KANSAS HEALTH ADVANTAGE

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# 2027 Prior Authorization List

## Prior authorizations are required for the following covered services (by service level)❖

- **Inpatient Care** (including but not limited to: Inpatient Acute, Inpatient Psychiatric, etc.)
- **Skilled Nursing Facility** (Medicare required three midnight stay is waved)
- **Partial Hospitalization**
- **Outpatient Observation**
- **Outpatient Hospital and Ambulatory Surgery Services**
- **Genetic Testing**
- **Home Health Care**
- **DME, Prosthetics and Orthotics** (with billed charges in excess of $250)
- **Diabetic Supplies** (with billed charges in excess of $250)
- **Therapy Services** (Physical, Speech and Occupational Therapy) **Not** performed at LTC residence or other SNF Therapy Setting
- **Diagnostic Radiological Services** (e.g. High-Tech Radiology Services including but not limited to: MRI, MRA, PET, CTA, CT Scans and SPECT require prior authorization. **NOTE:** No authorization is required for Outpatient X-ray Services)
- **Cardiac Rehabilitation and Intensive Cardiac Rehabilitation**
- **Ambulance Services** (Medicare covered non-emergency Ambulance transportation services **NOTE:** No authorization is needed for non-emergency hospital to nursing home and nursing home to hospital)
- **Medicare Part B Chemotherapy Drugs** (Drugs with billed charges in excess of $250)
- **Other Medicare Part B Drugs** (covered drugs with billed charges in excess of $250)
- **Out-of-Network Providers** (including but not limited to: physicians, cardiac rehab/intensive cardiac rehab, DME/Prostheticssuppliers, diagnostic tests and/or procedures, Genetic testing, non-emergent ambulance, therapeutic radiological services, ambulatory surgery center, outpatient hospital, inpatient hospital, home health care, outpatient physical therapy, outpatient speech-language therapy, outpatient occupational therapy, outpatient hospital observation, skilled nursing facility, etc.)

**NOTE:** No authorization is required for medically necessary emergent services, urgently needed care, or dialysis services

**Services must be provided according to the Medicare Coverage Guidelines and limitations and are subject to review. All medical care, services, supplies and equipment must be medically necessary.**