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

1. Inpatient Admissions • Elective Admission 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/endtropion • Congenital Cleft Lip/Palate (birth defect) • Nose (Rhinoplasty, Septoplasty, Submucous Resection) • Varicose Veins • Ventral Hernias	**3. New Technology, Cancer Clinical Trails, Investigational or Experimental Procedures** (MD Review Required)
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** • Home Care (Skilled)
7. Personal Care Services (not for inpatient or resident at a facility) • Home Attendant Custodial Care (Medicaid only) • Nursing Assessment Evaluation	**8. Infusion Services (Home)**	**9. Injectables (see list for more details)**
10. Intravenous Immunoglobulin Therapy (IVIG) (see list for more details)	**11. Hospice**	**12. Hyperbaric O2 Therapy**
13. Out of Service Area and Out of Plan (MD Review Required)	**14. Radiology (see list for more details)** • Pet Scan • MRI • MRA	**15. Proton Radiation Therapy**
16. Transplant Procedures • Renal • Liver • Pancreas • Heart • Lung Intestine	**17. Transportation** • Ambulance • Ambulette • Taxi Air	

*** 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 polices 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 services require precertification:

Service	Description
Surgery	**Morbid Obesity**
	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
	Excessive skin and subcutaneous tissue excision
	Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen
	Excision, excessive skin and subcutaneous tissue (including lipectomy); thigh
	Excision, excessive skin and subcutaneous tissue (including lipectomy); leg
	Excision, excessive skin and subcutaneous tissue (including lipectomy); hip
	Excision, excessive skin and subcutaneous tissue (including lipectomy); buttock
	Excision, excessive skin and subcutaneous tissue (including lipectomy); arm
	Excision, excessive skin and subcutaneous tissue (including lipectomy); forearm or hand
	Excision, excessive skin and subcutaneous tissue (including lipectomy); submental fat pad
	Excision, excessive skin and subcutaneous tissue (including lipectomy); other area
	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (includes umbilical transposition and fascial plication) (add-on code to 15830)
	Breast (Covered with a diagnosis of cancer)
	Mastectomy for gynecomastia
	Mastectomy, partial (e.g., 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 mammaplasty
	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
	Ear
	Otoplasty, protruding ear, with or without size reduction
	Eye/Eyelid
	Blepharoplasty, upper or lower eyelid
	Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g. banked fascia)
	Repair of ectropion, excision tarsal wedge
	Repair of ectropion, extensive (eg, tarsal strip operations)
	Repair of Entropion; suture
	Repair of Entropion; thermocauterization
	Repair of Entropion; excision tarsal wedge
	Repair of Entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)
	Congenial – Cleft lip cleft palate-birth defect
	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
	Repair of nasal vestibular stenosis (e.g.), spreader grafting, lateral nasal wall reconstruction)
	Septoplasty or submucout resection, with or without cartilage scoring, contouring or replacement with graft
	Repair choanal atresia; intranasal
	Repair transpalatine
	Lysis intranasal synechia
	Repair fistula; oromaxillary
	Repair fistula; oronasal
	Septal or other intranasal dermatoplasty
	Repair nasal septal perforations
	Nose
	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
	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; 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
	Repair choanal atresia; transpalatine
	Lysis intranasal synechia
	Repair fistula; oromaxillary

	Repair fistula; oronasal
	Septal or other intranasal dermatoplasty
	Repair nasal septal perforations
	Varicose Veins
	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
	Ventral Hernias
	Repair initial or recurrent incisional or ventral hernia; reducible or Repair spigelian hernia
Cancer Clinical Trials	**Medical Director Review Required**
DME	**Durable Medical Equipment - Plans with a DME Rider (includes Basic DME)**
	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.
	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
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 polices for specific coverage guidelines.**

	Artificial Insemination services (including laboratory and radiology procedures)
	Artificial Insemination; intra-cervical
	Artificial Insemination; 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 (e.g. sperm wash and swim up) for insemination or diagnosis with semen analysis
	Sperm isolation; complete prep (e.g. Percoll gradient, albumin gradient) 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, intra-uterine
	Gamete, zygote, or embryo intrafollopian 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
	Assisted oocyte fertilization, microtechniques; greater than 10 oocytes
	Thawing of cryopreserved; embryo(s)
Investigational or Experimental Procedures	**Medical Director Review Required**
New Technology	**Medical Director Review Required**
Home Care	
Skilled	Home Health Aide or Certified Nurse Assistant, per hour
	Skilled Nursing Visit, Nursing care, in the home; by registered nurse, per hour
	Nursing care, in the home; by licensed practical nurse, per hour
	Medical Social Service
	Speech Therapy
	Occupational Therapy
	Physical Therapy
	Wound care

	Nutritionist
Personal Care Services (PCS)	Home Attendant Custodial Care (Medicaid Only)
	Nursing Assessment Evaluation
	Personal Care Services – not for inpatient or resident at a facility
Infusion Services	
	Nursing visit, Home infusion/specialty drug administration, per visit (up to 2 hours)
	Nursing visit, Home infusion/specialty drug administration, each additional hour (add-on code)
	Hydration Therapy
	Infusion therapy (e.g., antibiotic therapy, TPN, enteral nutrition)
Injectables	
	RSV MAB IM 50MG
	THER/PROPH/DIAG IV INF INIT
	THER/PROPH/DIAG IV INF ADDON
	TX/PROPH/DG ADDL SEQ IV INF
	THER/DIAG CONCURRENT INF
	SC THER INFUSION UP TO 1 HR
	SC THER INFUSION ADDL HR
	SC THER INFUSION RESET PUMP
	THER/PROPH/DIAG INJ SC/IM
	THER/PROPH/DIAG INJ IA
	THER/PROPH/DIAG INJ IV PUSH
	TX/PRO/DX INJ NEW DRUG ADDON
	TX/PRO/DX INJ SAME DRUG ADON
	APPLICATON ON-BODY INJECTOR
	THER/PROP/DIAG INJ/INF PROC
	RADIUM RA223 DICHLORIDE THER
	NOC THERAPEUTIC RADIOPHARM
	AFLIBERCEPT INJECTION
	INJECTION, RUCONEST, 10 UNITS
	C-1 ESTERASE, BERINERT
	C-1 ESTERASE, CINRYZE
	COLLAGENASE, CLOST HIST INJ
	CORTICOTROPIN, TO 40 UNITS, INJECT
	ECALLANTIDE INJECTION
	INJ FERRIC CARBOXYMALTOS 1 MG
	INJ IVIG PRIVIGEN 500 MG
	INJ, IMM GLOB BIVIGAM, 500 MG
	GAMMAPLEX INJECTION
	HIZENTRA INJECTION
	GAMMA GLOBULIN, OVER 10 CC,IM INJCT
	GAMUNEX-C/GAMMAKED
	IMMUNE GLOBULIN SUBCUTANEOUS
	IMMUNE GLOBULIN, POWDER
	OCTAGAM INJECTION
	GAMMAGARD LIQUID INJECTION
	FLEBOGAMMA INJECTION
	INJ HYQVIA 100 MG IMMUNEGLOBULIN

	HYDROXYPROGESTERONE CAPROATE
	ICATIBANT INJECTION
	INFLIXIMAB INJECTION
	OMALIZUMAB INJECTION 5MG
	PEGAPTANIB SODIUM INJECTION
	RANIBIZUMAB
	USTEKINUMAB INJECTION
	INJECTION, VEDOLIZUMAB, 1 MG
	INJECTION, FACTOR X, (HUMAN), 1 IU
	INJ,VONVENDI 1 IU VWF:RCO
	FACTOR XIII ANTI-HEM FACTOR
	FACTOR XIII RECOMB A-SUBUNIT
	FACTOR VIII RECOMB NOVOEIGHT
	WILATE INJECTION
	XYNTHA INJ
	ANTIHEMOPHILIC VIII/VWF COMP
	INJ VONWILLEBRAND FACTOR IU
	FACTOR VIII RECOMB OBIZUR, PER I.U.
	FACTOR VIIA
	FACTOR VIII (HUMAN) PER IU
	FACTOR VIII RECOMBINANT
	FACTOR IX NON-RECOMBINANT
	FACTOR IX COMPLEX
	FACTOR IX RECOMBINANT NOS
	ANTI-INHIBITOR
	HEMOPHILIA CLOT FACTOR NOC
	FACTOR IX RECOMBINAN RIXUBIS
	FACTOR IX FC FUSION RECOMB
	INJ FACTOR IX IDELVION 1IU
	FACTOR VIII FC FUSION RECOMB PER IU
	FACTOR VIII PEGYLATED RECOMB 1 IU
	INJ, FACTOR VIII NUWIQ RECOMB 1IU
Intravenous Immunoglobulin Therapy (IVIG)	
	INJ Immune Globulin IV Non-lyophilized 500 MG
	INJ Immune Globulin SQ 100MG
	INJ Gamma Globulin Intramuscular over 10CC
	INJ IG Gamunex IV Non-lyophilized 500 MG
	INJ IG IV Lyophilized Not Otherwise Spec 500 MG
	INJ IG Gammagard Liq IV Non-lyophilized 500 MG
	INJ Immune Globulin IV Non-lyophilized 500 MG
	INJ Immune Globulin IV Non-lyophilized, Not Otherwise Spec
Hospice	
	Hospice care, in the home, per diem
	Hospice care provided in inpatient hospital or inpatient hospice facility
Out of Plan	**Medical Director Review Required**

	Out of Plan providers seeking in-network coverage must request it in advance of services being performed.
Out of Service Area	**Medical Director Review Required**
Radiology (PET/MRI/MRA)	
	Pet Scan
	Tumor Image Pet/CT, Skull to thigh
	Tumor Image Pet/CT, Whole body
	MRA
	MRA Head without contrast
	MRA Head with contrast
	MRA Head with and without contrast
	MRA Neck without contrast
	MRA Neck with contrast
	MRA Neck with and without contrast
	MRI
	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
	MRI Orbit, Face and/or Neck without contrast

	MRI Orbit, Face and/or Neck with contrast
	MRI Orbit, Face and/or Neck with and without contrast
	Breast MRI, Unilateral
	Breast MRI, Bilateral
	Proton Radiation Therapy
	Proton Treatment Simple W/O Comp
	Proton Treatment Simple W/Comp
	Proton Treatment Intermediate
	Proton Treatment Complex
Transplant Procedures	
	Renal
	Donor nephrectomy; from cadaver donor, unilateral or bilateral
	Donor nephrectomy; open, from living donor
	Renal autotransplantation, reimplantation of kidney
	Pancreas
	Donor pancreatectomy (including cold preservation) with or without duodenal segment of transplant
	Backbench starndard-prep of cadaver donor
	Liver
	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
	Heart
	Donor cardiectomy-pneumonectomy
	Donor cardiectomy
	Lung
	Donor pneumonectomy, from cadaver donor
	Lung transplant, single; without cardioplumonary bypass
	Lung transplant, single; with cardiopulmonary bypass
	Lung transplant, double with or without cardiopulmonary bypass
	Intestine
	Allograft Preparation
	Donor Enterectomy
	Removal of Allograft

Transportation	
	Ambulance, Ambulette, Taxi, Air
	Emergency Ambulance - ALS or BLS, Level 1 and 2 Conventional air services, transport, one way (Fixed wing or rotary wing)
	Specialty care transport (SCT) **Non-emergency** Ambulance Taxi
	Wheelchair van
	Unlisted ambulance service