ADVANTAGE HEALTH SOLUTIONS™
2016 Prior Authorization Process

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I. Paperless referral process:

Primary Care Physicians (PCP) will continue to direct patient care by referring HMO members to in-network specialists as defined by the network's specialist's directories. A physician order may be used for this referral. PCP's should document the referral in the patient record.

Verification of member's insurance eligibility is recommended at every visit.

If the specialist finds an additional problem outside of the original diagnosis or cause, but within the scope of his/her specialty, the specialist may treat the problem and report findings back to the PCP. If an additional problem arises that is not within the scope of this specialty, the member's care should be coordinated by the member's PCP as part of their medical home, and therefore the member must be referred back to the PCP for additional referral to another specialist.

II. The following services **MUST BE CALLED AND/OR FAXED FOR PRIOR APPROVAL** by ProHealth Medical Management staff

1. **All out of network requests for physicians and facilities**. This includes Indiana University Health, St. Vincent, Eskananzi and St. Francis
2. All services which may be deemed cosmetic/aesthetic (i.e. moles, skin lesions, varicose veins)
3. All transplant services
4. All services where benefit coverage is questioned (i.e. breast reduction, bariatric surgery)
5. All referrals for infertility services
6. Genetic testing, excluding routine pre-natal testing
7. All referrals for pain management programs
8. All outpatient back and neck surgeries
9. All rhinoplasties and septoplasties **(NEW 2016)**
10. All inpatient admissions, including rehabilitation and LTAC facilities
11. Any surgery that will result in a scheduled inpatient admission
12. Endoscopic Procedures
13. Colonoscopies for patients under the age of 50 **(NEW 2016)**
14. Radiology:
    a. MRI of the spine (cervical, thoracic, lumbar, sacrum)
    b. MRI of the knees
    c. Non-oncology related PET scans
15. Home Care/ Hospice/TPN Administration in the home

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16. Skilled Nursing Facilities
17. Durable Medical Equipment> 200.00 dollars (per item). Includes initial referral for wheelchairs, CPAP and in-home use of hospital beds. (Once CPAP or an insulin pump is approved, additional requests for supplies are not required)
18. Emergency Room referrals.
19. Dialysis and Epogen administration with Dialysis

Please submit requests as soon as possible to allow time for review.

Routine requests for authorizations are processed within 2 business days after receipt of all needed information.

A new referral for the services outlined above is required at a minimum annually.

A CPT list of procedures that require prior authorization is attached.

Please note that this list is not entirely inclusive; new procedures, experimental or investigation procedures, cosmetic procedures and limited benefits may not be listed. Authorization does not guarantee payment; payment is based on benefit structure and limitations