



Authorization List

The primary objective of prior authorization review is to facilitate the provision of cost-efficient, effective and quality services to our MDwise Hoosier Alliance members.

Prior-Authorization:

1. **Services by out-of-network physicians / providers / facilities**
2. **Hospital inpatient admissions (including Skilled Nursing, Rehabilitation, Burn Unit admissions)**
3. **Hospital observation admissions**
4. **Specified surgical services:**
 - a. Bariatric surgery
 - b. Reduction mammoplasty
 - c. Podiatric surgeries
 - d. Maxillofacial surgeries including TMJ
 - e. Reconstructive or plastic surgeries that may be considered cosmetic
 - f. Surgery for sleep apnea (UPPP, LAUP)
 - g. Transplants
 - h. Hysterectomy
 - i. Tonsillectomy
 - j. Adenoidectomy
 - k. Myringotomy with / without tubes
5. **Specified Chiropractic services**
 - a. Muscle testing
 - b. Temperature gradient studies
One (1) study, one (1) unit of service, per member, per 30-day period does not require PA
6. **Specified Specialist services**
 - a. All out of network specialist services
 - b. Pain management evaluation and treatment
 - c. Transplant specialty referrals and work-up
7. **DME**
 - a. DME with a purchase price > \$500.00
 - b. All miscellaneous DME codes (i.e. E1399)
 - c. DME rental items
8. **Orthotics / Prosthetics**
 - a. Orthotic / Prosthetic with a purchase price > \$500.00
 - b. All miscellaneous Orthotic / Prosthetic codes (i.e.L1899)
9. **Therapy (Occupational, Physical, Respiratory, and Speech)**
 - a. Initial evaluation is exempt from authorization
 - b. Therapy services post-hospitalization are exempt from authorization with proof of physician's order attached to submitted claim, not to exceed thirty (30) units within thirty (30) calendar days post discharge.
 - c. All other therapy services require authorization
10. **Home Health**
 - a. Home health post-hospitalization is exempt from authorization with proof of physician's order attached to submitted claim, not to exceed one hundred twenty (120) units within thirty (30) calendar days post discharge.
 - b. All other home health services require authorization
11. **Diagnostic Imaging**
 - a. CT Scans
 - b. MRI
 - c. PET Scans
12. **Home Infusion, including Hemophilia Factor medication**
13. **Air Ambulance**

NOTE: A sleep study is considered an outpatient service, and requires an authorization if performed in a non-contracted location.

Notification:

1. Maternity related inpatient admissions
2. Maternity related observation admissions
3. NICU related inpatient admissions

Retrospective / Concurrent Review:

1. All services listed above may be subject to retrospective and / or concurrent review.
2. Services not specifically listed above may be subject to retrospective and / or concurrent review