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 use the Prior Authorization Verification Tool, located in your Provider Portal or in the Provider section of AlliantPlans.com, or contact 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

AHP – PRIOR AUTHORIZATION REQUIREMENTS

January 2019
## PRIOR AUTHORIZATION REQUIREMENTS

<table>
<thead>
<tr>
<th><strong>DRUG SCREENS</strong></th>
<th>Drug Screens</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EXCEPTIONS:</strong> Drug screens billed with a POS 11 (Office) or POS 81 (Independent Laboratory) do <strong>not</strong> require Prior Authorization.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>HEARING SERVICES</strong></th>
<th>Hearing Aids for children 18 years of age or younger</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NOTE:</strong> Hearing Aids for adults are not covered. Refer to the Certificate of Coverage for Non-Covered Services.</td>
<td></td>
</tr>
</tbody>
</table>

| **HOME HEALTH AND HOSPICE** | All Home Health and Hospice Services |

<table>
<thead>
<tr>
<th><strong>HOME INFUSION THERAPY (HIT)</strong></th>
<th>• Specialty Pharmacy Drugs (when drug is billed with per diem)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Home Infusion Therapy</td>
</tr>
<tr>
<td><strong>EXCEPTIONS:</strong> Home Infusion Therapy for antibiotic administration and IV Hydration administration do not require Prior Authorization.</td>
<td></td>
</tr>
</tbody>
</table>

| **HYPERBARIC OXYGEN THERAPY** | All Hyperbaric Oxygen Therapy |

<table>
<thead>
<tr>
<th><strong>INPATIENT ADMISSION</strong></th>
<th>All inpatient admissions require Prior Authorization, including but not limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Neonatal Intensive Care Unit admissions Levels II, III, or IV (Revenue codes 0172, 0173, or 0174)</td>
</tr>
<tr>
<td></td>
<td>• Inpatient rehabilitation</td>
</tr>
<tr>
<td></td>
<td>• Skilled Nursing Facility (SNF)</td>
</tr>
<tr>
<td><strong>EXCEPTION:</strong> Maternity related inpatient admissions do <strong>not</strong> require Prior Authorization.</td>
<td></td>
</tr>
</tbody>
</table>

| **LABORATORY SERVICES** | Genetic, Chromosomal, DNA, Molecular Pathology |

<table>
<thead>
<tr>
<th><strong>OBSERVATION STAYS</strong></th>
<th>All Observation stays require Prior Authorization, except observation admissions from the Emergency Room do not require Prior Authorization.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NOTE:</strong> Prior Authorization for inpatient admission requests are required within one business day if admitted.</td>
<td></td>
</tr>
</tbody>
</table>

| **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 |

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AHP – PRIOR AUTHORIZATION REQUIREMENTS  
January 2019
### OUTPATIENT SERVICES (CONT’D)

- Implantable Devices
- Interdental Fixation
- Joint Repair/Reconstruction/Replacement
- Mastectomy
  - **EXCEPTION:** Breast cancer diagnoses do **not** require Prior Authorization.
- Mohs Surgery
- Orchietomy
- 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

- For specialty or other pharmacy medication administered in any setting other than inpatient, a prior authorization may be required. Contact Magellan Rx, Alliant Health Plan’s Pharmacy Benefit Manager, at (800) 424-1799 option 3, option 1.
**PRIOR AUTHORIZATION REQUIREMENTS**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reconstructive Surgery</strong></td>
<td>Reconstructive Surgery, including, but not limited to breast reconstruction, is covered only to the extent Medically Necessary. &lt;br&gt;<strong>Note:</strong> Beautification Procedures are not covered. Refer to the Certificate of Coverage for Non-Covered Services.</td>
</tr>
<tr>
<td><strong>Transplant Services</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Transportation</strong></td>
<td>• Ambulance ground transport: Non-emergent &lt;br&gt;• Ambulance air transport: Non-emergent</td>
</tr>
<tr>
<td><strong>Non-Covered Services and Procedures</strong></td>
<td>Refer to the Certificate of Coverage for Non-Covered Services.</td>
</tr>
</tbody>
</table>

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.