PRIOR AUTHORIZATION REQUIREMENTS

The requesting provider is responsible for verifying the member's eligibility and benefits on the date of service. Prior Authorization approval is subject to all plan limits and exclusions. Please note, Prior Authorization requirements apply to all in-network and out-of-network providers. Alliant Health Plans may need to assist in returning the Member to an in-network Provider when it is medically safe.

The below list of services which require Prior Authorization is not inclusive. For prior authorization requirements by specific code you may contact Utilization Management at **(800) 865-5922** or Customer Service at **(800) 811-4793.**

ADVANCED IMAGING	• CT • PET • MRI • MRA • Magnetic Resonance Cholangiopancreatography • Magnetic Resonance Spectroscopy • Myocardial Perfusion Imaging • Magnetic Resonance Guidance
BEHAVIORAL HEALTH	• Detoxification • Inpatient • Intensive Outpatient Treatment Program • Partial Hospitalization Program (PHP) • Residential Treatment Center services • Group Psychotherapy
CLINICAL TRIAL RELATED SERVICES	All covered services related to an approved clinical trial
DIALYSIS	All Dialysis
DURABLE MEDICAL EQUIPMENT (DME), ORTHOTIC AND PROSTHETIC (O&P), MEDICAL SUPPLY	DME: • Ambulatory Assistive Devices (excluding crutches, canes and walkers) • Continuous Glucose Monitoring • Continuous Passive Motion Machines • CPAP and BIPAP machines • Custom DME Home Ventilators • Helmets • Hospital Beds and Accessories • Insulin Pumps • Orthotics • Prosthetics (excluding breast prosthetics) • Speech Generating Devices • Wheelchairs and accessories • Wound Vac devices • Insulin Pump Supplies
DRUG SCREENS	Drug Screens

PRIOR AUTHORIZATION REQUIREMENTS

	Exceptions: Drug screens billed with a POS 11 (Office) or POS 81 (Independent Laboratory) do **not** require Prior Authorization.
Hearing Services	Hearing Aids for children 18 years of age or younger
	Note: Hearing Aids for adults are not covered. Refer to the Certificate of Coverage for Non-Covered Services.
Home Health and Hospice	All Home Health and Hospice Services
Home Infusion Therapy (HIT)	• Specialty Pharmacy Drugs (when drug is billed with per diem) • Home Infusion Therapy
	Exceptions: Home Infusion Therapy for antibiotic administration and IV Hydration administration do not require Prior Authorization.
Hyperbaric Oxygen Therapy	All Hyperbaric Oxygen Therapy
Inpatient Admission	All inpatient admissions require Prior Authorization, including but not limited to: • Neonatal Intensive Care Unit admissions Levels II, III, or IV (Revenue codes 0172, 0173, or 0174) • Inpatient rehabilitation • Skilled Nursing Facility (SNF)
	Exception: Maternity related inpatient admissions do **not** require Prior Authorization.
Laboratory Services	• Genetic • Chromosomal • DNA • Molecular Pathology
Observation Stays	All Observation stays require Prior Authorization, except observation admissions from the Emergency Room do not require Prior Authorization.
	Note: Prior Authorization for inpatient admission requests are required within one business day if admitted.
Outpatient Services	• Abdominoplasty • Arthroscopy • Blepharoplasty • Brachytherapy • Breast Reduction • Cardiac Surgery and Procedures • Carpal Tunnel Surgery • Chemodenervation • Chemotherapy • Cochlear Device • Dental Related • Electroencephalogram • Excess Skin Removal • Facial and Ear Revision/Augmentation/Reconstruction • Gastrointestinal Capsule Endoscopy • Hysterectomy and Related Procedures • Implantable Devices

PRIOR AUTHORIZATION REQUIREMENTS

OUTPATIENT SERVICES (CONT'D)	• Interdental Fixation
	• Joint Repair/Reconstruction/Replacement
	• Mastectomy
	    ○ **EXCEPTION:** Breast cancer diagnoses do **not** require Prior Authorization.
	• Mohs Surgery
	• Orchiectomy
	• Pain Management Invasive Procedures (including but not limited to Epidural Steroid, Facet and Botox injections)
	• Panniculectomy
	• Reconstructive Repair Pectus Excavatum
	• Scrotoplasty
	• Sinus and Nasal Surgery
	• Skin Color Correction
	• Sleep Studies
	    ○ Exception – Unattended sleep studies
	• Spine Surgery
	• Stomach/Colon Surgery
	• Therapeutic Repetitive Transcranial Magnetic Stimulation (TMS)
	• Transplant Related Services/Procedures
	• Treatment of contour defects
	• TPN
	• Pregnancy Reduction(s)
	• Neurostimulator
	• Radiopharmacologic diagnostic agent
	• Unlisted Procedure Male Genital System
	• Unlisted Procedure Nervous System
	• Vaginal/Perineum Surgery
	• Venous Surgery
	• Vein Ligation
	• Varicose Vein Treatment
	• Vascular Embolization or Occlusion

OUTPATIENT THERAPIES	All Outpatient Therapies
	EXCEPTIONS: • Evaluations • Initial eight (8) Occupational Therapy, Speech Therapy, and Physical Therapy visits • Chiropractic therapeutic rehabilitation services
PHARMACY	Drugs with JW modifier codes
RECONSTRUCTIVE SURGERY	Reconstructive Surgery, including, but not limited to breast reconstruction, is covered only to the extent Medically Necessary.
	NOTE: Beautification Procedures are not covered. Refer to the Certificate of Coverage for Non-Covered Services.
SPECIALTY PHARMACY	Many specialty pharmacy medications administered in any setting other than inpatient

PRIOR AUTHORIZATION REQUIREMENTS

	A complete listing of specialty pharmacy medications can be viewed online at https://magellan.adaptiverx.com/web/pdf?key=cnhmbGV4LnBsYW4uUGxhblBkZlR5cGUtMjEy. To initiate a Prior Authorization contact Magellan Rx, Alliant Health Plan's Pharmacy Benefits Manager at **(866) 554-2673.**
TRANSPLANT SERVICES	All transplant procedures, including transplant evaluations must be Prior Authorized and be Medically Necessary and not Experimental or Investigational, according to criteria established by Alliant. Providers should contact Alliant Health Plans to verify participating facilities in the transplant network before referring Members for transplant evaluation or services, which could result in a transplant (e.g., high dose chemotherapy). It is critically important, to both the Provider and Member, that Alliant Health Plans Case Management Department be contacted as soon as the Member has completed the evaluation and the Provider has deemed the Member as an appropriate candidate to be listed for transplant. To initiate a transplant authorization, call Alliant Health Plans at **(800) 865-5922**.
TRANSPORTATION	• Ambulance ground transport: Non-emergent • Ambulance air transport: Non-emergent
NON-COVERED SERVICES AND PROCEDURES	Refer to the Certificate of Coverage for Non-Covered Services.

The information included on this list may change periodically. For updates to the listing, visit AlliantPlans.com, select Providers, and select Forms and Documents under the Main Menu. Select "Procedures Requiring Prior Authorization" under Medical Resources.

To obtain a Prior Authorization, please call **(800) 865-5922** or fax a completed Prior Authorization form to **(866) 370-5667**.

If you have additional questions, please contact Customer Service at (800) 811-4793.