



## **CMO Guidelines for Obtaining Authorization**

The Medical Management Department at CMO should be notified at least 72 hours in advance when services require authorization (see Precertification List). If a requested service requires precertification, 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(s) are 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- The Care Management Company, must be contacted by the next business day.

### **How to submit a precertification request:**

#### **CareLink:**

Providers that have access to CareLink should submit their requests for authorization electronically. Once submitted a provider can view the status of a previously submitted authorization request in the "Authorization History" tab of the CareLink module. 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 CareLink, you can submit your requests for authorization by calling CMO Customer Service at 914.377.4400 or toll free 800.MONTE.CMO. (For services requiring prior authorization for SecureHorizons members, please call 800.876.7455)

#### **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 CARELINK.**

If you would like to request access, please email [CMOProviderRelations@montefiore.org](mailto:CMOProviderRelations@montefiore.org) and a representative will contact you regarding set-up.



The Care Management Company™

## Precertification List Overview\*

Precertification Phone Lines: 914.377.4400 · 800.MONTE.CMO

(For services requiring precertification for SecureHorizons members, call 800.876.7455)

Precertification Fax Line: 914.377.4798 · Radiology Precertification Fax Line: 914.457.9509.

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### 1. Inpatient Admissions

- Elective Admissions require prior authorization at least 5 days prior to admission
- Urgent/emergent admissions require notification within 24 hours of admission

### 2. Surgery

- Morbid Obesity
- Excessive skin/scar and subcutaneous tissue excision/repair
- Breast (*Covered with a diagnosis of cancer*)
- Ear (*Otoplasty*)
- Eye/Eyelid (*Blepharoplasty, Repair of Blepharoptosis/ectropion/endropion*)
- Nose (*Rhinoplasty, Septoplasty, Submucous Resection*)
- Varicose Veins
- Ventral Hernias

### 3. New Technology, Cancer Clinical Trials, Investigational or Experimental Procedures,

(Must be reviewed by Medical Director)

### 4. Durable Medical Equipment

- DME items other than Basic DME\*\* and items requiring a rider.

### 5. Infertility\*\*\* (*Per benefit and dollar limits*)

- Artificial Insemination services (Including laboratory and radiology procedures)
- In-Vitro (IVF) is only covered with the benefit.

### 6. Home Care

### 7. Infusion Services (Home)

### 8. Hospice

### 9. Hyperbaric O2 Therapy

### 10. Out of Service Area and Out of Plan\*\*\*\* (*Must be reviewed by the Medical Director*)

### 11. Radiology (see list for more detail)

- Pet scan
- MRI

### 12. Transplant Procedures

- Renal
- Liver
- Heart
- Lung
- Intestine

### 13. Transportation

- Ambulance
- Ambulette
- Taxi
- Air

\*Depending on the reason for a referral, a referral may require authorization (pre-certification). 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. (*Note: the 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.*)

\*\*Basic DME includes Canes, Crutches, Walkers. Please see specific DME code list available online at [www.CMOcares.com/health\\_provide](http://www.CMOcares.com/health_provide) for items that require a DME rider but no authorization.

**Enteral Formulas and supplies (B4000-B9999) and Medical/ Surgical Supplies (A4000- A8999) are covered under the Medical Benefit.**

\*\*\*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.**

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

**Below please find a list of services requiring precertification:**

| <b>Service</b> | <b>Description</b>   |
|----------------|--|
| <b>Surgery</b> | <b>Morbid Obesity</b>  |
|                | Laparoscopy, surgical; gastric restrictive procedure; with gastric bypass  |
|                | with gastric bypass and small intestine reconstruction to limit absorption   |
|                | Laparoscopy, surgical; implantation or replacement of gastric stimulator   |
|                | revision or removal of gastric neurostimulator   |
|                | Laparoscopy, surgical; transection of vagus nerves, truncal  |
|                | selective or highly selective  |
|                | gastrostomy, without construction of gastric tube  |
|                | Unlisted laparoscopy procedure, stomach  |
|                | Laparoscopy, surgical, gastric restrictive procedure, placement of adjustable gastric restrictive device   |
|                | revision of adjustable gastric restrictive device component only   |
|                | removal of adjustable gastric restrictive device component only  |
|                | removal and replacement of adjustable gastric restrictive device component only  |
|                | removal of adjustable gastric restrictive device and subcutaneous port components  |
|                | 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 to limit absorption                              |
|                | with short limb Roux-en-Y gastroenterostomy  |
|                | with small intestine reconstruction to limit absorption  |
|                | Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device, (separate procedure)                    |
|                | Bariatric Surgery-Gastric restrictive procedure, open; revision of subcutaneous port component only  |
|                | Bariatric Surgery-removal of subcutaneous port component only  |
|                | Bariatric Surgery-removal and replacement of subcutaneous port component only  |
|                | <b>Excessive skin and subcutaneous tissue excision</b>   |
|                | Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen  |
|                | " " " " " , thigh  |
|                | " " " " " , leg  |
|                | " " " " " , hip  |
|                | " " " " " , buttock  |
|                | " " " " " , arm  |
|                | " " " " " , forearm or hand  |
|                | " " " " " , submental fat pad  |
|                | " " " " " , other area   |
|                | Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (includes umbilical transposition and fascial plication) (add-on code to 15830) |
|                | <b>Breast (Covered with a diagnosis of cancer)</b>   |
|                | Mastectomy for gynecomastia  |
|                | Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy)   |
|                | with axillary lymphadenectomy  |
|                | 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  |
|                | Reduction mammoplasty  |
|                | 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   |
|                | Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion  |
|                | <b>Ear</b>   |
|                | Otoplasty, protruding ear, with or without size reduction  |
|                | <b>Eye/Eyelid</b>  |
|                | Blepharoplasty, upper or lower eyelid  |
|                | Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)   |
|                | Repair of ectropion, excision tarsal wedge   |
|                | Repair of ectropion, extensive (eg, tarsal strip operations)   |
|                | Repair of Entropion; suture  |
|                | " ; thermocauterization  |
|                | " ; excision tarsal wedge  |
|                | " ; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)  |

| Service                       | Description  |
|-------------------------------|--|
|                               | <b>Nose</b>  |
|                               | Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip  |
|                               | Rhinoplasty, complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip   |
|                               | Rhinoplasty, including major septal repair   |
|                               | Rhinoplasty, secondary; minor revision (small amount of nasal tip work)  |
|                               | Rhinoplasty, major revision (bony work and osteotomies)  |
|                               | Rhinoplasty, 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   |
|                               | " " ; oronasal   |
|                               | Septal or other intranasal dermatoplasty   |
|                               | Repair nasal septal perforations   |
|                               | <b>Varicose Veins</b>  |
|                               | Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk or face  |
|                               | Injection of sclerosing solution; single vein and multiple veins, same leg   |
|                               | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous and percutaneous laser, radiofrequency; first vein and subsequent veins treated in a single extremity, each through separate access sites |
|                               | Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)   |
|                               | Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions   |
|                               | Ligation, division, and stripping, short saphenous vein or long 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  |
|                               | Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open  |
|                               | Stab phlebotomy of varicose veins, one extremity; 10 - 20 stab incisions and 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), one leg   |
|                               | <b>Ventral Hernias</b>   |
|                               | Repair initial or recurrent incisional or ventral hernia; reducible or Repair spigelian hernia   |
| <b>Cancer Clinical Trials</b> | <b>Medical Director Review</b>   |
| <b>DME</b>                    | <b>Durable Medical Equipment - Plans with a DME Rider (includes Basic DME)</b>   |
|                               | DME items Other than Basic DME* (Canes, Crutches, Walkers), Require precertification.  |
|                               | 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.   |
|                               | <b>Plans without the DME rider include these Basic DME* items only:</b>  |
|                               | No Precertification is required for Basic DME items.   |
|                               | <b>Canes</b>   |
|                               | includes canes of all materials, including quad or three-prong, adjustable or fixed, with tips   |
|                               | <b>Crutches</b>  |
|                               | 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  |
|                               | <b>Walkers</b>   |
|                               | 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  |
|                               |  |
|                               |  |



| Service                      | Description  |
|------------------------------|--|
| <b>Radiology (PET/MRI)</b>   |  |
|                              | <b>Pet Scan</b>  |
|                              | Tumor Image Pet/CT, Skull to thigh   |
|                              | Tumor Image Pet/CT, Whole body   |
|                              | <b>MRI</b>   |
|                              | MRI Brain without contrast   |
|                              | MRI Brain with contrast  |
|                              | MRI Brain without contrast and with contrast   |
|                              | MRI Neck Spine without contrast  |
|                              | MRI Neck Spine with contrast   |
|                              | MRI Thoracic Spine without contrast  |
|                              | MRI Thoracic Spine with contrast   |
|                              | MRI Lumbar Spine without contrast  |
|                              | MRI Lumbar Spine 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   |
|                              | MRI Upper Extremity Joint with contrast  |
|                              | MRI Upper Extremity Joint without contrast followed by contrast  |
|                              | MRI Lower Extremity joint without contrast   |
|                              | MRI Lower Extremity joint with contrast  |
|                              | MRI Lower Extremity joint without contrast followed by contrast  |
|                              | Breast MRI, Unilateral   |
|                              | Breast MRI, Bilateral  |
| <b>Transplant Procedures</b> |  |
|                              | <b>Renal</b>   |
|                              | Donor nephrectomy; from cadaver donor, unilateral or bilateral   |
|                              | Donor nephrectomy; open, from living donor   |
|                              | Renal autotransplantation, reimplantation of kidney  |
|                              | <b>Liver</b>   |
|                              | Donor hepatectomy, from cadaver donor  |
|                              | Liver allotransplantation, orthotopic, partial or whole, from cadaver or living donor, any age                                   |
|                              | Liver allotransplantation, heterotopic, partial or whole, from cadaver or living donor, any age                                  |
|                              | Donor hepatectomy from living donor  |
|                              | <b>Heart</b>   |
|                              | Donor cardiectomy-pneumonectomy  |
|                              | Donor cardiectomy  |
|                              | <b>Lung</b>  |
|                              | Donor pneumonectomy, from cadaver donor  |
|                              | Lung transplant, single; without cardioplumunary bypass  |
|                              | " " " with cardiopulmonary bypass  |
|                              | Lung transplant, double with or without cardiopulmonary bypass   |
|                              | <b>Intestine</b>   |
|                              | Allograft Preparation  |
|                              | Donor Enterectomy  |
|                              | Removal of Allograft   |
| <b>Transportation</b>        | <b>Ambulance, Ambulette, Taxi, Air</b>   |
|                              | <b>Emergency</b> Ambulance - ALS or BLS, Level 1 and 2 Conventional air services, transport, one way (Fixed wing or rotary wing) |
|                              | Specialty care transport (SCT) <b>Non-emergency</b> Ambulance Taxi   |
|                              | Wheelchair van   |
|                              | Unlisted ambulance service   |