Ohio Medicaid Prior Authorization List

- All Facility Care
  - Acute Medical and Behavioral Health Admissions
  - Maternity Admissions only require delivery notification
  - NICU Admissions
  - Skilled Nursing Facility Admissions
  - Rehabilitation Facility Admissions
  - Long Term Acute Care Facility Admissions
  - Institution for Mental Disease (IMD) Admissions
- Transcranial Magnetic Stimulation
- Partial Hospitalization Program (PHP) > 30 visits
- SUD Residential > 31 consecutive days for first 2 stays. This applies only for codes H2034 and H2036. Additional stays to require a prior authorization for the entire stay.
- Intensive Home Based Treatment (IHBT)
- Assertive Community Treatment (ACT)
- Applied behavior analysis (ABA)
- Home Care Services
  - Private Duty Nursing
  - Skilled Nurse visits greater than 30 visits per year
  - Home Health Aide visits
  - Physical Therapy visits greater than 10 visits per year
  - Occupational Therapy visits greater than 10 visits per year
  - Speech Therapy visits greater than 10 visits per year
  - Medical Social Worker visits greater than 10 visits per year

- Urinary Drug Testing (UDT):
  - UDT tests > 30 presumptive and/or > 12 confirmatory UDT per member per calendar year.
  - All non-participating provider or lab/facility require a PA for all tests with the exception of the emergency room setting.
  - CareSource will cover up to 12 dates of service for definitive UDT per member per calendar year. In determining medical necessity for additional tests, current clinical information will be considered as well as review of prior medical records will be performed to determine the medical appropriateness of the initial 30 presumptive and 12 definitive drug tests ordered within a year.

- Organ Transplants
- Selected Genetic Testing
- Audiology Services after 4 units per year
- Ambulance transportation – Modifier HR only
- Ambulette transportation – Modifier HR only
- All Fixed Wing Transports
- Pain Management Services
  - Facets
  - Epidurals
  - Facets Neurotomy
  - SI Joints
  - Implanted Spinal Cord Stimulators (SCS)
- Any inpatient/outpatient procedures that are potentially cosmetic or investigational

- Durable Medical Equipment:
    - All powered or customized wheelchairs and repairs
    - All manual wheelchair rentals over 3 months
    - All miscellaneous codes (example: E1399)
    - CPAPs after the first 3 months. Must submit documentation of compliance for months 4-10
    - Insulin Pumps and Glucose Monitors
    - Cranial Orthotics
    - Food supplements/nutritional supplements/enteral feeds – greater than 30 cans per month or greater than 1 can per day or >72 units per month (with the exception of B4162)
    - Speech Generating Devices
    - Defibrillators
    - Bone Growth Stimulator
    - Implantable Cardioverter-Defibrillator (ICD)
    - Chest Compression Vest and Intrapulmonary Percussive Ventilation (IPV)
    - Standing Frames
    - Stretching Devices for the Treatment of Joint Stiffness and Contracture
    - Wheel Mobility Devices
    - UV Light Therapy requires a PA in the home setting only
    - Prosthetic and Orthotic devices >$750 billed charges
    - Contact Lens- Including the fitting fee
    - Diapers over 300 per month for 20 and under and 200 per month for 21 and over
    - Hearing Aids
    - Pain pumps
- Services beyond any benefit limit for members 20 years of age and under would require a prior authorization.
- All benefits to be applied per a calendar year.

Important Information:

- Any health care provider who is not participating with CareSource must obtain prior authorization for all non-emergency services rendered to a CareSource member.
- 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.
- 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.
- Please reference our Dental Services Handbook for the Prior Authorization list for services that require review for prior authorization.

Providers: Please contact NIA at 1-800-424-5600 or their web portal @ www.radmd.com for all CT, CTA, MRI, MRA, PET Scans.