PRESBYTERIAN
Health Plan, Inc.

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May 28, 2021

Subject: Presbyterian Will Update the Prior Authorization Guide

Presbyterian Health Plan, Inc. and Presbyterian Insurance Company, Inc. (Presbyterian) would like to inform providers that Presbyterian updates its Prior Authorization Guide regularly. Effective June 25, Presbyterian will add and/or modify the following procedures in the Prior Authorization Guide:

- Genetic Testing for Non-Invasive Prenatal Testing (NIPT)
- Durable Medical Equipment (DME): Rehabilitation and Mobility Devices
- Panniculectomy and Abdominoplasty
- Prostate: Surgical Treatment for Benign Prostate Hyperplasia
- Genetic Testing: Hypercoagulability/Thrombophilia
- Investigative List (Non-Covered Services) and New Technology Assessment
- Varicose Vein and Venous Stasis Disease of Lower Extremity Procedures

Please note that providers must submit a prior authorization (PA) form for services that require one. The PA form helps ensure that members and patients see in-network providers who have the appropriate equipment and are trained to perform the procedure. Providers can find the new PA form at the following link: **www.phs.org/providers/authorizations/Pages/default.aspx**.

Providers can also verify if a PA is required and submit PA requests using their myPRES Provider Portal account. Please use the following steps to access Presbyterian's PA tools:

- Log into your myPRES Provider Portal Account.
- Click on the "Authorizations" tab.
- Select "All other medical authorization requests."
- Click "Submit an Electronic Authorization Request."

To help providers navigate the new PA tools, Presbyterian developed the myPRES Prior Authorization User Manual. Providers can view the myPRES Prior Authorization User Manual at **www.phs.org/providermanual**.

To assist providers with billing for these procedures, please see the table below that outlines the updated and new policies and other important information.

Policy	Common Procedural Terminology Code(s) and Important Information	Is a Prior Authorization Required?
Genetic Testing for Non-Invasive Prenatal Testing (NIPT), MPM 20.15	The coverage for this policy will change. Please see the following changes: • Coverage for all singleton pregnancies after 10 weeks gestational age • Common Procedural Terminology (CPT) codes 81420 or 81507 will continue to require a prior authorization (PA) The policy will also be updated with limitation language. The change will state that no more than two NIPT episodes in a rolling 12-month period will be paid. When prenatal testing is performed, only one screening approach should be used, either fetal aneuploidy testing (81420/81507), or other sequential pregnancy screening tests (81508, 81511 and 81512).	Yes
DME: Rehabilitation and Mobility Devices, MPM 4.2	For those items in the policy, where there isn't any criteria guidance by the Human Services Department (HSD), the policy now includes the following statement: Medicaid will follow the criteria by the Local Coverage Determinations (LCDs). • **Augmentative Speech Device**: Continue using LCD L33739 for commercial and Medicare and New Mexico Administrative Code (NMAC) 824.5 for Medicaid. The trial rental period of up to 60 days was added to Medicaid. The language regarding the purchase of 60 days requirement will be removed. A PA is required • **Continuous Passive Motion (CPM) devices**: These devices will continue to use National Coverage Determination (NCD) 280.1 for commercial, Medicare and Medicaid. It will continue to cover E0936	Yes

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	for post -surgical repair of shoulder, even though the Centers for Medicare & Medicaid Services (CMS) limits use to knee procedures only. A PA is required • **Mechanical Stretching Devices for Static or Dynamic Joint Extension and Flexion**: These devices will continue to follow Milliman Clinical Care Guideline (MCG) A-0882 for Dynamic Joint and add to follow MCG A-0889 for static joint, which was erroneously left out. A PA is only required for E1399 • **Mobility Assistive Equipment (MAE):** Please see the following MAEs that will change: A. Canes and Crutches: Continue using L33733 for all product lines. A PA is not required B. Knee Crutch Hands Free Walker (E0118): Continue using LCD L33733 for all product lines. The following language will be added: “Based on medical necessity, a crutch substitute is covered only if the functional mobility deficit cannot be sufficiently resolved by the use of a cane or crutch.” Please continue to use E0118 for PAs. Code E0114 was reviewed and will not require a PA C. Walkers: Continue using LCD L33791 for all product lines. The criteria will be added from LCD. Code E0140 will be removed from the PA grid and code E0144 will be set to not pay. According to CMS, the reasonable and necessary use of enclosed frame walker has not	

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	been established D. Gait Trainer: Adult gait trainer will continue to use LCD L33791 for all product lines. Rollator (E0143) is considered a gait trainer and will now require PA for all product lines. Pediatric gait trainers will now follow MCG A-0886 for Centennial Care members only and will continue to require a PA E. Four-wheeled walker with seat and brakes: Continue to follow LCD L33791 for all product lines F. Manual Wheelchair Bases: Continue to follow LCD L33788 for all product lines. A PA is required for codes E1038, E1039, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0005, K0006, K0007, K0008 and K0009. Codes E1037, E1161, K0001, K0002, K0003 and K0004 will be added and will require a PA. A bundling table that shows items that are included in the wheelchair bases will be added G. Power Mobility Devices: Continue to follow LCD L33789 for all product lines and will continue to require a PA. No new PAs will be added H. Wheelchair Options/Accessories: Continue to follow LCD L33792 for all product lines and will continue to require a PA. No new PAs will be added. List the items names for Group 1 thru Group 9. Will look into configuration of codes using the bundling table contained in the	

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	Wheelchair Options and Accessories LCA (A52504) I. Wheelchair Seat Cushion: Continue to follow LCD L33312 for all product lines. There are no new PAs that will be added • **Prone Standers (Covered for Medicaid Only):** The language will be updated to state that all standers are not covered for commercial and Medicare. Code E0638 will be configured to not pay for Medicare and commercial product lines • **Neuromuscular Electrical Stimulation (NMES) and Functional Electrical Stimulations (FES)**: The policy will continue to follow NCD 160.12 for both treatment of muscle atrophy and spinal cord injury. NMES supplies A4556, A4557, A4558 and A4595 will be configured to not pay per CMS (SI-N). A PA is required • **Specialty Beds and Mattresses**: Continue to follow the listed LCDs for all product lines • **Total Electric Beds**: Codes E0265, E0266, E0296 and E0297 will be set to deny as non-covered for all product lines according to CMS • **Semi-Electric Beds**: Codes E0260, E0261, E0294, E0295 and E0329 will now require a PA • **Heavy Duty Beds**: Codes E0301, E0302, E0303 and E0304 require a PA • **Specialty Car Seats (Only Centennial Care)**: The policy will continue using	

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	homegrown criteria and will require a PA for code E1399 • **Patient Lifts:** The policy will follow LCD L33799 for all product lines. Patient lifts codes E0636, E0639, E0640, E1035 and E1036 will continue to require a PA. Codes E0630 and E0635 will now require a PA for all product lines. Code E0625 will be set as non-covered for all product lines According to LCA (A52516), it is not primarily medical in nature. Seat Lifts will follow LCD L33801 for all product lines and the applicable codes E0172, E0627 and E0629. Codes E0627 and E0629 will now require a PA for all product lines. Code E0172 will be set as non-covered for all product lines. A seat lift placed over or on top of a toilet, any type (E0172) is non-covered, according to LCA (A52518). Power seating systems are a new non-covered item added to the policy. The non-covered codes E2300, E2301, E2331, A9270, E1028 and E2230 will be set not to pay for all product lines according to the Wheelchair Options Accessories - Policy Article (A52504). • **Post-Operative Shoes and Boots**: The policy will continue to follow the LCD L33641 for all product lines. Medicaid will also follow NMAC guidance. A PA is not required. Codes L3215, L3216, L3217, L3219, L3221 and L3222 will be set to not pay for outpatient setting, Status Indicator-E1. See non-covered items listed by CGS, Jan. 06, 2017	

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Panniculectomy and Abdominoplasty, MPM 16.5	Presbyterian will now cover abdominoplasty, code 15847. It is no longer in the exclusion section. Please use codes 15830 and 15847 for PAs. This policy will continue to follow CMS LCD L35090, Cosmetic and Reconstructive Surgery and the related article LCA A56587 for Medicare, commercial and Medicaid.	Yes
Prostate: Surgical Treatment for Benign Prostate Hyperplasia, MPM 12.3. (Formerly Prostate Ablation Treatment for Prostate Cancer)	The policy changed to only cover for benign prostate hyperplasia (BPH) treatment and not prostate cancer. The title changed to reflect the removal of prostate cancer, since the laser ablation treatment for prostate cancer is still considered experimental. Laser ablation treatment for BPH will be covered for commercial, Medicaid and Medicare. The new to policy is Aquablation (Aquabeam) therapy. Aquabeam will be for Medicare members only for the treatment of LUTS/BPH.	No
Genetic Testing: Hypercoagulability/Thrombophilia, MPM 7.10	This is a new policy. Thrombosis panel for risk assessment for venous thromboembolism was moved from MPM 7.1. Non-Medicare members will follow MCG A-0613 (for F-II) and MCG A-0600 (for F-V). Medicare will follow LCD L36400 and LDC L35062. CPT codes 81240 and 81241 will pay only for Medicare with those ICD-10 codes listed in CMS LCA A56541. CPT code 81291 is investigational, there is broad consensus in the medical literature that MTHFR genotyping has no clinical utility in any clinical scenario. A PA is required for codes 81240 and 81241.	Yes
Investigative List (Non-Covered Services) and New Technology Assessment, MPM 36.0	This is a new policy. This policy consists of past and present procedures that were reviewed by the Technology Assessment Committee	No

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	(TAC). The TAC concluded that this policy is investigative and/or experimental. Policies denoted to be investigative procedures may or may not have been retired. The intent is to list investigative procedures(s) that reside in separate policies and consolidate them into one policy.	
Varicose Vein and Venous Stasis Disease of Lower Extremity Procedures, MPM 22.1	Novitas LCD L34924 has significant changes. The criteria between the two relevant LCDs for New Mexico are different based on the condition and/or chronicity of vessels of the lower extremities. The new revision of Novitas LCD L34924 will now include the CEAP system and Venous Clinical Severity Score requirements for the treatment of chronic venous insufficiency. The weight reduction of body mass index less than 35 and utilization guideline items will be removed from this policy. The Wisconsin Physicians Service, LCD L34536, for the treatment of varicose veins will remain the same. CPT codes in the policy will also remain the same.	Yes

For any questions or assistance, please use the following information to contact your assigned Provider Network Operations relationship executive. As always, thank you for partnering with us to improve the health and wellness of the patients, members and communities we serve.

Provider Network Operations

Hours: Monday through Friday, 8 a.m. to 5 p.m.

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