Referral and Prior Authorization
You can get many services without a referral from your primary medical provider (PMP). This means that your PMP does not need to arrange or approve these services for you. Services that do not require a referral mean that you can go to any of our participating health partners for services needed, for example:

- Dentist (teeth care)
- Optometrist (eye care)
- Obstetrician/Gynecologist (female care)
- Psychologist (mental health care)
- Chiropractor (back care)
- Podiatrist (foot care)

Other services require a referral. That means you must get an okay from your PMP before you can receive the service. The PMP will do one of the following:

- Arrange the services for you
- Give you a written okay to take with you when you get the service
- Tell you how to get the service

Some services require a referral from your PMP and a prior authorization from CareSource before you can get them. This means that your PMP has to okay the service and get an okay from CareSource too. Your PMP will ask for a prior authorization from us then schedule these services for you. If you are seeing a specialist, he/she will get approval from your PMP then your appointment or services will be scheduled. Examples of these services are:

- Home health services
- In-patient hospital services – (Emergency services do not require a referral or prior authorization)
- Nursing facility services for a short-term rehabilitative stay
- Hospice care (care for terminally ill, e.g., cancer patients)
- Some durable medical equipment, including hearing aids
- Orthotics/prosthetics
- Some pain management services
- Services from an out-of-network provider

CareSource covers all medically necessary Medicaid-covered services that are included in the Hoosier Healthwise or Healthy Indiana benefit plans. They are covered at no cost to you.

INDIANA MEDICAID PRIOR AUTHORIZATION LIST

- All Inpatient Services
- All Inpatient Rehabilitative Service
- Applied behavior analysis therapy services (ABA)
- All Inpatient Behavioral Health admissions
- Applied Behavior Analysis (ABA)
- Transcranial Magnetic Stimulation
- Intensive Outpatient Program Services
- Partial Hospital Program Services

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

- Durable Medical Equipment:
  - All powered or customized wheelchairs and supplies
    - Wheelchair repairs
  - All DME miscellaneous codes (example: E1399)
  - CPAPs greater than 3mos
  - Insulin Pumps and CGMs
  - Cranial Orthotics
  - Food supplements/nutritional supplements/enteral feeds – greater than 30 cans per month or greater than 1 can per day
  - Speech Generating Devices
  - Defibrillators
  - Bone Growth Stimulation
  - Implantable Cardioverter-Defibrillator (ICD)
  - Implanted Spinal Cord Stimulators (SCS)
  - Chest Compression Vest and Intrapulmonary Percussive Ventilation (IPV)
  - Pneumatic Artificial Voicing Systems
  - Standing Frames
  - Stretching Devices for the Treatment of Joint Stiffness and Contracture
  - Wheel Mobility Devices
  - UV Light Therapy
- Prosthetic and Orthotic devices >$1200
- Fixed Wing Transports
- Ambulance Transport – non-emergent
- Genetic Testing
- Hearing Aids
- Home Health Care Services
- Intensive Outpatient Program (IOP) greater than 30 visits
- Skilled Nursing Facility Services
- Organ Transplants
- Outpatient Services:
  - Cosmetic/Plastic/Reconstructive Procedures
  - Spinal Cord Stimulators
  - Implantable Pain Pumps
- Pain Management Services
  - Facets
  - Epidurals
  - Facets Neurotomy
  - SI Joints
- Partial Hospitalization Program (PHP) greater than 30 visits
- Residential services
- Services beyond benefit limits for members 20 years of age and under
- Gender Dysphoria Surgeries

Any surgery or procedures that are potentially cosmetic or investigational will require a prior authorization.

Please reference our Dental Quick Reference Guide for the prior authorization list for dental services.

For advanced imaging ordering health partners must obtain prior authorization for the following outpatient, non-emergent diagnostic imaging procedures:

- MRI/MRAs
- CT/CTA scans
- PET scans

Ordering health partners can obtain prior authorization from NIA for imaging procedures at RadMD's website or by calling 1-800-424-1741 and following the appropriate menu options.

Any health care partners who are not participating with CareSource must obtain prior authorization for all non-emergency services rendered to a CareSource member.

CareSource does not require Prior Authorization for unlisted procedure CPT codes; however, we require a 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 appeal process with pertinent clinical records.

IN-MMED-1809; Date Issued 8/23/2017 OMPP Approved 8/23/217