2018 MyCare Prior Authorization List

Services are provided within the benefit limits of the member's enrollment:

- All Inpatient Care including Skilled Nursing Facility, Acute, Inpatient Rehab, Long Term Acute Care (LTAC), and Respite Care
- All Inpatient Behavioral Health Admissions
- Transcranial Magnetic Stimulation
- Intensive Outpatient Program Services
- Intensive Home Based Treatment (IHBT)
- Assertive Community Treatment (ACT)
- Substance Use Disorder (SUD) Partial Hospitalization Program (PHP) > 30 visits per calendar year
- SUD Residential > 31 consecutive days for the first 2 stays. Additional stays to require a prior authorization for the entire stay.

**There are no benefit limits for the above services.*

- Ambulance/Ambulette transportation - with HR modifier
- Fixed Wing (Airplane) Transportation
- Chiropractic visits greater than 15 per calendar year
- Contact Lens and Fittings
- Cosmetic procedures and plastic surgery
- Dental Services: please reference our Dental Services Handbook for a list for services that require review for prior authorization, https://www.caresource.com/providers/ohio/
- Durable Medical Equipment over $750 billed charges
    - All powered or customized wheelchairs
    - All miscellaneous codes (i.e.: E1399)
    - All CPAPs
- Food supplements/nutritional supplements/enteral feeds greater than 30 cans per month
- Genetic Testing
- Hearing Aids
- Homecare Services:
    - All Private Duty nursing hours
    - All Home Health Aide visits
    - Skilled Nurse visits greater than 3 visits/year
    - Physical Therapy visits greater than 3 visits/year
    - Occupational Therapy visits greater than 3 visits/year
    - Speech Therapy visits greater than 3 visits/year
    - Social Worker visit greater than 2 visits/year

- Hospice Care
- Skilled Nursing Facility Services
- Occupational Therapy visits greater than 30 per calendar year in an outpatient setting and under Part B
- Organ transplants
- Pain Management Services
    - Facets
    - Epidurals
    - Facets Neurotomy
    - Trigger Points
    - SI Joints
- Partial Hospitalization Program services greater than 30 visits per calendar year
- Physical Therapy visits greater than 30 per calendar year in an outpatient setting and under Part B
- Prosthetic/Orthotics devices over $750.00 billed charges
- Speech Therapy visits greater than 30 per calendar year in an outpatient setting and under Part B

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 with the one exception of RAPHL providers.
- 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 Only: Please contact NIA at 1-800-424-5600 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.