2026 CareSource Prior Authorization List

CareSource Dual Advantage™ (HMO D-SNP)

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
  - 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.*
- Select Part B Drugs
- Oral surgery that is dental in origin
- Medicare-covered dental services and implants
- 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
- Transcranial magnetic stimulation (TMS)
- Partial Hospitalization Program (PHP) services
- Opioid treatment program (OTP) services
- Substance Use Disorder (SUD)
- Intensive Outpatient Services (IOP)

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
- Continuous glucose monitors
- 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

- 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

Pharmacy Services

- The plan has a formulary or Drug List. It tells you which Part D prescription drugs are covered under the Part D benefit of the plan. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare. For drugs that are not on the

formulary you, your authorized representative, or prescriber can ask us for a formulary exception.

- Some prescription drugs on our formulary have special rules or restrictions like prior authorization (PA), step therapy (ST), or quantity limits (QL). Special rules restrict how and when HAP CareSource covers them. The same team of doctors and pharmacists developed these rules to encourage you and your prescriber to use drugs in the most effective way and are approved by Medicare.

- You can look up drugs on our formulary or by using “Find My Prescriptions” online search tool (links below). We tell you which drugs have restrictions, including:
    - **Prior authorization** (PA) For certain drugs, you or your prescriber need to get approval from the plan before we will agree to cover the drug for you.
    - **Step therapy** (ST) This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition and Drug A is less costly, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B.
    - **Quantity Limits** (QL) For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.
- You can find both the formulary and the Find My Prescriptions online search tool at this link: www.caresource.com/ga/plans/dsnp/plan-documents/

Additional Important Information:

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