

Appendix A
Select Diagnoses and Procedures Pre–certification List
Effective January 1, 2010*

DIAGNOSES/SYMPTOMS REQUIRING PRE–CERTIFICATION
FOR ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES MEDICAL ASSISTANCE RECIPIENTS

Diagnosis	ICD–9 CM Diagnosis Code	LOCATION		REVIEW METHOD	
		Inpatient	Outpatient	Telephonic /Fax	Clinical Records
Gastroenteritis	001.1, 002.0, 002.9, 003.0, 004.9, 005.0, 005.1, 005.9, 006.0 through 006.2, 006.9, 007.1, 007.2, 007.8, 007.9 008.00 through 008.04, 008.09, 008.1, 008.2, 008.3, 008.5, 008.8, 008.41 through 008.47, 008.49, 008.61 through 008.69, 008.8, 009.0, through 009.3, 014.80-014.86, 112.85, 487.8, 536.8, 556.0 through 556.9, 557.0, 557.1, 557.9, 558.1, 558.2, 558.3, 558.41, 558.9, 564.9, 569.9	✓		✓	
Cellulitis	682.0 through 682.9	✓		✓	
Respiratory Illness Bronchitis	466.0 through 466.19 (Children under the age of five (<i>1825 days</i>) are excluded from pre–certification. Continued Stay Review is required after day 3, as are all hospital stays.)	✓		✓	
Pneumonia	480.9 through 486 (Children under the age of five (<i>1825 days</i>) are excluded from pre–certification. Continued Stay Review is required after day 3, as are all hospital stays.)	✓		✓	
Physical Rehabilitation	V57.0, V57.1, V57.21, V57.22, V57.3, V57.4, V57.81, V57.89, V57.9	✓		✓	
All Admissions to Long Term Acute Care Facilities (LTAC)		✓		✓	

All categories on this page require the facility’s Utilization Review Department to notify Qualis Health of urgent/emergent admits within 24 hours or the next business day. The attending physician is responsible for pre-certifying any non-urgent/emergent admissions for the above diagnoses/symptoms.

PROCEDURES REQUIRING PRE-CERTIFICATION
FOR ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES MEDICAL ASSISTANCE RECIPIENTS

Procedure	ICD-9 CM Procedure Code	CPT® Code	LOCATION		REVIEW METHOD	
			Inpatient	Outpatient	Telephonic /Fax	Clinical Records
Alcohol Detoxification	94.62	90899	✓		✓	
Drug Detoxification	94.65	90899	✓		✓	
Combined Alcohol & Drug Detoxification	94.68	90899	✓		✓	
Cochlear device implantation	20.95, 20.96, 20.97, 20.98, 20.99	69930	✓	✓	✓	
Cholecystectomy	51.21 through 51.24	47562, 47563, 47564, 47600, 47605, 47610, 47612, 47620	✓	✓	✓	
Gastric Bypass for Obesity	44.31	43644, 43645, 43775 , 43845, 43846, 43847, 43848, 43850, 43886, 43887, 43888, 47740, 47741				
Laparoscopic Gastroplasty/Gastric Bypass	44.68	43645, 43843	✓	✓		✓
Gastric Adjustable Band	44.95	43845, 43770, 43771, 43772, 43773, 43774, 43842				
Duodenal Switch	43.89, 45.91	43845				
Hysterectomy (All Hysterectomies must have informed consent and meet the following criteria: <ul style="list-style-type: none"> • Patient must be over 21 years of age • Patient must be mentally competent) 						
Abdominal	68.39, 68.49, 68.69	58150, 58152, 58180, 58200, 58951, 58953, 58954, 58956, 59135, 59525	✓	✓	✓	
Vaginal	68.51, 68.59, 68.71, 68.79	58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294	✓	✓	✓	
Laparoscopic	68.31, 68.41, 68.51, 68.61, 68.71	58550, 58552, 58553, 58554, S2078, 58541, 58542, 58543, 58544, 58548, 58570, 58571, 58572, 58573, 58578	✓	✓	✓	
Radical	68.8	58210, 58240, 58548	✓	✓	✓	
Laminectomy/Diskectomy	03.02, 03.09, 80.50, 80.51	63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63050, 63051, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102, 63103, 63170, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200, 63250, 63251, 63252, 63265, 63266, 63267, 63268, 63270, 63271, 63272, 63273, 63275, 63276, 63277, 63278, 63280, 63281, 63282, 63283, 63285, 63286, 63287, 63290, 63295	✓	✓	✓	

PROCEDURES REQUIRING PRE-CERTIFICATION
FOR ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES MEDICAL ASSISTANCE RECIPIENTS

Procedure	ICD-9 CM Procedure Code	CPT® Code	LOCATION		REVIEW METHOD	
			Inpatient	Outpatient	Telephonic /Fax	Clinical Records
Division of intra-spinal nerve root-Rhizotomy	03.1	63185, 63190, 0090T, 0091T, 0092T, 0093T, 0095T, 0096T, 0098T	✓	✓	✓	
Internal fixation of bone without fracture reduction	78.59	22841	✓		✓	
Spinal Fusion (arthrodesis)	81.00 through 81.08, 81.30 through 81.39, 84.51, 84.52, 81.62, 81.63, 81.64	22585, 22614, 22632, 22800, 22802, 22804, 22808, 22810, 22812, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 22851, 27280	✓		✓	
Cervical including revision	81.01, 81.02, 81.03, 81.31, 81.32, 81.33	22548, 22554, 22590, 22595, 22600	✓	✓	✓	
Dorsal/Thoracic including revision	81.04, 81.05, 81.34, 81.35	22532, 22556, 22610	✓	✓	✓	
Lumbar/Lumbosacral including revision	81.06, 81.07, 81.08, 81.36, 81.37, 81.38	22533, 22534, 22558, 22612, 22630	✓	✓	✓	
Insertion of Spinal disc prosthesis	84.60	22851, 22852, 22855, 22857, 22862, 22864, 22865, 0090T, 0092T, 0163T				
Revision or Replacement	84.69					
Cervical						
Insertion of partial spinal disc prosthesis	84.61					
Insertion of total spinal disc prosthesis	84.62					
Revision, Replacement or Removal	84.66					
Dorsal/Thoracic						
Insertion of partial spinal disc prosthesis	84.63					
Revision or Replacement	84.67					
Lumbar/Lumbosacral						
Insertion of partial spinal disc prosthesis	84.64					
Insertion of total spinal disc prosthesis	84.65					
Revision or Replacement	84.68					
Mastopexy	85.6, 85.70, 85.71, 85.72, 85.73, 85.74, 85.75, 85.76, 85.79					
Mastectomy	85.4, 85.41	19300, 19301, 19302, 19303, 19304, 19305, 19306, 19307				
Mammoplasty (reduction)	85.31 (unilateral) 85.32 (bilateral)	19318				
Mammoplasty	85.5, 85.50	19324				
Unilateral injection to breast for augmentation	85.51	19324				

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Procedure	ICD-9 CM Procedure Code	CPT® Code	LOCATION		REVIEW METHOD	
			Inpatient	Outpatient	Telephonic /Fax	Clinical Records
Bilateral injection to breast for augmentation	85.52	19324				
Unilateral prosthetic implant	85.53	11970, 19325, 19340, 19342				
Bilateral prosthetic implant	85.54	19325, 19340, 19342				
Removal of prosthetic implant	85.94	19328, 19330				
Revision of implant of breast	85.93	19342				
Breast reconstruction with insertion of breast tissue expander	85.95	19357				
Removal of breast tissue expander	85.96	19357				
Other	85.99, 85.85, 85.87	19350, 19355, 19361, 19364, 19366, 19367, 19368, 19369, 19396				
Revision of reconstructed breast	85.53, 85.89	19342, 19380				
Unlisted procedure, breast	85.99	19499				
Unilateral Subcutaneous mastectomy with implant	85.33	19304				
Unilateral Subcutaneous mastectomy NEC	85.34	19304				
Bilateral Subcutaneous mastectomy with implant	85.35	19304				
Other bilateral subcutaneous mastectomy	85.36	19304				
Breast DIEP Flap Reconstruction	85.85	S2068				
Panniculectomy/Abdominoplasty	86.83	15830, 15847	✓	✓		✓
Total Knee Replacement	81.54	27440, 27441, 27442, 27443, 27445, 27446, 27447				
Revision of Knee Replacement	81.55, 81.59, 00.80, 00.81, 00.82, 00.83, 00.84	27486, 27487	✓		✓	
Meniscectomy, Knee (<i>Inpatient only</i>)	80.6	27332, 27333, 29880, 29881	✓		✓	
Total Hip Replacement	81.51	27130	✓		✓	
Revision-Total or Partial	81.53, 81.59, 00.70, 00.71, 00.72, 00.73, 00.74, 00.75, 00.76, 00.77, 00.85, 00.86, 00.87	27132, 27134, 27137, 27138	✓		✓	
Partial Hip Replacement	81.52	27125	✓		✓	
Total Ankle Replacement including revision	81.56, 81.59	27700, 27702, 27703	✓		✓	
Video/telemetric EEG Monitoring	89.19	95950, 95951, 95953, 95956	✓		✓	

PROCEDURES REQUIRING PRE-CERTIFICATION
FOR ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES MEDICAL ASSISTANCE RECIPIENTS

IMPORTANT COVERAGE INFORMATION ABOUT TRANSPLANTS

• **Alaska Medicaid Regulations provide for limited coverage of transplants.**

- All transplants must be medically necessary.
- Kidney/cornea/skin/bone transplants do not require preauthorization from Qualis Health
- All other covered transplants listed below require preauthorization from Qualis Health.
- Multiple organ transplants including any of the procedures below require preauthorization.

TRANSPLANTS NOT LISTED BELOW ARE NOT COVERED BY ALASKA MEDICAID.

Transplant Procedures Requiring Special Review

Procedure	ICD-9 CM Procedure Code	CPT® Code	LOCATION		REVIEW METHOD	
			Inpatient	Outpatient	Telephonic /Fax	Clinical Records
Bone Marrow Transplant (includes stem cell transplant) Autologous	41.00, 41.01, 41.04, 41.07, 41.09	38241	} Commonly performed for many leukemia's, however some cases require special review, depending on clinical circumstances.	✓	✓	
Allogenic	41.02, 41.03, 41.05, 41.06, 41.08	38240 38242				
Liver Transplant (Cadaver)	50.51, 50.59	47135, 47136				
Liver Transplant (Living Donor)	50.59	47135, 47136	✓			✓
Heart Transplant, including Artificial Heart (All ages covered, effective 8/26/08)	37.51, 37.52, 37.53, 37.54	33945	✓			✓
Lung Transplant (All ages covered, effective 8/26/08)	33.50, 33.51, 33.52	32851, 32852, 32853, 32854	✓			✓
Heart/Lung Transplant (All ages covered, effective 8/26/08)	33.6	33935	✓			✓

Other Surgical Procedures Requiring Special Review

Gastric Neurostimulator	04.92, 86.94	43647, 43648, 43881, 43882, 64590, 64595	✓	✓		✓
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