



2021 CareSource Marketplace Prior Authorization List

Prior authorization is the process used by us to determine whether the services listed below meet evidence based criteria for Medical Necessity. Your provider must get prior authorization for the listed services in order for you to receive benefits under your plan.

If you see a provider who is **not** part of CareSource's network, you or the provider must get prior authorization before **any service** is rendered, not just those listed below. Failure to do so may result in a denial of reimbursement. Exceptions include emergency services.

Services must conform to all terms and conditions of your plan including, but not limited to, eligibility, medical necessity, coverage restrictions, and benefit limitations.

Refer to your Evidence of Coverage for additional details and information around the prior authorization process.

Services That Require Prior Authorization

- All Medical Inpatient Care – including Skilled Nursing Facility, Acute, Inpatient Rehabilitation/Therapy, long term and respite care
- All elective surgeries
- All reconstructive services, including but not limited to:
 - Rhinoplasty
 - Limb deformities
 - Cleft lip and palate
 - Breast reconstruction
- Vagus nerve stimulation
- Diagnostic outpatient mammograms
- All clinical trials
- All unproven and experimental or investigational items and services (life-threatening illness exceptions)
- Oral surgery that is dental in origin for adults
- Bariatric/gastric obesity surgery
- Knee/hip replacements, knee orthoses
- Arthroscopies/arthroplasties
- Laminectomies/laminotomies
- Cervical fusions
- Laparoscopies
- UPPP surgery: (Uvulopalatopharyngoplasty)
- Coronary artery bypass graft (CABG)
- Abortions
- Genetic testing in some situations
- Hospice supportive care including medical social services (i.e., bereavement)
- Hyperbaric oxygen therapy
- Infusion services
- Sleep studies

- Long-term antibiotic treatment for Lyme Disease
- Voluntary sterilizations
- Gender dysphoria services including but not limited to gender transition surgeries
- All treatments and services associated to temporomandibular or craniomandibular joint disorder and craniomandibular jaw disorder
- Oral nutrition (for medical purposes) and enteral nutritional therapy
- Maternal Delivery and inpatient stay if scheduled less than 39 weeks or if stay exceeds 48 hours for vaginal or 96 hours for cesarean delivery.
- With the exception of facility-to-facility transportation, all non-emergent ambulance services.
- Urine drug testing after 30 presumptive and/or 12 confirmatory
- Autism spectrum disorder treatment – including applied behavioral analysis (ABA) therapy.

- **Behavioral Health Services:**
 - All inpatient stays*
 - * **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.
 - Partial hospital program services (PHP)^
 - Intensive outpatient program (IOP)^ – after 15 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.
 - Transcranial magnetic stimulation
 - Outpatient mental health therapy
 - Children after 20 visits per calendar year
 - Adults after 20 visits per calendar year
 - Residential treatment services

- **Medical Supplies, Durable Medical Equipment (DME), and Appliances**
 - The following **always** require a prior authorization:
 - All powered or customized wheelchairs and associated accessories
 - Insulin infusion device
 - All miscellaneous codes (example: E1399)
 - Cochlear implants including any replacements. PA will also consider the post-cochlear implant aural therapy
 - CPAP and NPPV machines
 - All DME repairs/replacements exceeding 1 calendar year
 - Enteral feeding – if greater than 72 units per day
 - Parenteral feeding
 - Donor milk
 - Left ventricular artificial device (LVAD)
 - Emergency response system
 - Automatic medication dispenser

- The majority of remaining DME and supplies require prior authorization when over \$500.00 billed charges, including but not limited to:
 - Food supplements/nutritional supplements
 - Automated external defibrillators
 - Bone stimulators
 - Cough assist (insufflator/exsufflator)
 - High frequency chest wall oscillator
 - Hospital beds
 - Prosthetic/orthotic devices**
 - Oral appliances for obstructive sleep apnea
 - Patient transfer systems
 - Pneumatic compression devices
 - Power wheelchair repairs
 - Speech generating devices and accessories
 - Spinal cord stimulators
 - Tumor treatment field therapy
 - Ventilators
 - Wound pump

***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.*

- **Home Care Services and Therapies**

- All home health aide visits including private duty nursing (PDN not covered in Georgia)
- Skilled nurse visits greater than 3 visits per calendar year
- Social worker visits greater than 2 visits per calendar year
- Infusion therapy including chemotherapy
- Occupational therapy
- Speech therapy
- Physical therapy

- **Outpatient Therapies** – *Prior authorization requirements for include Habilitative, Rehabilitative, or a combination of both.*

- Occupational therapy
- Speech therapy
- Physical therapy
- All manipulation/chiropractic office visits – greater than 15 visits per calendar year
- Cardiac rehabilitation therapy
- Cognitive rehabilitation therapy
- Pulmonary rehabilitation therapy
- Inhalation therapy

- **Physical Medicine and Rehabilitation Services** including day rehabilitation and acute inpatient rehabilitation facility stays

- **Transplants – All organ transplants, including but not limited to:**

- Heart transplants
- Islet cell transplant
- Kidney transplant
- Liver transplant
- Lung or double lung transplant

- Multivisceral transplant
 - Pancreas transplant
 - Simultaneous pancreas/kidney
 - Small bowel transplant
 - Stem cell/bone marrow transplant (with or without myeloablative therapy)
 - Transportation & lodging costs
 - Bone marrow/stem cell donor search fees
- **Pain Management**
 - Epidural steroid injections
 - Trigger point injections
 - Implantable pain pump
 - Implantable spinal cord stimulator
 - Sacroiliac joint procedures
 - Sacroiliac joint fusion
 - Facet joint interventions
 - **West Virginia ONLY: Chronic Pain Healthcare Services** * - This benefit is in addition to the Outpatient Therapies listed above.

** West Virginia Chronic Pain Services only: PCP Office Visit cost 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.*

- **Radiology**
 - Advanced imaging including CT, CTA, MRI, MRA, PET Scans
 - Phototherapy
 - Myocardial perfusion imaging (MPI)
 - MUGA scans
 - Echocardiography (transthoracic/transesophageal)
 - Stress echocardiography
 - Nuclear cardiology

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

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

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

- **Pediatric Dental Services**
 - Precertification estimate is recommended for any service in excess of \$300
 - Intraoral complete set of radiographic images including bitewings & Panoramic radiographic image if done within sixty (60) months of the previous service
 - All onlays and crowns (excluding pre-fabricated crowns)

- Any core build up
 - Any post and/or core
 - Labial veneer
 - Inlay, onlay, veneer, or crown repair (excluding re-cements)
 - Apexification/recalcification
 - Apicoectomy/periradicular surgery
 - Root amputation and any hemisection
 - All Class III periodontics, removable and fixed prosthodontics, and implants
 - All Class III oral & maxillofacial surgery services with exception to surgical removal of erupted tooth and incision and drainage of abscess
 - All Class IV Orthodontics
 - Deep sedation/general anesthesia and intravenous moderate sedation
 - Therapeutic parenteral drug
 - Treatment of complications (post-surgical) unusual circumstances
 - Occlusal guard
- **Adult Dental Services**
 - Where coverage is available*
 - Precertification estimate is recommended for any service in excess of \$300
 - Intraoral complete set of radiographic images including bitewings and panoramic radiographic image if done within sixty (60) months of the previous service
 - All onlays and crowns (excluding pre-fabricated crowns)
 - Any core build up
 - Any post and/or core
 - Inlay, onlay, veneer, or crown repair (excluding re-cements)
 - Apexification/recalcification
 - Apicoectomy/periradicular surgery
 - Root amputation and any hemisection
 - All Class III periodontics, removable and fixed prosthodontics, and implants
 - All Class III oral and maxillofacial surgery services with exception to surgical removal of erupted tooth and incision and drainage of abscess
 - Deep sedation/general anesthesia and intravenous moderate sedation
 - Therapeutic parenteral drug
 - Treatment of complications (post-surgical) unusual circumstances
 - Occlusal guard
- **Pharmacy Services**
 - Selected covered prescription drugs on the Prescription Drug Formulary may require prior authorization to ensure medical necessity and safe for use. The specific drugs are indicated on the Prescription Drug Formulary and in our Find My Prescriptions online tool, both which can be found at: <https://www.caresource.com/plans/marketplace/benefits-services/pharmacy/preferred-drug-list/> (Once there, select your plan state). In the formulary, those drugs requiring review prior to coverage will be indicated by the following abbreviations:
 - Clinical Prior Authorizations (PA)
 - Quantity and Dosing Limits (QL)
 - Step Therapy (ST)
 - Any non-formulary drugs require a formulary exceptions review to ensure they are medically necessary instead of covered formulary drugs offered by your plan. Non-formulary drugs are any prescription drug which are not listed on the Formulary.

Additional Important Information:

- Providers are responsible for verifying eligibility and benefits before providing services.
- 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.

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