MEDSTAR FAMILY CHOICE DISTRICT OF COLUMBIA AUTHORIZATION GUIDE Effective 04/15/2024	MEDSTAR FAMILY CHOICE DC Healthy Families	MEDSTAR FAMILY CHOICE DC Alliance
Authorization is subject to quantity limits based on the DC Medicaid Fee Schedule		
ALL OUT-OF-NETWORK/ NON-PAR SERVICE	**Prior Authorization Required**	**NOT A COVERED BENEFIT** Some excluded services may be covered through DC Mediciad Fee-For-Service
Emergency Medical Conditions (ED)	**NO** Prior Authorization Required	**NOT COVERED BENEFITS by MedStar Family Choice-DC** as described in DHCF Policy Number HCPRA-2013-02R
INPATIENT ADMISSIONS (Concurrent Reviews & Elective Procedures) **(In Network and Out of Network)**	**Prior Authorization Required**	**Prior Authorization Required** **NOT COVERED BENEFITS:** - Service by Out-of-Network Out of State providers - Cosmetic surgery - Deliveries - Open heart surgery - Temporal Mandibular Joint (TMJ)- Services, and Supplies for surgery and treatment - Transplantation Surgery - Treatment for Obesity
INPATIENT ADMISSIONS for Psychiatric diagnoses **(In Network and Out of Network)** **OUTPATIENT RESIDENTIAL TREATMENT for Substance Use diagnosis** **(In Network and Out of Network)**	**Prior Authorization Required**	**NOT COVERED BENEFITS by MedStar Family Choice-DC** Refer/Submit claims to Dept of Behavorial Health (DBH).
OUTPATIENT In-Network **(Practitioner AND Facility)** **Facility based procedures (includes outpatient Chemotherapy and Radiation Therapy)**	**NO** Prior Authorization Required, unless included below under the 'Exceptions Requiring Prior Authorization' section (See **EXCEPTIONS** below)	**No** Prior Authorization Required, unless included below under the 'Exceptions Requiring Prior Authorization' section **NOT COVERED BENEFIT:** - Service by Out-of-Network Out of State providers - (See **EXCEPTIONS** below)
EXCEPTIONS REQUIRING PRIOR AUTHORIZATION		
ABA Services	**Prior Authorization Required**	**Prior Authorization Required**
Abortions	Elective Therapeutic Abortions are **NOT A COVERED BENEFIT by MedStar Family Choice-DC.** Prior Authorization Required for Medical Abortions ONLY if the Federal Criteria are met	Elective Therapeutic Abortions are **NOT COVERED BENEFITS by MedStar Family Choice-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 ***per calendar year***	Not Applicable - there are no children in Alliance
Acupuncture for Enrollees >21 years old	**NOT A COVERED BENEFIT**	**NOT A COVERED BENEFIT**
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 osseointergrated devices Auditory Rehab codes: 92626, 92627, 92630 and 92633 done by any provider type	**Prior Authorization Required** for: - Cochlear implant (BAHA) devices. - Replacement components (except microphone, transmitting cables and transmitting coils,) - All hearing aids - All auditory osseointergrated devices Auditory Rehab codes: 92626, 92627, 92630 and 92633 done by any provider type
Bariatric Surgery Program - Including OP Surgeries	**Prior Authorization Required**	**NOT A COVERED BENEFIT**
Cardiac Rehabilitation	**Prior Authorization Required**	**Prior Authorization Required**
Chiropractic Services for Enrollees <21 years old	**Prior Authorization Required** for >10 visits ***per calendar year***	Not Applicable - there are no children in Alliance
Chiropractic Services (Services provided by a Chiropractor to include PT) for Enrollees >21 years old	**NOT A COVERED BENEFIT**	**NOT A COVERED BENEFIT**
Clinical Trials	**Prior Authorization Required**	**NOT A COVERED BENEFIT**
Continuous Glucose Monitors (CGM) **Insulin Pumps** DEXCOM FREESTYLE LIBRE	NO Prior Authorization Required (Subject to quantity limits)	NO Prior Authorization Required (Subject to quantity limits)
Cosmetic procedures	**NOT A COVERED BENEFIT:** Include (but not limited to): -Breast reduction (male or female) -Blepharoplasty -Brow ptosis -Rhinoplasty -Sclerotherapy -Septoplasty -Skin tag removal -Panniculectomy	**NOT A COVERED BENEFIT** Include (but not limited to): -Breast reduction (male or female) -Blepharoplasty -Brow ptosis -Rhinoplasty -Sclerotherapy -Septoplasty -Skin tag removal -Panniculectomy
Coumadin Clinics	**Prior Authorization Required**	**Prior Authorization Required**
Diabetes and Nutritional Counseling	**Prior Authorization Required** after > THREE (3) visits ***per Calendar Year*** (Office, Homecare or Hospital Based services)	**Prior Authorization Required** after > THREE (**3**) visits ***per Calendar Year*** (Office, Homecare or Hospital Based services) Nutritional Counselling for the treatment of Obesity is not a covered benefit.
Early Intervention (EI) Services	**Prior Authorization Required**	N/A - there are no children in Alliance

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Epidural injections (cervical and lumbar) **Facet blocks** **Rhizotomies** **SI Joint**	**NO** Prior Authorization Required	**NO** Prior Authorization Required
Erectile Dysfunction Procedures	**Prior Authorization Required**	**Prior Authorization Required**
Eye procedures and surgeries	**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; ***Some eye procedures may be found under the Cosmetic Procedures***	**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; ***Some eye procedures may be found under the Cosmetic Procedures***
Fertility Treatment	**NOT A COVERED BENEFIT**	**Prior Authorization Required** **(Up to three (3) cycles of Medication Only) PER ENROLLEE'S LIFETIME**
Genetic Counseling	**Prior Authorization Required**	**Prior Authorization Required**
Genetic Testing	**Prior Authorization Required**	**Prior Authorization Required**
Gender Reassignment Surgery/Transgender Surgery	**Prior Authorization Required**	**NOT A COVERED BENEFIT**
Heart Failure Clinics	**Prior Authorization Required**	**Prior Authorization Required**
Home Health Care	**Prior Authorization Required for all visits**	**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)	**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** ***SNF limited to 90 day*** ***Custodial Care (long-term care) not covered by the MCO***	**Prior Authorization Required** ***SNF limited to 30 days*** ***Custodial Care (Long-Term Care) not covered by the MCO***
Hyperbaric Oxygen	**Prior Authorization Required**	**Prior Authorization Required**
Investigational Surgery **Emerging Technology, Services, Procedures** **(Also See Clinical Trials)**	**Prior Authorization Required**	**NOT A COVERED BENEFIT**
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.	**No** Prior Authorization Required if done at an in-network freestanding lab facility. **Prior authorization required** for: Lab testing at a hospital, non contracted lab, reference lab, etc .
Medications - High Cost Med List	**Prior Authorization Required** whether being administered inpatient or outpatient for the following medications: Abecma, Actimmune, Adcetris, Oxlumo, Amondys 45, **Blincyto,** Breyanzi, Cablivi, Carvykti, Cerezyme, Cinryze, Crysvita, Danyelza, Elaprase, Empaveli, Evkeeza, Gattex, Haegarda, Hemlibra, Kimmtrak, Korlym, Krystexxa, Myalept, Nexviazyme, Novoseven, Nulibry, Onpattro, Orfadin, Orladeyo, Oxlumo, Poteligeo, Procysbi, Pyrukynd, Ravicti, Revcovi, Scemblix, Soliris, Spinraza, Takhzyro, Tepezza, Tivdak, Ultomiris, Uplizna, Viltepso, Vimizim, Vyondys 53, Vyvgart, Yervoy, Zolgensma, Zynlonta **Post-administration retropsective requests for authorization will not be accepted for review.**	**Prior Authorization Required** whether being administered inpatient or outpatient for the following medications: Abecma, Actimmune, Adcetris, Amondys 45, Blincyto, Breyanzi, Cablivi, Carvykti, Cerezyme, Cinryze, Crysvita, Danyelza, Elaprase, Empaveli, Evkeeza, Gattex, Haegarda, Hemlibra, Kimmtrak, Korlym, Krystexxa, Myalept, Nexviazyme, Novoseven, Nulibry, Onpattro, Orfadin, Orladeyo, Oxlumo, Poteligeo, Procysbi, Pyrukynd, Ravicti, Revcovi, Scemblix, Soliris, Spinraza, Takhzyro, Tepezza, Tivdak, Ultomiris, Uplizna, Viltepso, Vimizim, Vyondys 53, Vyvgart, Yervoy, Zolgensma, Zynlonta **Post-administration retropsective requests for authorization will not be accepted for review.**

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Mount Washington Pediatric Hospital Services (Weight Smart Program/Outpatient Feeding Program and Sleep Studies)	**Prior Authorization Required**	N/A - there are no children in Alliance
Neuropsychological Testing	**Prior Authorization Required**	**Prior Authorization Required**
Outpatient Rehabilitation Services **Physical Therapy (PT)** **Occupational Therapy (OT)** **Speech Language Pathology (SLP)**	**Prior Authorization Required** after >30 visits ***per calendar year***	**Prior Authorization Required** for **>30 visits *per Calendar Year***
Personal Care Aide (PCA)	**Prior Authorization Required** For Assessments (Initial/ Recertifcation/condition change): Submit **ePOF** (Electronic Prescription Order Form), along with any clinical information from the PCP/ treating Practitioner via DHCF portal	**NOT A COVERED BENEFIT**
PET Scans	**NO** Prior Authorization Required if performed at participating free-standing facilities or at contracted hospital	**NO** Prior Authorization Required if performed at participating free-standing facilities or at contracted hospital
Psychiatric Diagnostic Evaluation	**NO** Prior Authorization Required	**NOT A COVERED BENEFIT**
Private Duty Nursing	**Prior Authorization Required**	**NOT A COVERED BENEFIT**
Pulmonary Rehabilitation	**Prior Authorization Required**	**Prior Authorization Required**
Radiology: CT Scans, MRI's, X-RAYS, Nuclear Medicine, Sonograms, Digital Mammography	**NO** Prior Authorization Required **if performed a**t a participating free-standing facilities or at a contracted hospital.	**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.	**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**	**Prior Authorization Required**
Sterilization Reversals	**NOT A COVERED BENEFIT**	**NOT A COVERED BENEFIT**
Transplant Services: Pre-Transplant and Post-Transplant services Only	**Prior Authorization Required** HLA Testing for BMT requires prior authorization.	**Prior Authorization Required**
Transplant Surgery	Prior Authorization Required **BY DHCF** for the Transplant surgery. MFC-DC only covers pre and post transplant services.	**NOT A COVERED BENEFIT**
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 effecctive 10/1/2021**	**No** Prior Authorization Required for: - PAR Vendors - DC Fire and Emergency Medical Services (DC FEMS); and - Emergent/Urgent hospital to hospital transfers inside DC **Prior Authorization Required** for: - Non-PAR vendors - Non Urgent hospital to hospital transfers and other transfers **Emergency Medical Transport covered by DHCF effecctive 10/1/2021**
Durable Medical Equipment (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.	PAR providers - **Prior authorization required** for items billed > $1000 or rental equipment over 90 days. Non PAR providers - Prior authorization required regardless of cost.
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**	**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	**Prior Authorization Required** for: - All Hearing Aids - All auditory osseointergrated 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** for items billed over $750, per Enrollee/per provider/per month	**Prior Authorization Required** for items billed over $750, per Enrollee/per provider/per month
***Please visit our website at MedStarFamilyChoiceDC.com for assistance with finding an network vendor, practitioner or facility**		

***** This is a Quick Authorization Guide *****
It is not meant to be all inclusive.
For questions, please contact MedStar Family Choice-DC at: 1-(855)-798-4244; Local: (202)-363-4348

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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.

An authorizaation does not guarantee payment of service, as all claims payment rules must be followed.