

<p style="text-align: center;">MEDSTAR FAMILY CHOICE - DC QUICK AUTHORIZATION GUIDE</p> <p style="text-align: center; color: red;">Effective 05/20/2026</p>	<p style="text-align: center;">MEDSTAR FAMILY CHOICE DC Healthy Families</p>			
<p style="color: red;">ALL OUT-OF-NETWORK/ NON-PAR SERVICE</p>	<p style="text-align: center; color: red;">Prior Authorization Required</p>			
<p>Emergency Medical Conditions (ED)</p>	<p>No Prior Authorization Required for Emergency Department visits</p>			
<p>INPATIENT Admissions (in network or out of network)</p>	<p>Authorization Required</p>			
<p>INPATIENT & OUTPATIENT Admission for a Psychiatric diagnosis when the Bed Type is for Psychiatric Services (in network or out of network)</p>	<p>Prior Authorization Required</p>			
<p>OUTPATIENT In-Network (Practitioner AND Facility)</p> <p>Facility based procedures (includes outpatient Chemotherapy and Radiation Therapy)</p>	<p>No Prior Authorization Required, <u>unless included below</u> under the 'Exceptions Requiring Prior Authorization' section</p> <p>(See EXCEPTIONS below)</p>			
<p>EXCEPTIONS REQUIRING PRIOR AUTHORIZATION</p>				
<p>ABA Services</p>	<p>Prior Authorization Required</p>			
<p>Abortions</p>	<p>Elective Therapeutic Abortions are NOT A COVERED BENEFIT by MFC-DC.</p> <p>Prior Authorization Required for Medical Abortions ONLY if the Federal Criteria are met</p>			

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<p>Acupuncture for Children < 21 years old</p>	<p>Prior Authorization Required for >10 visits <i>per calendar year</i></p>
<p>Acupuncture for Enrollees ≥21 years old</p>	<p>NOT A COVERED BENEFIT</p>
<p>Audiology Services Cochlear Implants</p>	<p>Prior Authorization Required for:</p> <ul style="list-style-type: none"> - Cochlear implant (BAHA) devices. - Replacement components (except microphone, transmitting cables and transmitting coils,) - All hearing aids - All auditory osseointegrated devices <p>Auditory Rehab codes: 92626, 92627, 92630 and 92633 done by any provider type</p>

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<p>Bariatric Surgery Program - Including OP Surgeries</p>	<p>Prior Authorization Required</p>
<p>Cardiac Rehabilitation</p>	<p>Prior Authorization Required</p>
<p>Chiropractic Services for Enrollees <21 years old</p>	<p>Prior Authorization Required for >10 visits <i>per calendar year</i></p>
<p>Chiropractic Services for Enrollees ≥21 years old</p>	<p>NOT A COVERED BENEFIT</p>
<p>Clinical Trials</p>	<p>Prior Authorization Required</p>

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<p>Cosmetic procedures</p>	<p>NOT A COVERED BENEFIT</p> <p>Examples of cosmetic procedures include (but not limited to):</p> <ul style="list-style-type: none"> -Breast reduction (male or female) -Blepharoplasty -Brow ptosis -Rhinoplasty -Sclerotherapy -Septoplasty -Skin tag removal -Panniculectomy
<p>Coumadin Clinics</p>	<p>Prior Authorization Required</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 Services</p>	<p>Prior Authorization Required</p>
<p>Epidural injections (cervical and lumbar) Facet blocks Rhizotomies SI Joint</p>	<p>No Prior Authorization Required</p>
<p>Erectile Dysfunction Procedures</p>	<p>Prior Authorization Required</p>

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<p>Eye procedures and surgeries</p>	<p>Prior Authorization Required for:</p> <ul style="list-style-type: none"> -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; <p>* Some eye procedure may be found under the Cosmetic Procedures *</p>
<p>Genetic Counseling</p>	<p>Prior Authorization Required</p>
<p>Genetic Testing</p>	<p>Prior Authorization Required</p>

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<p>Gender Reassignment Surgery/Transgender Surgery</p>	<p>Prior Authorization Required</p>
<p>Heart Failure Clinics</p>	<p>Prior Authorization Required</p>
<p>Home Health Care</p>	<p>Prior Authorization Required for all visits</p>
<p>Hospice Care (IP and OP) Skilled Nursing Facility Acute Rehab Facility</p>	<p>Prior Authorization Required <i>Custodial Care (long-term care) not covered by the MCO</i></p>
<p>Hyperbaric Oxygen</p>	<p>Prior Authorization Required</p>
<p>Infertility Services</p>	<p>NOT A COVERED BENEFIT</p>

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<p>Infusion Services (in the Home and Free-Standing Facility)</p>	<p>No Prior Authorization Required for the Home Infusion Therapy or Medications from in-network provider</p>
<p>Investigational Surgery Emerging Technology, Services, Procedures (Also See Clinical Trials)</p>	<p>Prior Authorization Required</p>
<p>Laboratory Services (includes Genetic Testing)</p>	<p>No Prior Authorization Required if done at an in-network freestanding lab facility.</p> <p>Prior Authorization Required for: genetic testing, lab testing at a hospital, non contracted lab, reference lab, etc.</p>
<p>Mount Washington Pediatric Hospital Services (Weight Smart Program/Outpatient Feeding Program and Sleep Studies)</p>	<p>Prior Authorization Required</p>

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<p>Neuropsychological Testing</p>	<p>Prior Authorization Required</p>
<p>Outpatient Rehabilitation Services Physical Therapy (PT) Occupational Therapy (OT) Speech Language Pathology (SLP)</p>	<p>Prior Authorization Required <i>after >30 visits <u>per calendar year</u></i></p>
<p>Personal Care Aide (PCA)</p>	<p>Prior Authorization Required</p> <p>For Assessments (Initial/ Recertification/condition change): Submit ePOF (Electronic Prescription Order Form), along with any clinical information from the PCP/ treating physician <u>via DHCF portal</u></p>
<p>PET Scans</p>	<p>The following PET/PET CT codes require Prior Authorization: 78811, 78812, 78813, 78814, 78815, and 78816.</p> <p>All other PET scan codes do not require prior authorization if performed at a participating free-standing radiology facility or contracted hospital</p>
<p>Private Duty Nursing</p>	<p>Prior Authorization Required</p>
<p>Pulmonary Rehabilitation</p>	<p>Prior Authorization Required</p>

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<p>Radiology: CT Scans, MRI's, X-RAYS, Nuclear Medicine, Sonograms, Digital Mammography</p>	<p>The following Advanced Imaging services/codes requires Prior Authorization: Breast Imaging: 77049 Cardiac Imaging: 75561, 75571, 75572, 75574 CT/CTA:70450, 70460, 70470, 70486, 70491, 70496, 70498, 71250, 71260, 71275, 72125, 72128, 72131, 73200, 73700, 74150, 74160, 74174, 74176, 74177, 74178 MRI/MRA: 70543, 70544, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 72141, 72146, 72148, 72156, 72157, 72158, 72192, 72195, 72197, 73218, 73220, 73221, 73222, 73223, 73718, 73720, 73721, 73723, 74181, 74183 Nuclear Cardiology: 78451, 78452, 78459, 78491, 78492 PET/PET CT: 78811, 78812, 78813, 78814, 78815, 78816</p> <p>All other Radiology services and codes No Prior Authorization required if performed at participating free standing radiology facilities or a contracted hospital.</p>
<p>Site of Service Prior Authorization Requirements</p>	<p>The following codes No Prior auth required if performed in an in network Ambulatory Surgery Center POS 24. Prior auth required in Off Campus Outpatient Hospitals POS 19, On Campus Outpatient Hospital POS 22 and Out of network. CPT Codes: 29888, 42820, 43239, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45398, G0105 and G0121</p>
<p>Sleep Studies and Polysomnograms</p>	<p>No Prior Authorization Required if performed at a participating free-standing facilities or at a contracted hospital.</p>
<p>Spinal Cord Stimulators, Vagus Nerve Stimulators and Sacral Nerve and Peripheral Nerve Stimulators trial and implantation</p>	<p>Prior Authorization Required</p>
<p>Sterilization Reversals</p>	<p>NOT A COVERED BENEFIT</p>
<p>Transplant Services: Pre-Transplant and Post-Transplant services</p>	<p>Prior Authorization Required</p> <p>HLA Testing for BMT requires prior authorization.</p>
<p>Transplant Surgery</p>	<p>Prior Authorization Required BY DHCF for the Transplant surgery. MFC-DC only covers pre and post transplant services.</p>

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<p>Viscosupplementation for Knee Osteoarthritis</p>	<p>The following drugs require prior authorization. Durolane J7318 Gel-One J7326 Eufflexa J7323</p>
<p>Transportation: - Ambulance - Van Transport - Wheelchair</p>	<p>No Prior Authorization Required for: - PAR Vendors - DC Fire and Emergency Medical Services (DC FEMS); and - Urgent hospital to hospital transfers</p> <p>Prior Authorization Required for: - Non-PAR vendors - Non Urgent hospital to hospital transfers and other transfers</p> <p>Emergency Medical Transport covered by DHCF effective 10/1/2021</p>
<p>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.</p>	<p>*Visit website or contact Enrollee Services (1-888-404-3549) for in-network providers.</p>
<p>Custom shoes Diabetic Shoes Orthotics (Braces, Splints) Prosthetics</p>	<p>Prior Authorization Required per item billed over \$500 or exceeds Max Units for PAR provider.</p> <p>No Prior Authorization Required for CAM Walking Boots. The specific codes are: L4360, L4361, L4386, L4387</p>

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QUICK AUTHORIZATION GUIDE**

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***** 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.