2020 CareSource Marketplace Prior Authorization List

Services That Require Prior Authorization

Services are provided within the benefit limits of the member's enrollment. They include, but are not limited to the following services:

- All Medical Inpatient Care – including Skilled Nursing Facility, Acute, Inpatient Rehabilitation, Long Term and Respite Care
- All elective surgeries
- All cosmetic procedures and plastic surgery
- Rhinoplasty
- Vagus nerve stimulation
- Diagnostic outpatient mammograms
- All clinical trials and all unproven services
- Bariatric/gastric obesity surgery
- Knee/hip replacements, knee orthoses
- Arthroscopies/arthroplasties
- Laminectomies/laminotomies
- Cervical fusions
- Laparoscopies
- UPPP surgery: (Uvulopalatopharyngoplasty)
- Coronary Artery Bypass Graft (CABG)
- All abortions
- Genetic testing
- Transcranial magnetic stimulation
- Hospice care/supportive care
- Hyperbaric oxygen therapy
- Infusion services
- Sleep studies
- With the exception to facility to facility transportation, all non-emergent ambulance requires a Prior Authorization.
- Behavioral Health Services:
    - All Inpatient Behavioral Health Admissions
      *** West Virginia Only:** Substance Abuse Disorder: The facility or office to notify CareSource of both the admission and/or initial treatment within 48 hours of the admission and/or initiation of treatment. Prior Authorization is required for stays lasting longer than 48 hours.
    - Residential treatment programs
    - Applied Behavioral Analysis (ABA)
      *** Ohio exception:** for ABA related physical rehab based outpatient services, prior authorization is only required for greater than 20 hours per week. All other ABA services in Ohio always require a prior authorization.
    - Intensive Outpatient Program (IOP)* – after 30 visits per calendar year
    - Partial Hospital Program services (PHP)* – after 30 visits per calendar year
      *** West Virginia only:** Benefits for the first five days of intensive outpatient or partial hospitalization services will be provided without any retrospective review of medical necessity.
      *** West Virginia only:** Benefits beginning day six and every six days thereafter of intensive outpatient or partial hospitalization services is subject to concurrent review of the medical necessity of the services.

- **Durable Medical Equipment** and other supplies over $500.00 billed charges, including but not limited to:
    - CPAP machines and accessories
    - Food supplements/nutritional supplements/enteral feeds greater than 30 cans per month
    - Oxygen rentals (includes CPAP, NPPV, Oxygen Tank, and Oxygen Concentrator)
    - Automated external defibrilators
    - Bone stimulators
    - Cough assist (insufflator/exsufflator)
    - High frerquency chest wall oscillator
    - Left ventricular assist device
    - Non-standard wheelchairs
    - Non-standard beds
    - Prosthetic/orthotic devices**
    - Oral appliances for obstructive sleep apnea
    - Patient transfer systems
    - Pneumatic compression devices
    - Power wheelchair repairs
    - Sleep study related equipment and supplies
    - Speech generating devices and accessories
    - Spinal cord stimulators
    - Tumor treatment field therapy
    - Ventilators
    - Wound pump
- The above $500.00 rule does not apply to the following DME/other items (these require prior authorization):
    - All powered or customized wheelchairs and accessories
    - All miscellaneous codes (example: E1399)
    - Cochlear implants
    - All DME repairs/replacements exceeding 1 calendar year require a prior authorization.
- **Home Care Services and Therapies**
    - All Home Health Aide visits
    - Skilled nurse visits greater than 3 visits per calendar year
    - Social Worker visits greater than 2 visits per calendar year
    - Occupational therapy greater than 10 visits per calendar year
    - Speech therapy greater than 10 visits per calendar year
    - Physical therapy greater than 10 visits per calendar year
- **Outpatient Therapies** – *Prior Authorization requirements for Physical Therapy, Occupational Therapy, and Speech Therapy include Habilitative, Rehabilitative, or a combo of both.*
    - Occupational therapy greater than 10 visits per calendar year
    - Speech therapy greater than 10 visits per calendar year
    - Physical therapy greater than 10 visits per calendar year
    - All manipulation/chiropractic office visits – greater than 15 visits per calendar year
- **Transplants – All organ transplants, including but not limited to:**
    - Heart transplants
    - Islet cell transplant
    - Kidney transplant
    - Liver transplant
    - Lung or double lung transplant
    - Multi-viceral transplant
    - Pancreas transplant
    - Simultaneous pancreas/kidney
    - Small bowel transplant
    - Stem cell/bone marrow transplant (with or without myeloablative therapy)

- **Pain Management**
  - **West Virginia ONLY:** ***Chronic Pain Healthcare Services*** ***** - after a total of 20 visits per calendar year. This benefit is in addition to the outpatient therapies listed above.
  - Facets
  - Epidurals
  - Facets neurotomy
  - Trigger points
  - SI joints

- **Radiology**
  - CT, CTA, MRI, MRA, PET Scans
  - Phototherapy
  - Myocardial Perfusion Imaging (MPI)
  - MUGA Scans
  - Echocardiography (Transthoracic/Transesophageal)
  - Stress Echocardiography
  - Nuclear Cardiology

Providers: Please contact NIA at the following numbers for your Marketplace state:

Ohio:	800-424-5660
Indiana:	800-424-5664
Kentucky:	800-424-5675
West Virginia:	800-424-1746
Georgia:	800-424-5358.

More detailed information is available @ www.radmd.com for *all related* prior authorization requirements, billing instructions, and how to submit prior authorization requests.

** **West Virginia Chronic Pain Services only**: PCP Office Visit Share for combined limit of 20 visits per Event for physical therapy, occupational therapy, osteopathic manipulation, a chronic pain management program, and chiropractic services stemming from chronic pain which is defined as a non-cancer, non-end of life pain lasting more than three months or longer than the duration of normal tissue healing.*

**Orthotics can be replaced once per benefit year when medically necessary. Additional replacements may be allowed if damage and unable to repair or if need driven by rapid growth and member is under 18 years of age. Excludes repair/replacement due to lost or stolen, misuse, malicious breakage, or gross neglect.

Important Information:

- Any provider who is not participating with CareSource must obtain prior authorization for all non-emergency services rendered to a CareSource member with the one exception of RAPHL providers in a participating hospital or facility.
- Providers are responsible for verifying eligibility and benefits before providing services. Except for an emergency, failure to obtain a prior authorization for the services on this list may result in a denial for reimbursement.
- Authorization is not a guarantee of payment for services.
- Both pharmacy and dental Prior Authorization lists are maintained separately.
- CareSource does not require prior authorization for unlisted procedure CPT codes; however, we require a signed, clinical record be submitted with your claim to review the validity of the unlisted procedure CPT code. Claims submitted without clinical records for unlisted procedure CPT codes will be denied. Denials will be reconsidered through the claims appeal process with pertinent clinical records and should be sent directly to claims for consideration.