Individual and Family Plan
UM Authorization Guidelines

Chorus Community Health Plans (CCHP) contracted providers are responsible for obtaining prior authorization before they provide services to covered members.

***Disclaimer:** Prior Authorization does not guarantee payment or verify eligibility. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the member's Evidence of Coverage at the time of service.*

In-Network Prior Authorization requests should be submitted through the CareWebQI Authorization Tool via the Provider Portal (https://providerauth.cchpservices.com/).

Out-of-Network Prior Authorizations and providers must submit an OON PA Request Form (attached). For assistance or questions call 1-844-450-1926

- To avoid delays in processing, attach **ALL** documentation to support medical necessity.
- If an approved authorization, spanning the service date, is not in place, the submitted claim will be DENIED.
    - Individual and Family Plan requests will not be reviewed for services that have already been rendered.

Notification is required ***within 24 hours*** for **ALL Inpatient Admissions**.

Have questions or need support? Please call 1-877-227-1142 (Option 2) or 414-266-5707.

Type of Prior Authorization Request	Timeline for Decision and Notification	Clinical Documentation Due from Provider
Urgent Concurrent*	Next Calendar Day	At Submission
Urgent Preservice*	Three (3) Calendar Days	At Submission
Non-Urgent Preservice	Fourteen (14) Calendar Days	At Submission
Post Service	Thirty (30) Calendar Days	At Submission

**The requested service must meet the definition of Urgent as noted in the Provider and Practitioner Manual.*

Abortion Payment Process

- The services do not require a prior authorization but require the Abortion Attestation Form to be signed by the practitioner and submitted with the claim. The Abortion Attestation Form is available on the Provider Forms page.

Ambulance (Non-Emergency Air and Ground)

- Nonemergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as CCHP determines appropriate) between facilities when the transport is any of the following:
  - From an out-of-network hospital to an in-network hospital.
  - To a hospital that provides a higher level of care that was not available at the original hospital.
  - To a more cost-effective acute care facility.
  - From an acute facility to a sub-acute setting. Please call the reviewing nurse to discuss the non-emergent transfer.

Autism Spectrum Disorder Services

- Please refer to the covered services and the exclusions for autism spectrum services in the Evidence of Coverage. Any service request for autism spectrum services must include one of the following autism spectrum diagnoses: F84.0; F84.3; F84.5; F84.8; F84.9; R41.84; R41.840; R84.841; R41.842; R41.843; R41.89 Durable Medical Equipment is NOT a covered benefit for a primary diagnosis of an Autism Spectrum Disorder.

Bone Anchored Hearing Procedure

- Bilateral or unilateral conductive or mixed hearing loss of greater than 20 dB. Cortical bone thickness of 3 mm or more. Middle or external ear pathology not amenable to surgical reconstruction. Pure tone average bone conduction hearing threshold (measured at 0.5, 1, 2, and 3 kHz) less than or equal to level appropriate for model to be implanted. Speech discrimination score greater than or equal to 60% in affected ear. DME items must be requested on a separate authorization request. ADDITIONAL CRITERIA WILL APPLY. Air Conduction hearing aids are covered under the DME benefit.

Breast Reconstruction Surgery (No Prior Authorization Required)

- Benefits are available for breast reconstruction related to a covered mastectomy, which includes:
  - Reconstruction of the breast on which the mastectomy was performed.
  - Surgery and reconstruction of the other breast to produce an even appearance.
  - Prosthesis and treatment of physical complications at all stages of the mastectomy.

*If you enter an authorization request with any of these codes, you will receive a response of No Prior Authorization Required.

Cellular Immunotherapy, Cancer Immunotherapy & Chimeric Antigen Receptor T-cell (CAR T) Therapy

Includes the following therapies:

Tumor-Infiltrating Lymphocyte (TIL) Therapy
Natural Killer (NK) Cell Therapy
T-Cell Receptor Therapy (TCR)
Autologous T-cell immunotherapy
Other Miscellaneous Biologics

CCHP requires prior authorization for the following Cellular/Biologic Products and related services, including outpatient or inpatient evaluation, collection, conditioning chemotherapy and the Biologic or chimeric antigen receptor T-cell (CAR-T) outpatient or inpatient encounter for Infusion.

All FDA Approved Chimeric Antigen Receptor T-cell (CAR T) Therapy:

- Axicabtagene ciloleucel (Yescarta®) Q2041
- Brexucabtagene autoleucel (Tecartus™) C9073
- Ciltacabtagene autoleucel (CARVYKTI™) Q2056
- Idecabtagene vicleucel (Abecma™) C9081
- Lisocabtagene maraleucel (Breyanzi®) C9076
- Tisagenlecleucel (Kyrmriah®); Q2042

HCPCS Codes:

S2107 Adoptive immunotherapy i.e., development of specific anti-tumor reactivity (e.g., tumor-infiltrating lymphocyte therapy) per course of treatment

C9399 Unclassified drugs or biologicals

J3590 Unclassified biologics

Revenue Code: 891 (MS-DRG 018)

CPT-III Codes: 0537T, 0538T, 0539T, 0540T

- These services will be reviewed and managed in the same manner as blood or marrow transplantation.
  - CCHP will review clinical trials that use Cellular Immunotherapy or T-cell Therapy investigational agents within the trial.
  - All Plan requirements listed under the Evidence of Coverage (EOC) Clinical Trial Language must be met for consideration of coverage.
  - The clinicaltrials.gov **NCT #** must be provided with Trial requests.

*Electronically submit the request with the appropriate records under "TRANSPLANT SERVICES".

NOTE: New Biologic T Cell Products may be submitted for review and are subject to FDA Approval, indications and plan benefits.

Clinical Trials (No Prior Authorization Required for In-Network Providers)
**ALL Out-of-Network Clinical Trials Require Prior Authorization*

- Providers may submit a proposed plan of care within a Clinical Trial, with medical records for review and Pre-determination.
  - The Cancer Clinical Trials will be reviewed and managed in the same manner as blood or marrow transplantation. Please refer to the **Transplant** section.
    - All Plan requirements listed under the Evidence of Coverage (EOC) Clinical Trial Language must be met for consideration of coverage of an Approved Clinical Trial.
      - Phase I, Phase II, Phase III, or Phase IV clinical trial;
      - Being conducted in relation to the prevention, detection or treatment for Cancer or other life-threatening disease or condition
      - The clinicaltrials.gov **NCT #** must be provided with Trial requests.
- Claims must include an ICD 10-CM code of **Z00.6** - Encounter for examination for normal comparison and control in clinical research program.
- The **8-digit clinical trial number** must be included on all related claims.
- Modifiers QØ and Q1 must be used on each line item to distinguish items related to the trial and routine care.

Modifier Q0	Investigational clinical service provided in a clinical research study that is in an approved clinical research study
Modifier Q1	Routine clinical service provided in a clinical research study that is in an approved clinical research study

Healthcare Common Procedural Coding System (HCPCS) Codes cannot be accepted alone, for any Trial Pre Determination review.
S9988 Services provided as a part of a phase I clinical trial
S9990 Services provided as a part of a phase II clinical trial
S9991 Services provided as a part of a phase III clinical trial

Chorus Community Health Plans follows PPACA coverage requirement of routine costs.

DEFINITION: Routine Costs

Routine costs include all services and treatment that would be covered if the patient were not in the trial. Routine costs of the clinical trial do not include the investigational items or devices.

Please refer to the EOC for the for full clinical trial language.

Cochlear Implant Procedure

- **Cochlear Implant for a child**: Age 12 months or older. Bilateral sensorineural hearing loss with unaided pure tone average thresholds of 90 dB or greater. Minimal speech perception 30% or less. Three-month to six-month trial of binaural hearing aids documents lack of or minimal improvement in auditory development.
- **Cochlear Implant for an adult:** Bilateral sensorineural hearing loss of greater than 70 dB. Less than 50% score on standardized open-set sentence recognition test in ear to be implanted and less than 60% in contralateral ear when using appropriately fitted hearing aids. Zero or marginal speech perception benefit from hearing aids. DME items must be requested on a separate authorization request. ADDITIONAL CRITERIA WILL APPLY. Air Conduction hearing aids are covered under the DME benefit.

Cosmetic or Reconstructive Surgery

- Surgical or other services for cosmetic purposes performed to repair or reshape a body structure for the improvement of the person's appearance or for psychological or emotional reasons, and from which no improvement in physiological function can be expected, except as such surgery or services are required to be covered by law. Excluded services include, but are not limited to – Port wine stains, augmentation procedures, reduction procedures, scar revisions.

Dental Anesthesia

- Benefits are available with prior authorization for hospital or ambulatory surgery center services, including: anesthetics; for dental care furnished in the facility; if any of the following applies:
  - The covered member is a child under the age of 5
  - The covered member has a chronic disability as defined by applicable state law
  - The covered member has a medical condition that requires hospitalization or general anesthesia for dental care

Dialysis

- A case manager will be available to assist the member with care coordination. Please complete the Case/Disease Management Referral Form for the member.

- Prior Authorization required for:
  - Services while on vacation or while traveling in Wisconsin, the US or outside the US
  - Hemodialysis provided in the Home
  - All out-of-network providers
    - Review the Chorus Community Health Plans Provider Directory to find an in-network provider https://chorushealthplans.org/our-plans/find-a-doctor)

Durable Medical Equipment (including standard hearing aids)

*Quantity limits apply, see the list of DME codes with quantity limits and monthly quantity limits.

- The benefit plan authorizes DME based on the retail price of the individual item or the monthly rental price. CCHP will determine whether the item should be purchased or rented for Individual and Family Plans. Multiple items may appear on an authorization. Only the items with the check box for retail price/monthly rental price of greater than $500 will require review (completion of this field is mandatory).
- Clinical documentation to support the need for each item that requires review must be submitted with the request. Items not meeting the retail price criteria for review will be assigned a no prior authorization required code status. Please note that there is a list of DME items that always requires prior authorization despite their retail price, these items are covered by internal medical policies.

Durable Medical Equipment (always requiring Prior Authorization)

- Some DME codes require a prior authorization despite their retail price. These codes are subject to an internal medical policy in addition to the MCG guideline.

- ***Repair of Equipment***
  - The cost of repairs may not exceed 50% of the contracted payment of the device. The device must be beyond the warranty period from the OEM or distributor. The repair is not covered if the damage is due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

EEG Video Monitoring

- Inpatient admission for video EEG monitoring will be considered when the following criteria are met:
  - Alternative evaluation was performed but was nondiagnostic
  - Withdrawal of anticonvulsant medication as outpatient deemed unsafe
  - Alternative evaluation deemed not clinically helpful or appropriate for specific patient situation
  - Seizures or seizure-like events occur infrequently
  - Continuous ambulatory EEG monitoring may be indicated when the following criteria are met:
    - Differentiation of epileptic from nonepileptic events
    - Seizures, known, and need to characterize seizure type, syndrome, and frequency in nonclinical setting
    - Seizures, known, and withdrawal of anticonvulsant medication under consideration / seizures, suspected, after nondiagnostic noninvasive EEG

Elective Surgery

- Authorizations are granted for the procedure if the procedure requires inpatient admission, the hospital must notify of the admission according to the Inpatient Admission process. If the procedure is performed as an outpatient, the authorization for the procedure will cover the related services required at the ambulatory surgical center or the hospital outpatient surgical department.

Genetic Testing

- Benefits are available for genetic testing and genetic counseling if it is not experimental or investigational and found to be medically necessary in the treatment/management of a medical condition.
- CCHP utilizes Milliman Care Guidelines (MCG) to determine the medical utility of a genetic test based on the available medical evidence. CCHP provides coverage for a genetic test when the clinical application is considered medically necessary for the member only. Prior authorization is required for genetic testing.

- **Excluded Services** – Genetic counseling and testing not medically necessary for treatment of a defined medical condition, except when such coverage is required by the Affordable Care Act.

Hyperbaric Oxygen Therapy (HBOT)

Prior Authorization for ***Inpatient Services*** is NOT required:

- For HBOT provided in an inpatient hospital setting, providers should submit an institutional claim and follow appropriate revenue code and procedure code billing per NUBC (National Uniform Billing Committee) billing instructions.

Prior Authorization for ***Outpatient Services*** is required:

- For HBOT provided in an outpatient hospital or office setting, providers may submit the following procedure codes:
  - **G0277** (Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval), outpatient hospital code.
  - **99183** (Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session).

Home Health Care (including home infusion therapy supplies)

*Infusion pumps are covered under the DME Process

- Benefits are available for Home Health Care services only when each of the following applies:
  - A formal home care program furnishes the services in the member's home;
  - The services provided are skilled nursing or rehabilitative services;
  - A network practitioner orders, supervises and reviews the care every two months;
  - Hospitalization or confinement in a skilled nursing facility would be necessary if Home Health Care services were not provided;
  - The services are medically necessary. Home Health Care is limited to 60 visits in a calendar year. Each consecutive four-hour period that a home health aide provides services is one visit. Services are covered only when provided in the plan's service area. Physical, occupational and speech therapy rendered in the home will apply to the Home Health Care visit maximum. Nursing or rehabilitative services may be palliative care as long as the services are not custodial. A service will not be determined to be "skilled" nursing or rehabilitation simply because there is not an available caregiver.

Hospice Care

- Hospice care is covered:
  - If the covered member's practitioner certifies that the member or the member's covered dependent's life expectancy is six months or less;
  - The care is palliative; and
  - The hospice care is received from a licensed Hospice agency;
  - Services may be furnished in a hospice facility housed in a hospital, a separate hospice unit or in the member's home. A hospice facility housed in a hospital must be, in a separate and distinct area;
  - Hospice care services are provided according to a written care delivery plan developed by a hospice care practitioner and by the recipient of the hospice care services.
  - Hospice care services include but are not limited to: physician services; nursing care; respite care;
  - Medical and social work services;
  - Counseling services; nutritional counseling; pain and symptom management;
  - Medications, medical supplies and durable medical equipment; occupational, physical, or speech therapies; volunteer services;
  - Home Health Care services; and bereavement services.
  - Respite care may be provided only on an occasional basis (once per 60 days) and may not be reimbursed for more than five consecutive days at a time

Inpatient Hospitalization

- Notification within 24 hours of admission via the Provider Portal is required for all inpatient admissions, including: Medical, emergent medical/surgical, elective admissions (even if the procedure has been prior authorized by the practitioner), OB delivery, behavioral health, acute rehabilitation, LTAC and skilled nursing facility. CCHP utilizes the MCG Guidelines to determine the medical necessity of an admission for an Individual and Family Plan member.

Medical Nutrition Therapy

- Medical Nutrition Therapy visits under CPT 97802 and 97803 are limited to three (3) days of service per calendar year. No single day of service may exceed 8 units of either code. CPT 97802 is only covered for the first date of service in a calendar year.

Mental Health & Substance Abuse Services-Outpatient

- Partial Hospitalization Program (PHP)/Day treatment, Intensive Outpatient Program (IOP), which may be provided in the community or during placement in residential treatment, requires Prior Authorization. Review the covered services and exclusions for further information.

Miscellaneous Procedure Codes

- CPT 99183 and HCPCS code G0277 are not covered for the following diagnoses: F84.0; F84.9; R41.84; R41.840; R84.841; R41.842; R41.843; R41.89

Pain Management

- Pain management procedures including but not limited to: epidural steroid injections, radio frequency ablation and spinal cord stimulators. Benefits will cover outpatient services performed by an In-network provider. CCHP will only pay for services that are medically necessary.

Positron Emission Tomography (PET)

- Pet Scans require Prior Authorization

Prosthetic Devices

- External prosthetic devices that replace a limb or a body part, limited to:
  - Replacement of natural or artificial limbs and eyes, ears and nose no longer functional due to physiological change or malfunction beyond repair.
  - If more than one prosthetic device can meet the member's functional needs, benefits are available only for the prosthetic device that meets the minimum specifications for the needs. If the member purchases a prosthetic device that exceeds these minimum specifications, our Individual and Family Plans will only pay the amount that would have been paid for the prosthetic that meets the minimum specifications, and the member will be responsible for paying any difference in cost.

- The prosthetic device must be ordered or provided by, or under the direction of a practitioner. There are no benefits for repairs due to misuse, malicious damage or gross neglect. There are no benefits for replacement due to misuse, malicious damage, gross neglect, or for lost or stolen prosthetic devices.
- Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses. (Covered under breast reconstruction.)

Proton Beam Therapy, Brachytherapy and Radiation Therapy

- These services require prior authorization. A case manager contact the member to help coordinate care during this difficult treatment. Please complete the Case / Disease Management Referral Form for the member.

Routine Foot Care and Special Foot Needs *(for persons with vascular and neurological diseases like Diabetes)*

- Examples include the cutting or removal of corns and calluses hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet:
  - Nail trimming, cutting, or debriding
  - Shoes
  - Shoe orthotics Shoe inserts – Covered members, who are at risk of neurological or vascular disease arising from diseases such as diabetes, will be considered for these services if they have one of the following diagnoses from the Diabetic and Neuropathy Diagnosis Codes shown right.

Skilled Nursing Facility

- Benefits are limited to 30 days per stay. Benefits are available only if both of the following are true:
  - If the initial confinement in a skilled nursing facility or inpatient acute medical rehabilitation facility was or will be a cost-effective alternative to an inpatient stay in a hospital.
  - The member will receive skilled care services that are not primarily custodial care

Skin Substitute

- CCHP will consider the use of skin substitutes in specific circumstances.

Transplants

- Please review the covered services and exclusions for further information. Benefits are provided for the following transplants and related costs:
  - Heart
    - Mechanical Cardiac Support Devices: Implantable cardiac mechanical devices for destination therapy (DT) or bridge to transplant (BTT (FDA approved or Trial Devices)
  - Liver
  - Liver/Small bowel
  - Pancreas
  - Peripheral Stem Cell or Bone Marrow (Autologous self to self or Allogeneic other to self)
  - Kidney
  - Heart/Lung
  - Single lung
  - Bilateral sequential lung
  - Corneal (Prior Authorization not required)
  - Kidney/Pancreas/Intestines
  - Any combination of organs

Related Costs:

- Re-transplantation for the treatment of organ failure or rejection
- Immunosuppressive or anti-rejection medications. These drugs must be for an approved transplant
- Cost sharing may apply, as described in the Scheduled of Benefits.
- Donor costs that are directly related to organ removal are covered services for which benefits are payable through the organ recipient's coverage under the covered member's Evidence of Coverage (EOC)

**See the Cellular Immunotherapy, Cancer Immunotherapy & Chimeric Antigen Receptor T-cell (CAR T) Therapy section for added guidance.

Unlisted Codes

- Submit documentation to describe the service requested and why a standard CPT/HCPCS code cannot be used. Unlisted codes may be used for potentially investigational or potentially cosmetic services and are subject to review.