ATRIO HEALTH PLANS

2019 Medicare Prior Authorization Grid

Please Note:

1. Services not reflected on this authorization grid do not require authorization.
2. All services must be medically necessary, subject to CMS regulations. If a service performed is not covered by Medicare or an additional benefit offered by ATRIO, the claim will be denied as a non-covered service per Medicare criteria. An approved authorization is not a guarantee of payment. Payment is based on benefits in effect at the time of service, member eligibility and medical necessity.
3. HMO SNP require a prior authorization for ALL out-of-network services.
4. PPO Plans do NOT require a prior authorization for out-of-network services.
5. Retroactive requests (services already rendered) need to be submitted as a claim.

Authorization is required for the following services/procedures									
Inpatient Hospital Services									
Inpatient Hospital / Partial Hospitalization / Psychiatric Inpatient Hospital									
Skilled Nursing Facility Services									
All SNF Services									
Home Health Services									
Assessment and first 5 visits do not require prior authorization. Subsequent visits require prior authorization									
Occupational Therapy Services									
Occupational Therapy requires prior authorization after the first 20 visits per plan year									
Physical and Speech Therapy Services									
Physical Therapy & Speech Therapy require prior authorization after the first 20 visits per plan year (combined)									
Cardiac Rehabilitation Services									
Cardiac Rehabilitation Services require prior authorization after the first 36 visits per plan year									
Pulmonary Rehabilitation Services									
Pulmonary Rehabilitation Services require prior authorization after the first 36 visits per plan year									
Outpatient Diagnostic and Therapeutic Radiology Services **Diagnostic Services - Radiology**									
Only the listed MRI and MRA Scans below require prior authorization									
70336	70545	71550	72146	72157	72197	73221	73719	73725	77058
70540	70546	71551	72147	72158	72198	73222	73720	74181	77059
70542	70547	71552	72148	72159	73218	73223	73721	74182	
70543	70548	72141	72149	72195	73219	73225	73722	74183	
70544	70549	72142	72156	72196	73220	73718	73723	74185	

Outpatient Hospital and Ambulatory Surgery Center Services												
Only the listed Outpatient surgical procedures provided in hospital outpatient setting or Ambulatory Surgery Center require prior authorization												
15822	22513	36478	37790	48550	62322	63016	63055	63662	64565	65757	67903	69720
15823	22514	36479	37799	48999	62323	63017	63056	63663	64568	65770	67904	69725
19324	22515	37700	43647	58578	62324	63020	63057	63664	64569	65772	67906	69740
19325	22551	37718	43648	61796	62325	63030	63064	63685	64575	65775	67908	69745
22100	22554	37722	43651	61797	62326	63035	63066	63688	64580	65778	67909	69799
22101	22612	37735	43652	61798	62327	63040	63075	64479	64581	65779	67911	69930
22102	22614	37760	43653	61799	63001	63042	63076	64480	64590	65780	67912	69949
22103	22856	37761	43870	61800	63003	63044	63620	64483	65710	65781	69711	
22505	22899	37765	43886	62281	63005	63045	63621	64484	65730	65782	69714	
22510	27446	37766	43887	62282	63011	63046	63650	64553	65750	67900	69715	
22511	36475	37780	43888	62320	63012	63047	63655	64555	65755	67901	69717	
22512	36476	37785	43999	62321	63015	63048	63661	64561	65756	67902	69718	

Ambulance Services
Only non-emergency ambulance transportation requires prior authorization

Durable Medical Equipment (DME), Prosthetics/Medical Supplies and Diabetic Supplies and Services
All DME rentals
DME purchases exceeding **$500.00** (**billed amount** per item)
Prosthetics/Medical Supplies purchases exceeding **$500.00** (**billed amount** per item)
Diabetic supplies and services exceeding **$500.00 billed amount** and for blood glucose monitoring supplies exceeding the following limits: 100 Test Strips and 100 lancets per 90-day supply for individuals who are non-Insulin dependent 300 Test Strips and 300 lancets per 90-day supply for individuals who are Insulin dependent 1 lancet device per 6 months for both Insulin dependent and non-Insulin dependent individuals

Medicare Part B Prescription Drugs											
Only the listed Part B Injectable drugs below require prior authorization											
J0585	J0881	J0885	J2323	J2350	J2469	J3490	J3590	J9035	J9299	Q3027	C9399
IVIG - J1459, J1559, J1561-J1569, J1572											

Comprehensive Dental Services
Facility fees and anesthesia services for dental services provided in an Ambulatory Surgery Center or hospital setting under general anesthesia

Other Services - Only applies to H3814 - Plan 007
97802 Medical nutrition, indiv, initial - up to one hour (4 units) per year
97803 Medical nutrition, indiv, subseq - up to one hour (4 units) per year
97804 Medical nutrition, group - up to 4 hours (16 units total) per year