MDwise St. Vincent Hoosier Healthwise Prior Authorization List
Effective January 1, 2014

*The following is a list of services that require prior authorization review for medical necessity and place of service*

1. **All Services and Visits by Out-of-network Physicians/Providers/Suppliers/Facilities**

2. **All Inpatient and Observation Hospital Admissions:** e.g. medical, obstetrics, surgical, and rehabilitation. Call medical management to verify

3. **In-Network Labor Checks do not require authorization**

4. **All Transfers** for inpatient and/or outpatient services between acute-care facilities

5. **Home Health and Therapy Services:** including infusion and outpatient therapy services
   - Physical
   - Speech
   - Occupational
   - Nursing Services

6. **Outpatient Services:** including but not limited to,
   - Dialysis
   - Laryngoplasty
   - Any Lesion removal
   - Neurospinal Simulator placement/replacement
   - Percutaneous Implant/electrode placement
   - Dressing changes requiring anesthesia
   - Hyperbaric Oxygen Therapy
   - Audiological Surgeries
   - Implantable DME

7. **Skilled Nursing Facility:** admission for alternate levels of care in a facility, either freestanding or part of a hospital, that accepts patients in need of skilled level rehabilitation and/or medical care that is of lesser intensity than that received in a hospital

8. **Diagnostic Services:** such as,
   - BSER with Anesthesia
   - Sleep Studies
   - All PET Scans
   - All Genetic Testing
   - Amniocentesis
   - Cardiac Catheterization
   - Pediatric Services requiring Anesthesia
   - Ultrasounds * Guidelines are stated in the IHCP Manual

9. **All Endoscopy/Gastroenterology Services**

10. **Surgical Procedures:** including but not limited to,
    - Bariatric
    - Experimental/Investigational
    - Exploratory of the ear and/or eye
    - Computer Assisted Surgery
    - Spinal Surgery
    - Nerve blocks
    - Inpatient hysterectomies
    - Device (re)placement
    - Percutaneous Vertebroplasty
    - TMJ Surgery or manipulation
    - Gastric Neurostimulator procedures
    - Orchiopexy
    - All T&A’s
    - All Skin grafts

*Guidelines are stated in the IHCP Manual*
11. **Transplant Evaluations and Procedures;**

12. **Cosmetic Procedures:** in any setting, including but not limited to,

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Procedure</th>
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</thead>
<tbody>
<tr>
<td>Abdominoplasty</td>
<td>Reduction Mammaplasty</td>
</tr>
<tr>
<td>Blepharoplasty</td>
<td>Ligation and stripping of the veins</td>
</tr>
<tr>
<td>Lipectomy</td>
<td>Rhinoplasty</td>
</tr>
<tr>
<td>Dermabrasion</td>
<td>Gastroplasty</td>
</tr>
<tr>
<td>Lesion removals (any method)</td>
<td></td>
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</tbody>
</table>

13. **Pain Management Services;** including injections (separate from surgical procedures)

14. **Air Ambulance Transportation;** as well as any transportation over 50 miles or across state lines

15. **Durable Medical Equipment (DME):** including but not limited to,

<table>
<thead>
<tr>
<th>Equipment</th>
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<tbody>
<tr>
<td>The rental/purchase of all wheelchairs (motorized/manual) and all wheelchair components</td>
</tr>
<tr>
<td>Implantable DME</td>
</tr>
<tr>
<td>Orthotics/Prosthetics</td>
</tr>
<tr>
<td>Enteral supplies i.e. formulas and parenteral</td>
</tr>
<tr>
<td>Electronic Breast Pumps</td>
</tr>
<tr>
<td>Glasses for after cataract surgery</td>
</tr>
</tbody>
</table>

*Refer to the IHCP Manual for extensive details on coverage and member benefits*

16. **Non-Routine Podiatry:** including but not limited to,

Trimming non-dystrophic nails, bunionectomy, osteotomy, and arthrodesis/mal/non-union repair of the foot, and orthotics or DME.

17. **Behavioral Health Service:** including but not limited to,

<table>
<thead>
<tr>
<th>Service</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuropsychological testing</td>
<td>Psychological testing</td>
</tr>
<tr>
<td>All inpatient admissions</td>
<td>Neurosynthesis</td>
</tr>
<tr>
<td>ECT</td>
<td>Psychiatric Placement evaluation of hospital records</td>
</tr>
<tr>
<td>Play therapy</td>
<td></td>
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</tbody>
</table>

*Office Visits: Please refer to the IHCP Manual for benefit and authorization guidelines*

18. **Non-covered Services;** please refer to the IHCP manual regarding coverage and benefit limitations:

[www.indianamedicaid.com](http://www.indianamedicaid.com)