



Hoosier Healthwise Prior Authorization List

EFFECTIVE: 6/01/2010

Note: The codes listed below are subject to change and are not considered an all inclusive list

| Service | Code/Type | Notes |
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| Non-par Providers | | All non-par providers require authorization |
| Inpatient Hospitalization | | All inpatient stays require authorization. |
| Observation | Revenue Codes: 760, 762 | All observations (revenue codes 760 and 762) require authorization. Maternity related observation (revenue codes 720-729) requires notification. Physician services would be covered under the facility authorization. Up to 72 hour stay. |
| Specified Surgery: | | Specified surgeries require authorization (see below) |
| Gastroplasty/Bariatric Surgery | CPT Codes: 43326, 43644, 43645, 43659, 43770 thru 43775, 43842 thru 43848 | |
| Reduction Mammoplasty | CPT Code: 19318 | |
| Reconstructive/Plastic Procedures | CPT Codes: 11200, 11201, 11960, 11970, 11971, 15780 thru 15823, 15830 thru 15839, 19300, 19316 thru 19318, 19324 thru 19325, 19340, 19342, 19350, 19357, 19361, 19364, 19366 thru 19371, 19380, 21172, 21175, 21179 thru 21184, 21188, 21193 thru 21196, 21206 thru 21215, 21230, 21235, 21244 thru 21249, 21270, 21275, 21280, 21282, 30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, 30465, 30520, 30620, 67900 thru 67909, 67911, 67912, 67914, 67916, 67917, 67921, 67923, 67924 | Cosmetic procedures are not covered unless they are for reconstructive purposes in which case an authorization is required. |
| Surgery for Sleep | CPT Code: 42145 | |

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| Apnea (UPPP, LAUP) | | |
| Transplants | CPT Codes: 15220 thru 15221, 15775, 15776, 27412 thru 27415, 29866, 29867 thru 29868, 32851 thru 32856, 33933, 33935, 33944, 33945, 38204, 38205, 38230, 38240 thru 38242, 38999, 44132 thru 44137, 44715 thru 44721, 47140 thru 47147, 48550 thru 48552, 48554 thru 48556, 50300, 50320, 50323 thru 50329, 50340, 50360, 50365, 50370, 50380, 50547 thru 50549, 54680, 58999, 60512, 65710, 65730 thru 65757, 65780 thru 65782, 88240, 88241 | Transplants are generally done in an inpatient setting and would be covered under the inpatient authorization. All soft and organ transplant as well as specialty workup for transplant requires authorization. |
| Hysterectomy | CPT Codes: 58150 thru 58294, 58541 thru 58579, 51925, 59525, 58940 thru 58960, 59135 | |
| Tonsillectomy | CPT Codes: 42820 thru 42826, 42842 thru 42845 | |
| Adenoidectomy | CPT Codes: 42830 thru 42836 | |
| Myringotomy | CPT Codes: 69420, 69421, 69433 thru 69436 | With and without tubes |
| Chiropractic Services | CPT Codes: 95831 thru 95857 | 50 office visits and spinal manipulation or physical medicine treatments per member per rolling 12 month period do not require authorization; For members included in Package C, treatments beyond 14 need authorization; Lab tests performed by chiropractors and muscle testing require authorization |
| Pain Management Services | CPT Codes: 61055, 62263 thru 62269, 62273 thru 62282, 62287 thru 62351, 62360 thru 62362, 63650 thru 63655, 63663 thru 63688, 64400 thru 64530, 64550 thru 64581, 64590 thru 64595, 64600 thru 64681, 64722 thru 64726, 96440 thru 96522 | All pain management procedures require authorization |
| Enteral/Nutritional Feedings and Supplies | CPT Codes: 99070 HCPCS Codes: B4034 thru B9999 | Does not include WIC contracted/noncontracted formulas |
| Durable Medical Equipment (DME) >\$500 | Revenue Codes: 290-299 CPT Codes: 93279 thru 93299 All HCPCS codes A-E, Q codes, Hearing Aids | DME items with billed charges of \$500 or more require authorization; All DME rentals (regardless of billed charges) |

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| | | <p>require authorization; DME rentals would only be reimbursed up to the purchase price.</p> <p>Any miscellaneous, unspecified, unclassified, or unlisted procedures regardless of billed charges require authorization (i.e. E1399)</p> |
| Prosthetics/Orthotics | All HCPCS L Codes | <p>All prosthetics/orthotics require authorization with purchase cost \$500.00 or greater</p> <p>Any miscellaneous, unspecified, unclassified, or unlisted procedures regardless of billed charges requires authorization (i.e. L1899)</p> |
| Respiratory, Speech, Physical, and Occupational Therapy Services | <p>Revenue Codes: 410-449</p> <p>CPT Codes: 92507, 92610 thru 92617, 95833 thru 95852, 97002 thru 97004, 97010 thru 97542, 97750 thru 97799</p> | All therapy services require authorizations except initial evaluations and 30 units within 30 days after hospital discharge |
| Home Health Services | <p>CPT Codes: 99600</p> <p>All Home Health HCPCS Codes G0151 thru G0153</p> | All home health services require authorization, except 120 units within 30 days following hospital discharge |
| <p>Diagnostic Imaging:</p> <p>CT Scans</p> <p>MRI</p> <p>MRA</p> <p>PET Scans</p> | <p>CPT Codes:</p> <p>CT scans: 70450 thru 70498, 71250 thru 71270, 72125 thru 72133, 72191 thru 72194, 74150 thru 74175, 76376, 76377, 77011 thru 77014</p> <p>MRIs: 71550 thru 71552, 72141 thru 72158, 72195 thru 72197, 73718 thru 73723, 74181 thru 74183, 76376, 76377, 77021 thru 77022</p> <p>MRAs: 70544 thru 70549, 71555, 72159, 72198, 73225, 73725, 74185</p> <p>PET scans: 78459, 78491, 78492, 78608, 78609, 78811 thru 78816</p> | <p>All of the following require authorization:</p> <p>CT scans: Head, Maxillofacial, cervical, thoracic and lumbar spine, thorax, abdomen, pelvis, needle guided CT scans, 3D CT scans</p> <p>MRIs: Cervical, Thoracic and Lumbar Spine, Chest, Abdomen, Pelvis, Lower Extremity, needle guided MRIs, 3D MRIs</p> <p>All MRAs</p> <p>All PET Scans</p> |
| Home Infusion Services | <p>CPT Codes: S9349, 99601, 99602</p> <p>All infusion HCPCS J Codes</p> | All home infusion services require authorization, including Hemophilia Factor |

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| | | Medications |
| Procedure Coded Medications | HCPCS Codes: J0129, J0585, J0878, J0881, J0885, J0886, J1325, J1500, J1550, J1561, J1566, , J1568, J1650, J1743, J1745, J1817, J1950, J2185, J2323, J2357, J2790, J3030, J3487, J3488, J3490, J7156, J7300, J7302, J7303, J7304, J7306, J7307, J7321, J7322, J7323, J7324, J7606, J7799, J9214, Q0179 | |

Note:

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

A scheduled procedure or visit needs to be performed/ initiated in a time not to exceed 90 calendar days from the initial authorization date. Should the date of the procedure be scheduled beyond the 90 day window then the provider is responsible to apply for an extension of that authorization and may be asked to resubmit information to get the request to meet medical necessity as determined by the normal authorization process.

Notification:

- 1. Maternity related inpatient admissions other than Cesarean Section**
- 2. Maternity related observation 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**