2025 CareSource Prior Authorization List

CareSource® MyCare Ohio (Medicare-Medicaid Plan)

Some health care services require your provider to get approval from CareSource before you can get the service. This is called prior authorization. We do this to make sure the care you get is appropriate and necessary. Your provider must get prior authorization for you to receive the services listed below. **Emergency care does not need prior authorization.**

CareSource works with certain doctors and providers to get you care. We call these in-network providers. To have your health care services covered by CareSource, you must go to an in-network provider. If your provider is **not** part of the CareSource network, you or the provider must get prior authorization or approval before you get ***any service***, not just the ones listed below. If you don't do this, you may not get reimbursed. Exceptions include emergency services.

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

Services That Require Prior Authorization or Approval

- All medical inpatient care including:
  - Acute
  - Skilled nursing facility
  - Inpatient rehabilitation/therapy
  - Long term and respite care
  - Inpatient hospice
- All out of network services
- Some elective surgeries (e.g., outpatient and inpatient)
- Transplant evaluations
- All transplants and services related to transplants:
  - Services related to transplants:
    - Transportation and 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 or c-section 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 (e.g., life-threatening illness exceptions)
- Bariatric/gastric obesity surgery
- Clinical trials
- Some radiation/oncology services
- 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. *Note: This includes all non-emergency 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
- Urine drug screening
- Part B drugs

Behavioral Health Services

- All inpatient stays
- Partial hospitalization program (PHP) services
- Transcranial magnetic stimulation (TMS)
- Substance use disorder (SUD) residential (prior authorization after 30-days for the first two admissions in a calendar year and initially for a third admission in a calendar year.)
- Assertive community treatment (ACT)
- Applied behavioral analysis (ABA)
- Intensive home-based treatment (IHBT)
- Opioid treatment program (OTP) services

Medical Supplies, Durable Medical Equipment (DME) and Appliances

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

- All custom equipment
- All miscellaneous codes (e.g., E1399)
- Cochlear implants
- Diabetic supplies
- Left ventricular assist device (LVAD)
- Oral appliances for obstructive sleep apnea
- Enteral nutrition and supplies
- Patient transfer systems and Hoyer lifts
- Power wheelchair repairs
- Prosthetics/specified orthotics
    - 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.
- Speech generating devices and accessories
- Spinal cord stimulators
- All powered or customized wheelchairs and 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 oscillator
    - Cough assist stimulating devices

    - Pneumatic compression devices
- Wound vacs (pump)
- All DME repairs/replacements exceeding 1 per calendar year require a prior authorization.

Home Care Services and Therapies

- No prior authorization required for assessments/evaluations
- Home health aide visits
- Private duty nursing (PDN)
- Skilled nurse visits
- Social worker visits
- Occupational therapy
- Speech therapy
- Physical therapy

Outpatient Therapies

Prior authorization requirements include habilitative, rehabilitative or a combination of both.

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

Physical Medicine and Rehabilitation Services

Including day rehabilitation and acute inpatient rehabilitation facility stays.

Pain Management

- Acupuncture
- Epidural steroid injections
- Trigger point injections
- Implantable pain pump
- Implantable spinal cord stimulator
- Facet sacroiliac joint procedures
- Sacroiliac joint fusion
- Facet joint interventions

Radiology

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

Dental Services

- Crowns and posts
- Dentures/partials
- Gum care (Periodontics)
- Surgical extractions
- Medicare dental services
- Preventive services (cleanings and exams)

Additional Important Information:

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

We will work with your provider if you need approval for any of the services listed above. If you have questions or need more information about any of these services, reach out to your provider. You can also call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711).**

CareSource® MyCare Ohio (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.

MyCareOhio
Connecting Medicare + Medicaid

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