hours of admission 	<p>2. Investigational or Experimental Procedures</p> <p style="text-align: center;">MD Review Required</p>	<p>3. New Technology - Category III Codes</p> <p>See the Precertification List below</p> <p style="text-align: center;">MD Review Required</p>
<p>4. Out of Plan/Out of Service Area services</p> <p>Out of Plan providers seeking in-network coverage must be requested in advance of services being performed.</p> <p style="text-align: center;">MD Review Required</p>	<p>5. Surgery – See the Precertification List below by body area.</p>	<p>6. Infertility** (Per benefit and dollar limits)</p> <ul style="list-style-type: none"> • Artificial Insemination services (Including laboratory and radiology procedures) • In-Vitro (IVF) is only covered with the benefit
<p>7. Radiology – MRA, MRI, PET, Proton Therapy</p> <p>See the Precertification List below.</p>	<p>8. Laboratory/Pathology</p> <ul style="list-style-type: none"> • Genetic Testing 	<p>9. Medicine</p> <ul style="list-style-type: none"> • Transcranial Magnetic Stimulation • Electroconvulsive therapy • Biofeedback • Capsule endoscopy • PAD/Cardiac Rehabilitation • PT/OT (see PT/OT guidelines) • Wound Care
<p>10. Home Care Services</p> <p>See the Precertification List below.</p>	<p>11. Hospice</p>	<p>12. Hyperbaric O2 Therapy</p>
<p>13. Injectables, including IVIG</p> <p>See the Precertification List below.</p>	<p>14. Transplant Procedures</p> <ul style="list-style-type: none"> • Lung • Heart • Bone marrow/Stem cell • Intestine • Liver • Renal • Cornea • Multivisceral 	<p>15. Transportation</p>
<p>16. Plans without a DME Rider include <u>Basic DME</u> * only – no precertification is required for:</p> <ul style="list-style-type: none"> • Canes • Crutches • Walkers 		<p>17. Plans with a DME Rider (including Basic DME) require precertification for non-Basic DME items.</p> <p>See the listing at: https://www.cmocares.org/documents/tools-and-forms/dme_guidelines.pdf</p>
<ul style="list-style-type: none"> • Enteral Formulas and supplies (B4000 - B9999) are not DME; they are covered under the Medical Benefit. • Medical/Surgical Supplies (A4000 - A8999) are not DME; they are covered under the Medical Benefit. 		

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* **Basic DME** includes Canes, Crutches and Walkers. As described in the DME code list available at http://www.cmocares.org/documents/tools-and-forms/dme_guidelines.pdf, certain items require a DME rider but no authorization.

Enteral Formulas and supplies (B4000-B9999) and **Medical Surgical** supplies are covered under the **Medical Benefit**. Please refer to the HCPCS coding book to determine coverage guidelines.

New York State Department of Insurance regulations prohibit excluding coverage for hospital, surgical and medical care for the diagnosis and treatment for correctable medical conditions solely because the condition results in infertility. Coverage includes diagnostic tests, hysterosalpingography, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post-coital tests, testis biopsy, semen analysis, blood tests and ultrasound. **Please refer to Health Plan policies for specific coverage guidelines.

Please Note:

Depending on the reason for a referral, a referral may require prior authorization. Requests for these services should be sent in advance to the CMO, and where possible, services should not be rendered until a determination is made.

Payment of all services is subject to the terms and conditions of the member's health plan contract as well as member eligibility at the time services are delivered to the member. The authorization or issuance of a referral is not a guarantee of payment.

Out of Plan providers seeking in-network coverage must request precertification in advance of services being performed.

The following procedure codes require precertification:

Service	Description
Inpatient admissions	Elective Admissions require prior authorization at least 5 days prior to admission. Urgent/emergent admissions require notification within 24 hours of admission.
Investigational or Experimental Procedures	Medical Director Review
New Technology	Medical Director Review
Category III Codes	Temporary codes for emerging technology, services, procedures or service paradigms.
	Corneal incisions in the recipient cornea created using a laser, in preparation for penetrating or lamellar keratoplasty
	Behavioral ID Assessment
	Observe Behavioral Assessment
	Observe Behavioral Assessment Additional
	Expose Behav Assessment
	Expose Behav Assessment Additional
	Adaptive Behavior Treatment
	Adaptive Behavior Treatment Additional
	Group Behavior Treatment
	Group Behavior Treatment Additional
	Behavior Treatment Modified
	Behavior Treatment Modified Additional
	Family Behavioral Treatment Guidance
	Multi Family Behavioral Treatment Guidance
	Social Skills Training Group
	Exposure Behavior Treatment
	Exposure Behavior Treatment Additional
	Destruction neurofibroma, extensive, (cutaneous, dermal extending into subcutaneous); face, head and neck, greater than 50 neurofibroma
	trunk and extremities, extensive, greater than 100 neurofibroma
	Implantation of non-biologic or synthetic implant (eg, polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to code for primary procedure)
Out of Plan/Out of Service Area	Medical Director Review
	Out of Plan providers seeking in-network coverage must be requested in advance of services being performed.
Integumentary Surgery	
	Fix skin color defect, up to 6 sq. cm
	6.1 to 20.0 sq. cm
	each additional 10 sq. cm

The following procedure codes require precertification:

Service	Description
	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
	1.1 to 5 cc
	5.1 to 10 cc
	over 10 cc
	Insertion of tissue expander(s) for other than breast, including subsequent expansion
	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less
	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
	Hair transplant punch grafts, 1 - 15
	16 +
	Dermabrasion, total face
	segmental, face
	other than face
	Superficial, any site
	Abrasion, lesion, single
	add-on
	Chemical Peel, face, epidermal
	face, dermal
	non-facial
	non-facial
	Plastic surgery, neck
	Blepharoplasty, revision, removal of fat pad hernia or excessive skin, upper or lower eyelid
	Removal of wrinkles, forehead
	neck
	brow
	cheek/chin/neck
	skin, SMAS flap
	Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen
	thigh
	leg
	hip
	buttock
	arm
	forearm or hand
	submental fat pad
	other area
	Graft for facial nerve paralysis; free muscle graft (including obtaining graft)
	free muscle graft (including obtaining graft)
	free muscle flap by microsurgical technique

The following procedure codes require precertification:

Service	Description
	regional muscle transfer
	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (includes umbilical transposition and fascial plication) (add-on code to 15830)
	Suction removal fat tissue, head/neck
	trunk
	arms
	legs
	Destruction/Chemical cauterization
	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq cm
	10.0 to 50.0 sq cm
	over 50.0 sq cm
	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement,) of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions.
	15 or more lesions
	Chemical cauterization of granulation tissue (i.e., proud flesh)
	Cryotherapy of skin
	Chemical skin peel for acne
	Electrolysis epilation, each 30 minutes
	Breast (Covered with a diagnosis of cancer.)
	Puncture aspiration of cyst of breast
	Mastectomy for gynecomastia
	Removal of breast tissue
	Mastectomy, simple, complete
	Mastectomy, subcutaneous
	Mastectomy, radical, including pectoral muscles, axillary lymph nodes
	Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes
	Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle
	Mastopexy
	Mammoplasty, augmentation; with or without prosthetic implant
	Removal of intact mammary implant
	Removal of mammary implant material
	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
	Nipple/areola reconstruction
	Correction of Inverted nipples

The following procedure codes require precertification:

Service	Description
	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
	Breast reconstruction with latissimus dorsi flap, without prosthetic implant
	Breast reconstruction with free flap
	Breast reconstruction with other technique
	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;
	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)
	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site
	Open periprosthetic capsulotomy, breast
	Periprosthetic capsulectomy, breast
	Revision of reconstructed breast (only after a mastectomy)
	Preparation of mouldage for custom breast implant
	Breast reconstruction with gluteal artery perforator (GAP) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast, unilateral
	Breast reconstruction of a single breast with "stacked" deep inferior epigastric perforator (DIEP) flap(s) and/or gluteal artery perforator (GAP) flap(s), including harvesting of the flap(s), microvascular transfer, closure of donor site(s) and shaping
	Breast reconstruction with deep inferior epigastric perforator (DIEP) flap or superficial inferior epigastric artery (SIEA) flap
Musculoskeletal Surgery	Reconstruction/Revision of Face/Bone or other Grafts
	Tissue grafts, other (eg, paratenon, fat, dermis) [covered for medically necessary breast reconstruction only]
	Genioplasty; augmentation (autograft, allograft, prosthetic material)
	Genioplasty; sliding osteotomy, single piece
	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
	Augmentation, mandibular body or angle; prosthetic material
	with bone graft, onlay or interpositional (includes obtaining autograft)
	Reduction forehead; contouring only
	contouring and application of prosthetic material or bone graft (includes obtaining autograft)
	contouring and setback of anterior frontal sinus wall
	Malar augmentation, prosthetic material
	Medial canthopexy (separate procedure)
	Lateral canthopexy

The following procedure codes require precertification:

Service	Description
	Reconstructive repair of pectus excavatum or carinatum; open
	minimally invasive approach (Nuss procedure), without thoracoscopy
	minimally invasive approach (Nuss procedure), with thoracoscopy
	Repair macrodactylia, each digit
	Autologous chondrocyte implantation, knee
Respiratory Surgery	Nose
	Excision or surgical planing of skin of nose for rhinophyma
	Rhinectomy; partial
	Rhinectomy; total
	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
	complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
	including major septal repair
	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
	intermediate revision (bony work with osteotomies)
	major revision (nasal tip work and osteotomies)
	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
	tip, septum, osteotomies
	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
	Repair choanal atresia; intranasal
	transpalatine
	Lysis intranasal synechia
	Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)
	Repair fistula; oronasal
	Septal or other intranasal dermatoplasty (does not include obtaining graft)
	Repair nasal septal perforations
	Larynx
	Revision of larynx
Cardiovascular Surgery	Varicose Veins
	Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk
	Injection of sclerosant; single incompetent vein (other than telangiectasia)
	multiple incompetent veins (other than telangiectasia), same leg
	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated
	subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

The following procedure codes require precertification:

Service	Description
	laser; first vein treated
	subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
	Ligation, division, and stripping, short saphenous vein
	long (greater) saphenous veins from saphenofemoral junction to knee or below
	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia
	Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open, 1 leg
	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions
	more than 20 incisions
	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)
	Ligation, division, and/or excision of varicose vein cluster(s), 1 leg
	Other Artery(ies)
	Penile revascularization, artery, with or without vein graft
Digestive Surgery	Lip/Mouth
	Vermilionectomy (lip shave), with mucosal advancement
	Excision of lip; transverse wedge excision with primary closure
	V-excision with primary direct linear closure
	Excision of lip; full thickness, reconstruction with local flap (eg, Estlander or fan)
	Excision of lip; full thickness, reconstruction with cross lip flap (Abbe-Estlander)
	Resection of lip, more than one-fourth, without reconstruction
	Bariatric procedures for Morbid Obesity
	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
	with gastric bypass and small intestine reconstruction to limit absorption
	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum
	Laparoscopy, surgical; transection of vagus nerves, truncal
	selective or highly selective
	Laparoscopy, surgical; gastrostomy, without construction of gastric tube (eg, Stamm procedure) (separate procedure)
	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)
	revision of adjustable gastric restrictive device component only

The following procedure codes require precertification:

Service	Description
	removal of adjustable gastric restrictive device component only
	removal and replacement of adjustable gastric restrictive device component only
	longitudinal gastrectomy (ie, sleeve gastrectomy)
	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
	other than vertical-banded gastroplasty
	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure
	Gastric restrictive procedure, open; revision of subcutaneous port component only
	removal of subcutaneous port component only
	removal and replacement of subcutaneous port component only
	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline
	Cholecystectomy (excisional)
	Cholecystectomy; excisional
	Other Procedures
	Umbilectomy, omphalectomy, excision of umbilicus (separate procedure)
Male/Female Surgery	Intersex Transformation
	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck
	Insertion of testicular prosthesis (separate procedure)
	Intersex surgery; male to female
	Intersex surgery; female to male
	Vulvectomy simple; partial [not covered for cosmetic indications]
	Plastic repair of introitus [not covered for cosmetic indications]
	Clitoroplasty for intersex state [not covered for cosmetic indications]
	Perineoplasty, repair of perineum, non-obstetrical (separate procedure) [not covered for cosmetic indications]
	Construction of artificial vagina; without or with graft [not covered for cosmetic indications]
	Vaginoplasty for intersex state [not covered for cosmetic indications]

The following procedure codes require precertification:

Service	Description
Nervous Surgery	
	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy
	with laminectomy
	Removal of previously implanted intrathecal or epidural catheter
	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
	nonprogrammable pump
	programmable pump, including preparation of pump, with or without programming
	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion
	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill
	with reprogramming
	with reprogramming and refill
	with reprogramming and refill (requiring skill of a physician or other qualified health care professional)
Eye Surgery	Eye/Eyelid
	Keratomileusis
	Keratophakia
	Epikeratoplasty
	Radial keratotomy
	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
	with autologous fascial sling (includes obtaining fascia)
	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
	external approach
	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
	Repair of blepharoptosis; conjunctive-tarso-Müller's muscle-levator resection (eg, Fasanella-Servet type)
	Reduction of overcorrection of ptosis
	Correction of lid retraction
	Repair of ectropion; suture
	thermo cauterization
	excision tarsal wedge
	extensive (eg, tarsal strip operations)

The following procedure codes require precertification:

Service	Description
	Repair of entropion; suture
	thermocauterization
	excision tarsal wedge
	extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)
Ear Surgery	Ear
	Ear piercing
	Otoplasty, protruding ear, with or without size reduction
Infertility	(per benefit and dollar limits)
New York State Department of Insurance regulations prohibit excluding coverage for hospital, surgical and medical care for the diagnosis and treatment for correctable medical conditions solely because the condition results in infertility. Coverage includes diagnostic tests, hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post-coital tests, testis biopsy, semen analysis, blood tests and ultrasound. Please refer to Health Plan policies for specific coverage guidelines.	
	Artificial Insemination services (including laboratory and radiology procedures)
	Artificial insemination; intra-cervical
	intra-uterine
	Sperm washing for artificial insemination
	Ultrasonic guidance for aspiration of ova, imaging and supervision
	Sperm Identification from aspiration (other than seminal fluid)
	Cryopreservation; sperm
	Sperm isolation; simple prep (eg, sperm wash and swim up) for insemination or diagnosis with semen analysis
	Sperm evaluation; hamster penetration test
	Sperm evaluation, Hyaluronan sperm binding test
	In-Vitro (IVF) is NOT COVERED without the benefit.
	Follicle puncture for oocyte retrieval, any method
	Embryo transfer, intrauterine
	Gamete, zygote, or embryo intrafallopian transfer, any method
	Culture of oocyte (s)/embryo (s), less than 4 days
	Culture of oocyte (s)/embryo (s), less than 4 days, with co-culture of oocyte(s)/embryo(s)
	Assisted embryo hatching, microtechniques (any method)
	Oocyte identification from follicular fluid
	Preparation of embryo for transfer (any method)
	Sperm-identification from aspiration (any method)
	Sperm-identification from testis tissue, fresh or cryopreserved
	Insemination of oocytes
	Extended culture of oocyte(s)/embryo(s), 4-7 days
	Assisted oocyte, fertilization, microtechniques; less than or equal to 10 oocytes

The following procedure codes require precertification:

Service	Description
	Assisted oocyte fertilization, microtechniques; greater than 10 oocytes
	Thawing of cryopreserved; embryo(s)
Radiology	MRA, MRI, Proton Therapy, PET
	MRA - Head/Neck
	MRA Head without contrast
	with contrast
	without contrast followed by contrast and further sequences
	MRA Neck without contrast
	with contrast
	without contrast followed by contrast and further sequences
	MRI
	MRI Orbit, Face and/or Neck without contrast
	with contrast
	without contrast followed by contrast and further sequences
	MRI Brain without contrast
	with contrast
	without contrast and with contrast
	MRI Neck Spine without contrast
	with contrast
	MRI Thoracic Spine without contrast
	with contrast
	MRI Lumbar Spine without contrast
	with contrast
	MRI Cervical Spine without contrast followed by contrast
	MRI Thoracic Spine without contrast followed by contrast
	MRI Lumbar Spine without contrast followed by contrast
	MRI Upper Extremity Joint without contrast
	with contrast
	without contrast followed by contrast
	MRI Lower Extremity joint without contrast
	with contrast
	without contrast followed by contrast
	Breast MRI , without contrast, Unilateral
	Bilateral
	Breast MRI , without contrast followed by with contrast, including CAD, Unilateral
	Bilateral
	Proton Therapy
	Proton treatment delivery, simple without compensation
	Proton treatment delivery, simple with compensation

The following procedure codes require precertification:

Service	Description
	Proton treatment delivery, intermediate
	Proton treatment delivery, complex
	PET
	Tumor Image PET/CT, Skull to thigh
	Tumor Image PET/CT, Whole body
	Radiopharmaceutical Therapy
	Radiopharmaceutical therapy, by intravenous administration
Laboratory/Pathology	Genetic Testing
	Tier 1 and Tier 2 Molecular Pathology Procedures, including BRCA1 and BRCA2
	Multianalyte Assays with Algorithmic Analyses
	Warfarin responsiveness testing by genetic technique, any method, any number of specimens
	Genetic testing for disease; DNA analysis
Medicine	
	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment, initial, including cortical mapping, motor threshold determination, delivery and management
	subsequent delivery and management, per session
	subsequent motor threshold re-determination with delivery and management
	Electroconvulsive therapy (includes necessary monitoring)
	Biofeedback
	Capsule Endoscopy
	Neurobehavioral status exam
	PAD/Cardiac Rehabilitation
	Peripheral arterial disease (PAD) rehabilitation, per session
	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)
	with continuous ECG monitoring (per session)
	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed;
	requiring skill of a physician or other qualified health care professional
	Physical Therapy (<i>refer to PT/OT guidelines</i>)
	Apply Modality,1+area, Hot/Cold pack
	Apply Modality,1+area, Traction, Mechanical
	Apply Modality,1+area, Electrical Stimulation
	Apply Modality,1+area, Vasopneumatic

The following procedure codes require precertification:

Service	Description
	Apply Modality,1+area, Paraffin bath
	Apply Modality,1+area, Microwave
	Apply Modality,1+area, Whirlpool
	Diathermy, e.g., Microwave
	Apply Modality,1+area, Infrared
	Apply Modality,1+area, Ultraviolet
	Apply Modality, Electrical Stimulation, ea 15 min
	Apply Modality, Iontophoresis, ea 15 min
	Apply Modality, contrast bath, ea 15 min
	Apply Modality, Ultrasound, ea 15 min
	Apply Modality, Hubbard Tank, ea 15 min
	Tx Procedure, 1+area, Tx exercise, ea 15 min
	Tx Procedure, 1+area, Neuro Reeducation, ea 15 min
	Tx Procedure, 1+area, Aquatic, ea 15 min
	Tx Procedure, 1+area, Gait Training, ea 15 min
	Tx Procedure, 1+area, Massage, ea 15 min
	Manual Therapy, 1+ Regions,ea 15 min
	Group Therapeutic Procedure(s)
	Orthotics Fit/Train, ea 15 min
	Prosthetics Train, Extremities, ea 15 min
	Tx Activities, Direct PT, ea 15 min
	Develop Cognitive Skills, ea 15 min
	Sensory Integrative Technique, ea 15 min
	Self-Care/Home Management Training, ea 15 min
	Community/Work Reintegration Training
	Wheelchair Management/Propulsion Training, ea 15 min
	Work Hardening/Conditioning, Initial 2 hrs
	Work Hardening/Conditioning, each additional hour
	Orthotic/Prosthetic Checkout
	Physical Performance Test/Measurement, ea 15 min
	Assistive Technology Assessment, ea 15 min
	Orthotic Management & Training, 1st encounter
	Prosthetic Training, 1st encounter
	C/O For Orthotic/Prosthetic Use
	Orthotic/Prosthetic Management, Subsequent encounter
	Wound Care Management/Assessment/Therapy
	Debridement (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, wound assessment, use of whirlpool, when performed and instruction(s) for ongoing care, per session, total wound surface area; first 20 sq. cm or less and each additional 20 sq. cm or part thereof

The following procedure codes require precertification:

Service	Description
	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia, wound assessment, and instructions for ongoing care, per session
	Negative pressure wound therapy
	Low frequency, non-contact, non-thermal ultrasound, including topical application, when performed, wound assessment and instructions for ongoing care, per day
	Electrical stimulation (unattended), for chronic Stage III and IV pressure ulcers, etc., as part of a therapy plan of care
	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
Home Care	Home Visit/E&M by MD or other Non-Physician Practitioner
	Home visit for the evaluation and management of a new patient ; Straight-forward decision making, low severity; 20 minutes are spent face-to-face with the patient and/or family.
	low complexity decision making, moderate severity; 30 minutes are spent face-to-face with the patient and/or family.
	moderate complexity decision making, moderate to high severity; 45 minutes are spent face-to-face with the patient and/or family.
	moderate complexity decision making, high severity; 60 minutes are spent face-to-face with the patient and/or family.
	high complexity decision making. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention; 75 minutes are spent face-to-face with the patient and/or family.
	Home visit for the evaluation and management of an established patient ; Straight-forward decision making, problem focused; 15 minutes are spent face-to-face with the patient and/or family.
	expanded problem focused interval history; low complexity decision making; 25 minutes are spent face-to-face with the patient and/or family.
	detailed examination; moderate complexity decision making; 40 minutes are spent face-to-face with the patient and/or family.
	comprehensive examination; moderate to high complexity decision making; 60 minutes are spent face-to-face with the patient and/or family.
	Home services by RN/LPN, RT, etc.
	Home visit for respiratory therapy care (eg, bronchodilator, oxygen therapy, respiratory assessment, apnea evaluation)
	mechanical ventilation care
	stoma care and maintenance including colostomy and cystostomy
	intramuscular injections
	care and maintenance of catheter(s) (eg, urinary, drainage, and enteral)
	assistance with activities of daily living and personal care
	individual, family, or marriage counseling
	fecal impaction management and enema administration

The following procedure codes require precertification:

Service	Description
	hemodialysis
	Unlisted home visit service or procedure
	Home infusion/specialty drug administration, per visit (up to 2 hours);
	each additional hour (List separately in addition to code for primary procedure)
	Home Sleep Studies
	Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation
	Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation
	Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels
	Adult Day Care
	Day care services, adult; per diem
	center-based; services not included in program fee, per diem
	Emergency Response Systems
	Emergency response system; installation and testing
	Emergency response system; service fee, per month (excludes installation and testing)
	Emergency response system; purchase only
	Skilled Care (RN, PT/OT/ST, HHA, CSW, etc.) - CHHA
	Home Health Aide or Certified Nurse Assistant, per hour
	Skilled Nursing Visit, Nursing care, in the home; by registered nurse, per hour
	Medical Social Service
	Speech Therapy
	Occupational Therapy
	Physical Therapy
	Nutritional counseling, dietitian visit
	Other Home Care services - LCHSA
	Home infusion therapy, insertion of midline venous catheter, nursing services only (no supplies or catheter included)
	Home uterine monitor with or without associated nursing services
	Home visit for wound care
	Home management of postpartum hypertension, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with any home infusion per diem code)

The following procedure codes require precertification:

Service	Description
	Home Infusion therapy, (pain management, chemotherapy, hemodialysis, anticoagulant therapy)
	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with home infusion codes for hourly dosing schedules S9497-S9504)
	Home therapy; hematopoietic hormone injection therapy (e.g., erythropoietin, G-CSF, GM-CSF); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
	Personal Care Services (Medicaid only)
	Nursing assessment/evaluation
	Services of a qualified nursing aide, up to 15 minutes
	Personal care services, per 15 minutes
	Personal care services, per diem
	Home health aide or certified nurse assistant, per visit
	Nursing care, in the home, by registered nurse, per diem
	Other Home Services
	Homemaker service, NOS; per 15 minutes
	Home delivered meals, including preparation; per meal
	Other services
	Other specified case management service not elsewhere classified
	Mental health assessment, by non-physician
	Mental health service plan development by non-physician
	Hospice
	Hospice care, in the home, per diem
	Hospice - Assisted Living Facility
	Hospice - Nursing Long Term facility or non-skilled facility
	Hospice - Skilled Nursing facility
	Hospice - Inpatient hospital (hospice bed)
	Hospice - Inpatient hospice facility
	Hospice - Long Term Facility
	Hospice - Inpatient Psychiatric facility
	Hospice - provided in place Not otherwise specified
	Hyperbaric O2 therapy
	Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval
	Physician attendance and supervision of hyperbaric oxygen therapy, per session

The following procedure codes require precertification:

Service	Description
Injectables	
	Abraxane/Paclitaxel
	Actemra/Tocilizumab
	Acthar/Corticotropin
	Adagen/Pegademase
	Aldurazyme/Llaronidase
	Alimta/Pemetrexed
	Aliqopa/Copanlisib
	Aralast, Glassia, Prolastin, Zemaira/Alpha 1 Proteinase Inhibitor
	Avastin/Bevacizumab
	Bavencio/Avelumab
	Benlysta/Belimumab
	Berinert/C-1
	Besponsa/Inotuzumab
	Blinicyto/Blinatumomab
	Botox, Xeomin/Onabotulinum
	Brineura/Cerliponase
	Cerezyme/Imiglucerase
	Cimzia/Certolizumabpegol
	Cinquair/Reslizumab
	Cinryze/C-1 esterase inhibitor
	Elaprase/Idursulfase
	Eleyso/Taliglucerase alfa
	Entyvio/Vedolizumab
	Erbix/Cetuximab
* Not covered under Medicaid plans	Euflexxa/Hyaluronate *
	Exondys51/Eteplirsen
	Eylea/Aflibercept
	Fabrazyme/Agalsidase beta
	Fasenra/Benralizumab
	Firazyr/Icatibant
	Fusilev/Levoleucovorin calcium
	Gel One/Hyaluronate *
	Genvisc *
	Halaven/Eribulin mesylate
	Hemophilia factors
	Herceptin/Trastuzumab
	Histrelin/Vantus
	Hyalgan/Hyaluronic acid *
	Ilaris/Canakinumab
	Ilumya/Tildrakizumab
	Inflectra/Infliximab

The following procedure codes require precertification:

Service	Description
	IVIG products
	Jevtana/Cabazitaxel
	Kadcyla/Ado-trastuzumab
	Kalbitor/Ecallantide
	Keytruda/Pembrolizumab
	Krystexxa/Pegloticase
	Kymriah/Tisagenlecleucel
	Lemtrada/Alemtuzumab
	Lucentis/Ranibizumab
	Lumizyme/Alglucosidase alfa
	Lutathera/Lutetium LU 177 Dotate
	Luxterna/Voretigene Neparvovec
	Macugen/Pegaptanib Octasodium
	Makena/Hydroxyprogesterone caproate
* Not covered under Medicaid plans	Monovisc/Hyaluronc acid *
	Mvasi/Bevacizumab AWWB
	Mylotarg/Gemtuzumab
	Naglazyme/Galsulfase
	Nplate/Romiplostim
	Nucala/Mepolizumab
	Ocrevus/Ocrelizumab
	Octreotide Injection, Depot
	Onpattro/Patisiran
	Opdivo/Nivolumab
	Orencia/Abatecept
	Orthovisc/Hyluronate *
	Perjeta/Pertuzumab
	Poteligeo/Mogamulizumab
	Prolia/Denosumab
	Provenge/Sipuleucel-T
	Reclast/Zoledronic acid
	Remicade/Infliximab
	Renflexis
	Rituxan/Rituximab
	Ruconest/C1 Esterase Inhibitor
	Signifor/Pasireotide
	Simponi Aria/Golimumab
	Soliris/Eculizumab
	Spinraza/Nusinersen
	Stelara/Ustekinumab
	Supartz/Hyaluronate *
	Synagis/Palivizumab

The following procedure codes require precertification:

Service	Description
	Synvisc/Hylan polymers *
	Tecentriq/Atezolizumab
	Temodar/Temozolomide
	Thyrogen/Throtropin
	Trivisc/Hyaluronan *
	Tysabri/Natalizumab
	Unituxin/Dinutuximab
	Vantus/Histrelin
	Vectibix/Panitumumab
	Velcade/Bortezomib
	Vidaza/Azacitidine
	Vpriv/Velaglucerase alfa
	Xgeva/Denosumab
	Xiaflex/Collagenase, clostridium histolyticum
	Xofigo/Radium RA223 dichloride
	Xolair/Omalizumab
	Yervoy/Ipilimumab
	Yescarta/Axicabtagene
	Zevalin/Ibritumomab
	Zilretta/Tramcinolone
* Not covered under Medicaid plans	
Transplant Procedures	Lung
	Donor pneumonectomy(s) (including cold preservation), from cadaver donor
	Lung transplant, single; without cardiopulmonary bypass
	with cardiopulmonary bypass
	Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass
	with cardiopulmonary bypass
	Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; unilateral
	bilateral
	Lobar lung transplantation
	Donor lobectomy (lung) for transplantation, living donor
	Heart
	Donor cardiectomy-pneumonectomy (including cold preservation)
	Backbench standard preparation of cadaver donor heart/lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, and trachea for implantation
	Heart-lung transplant with recipient cardiectomy-pneumonectomy
	Donor cardiectomy (including cold preservation)

The following procedure codes require precertification:

Service	Description
	Backbench standard preparation of cadaver donor heart allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for implantation
	Heart transplant, with or without recipient cardiectomy
	Bone Marrow/Stem Cell
	Management of recipient hematopoietic progenitor cell donor search and cell acquisition
	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic
	autologous
	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage
	thawing of previously frozen harvest, without washing, per donor
	thawing of previously frozen harvest, with washing, per donor
	specific cell depletion within harvest, T-cell depletion
	tumor cell depletion
	red blood cell removal
	plasma (volume) depletion
	cell concentration in plasma, mononuclear, or buffy coat layer
	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor
	autologous transplantation
	HPC boost
	Allogeneic lymphocyte infusions
	Intestine
	Donor enterectomy (including cold preservation), open; from cadaver donor
	partial, from living donor
	Intestinal allotransplantation; from cadaver donor
	from living donor
	Removal of transplanted intestinal allograft, complete
	Backbench standard preparation of cadaver or living donor intestine allograft prior to transplantation, including mobilization and fashioning of the superior mesenteric artery and vein
	Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; venous anastomosis, each
	Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; arterial anastomosis, each
	Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; arterial anastomosis, each

The following procedure codes require precertification:

Service	Description
	Liver
	Liver allotransplantation; orthotopic, partial or whole, from cadaver or living
	Donor hepatectomy (including cold preservation), from living donor; left lateral segment only (segments II and III)
	total left lobectomy (segments II, III and IV)
	total right lobectomy (segments V, VI, VII and VIII)
	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; without trisegment or lobe split
	with trisegment split of whole liver graft into 2 partial liver grafts (ie, left lateral segment [segments II and III] and right trisegment [segments I and IV through VIII])
	with lobe split of whole liver graft into 2 partial liver grafts (ie, left lobe [segments II, III, and IV] and right lobe [segments I and V through VIII])
	Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; venous anastomosis, each
	arterial anastomosis, each
	Pancreas
	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells
	Donor pancreatectomy (including cold preservation), with or without duodenal segment for transplantation
	Backbench standard preparation of cadaver donor pancreas allograft prior to transplantation, including dissection of allograft from surrounding soft tissues, splenectomy, duodenotomy, ligation of bile duct, ligation of mesenteric vessels, and Y-graft arterial anastomoses from iliac artery to superior mesenteric artery and to splenic artery
	Backbench reconstruction of cadaver donor pancreas allograft prior to transplantation, venous anastomosis, each
	Transplantation of pancreatic allograft
	Removal of transplanted pancreatic allograft
	Simultaneous pancreas kidney transplantation
	Renal
	Donor nephrectomy (including cold preservation); from cadaver donor, unilateral or bilateral
	Donor nephrectomy (including cold preservation); open, from living donor
	Backbench standard preparation of cadaver donor renal allograft prior to transplantation
	Backbench standard preparation of living donor renal allograft (open or laparoscopic) prior to transplantation,
	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation

The following procedure codes require precertification:

Service	Description
	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; arterial anastomosis, each
	ureteral anastomosis, each
	Recipient nephrectomy (separate procedure)
	Renal allotransplantation, implantation of graft; without recipient nephrectomy
	Renal allotransplantation, implantation of graft; with recipient nephrectomy
	Removal of transplanted renal allograft
	Renal autotransplantation, reimplantation of kidney
	Percutaneous islet cell transplant, includes portal vein catheterization and infusion
	Laparoscopy for islet cell transplant, includes portal vein catheterization and infusion
	Laparotomy for islet cell transplant, includes portal vein catheterization and
	Cornea
	Keratoplasty (corneal transplant); anterior lamellar
	Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia)
	Keratoplasty (corneal transplant); penetrating (in aphakia)
	Keratoplasty (corneal transplant); penetrating (in pseudophakia)
	Keratoplasty (corneal transplant); endothelial
	Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)
	Corneal incisions in the recipient cornea created using a laser, in preparation for penetrating or lamellar keratoplasty
	Multivisceral organs
	Transplantation of multivisceral organs
Transportation	Ambulance, Ambulette, Taxi, Air
Emergency Ground	Ambulance transportation is covered without authorization for all plans and lines of business.
Medicaid Transportation - non-emergency	Medicaid non-Emergency transportation is a covered benefit through NYS Medicaid and should be arranged by the member through Logisticare.
	Ambulance service, outside state per mile, transport (Medicaid only)
	Nonemergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest
	vehicle provided by individual (family member, self, neighbor) with vested interest
	Nonemergency transportation; taxi
	Nonemergency transportation and bus, intra- or interstate carrier
	Nonemergency transportation: mini-bus, mountain area transports, or other transportation systems
	Nonemergency transportation: wheelchair van
	Nonemergency transportation and air travel (private or commercial) intra- or interstate
	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged);

The following procedure codes require precertification:

Service	Description
	Ground mileage, per statute mile
	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)
	Ambulance service, basic life support, nonemergency transport, (BLS)
	Ambulance service, conventional air services, transport, one way (fixed wing)
	Ambulance service, conventional air services, transport, one way (rotary wing)
	Specialty Care Transport
	Fixed wing air mileage, per statute mile
	Rotary wing air mileage, per statute mile
	Ambulance response and treatment, no transport
	Unlisted ambulance service
	Ambulance service, conventional air services, nonemergency transport, one way (fixed wing)
	Ambulance service, conventional air service, nonemergency transport, one way (rotary wing)
DME	Durable Medical Equipment - Plans with a DME Rider (includes Basic DME)
	DME items <u>Other than Basic DME*</u> (Canes, Crutches, Walkers), Require precertification. See the listing at: http://www.cmocares.com/tools_resources/DME_Guidelines/pdf
	Enteral Formulas and supplies (B4000 - B9999) are not DME; they are covered under the Medical Benefit.
	Medical/Surgical Supplies (A4000 - A8999) are not DME; they are covered under the Medical Benefit.
	Plans without the DME rider include these Basic DME* items only:
	No Precertification is required for Basic DME items.
	Canes
	includes canes of all materials, including quad or three-prong, adjustable or fixed, with tips
	Crutches
	Crutches, forearm, includes crutches of various materials, adjustable or fixed, each with tip and handgrip
	Crutches, underarm, articulating, spring assisted
	Crutch substitute, lower leg platform, with or without wheels, each
	Walkers
	Walker, adjustable or fixed height; folding; four sided; wheeled with posterior seat
	Walker, heavy duty with or without wheels; platform attachment; platform attachment, forearm; per seat attachment