



2027 WI Marketplace
Prior Authorization List

2027 CareSource Prior Authorization List
CareSource®

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.

Procedures and services
All Medical Inpatient Care – including Acute, Skilled Nursing Facility, Inpatient Rehabilitation/Therapy, Respite Care when member receives Hospice and Inpatient Hospice.
Elective surgeries (outpatient and inpatient)



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Reconstructive and/or potential cosmetic services including, but not limited to:
• Abdominoplasty • Rhinoplasty • Breast Reduction/Reconstruction • Blepharoplasties • Most limb deformities • Panniculectomy • Procedure for Deviated Nasal Septum • Cleft lip and palate
All clinical trials
All unproven, experimental or investigational items and services
Oral surgery that is dental in origin
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
Some laboratory services
Hyperbaric oxygen therapy
Sleep studies outside of home setting
Voluntary sterilizations



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Treatments and services associated with temporomandibular or craniomandibular joint disorder and craniomandibular jaw disorder
Maternity: Delivery and inpatient stay if scheduled for less than 39 weeks or if stay exceeds 48 hours for vaginal or 96 hours for cesarean delivery.
Non-emergency ambulance services
Some radiation/oncology services
Cardiac diagnostic outpatient and inpatient implantable procedures; including cardiac catheterization, pacemakers, valve procedures
Some miscellaneous or not otherwise classified (NOC) procedures
Termination of Pregnancy
Some Hearing Services
Some Vision services
Medical Formulas
Some radiation/oncology services
Some Varicose Vein procedures
Diagnostic Labs
Urine Drug Testing (UDT)
Applied Behavioral Analysis
Behavioral Health
All inpatient services
Some Outpatient services
Residential treatment services
Partial Hospitalization Program (PHP) services (After 5 days per plan year for both Mental Health and Substance Use Disorder)
Psychiatric Diagnostic Evaluation (Greater than 1 per plan year)



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Intensive Outpatient Program/Treatment (IOP/IOT) services (After 5 days per Plan year for both Mental Health and Substance Use Disorder)
Transcranial Magnetic Stimulation (TMS)
Intensive Home-Based Treatment (IHBT)
Community Support services (After 30 initial visits per plan year)
Substance Use Disorder (SUD) Residential
Opioid Treatment Program (OTP)
Intensive Customized Care (IC3)
Durable Medical Equipment (DME)
Wheelchairs and some associated accessories
All custom equipment
Insulin infusion device
Continuous Glucose Monitors
Oral nutrition (for medical purposes) and enteral nutritional therapy
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



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• Speech generating devices and accessories • Infusion pumps
Miscellaneous codes (example: E1399)
Cochlear implants including most replacements. PA will also consider the post cochlear implant aural therapy
Cranial remodeling helmets
Donor milk
Left Ventricular Assist Device (LVAD)
Wound Vacs
All DME Repairs/Replacements exceeding 1 calendar year require prior authorization.
Prosthetic/orthotic devices • Orthotics can be replaced once per benefit year when medically necessary. • Additional replacements may be allowed if damage and unable to be repaired or if need driven by rapid growth and members are under 18 years of age. Excludes repair/replacement due to lost or stolen, misuse, malicious breakage, or gross neglect.
Enteral nutrition and supplies
Oral appliances for obstructive sleep apnea
Patient transfer systems/Hoyer lifts
Phototherapy beds (Bili beds)
Power wheelchair repairs
Skin and soft tissue substitutes for wounds (Skin Substitutes)
Some DME (medical supplies)



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Spinal cord stimulators	
Home Care Services and Therapies	
No prior authorization required for assessments/evaluations	
Home Health aide visits	
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	
Some outpatient therapy/services	
Post cochlear implant aural therapy	
Manipulation Therapy (Chiropractic/Physical Therapy)	
Transplants and Related Services	
Heart	
Islet cell transplant	
Kidney transplant	
Liver transplant	
Lung or double lung transplant	
Multivisceral transplant	
Pancreas transplant	
Simultaneous pancreas/kidney	
Small bowel transplant	



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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
Facet sacroiliac joint procedures
Most sacroiliac joint procedures
Sacroiliac joint fusion
Chronic Pain Healthcare Services- in addition the OP therapies listed above.
Most facet joint interventions
Prior Authorization Requirements with our Partners
Radiology- Evolent or their web portal at www.radmd.com
Advanced Imaging including CT, CTA, MRI, PET Scans
Phototherapy
Myocardial perfusion imaging
MUGA scans
Echocardiography (transthoracic/transesophageal)
Stress echocardiography
Nuclear cardiology



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Turning Point - Turning Point or their web portal at www.myturningpoint-healthcare.com
Select Cardiac Services
Select Musculoskeletal Services
EyeMed - or their web portal at www.eyemed.com
Some vision services

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 “Price A Medication” 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 to be covered by CareSource. You, your authorized representative, or your prescribing physician may request a formulary exception review to determine if the Non-Formulary drug is clinically appropriate.

You can find both the Prescription Drug Formulary and the Price A Medication online search tool at this link: <https://www.caresource.com/plans/marketplace/benefits-services/pharmacy/preferred-drug-list/>.

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