

<p style="text-align: center;">MEDSTAR FAMILY CHOICE DISTRICT OF COLUMBIA QUICK AUTHORIZATION GUIDE</p> <p style="text-align: center; color: red;">Effective 04/15/2024</p>	<p style="text-align: center;">MEDSTAR FAMILY CHOICE DC Healthy Families</p>
Authorization is subject to quantity limits base on the DC Fee Schedule	
ALL OUT-OF-NETWORK/ NON-PAR SERVICE	Prior Authorization Required
INPATIENT ADMISSIONS (Concurrent Reviews & Elective Procedures) (In Network and Out of Network)	Prior Authorization Required
INPATIENT ADMISSIONS for Psychiatric diagnoses OUTPATIENT RESIDENTIAL TREATMENT for Substance Use diagnosis (In Network and Out of Network)	Prior Authorization Required
OUTPATIENT In-Network (Practitioner AND Facility) Facility based procedures (includes outpatient Chemotherapy and Radiation Therapy)	NO Prior Authorization Required, <u>unless included below</u> under the 'Exceptions Requiring Prior Authorization' section (See EXCEPTIONS below)
EXCEPTIONS REQUIRING PRIOR AUTHORIZATION	
ABA Services	Prior Authorization Required
Abortions	Elective Therapeutic Abortions are NOT A COVERED BENEFIT by MFC-DC. Prior Authorization Required for Medical Abortions ONLY if the Federal Criteria are met
Acupuncture for Children < 21 years old	Prior Authorization Required for >10 visits <i>per calendar year</i>
Audiology Services Cochlear Implants	Prior Authorization Required for: - Cochlear implant (BAHA) devices. - Replacement components (except microphone, transmitting cables and transmitting coils.) - All hearing aids - All auditory osseointegrated devices Auditory Rehab codes: 92626, 92627, 92630 and 92633 done by any provider type

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Bariatric Surgery Program - Including OP Surgeries	Prior Authorization Required
Cardiac Rehabilitation	Prior Authorization Required
Chiropractic Services for Enrollees <21 years old	Prior Authorization Required for >10 visits <u>per calendar year</u>
Clinical Trials	Prior Authorization Required
Insulin Pumps	Prior Authorization Required
Coumadin Clinics	Prior Authorization Required
Dental	<p>Prior Authorization Required for: detailed and extensive oral evaluation-new or established patient</p> <ul style="list-style-type: none"> -cone beam ct capture and interpretation +/- field of dental arch, mandible -cone beam ct capture and interpretation of field of view of both jaws +/- cranium -study models -provisional crown -retreatment of previous root canal therapy-anterior, premolar and molar, -apexification/recalcification-initial visit -bone graft in conjunction with periradicular surgery per tooth single site and contiguous tooth in the same surgical site -guided tissue regeneration resorbable barrier per site in conjunction with periradicular surgery -surgical repair of root resorption-anterior, premolar, molar -decoronation or submergence of an erupted tooth -gingivectomy or gingivoplasty- 1 to 3 or 4 or more contiguous teeth or tooth bounded spaces per quadrant, or for restorative procedure -gingival flap, non-gingival flap -clinical crown lengthening -osseous surgery -bone replacement grafts -biologic materials to aid regeneration -guided tissue regeneration -periodontal scaling and root planning -full mouth debridement -surgical placement of implant body-endosteal implant -prefabricated abutment -abutment supported porcelain/ceramic crown -implant scaling and debridement -implant supported crowns -provisional implant crown -accessing and retorquing screw per screw -remove broken implant retaining screw -abutment supported crown-porcelain fused to titanium or titanium alloys -surgical removal of implant body

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<p>Dental (continued)</p>	<p>Prior Authorization Required for: debridement of peri-implant of defects surrounding a single implant -debridement and osseous contouring of a peri-implant defect -implant/abutment supported removable denture for edentulous arch mandibular -semi-precision abutment/attachment-placement -coronectomy -incisional biopsy of oral tissue-hard (bone, tooth) -alveoloplasties -vestibuloplasties -removal of benign odontogenic cysts or tumors -removal of lateral exostosis, torus palatinus, torus mandibularis -marsupialization of odontogenic cyst -condylectomy -surgical discectomy -arthrotomy -osteoplasty -osseous, osteoperiosteal or cartilage graft of mandible/maxilla -buccal/labial or lingual frenectomy -excision of hyperplastic tissue -surgical resection of fibrous tuberosity -non-surgical sialolithotomy -comprehensive orthodontic treatment of adolescent dentition or orthognathic surgery -periodontic orthodontic treatment visit +/- orthognathic surgery -removal of fixed orthodontic appliances for reasons other than completion of treatment -replacement of lost/broken retainer-maxillary/mandibular -unspecified orthodontic procedure by report -occlusal guard-hard/soft, full arch/partial arch -occlusal adjustment-limited and complete -custom sleep apnea appliance fabrication and placement -reline custom sleep apnea appliance (indirect)</p>
<p>Diabetes and Nutritional Counseling</p>	<p>Prior Authorization Required after > THREE (3) visits <u>per Calendar Year</u> (Office, Homecare or Hospital Based services)</p>
<p>Early Intervention (EI) Services</p>	<p>Prior Authorization Required</p>
<p>Erectile Dysfunction Procedures</p>	<p>Prior Authorization Required</p>
<p>Eye procedures and surgeries</p>	<p>Prior Authorization Required for: -Blepharoplasty; -Capsulotomy; -Corneal relaxing incision for correction of surgically induced astigmatism; -Corneal wedge resection for correction of surgically induced astigmatism; -Destruction of lesion of lid margin; -Ectropion repair; -Entropion repair; -Eyelid lesion excision or reconstruction; -Implantation of Intraocular devices; -Insertion of intraocular lens prosthesis (secondary implant) not associated with concurrent cataract removal; -Keratoplasty, -Orbital Prosthesis; -Ptosis repair; -Radial keratotomy; -Strabismus repair; * <i>Some eye procedure may be found under the Cosmetic Procedures</i> *</p>

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Genetic Counseling	Prior Authorization Required
Genetic Testing	Prior Authorization Required
Gender Reassignment Surgery/Transgender Surgery	Prior Authorization Required
Heart Failure Clinics	Prior Authorization Required
Home Health Care	Prior Authorization Required for all visits
Home Infusion Services (in the Home and Free-Standing Facility)	NO Prior Authorization Required from In-Network provider (for the Home Infusion Therapy or Medications)
Hospice Care (IP and OP) Skilled Nursing Facility Acute Rehab Facility	Prior Authorization Required <i>SNF limited to 90 day</i> <i>Custodial Care (long-term care) not covered by the MCO</i>
Hyperbaric Oxygen	Prior Authorization Required
Investigational Surgery Emerging Technology, Services, Procedures (Also See Clinical Trials)	Prior Authorization Required
Laboratory Services (includes Genetic Testing)	NO Prior Authorization Required if done at an in-network freestanding lab facility. Prior Authorization Required for: genetic testing, lab testing at a hospital, non contracted lab, reference lab, etc.
Medically Necessary Contact Lenses	Prior Authorization Required
Mount Washington Pediatric Hospital Services (Weight Smart Program/Outpatient Feeding Program and Sleep Studies)	Prior Authorization Required
Neuropsychological Testing	Prior Authorization Required
Outpatient Rehabilitation Services Physical Therapy (PT) Occupational Therapy (OT) Speech Language Pathology (SLP)	Prior Authorization Required after >30 visits <i>per calendar year</i>
Personal Care Aide (PCA)	Prior Authorization Required For Assessments (Initial/ Recertification/condition change): Submit ePOF (Electronic Prescription Order Form), along with any clinical information from the PCP/ treating Practitioner via DHCF portal
PET Scans	NO Prior Authorization Required if performed at participating free-standing facilities or at contracted hospital
Private Duty Nursing	Prior Authorization Required
Pulmonary Rehabilitation	Prior Authorization Required

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Radiology: CT Scans, MRI's, X-RAYS, Nuclear Medicine, Sonograms, Digital Mammography	NO Prior Authorization Required if performed at a participating free-standing facilities or at a contracted hospital.
Sleep Studies and Polysomnograms	NO Prior Authorization Required if performed at a participating free-standing facilities, at a contracted hospital, Home.
Spinal Cord Stimulators, Vagus Nerve Stimulators and Sacral Nerve and Peripheral Nerve Stimulators trial and implantation	Prior Authorization Required
Transplant Services: Pre-Transplant and Post-Transplant services Only	Prior Authorization Required HLA Testing for BMT requires prior authorization.
Transplant Surgery	Prior Authorization Required BY DHCF for the Transplant surgery. MFC-DC only covers pre and post transplant services.
Transportation: - Ambulance - Van Transport - Wheelchair	NO Prior Authorization Required for: - PAR Vendors - DC Fire and Emergency Medical Services (DC FEMS); and - Emergent/Urgent hospital to hospital transfers Prior Authorization Required for: - Non-PAR vendors - Non Urgent hospital to hospital transfers and other transfers Emergency Medical Transport covered by DHCF effective 10/1/2021
DME: PAR providers - Prior authorization required for items billed > \$1000 or rental equipment over 90 days. Non PAR providers - Prior authorization required regardless of cost.	*Visit website or contact Enrollee Services (1-888-404-3549) for in-network providers.
Custom Shoes Diabetic Shoes Orthotics (Braces, Splints) Prosthetics	Prior Authorization Required per item billed over \$500 or exceeds Max Units for PAR provider. No Prior Authorization Required for CAM Walking Boots. The specific codes are: L4360, L4361, L4386, L4387
Hearing Aids Cochlear Implants Auditory Osseointegrated Devices	Prior Authorization Required for: - All Hearing Aids - All auditory osseointegrated devices (BAHA) - Cochlear implant devices and replacement components (except microphone, transmitting cables and transmitting coils) - Repair and replacement of any hearing devices
Soft supplies and disposable items: Includes enteral/parenteral (feeding) supplies, batteries, ear molds, components for hearing aids, cochlear implant or auditory osseointegrated devices, Ostomy Supplies, Catheters	Prior Authorization Required per item billed over \$750, per Enrollee/per provider/per month for PAR providers. *Visit our website or contact Enrollee Services (1-888-404-3549) for In-Network providers.

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QUICK AUTHORIZATION GUIDE

Effective 04/15/2024

MEDSTAR FAMILY CHOICE
DC Healthy Families

*Please visit our website at MedStarFamilyChoiceDC.com for assistance with finding in network vendors, physicians or facilities.

*** This is a Quick Authorization Guide.

It is not meant to be all inclusive.

For questions, please contact MFC-DC at: 1-(855)-798-4244; Local: (202)-363-4348

The codes and guidance in this document is subject to Enrollee eligibility and the existence of coverage per the DC Medicaid Fee Schedule on the date of service.