
















MyCare Ohio Prior Authorization Information

Category	Managed Care Plan				
					
ANCILLARY / DME SERVICES					
Ambulance & Ambulette Services (except emergency)	Yes	Yes	Yes	Yes	Yes
Durable Medical Equip	Necessity of PA is code specific, please refer to the Secure Provider Web Portal or the plan website.	Yes	Yes (>\$750)	Yes, refer to Molina's website for codes that require PA	Over \$1000 and certain codes (see website)
Hearing Aids	Yes	Yes	Yes	Yes	Yes
Home Health Services	Yes	Yes	Yes for all home care	Yes, after 3rd skilled nursing visit (CMN required)	Yes
Hospice care	Yes	Yes	Yes	No	Yes
Injectables	Necessity of PA is code specific, please refer to the Secure Provider Web Portal or the plan website.	Yes	Yes	Yes	Yes - Botox, Acthar, IVIG, Xolair, Makena
Orthotics/Prosthetics	Necessity of PA is code specific, please refer to the Secure Provider Web Portal or the plan website.	Yes	Yes (>\$750)	Yes, refer to Molina's website for codes that require PA	Yes
Therapy -Occupational, Physical & Speech	Yes	Yes	PT:>20 visits OT:>20 visits ST:>15 visits	Yes, after initial evaluation	No
Wound Vacs/ outpatient only	Necessity of PA is code specific, please refer to the Secure Provider Web Portal or the plan website.	Yes	Yes	Yes	Yes
Nursing Facility Admissions	Yes	Yes	Yes	Yes	Yes

Category	Managed Care Plan				
					
OUTPATIENT SERVICES					
Cardiac Rehab/excludes eval	Yes	No	No	Yes	No
Chemotherapy and Radiation	Necessity of PA is code specific, please refer to the Secure Provider Web Portal or the plan website.	Yes- if IP	No - Outpatient Yes - Inpatient	No - Outpatient Yes - Inpatient	No
Chiropractic Services	Yes	No	Yes >12 visits	Yes	No
<u>Diagnostic Testing:</u>					
PET, SPECT	Yes	Yes	Yes	Yes	Yes
MRI/MRA, CT Scans	Yes	Yes	Yes	Yes	Yes
OB Ultrasound	No	Yes	No	No	No
Ultrasound (non OB)	Necessity of PA is code specific, please refer to the Secure Provider Web Portal or the plan website.	Yes	No	No	No
Dialysis	No	No	No	No	No
Enteral Nutrition (infant Formula and oral nutrition/ if it does not meet OAC requirements)	Yes	Yes	Yes	Yes	Yes
Genetic testing for congenital Abnormalities	Yes	Yes	No	Yes	Yes
Outpatient Procedures: Arthroscopy, Cardiac, Catheterization, Laparoscopy, Radiation Therapy, Surgery	Yes	Yes	No for cosmetic and plastic procedures Yes	Yes for some procedures	Sleep apnea surgery
Pain Management	Necessity of PA is code specific, please refer to the Secure Provider Web Portal or the plan website.	Yes	No - Outpatient Yes - Inpatient	Yes	Spinal Stimulators

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Pulmonary Rehab/excludes eval	Yes	Yes	No	Yes	No
Transplant Eval & Admissions	Yes	Yes	Yes	Yes	Yes
Treatment of Varicose/Spider veins	Yes	Yes	Yes	Yes	Yes
SURGERIES					
Abortions	Yes	Yes	Yes	Yes	No
Bariatric Surgery	Yes	Yes	Yes	Yes	Yes
Blepharoplasty	Yes	Yes	Yes	Yes	Yes
Cosmetic/Plastic Surgery	Yes	Yes	Yes	Yes	Yes
Hysterectomy	Yes	Yes	No - Outpatient Yes - Inpatient	Yes	No
Mammoplasty	Yes	Yes	Yes	Yes	Yes
Oral Surgery	Yes	Yes	Yes	Yes	Yes
Otoplasty	Yes	Yes	Yes	Yes	Yes
Rhinoplasty/Septoplasty	Yes	Yes	Yes	Yes	Yes
Scar Revisions	Yes	Yes	Yes	Yes	Yes
Tubal Ligations	Yes	Yes	No	Yes	No
Vasectomy	Yes	Yes	No	Yes	No
Vagus Nerve Stimulation	Yes	Yes	No - Outpatient Yes - Inpatient	Yes	Yes

Category	Managed Care Plan				
					
BEHAVIORAL HEALTH					
Clinic Services and General Hospital Outpatient Psychiatric Services	Yes*	No	No	No	No
Day Treatment	Yes	Yes	Yes	Yes	Yes
Psychosocial Rehab Services	No	Yes	No	No	No
Substance Abuse Services at Addiction Treatment Centers:					
Ambulatory Detoxification	Yes	No	No	No	Yes
Assessment	No	No	No	No	No
Case Management	No	No	No	No	No
Counseling (Limited to 30 hours per week)	No	No	No	No	No
Crisis Intervention	No	No	No	No	No
Intensive Outpatient	Yes	Yes	Yes	No	Yes
Alcohol/Drug Screening Analysis/Lab Urinalysis	No	No	No	No	No
Medica/Somatic (Limited to 30 hours per week)	Yes	No	No	No	No
Methadone Administration	No	No	Yes	No	Yes
Office Administered Medications for Addiction including vivtrol and buprenorphine induction	No	No	No	No	No
Mental Health Services at Community Mental Health Centers:					
Mental Health assessment/diagnostic psychiatric interview (limited to 4 hours for non-physician assessment and 2 hours for physician interview per year)	No	No	No	No	Yes
CPST Services	No	No	No	No	No
Counseling and Therapy (limited to 52 hours of combined individual/group therapy per year)	No	No	No	No	No
Crisis Intervention	No	No	No	No	No
Pharmacological Management (limited to 24 hours per year)	No	No	No	No	No
Pre-hospital admission screening	No	Yes	No	No	No
Certain office administered injectable antipsychotic medications	Yes*	No	No	No	No
Partial Hospitalization	Yes	Yes	Yes	Yes	Yes
Inpatient Behavioral Health Services:					
Inpatient psychiatric care in private or public free-standing psychiatric hospital	Yes	Yes	Yes	Yes	Yes
Inpatient detoxification care	Yes	Yes	Yes	Yes	Yes
*Necessity of PA is code specific, please refer to the Secure Provider Web Portal or the plan website.					
**Clinical information can be submitted as indicated below. If urgent or time-sensitive, please indicate at time of request.					
***For pharmacy, dental, and vision services please reference specific MCP requirements located on their websites					
Notes: FOR MEDICAID ONLY MYCARE OHIO MEMBERS, PA IS NOT REQUIRED FOR MEDICARE SERVICES					
**ALL NON-PAR SERVICES REQUIRE PA, EXCEPT DURING CARE TRANSITION PERIODS					
(http://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/MyCareOhio/PlanPaymentReqs.pdf)**					
Contact Information:					
Plan Website	Phone				
www.aetnabetterhealth.com/ohio	855-364-0974				
www.bchpohio.com	800-224-1991				
www.caresource.com	800-488-0134				
www.molinahealthcare.com	800-642-4168				
www.uhccommunityplan.com	800-366-7304				