2020 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 and Pulmonary Rehabilitation Services									
Cardiac Rehabilitation Services require prior authorization after the first 36 visits per plan year									
Pulmonary Rehabilitation Service									
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	77046

70540	70546	71551	72147	72158	72198	73222	73720	74181	77047
70542	70547	71552	72148	72159	73218	73223	73721	74182	77048
70543	70548	72141	72149	72195	73219	73225	73722	74183	77049
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	22514	36479	43647	61796	62326	63040	63076	64483	65730	67900	69717
15823	22515	37700	43648	61797	62327	63042	63620	64484	65750	67901	69718
19324	22551	37718	43651	61798	63001	63044	63621	64553	65755	67902	69720
19325	22554	37722	43652	61799	63003	63045	63650	64555	65756	67903	69725
22100	22612	37735	43653	61800	63005	63046	63655	64561	65757	67904	69740
22101	22614	37760	43870	62281	63011	63047	63661	64565	65770	67906	69745
22102	22856	37761	43886	62282	63012	63048	63662	64568	65772	67908	69799
22103	22899	37765	43887	62320	63015	63055	63663	64569	65775	67909	69930
22505	27446	37766	43888	62321	63016	63056	63664	64575	65778	67911	69949
22510	27447	37780	43999	62322	63017	63057	63685	64580	65779	67912	
22511	36475	37785	48550	62323	63020	63064	63688	64581	65780	69711	
22512	36476	37790	48999	62324	63030	63066	64479	64590	65781	69714	
22513	36478	37799	58578	62325	63035	63075	64480	65710	65782	69715	
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							
J0129	J0587	J1438	J1562	J1572	J2350	J3490	Q5103
J0135	J0588	J1442	J1563	J1575	J2357	J3590	Q5104
J0178	J0638	J1447	J1564	J1595	J2502	J7639	Q5108
J0180	J0883	J1454	J1565	J1745	J2505	J7686	
J0202	J0885	J1459	J1566	J1826	J2507	J9203	
J0364	J0888	J1557	J1567	J1830	J2778	J9299	
J0585	J1212	J1559	J1568	J2323	J2796	J9400	
J0586	J1410	J1561	J1569	J2341	J3245	J9999	
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							