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 following services require Prior Authorization:

ADVANCED IMAGING	• CT • PET • MRI • MRA • Magnetic Resonance Cholangiopancreatography • Magnetic Resonance Spectroscopy • Myocardial Perfusion Imaging • Magnetic Resonance Guidance
BEHAVIORAL HEALTH	• Inpatient • Partial Hospitalization Program (PHP) • Residential Treatment Center services • Group Psychotherapy CPT 90583
DIALYSIS	All Dialysis

DURABLE MEDICAL EQUIPMENT (DME), ORTHOTIC AND PROSTHETIC (O&P), MEDICAL SUPPLY	• DME greater than $2,000
	• DME regardless of cost:
	  ○ Ambulatory Assistive Devices (excluding crutches, canes and walkers)
	  ○ Continuous Passive Motion Machines
	  ○ CPAP and BIPAP machines
	  ○ Custom DME Home Ventilators
	  ○ Helmets
	  ○ Insulin Pumps
	  ○ Orthotics
	  ○ Prosthetics (excluding breast prosthetics)
	  ○ Speech Generating Devices
	  ○ Wheelchairs and accessories
	  ○ Wound Vac devices
	• Insulin Pump Supplies – some have associated quantity limits. If additional supplies are needed, a Prior Authorization is required.
	  ○ Insulin Pump Supply Prior Authorization requirements are as follows:
	  ▪ Code A4225 – Per Prescription
	  ▪ Code A4230 – Quantity Limit of 20 every thirty days
	  ▪ Code A4231 – Quantity Limit of 20 every thirty days
	  ▪ Code A4232 – Quantity Limit of 20 every thirty days
	  ▪ Code A9274 – All require prior authorization
	  ▪ Code S5565 – Per prescription
	  ▪ Code S5566 – Per prescription

PRIOR AUTHORIZATION REQUIREMENTS

DRUG SCREENS	• Codes G0480-G0483 and G0659 • Codes 80305-80307 and 80320-80377 if the billed charge amount is $1,000 or greater
	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: • 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, including: • Observation stays less than or equal to 23 hours (observation admission from Emergency Room do not require Prior Authorization) • Observation stays 24 hours or more
	NOTE: Observation stays of 24 hours or more will be considered under inpatient benefits upon claims processing.
OUTPATIENT SERVICES	• Abdominoplasty • Arthroscopy • Blepharoplasty • Brachytherapy • Breast Reduction • Cardiac Surgery – **SURGERIES OTHER THAN CATHETERIZATION EFFECTIVE 6/15/2018** • Carpal Tunnel Surgery • Chemodenervation • Chemotherapy $10,000.00 and greater in billed charges per treatment • Cholecystectomy – **EFFECTIVE 6/15/2018** • Cochlear Device • Dental Related

PRIOR AUTHORIZATION REQUIREMENTS

OUTPATIENT SERVICES (CONT'D)	• Electroencephalogram with video • Excess Skin Removal • Facial and Ear Revision/Augmentation/Reconstruction • Gastrointestinal Capsule Endoscopy • Hysterectomy and Related Procedures • Implantable Devices • Interdental Fixation • Joint Repair/Reconstruction/Replacement • Mastectomy – CPT 19303, 19304 ○ **EXCEPTION:** Breast cancer diagnoses do **not** require Prior Authorization. • Mohs Surgery • Orchiectomy – CPT 54520 • Pain Management Invasive Procedures (including but not limited to Epidural Steroid, Facet and Botox injections) • Panniculectomy • Reconstructive Repair Pectus Excavatum • Scrotoplasty – CPT 55175, 55180 • Sinus and Nasal Surgery • Skin Color Correction • Sleep Studies performed in a lab or facility (home sleep studies do not require Prior Authorization) • Spine Surgery • Stomach/Colon Surgery • Transplant Related Services/Procedures • Treatment of contour defects • TPN • Pregnancy Reduction(s) • Neurostimulator • Radiopharmacologic diagnostic agent – CPT A4641 • Unlisted Procedure Male Genital System • Unlisted Procedure Nervous System • Vaginal/Perineum Surgery – CPT 56625, 56800, 56810, 57106, 57107 • 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

PRIOR AUTHORIZATION REQUIREMENTS

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 A complete listing of specialty pharmacy medications can be viewed online at https://magellan.adaptiverx.com/web/pdf?key=cnhmbGV4LnBsYW4uUGxhbIBkZlR5cGUtMjEy. To initiate a Prior Authorization contact Magellan Rx, Alliant Health Plan's Pharmacy Benefits Manager at **(800) 424-1799 OPTION 3, OPTION 1.**
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.