2021 CareSource Prior Authorization List

CareSource Advantage® (HMO), CareSource Advantage® Zero Premium (HMO) and CareSource Dual Advantage™ (HMO D-SNP) Plans

Prior authorization is how we decide if the health services listed below will be covered by your CareSource plan. Your provider must get prior authorization **before** you get any of these services. The services must be evidence-based and medically necessary for your care. They must also fall within the terms of your health plan. Emergency care does **not** need prior authorization.

If your provider is **not** part of the CareSource network, you or the provider must get prior authorization before you get ***any service***, not just those listed below. Your care may not be covered if you do not get prior authorization.

Services That Require Prior Authorization

- All Medical Inpatient Care – including Skilled Nursing Facility, Acute, Inpatient Rehabilitation/Therapy, long term and respite care
- Service provided by All Out of Network providers
- Elective surgeries (outpatient and inpatient)
- Reconstructive and/or potential cosmetic services, including but not limited to:
    - Rhinoplasty
    - Most limb deformities
    - Cleft lip and palate
- All clinical trials
- All unproven, 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, some knee orthoses
- Arthroscopies/arthroplasties
- Laminectomies/laminotomies
- Spinal fusions
- Laparoscopies
- UPPP surgery (Uvulopalatopharyngoplasty)
- Coronary artery bypass graft (CABG)
- Genetic testing in some situations
- Hyperbaric oxygen therapy
- Sleep studies outside of home setting
- Voluntary sterilizations
- Gender dysphoria services including but not limited to gender transition surgeries
- Treatments and services associated to temporomandibular or craniomandibular joint disorder and craniomandibular jaw disorder
- Maternity: Delivery and inpatient stay if scheduled less than 39 weeks or if stay exceeds 48 hours for vaginal or 96 hours for cesarean delivery.
- Non-emergent ambulance services.

Behavioral Health Services:

- All inpatient services
- Transcranial Magnetic Stimulation (TMS)

Medical Supplies, Durable Medical Equipment (DME), and Appliances
The following **always** require a 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.

The majority of remaining DME and supplies require prior authorization when over $500 billed charges. This includes but is 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 Defibrillators
- Bone stimulators
- Cough assist (Insufflator/Exsufflator)
- High frequency 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
-

***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

- Home Health aide visits
- Private duty nursing (PDN)
- 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, *Including but not limited to:*

- Occupational Therapy visits greater than 10 visits per calendar year
- Speech Therapy visits greater than 10 visits per calendar year
- Physical Therapy visits greater than 10 visits per calendar year
- Cardiac Rehabilitation Therapy
- Cognitive Rehabilitation Therapy
- Pulmonary Rehabilitation Therapy
- All Manipulation/Chiropractic Office Visits – greater than 15 visits per calendar year

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

Transplants, including but not limited to:

- Heart
- Islet cell transplant
- Kidney transplant
- Liver transplant
- Lung or double lung transplant
- Multiviceral 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
- Facet joint interventions
- Facets Neurotomy

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 1-800-424-5660 or their web portal at www.radmd.com for all CT, CTA, MRI, MRA or PET scans. Additional services requiring a prior authorization include myocardial perfusion imaging (MPI), MUGA scan, Echocardiography and Stress Echocardiography

Additional Important Information:

- Providers are responsible for verifying eligibility and benefits before providing services.
- Authorization is not a guarantee of payment for services.

Y0119_Multi-MA-M-294961_C