2024 CareSource Prior Authorization List

Prior authorization is the process used by CareSource 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. West Virginia members may qualify for an episode of care.

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 Acute, Skilled Nursing Facility, Inpatient Rehabilitation/Therapy, Long Term and Respite Care, Inpatient Hospice
- Out-of-Network services (excluding emergency services)
- Some elective surgeries (outpatient and inpatient)
- Transplant evaluations
- All transplants and services related to transplants:
    - Services related to transplants:
        - Transportation & lodging costs
        - Bone marrow/stem cell donor search fees
- Maternity:
    - Scheduled delivery less than 39 weeks
    - If stay exceeds 48 hours for vaginal or 96 hours for cesarean delivery
- Reconstructive and/or potential cosmetic services, including but not limited to:
    - Rhinoplasty
    - Breast reduction
    - Most limb deformities
    - Cleft lip and palate
- All unproven, experimental or investigational items and services (life-threatening illness exceptions)
- Bariatric/gastric obesity surgery
- Clinical trials
- Some genetic testing and some Laboratory services
- Gender dysphoria services including but not limited to gender transition surgeries
- Hyperbaric oxygen therapy
- Non-emergent ground and air transportation. Please note this includes all non-emergent transportation between facilities.
- Oral surgery that is dental in origin
- Sleep studies outside of the home setting
- Treatments and services associated to temporomandibular or craniomandibular joint disorder and craniomandibular jaw disorder

Behavioral Health Services:

- All inpatient stays
- Residential treatment services
    - Mental Health Diagnoses
    - Substance Use Disorder (SUD)
- Partial hospital program services (PHP) greater than five days
    - Benefits for the first five days of intensive outpatient or partial hospitalization services will be provided without any retrospective review of medical necessity.
    - 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.
- Intensive outpatient program (IOP) greater than five days
    - Benefits for the first five days of intensive outpatient or partial hospitalization services will be provided without any retrospective review of medical necessity.
    - 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
- Psychiatric diagnostic evaluation greater than 1

Medical Supplies, Durable Medical Equipment (DME), and Appliances

The following **always** require a prior authorization:

- All custom equipment
- All miscellaneous or unspecified codes (example: E1399)
- Cochlear implants including any replacements
- Cranial remodeling helmets
- Donor milk
- Left Ventricular Assist Device (LVAD)
- Oral appliances for obstructive sleep apnea
- Enteral nutrition and supplies
- Patient transfer systems/Hoyer lifts
- Phototherapy beds (Bili beds)
- Power wheelchair repairs
- Prosthetics/specified orthotics
- Speech generating devices and accessories
- Spinal cord stimulators
- Wheelchairs and some associated accessories
- All rental/lease items, including but not limited to:
    - CPAP/BiPAP
    - NPPV machines
    - Apnea Monitors
    - Ventilators
    - Hospital beds
    - Specialty mattresses
    - High frequency chest wall oscillators
    - Cough assist/stimulating device
    - Pneumatic compression devices
    - Infusion pumps
- Wound Vacs

Home Care Services and Therapies

- No prior authorization required for assessments/evaluations
- Home Health aide visits
- Private Duty nursing (PDN) *not covered in Georgia
- Skilled nurse visits
- Social worker visits
- Occupational therapy Speech therapy Physical therapy

Outpatient Therapies – *Prior authorization requirements for Habilitative, Rehabilitative, or a combination of*

- No prior authorization required for assessments/evaluations
- Occupational Therapy visits
- Speech Therapy visits
- Physical Therapy visits
- Cognitive rehabilitation therapy
- Pulmonary rehabilitation therapy

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

Pain Management

- Epidural steroid injections
- Trigger point injections
- Implantable pain pump
- Implantable spinal cord stimulator
- Facet sacroiliac joint procedures
- Sacroiliac joint fusion
- Facet joint interventions
- Chronic Pain Healthcare Services -This benefit is in addition to the Outpatient Therapies listed above: *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

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
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Pharmacy Services

- Some covered prescription drugs require prior authorization. Prior authorization helps promote appropriate and safe utilization and enforcement of guidelines for Prescription Drug Benefit coverage. Covered drugs are found on the Prescription Drug Formulary and in the “Find My Prescriptions” online search tool. If a covered prescription drug requires review prior to coverage, you will see one or more of the following abbreviations:
    - PA (indicating a clinical prior authorization is required for the drug)
    - QL (indicating a quantity or dose limit for the drug)
    - ST (indicating a step therapy requirement for the drug)

- Prescription drugs that are not on the Prescription Drug Formulary are called non-formulary drugs. non-formulary drugs always require a formulary exception review and approval in order to be covered by CareSource. You, your authorized representative, or your prescribing physician may request a formulary exception review. Exception reviews determine if the non-formulary drug is Medically Necessary instead of available covered drugs on the Prescription Drug Formulary.

- You can find both the Prescription Drug Formulary and the Find My Prescriptions online search tool here.

Additional Important Information:

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