



## 2021 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.
3. Payment is based on benefits in effect at the time of service, member eligibility and medical necessity.
4. HMO SNP members require a prior authorization for ALL out-of-network services.
5. PPO Plans do NOT require a prior authorization for out-of-network services.
6. Retroactive requests (services already rendered) need to be submitted as a claim.

<b>Authorization is required for the following services/procedures</b>
<b>Inpatient Hospital Services</b>
Inpatient Hospital / Partial Hospitalization / Psychiatric Inpatient Hospital / Planned Inpatient Surgeries
<b>Skilled Nursing Facility Services</b>
All SNF Services
<b>Home Health Services</b>
All Home Health Services
<b>Occupational Therapy Services</b>
Occupational Therapy requires prior authorization after the first 20 visits per plan year
<b>Physical and Speech Therapy Services</b>
Physical Therapy & Speech Therapy require prior authorization after the first 20 visits per plan year (combined)
<b>Cardiac Rehabilitation Services</b>
Cardiac Rehabilitation Services require prior authorization after the first 36 visits per plan year
<b>Pulmonary Rehabilitation Services</b>
Pulmonary Rehabilitation Services require prior authorization after the first 36 visits per plan year
<b>Genetic and Molecular Diagnostic Testing</b>
All Genetic and Molecular Diagnostic Testing
<b>Cosmetic Services</b>

All Cosmetic Procedures and associated codes

**Outpatient Diagnostic and Therapeutic Radiology Services - Radiology**

Only the listed Outpatient Diagnostic and Therapeutic Radiology codes below require prior authorization

70336	71551	72158	73220	73725	75635	77372	77799	78473	78598	78710	78805	79999
70540	71552	72159	73221	74181	75898	77373	78075	78481	78599	78725	78806	G6015
70542	71555	72195	73222	74182	76498	77385	78099	78483	78600	78730	78807	G6017
70543	72141	72196	73223	74183	77021	77386	78199	78491	78601	78740	78812	
70544	72142	72197	73225	74185	77022	77520	78299	78492	78602	78761	78813	
70545	72146	72198	73718	75557	77046	77522	78399	78494	78605	78799	78814	
70546	72147	72240	73719	75559	77047	77523	78459	78496	78608	78800	78815	
70547	72148	72255	73720	75561	77048	77525	78466	78499	78610	78801	78816	
70548	72149	72265	73721	75563	77049	77761	78468	78579	78660	78802	78999	
70549	72156	73218	73722	75565	77270	77762	78469	78580	78669	78803	79403	
71550	72157	73219	73723	75574	77371	77763	78472	78597	78700	78804	79440	

**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	37765	63011	64555	22511	26530	47370	62322	27443	64463	64581	42145	69715
15823	37766	63012	64561	22512	27438	64413	62323	30520	33225	64590	55862	21199
19324	43647	63015	64565	22513	30140	33220	62324	37227	33285	17999	51715	21256
19325	43648	63016	64568	21206	36483	33249	62325	53850	64510	21246	32998	23800
22100	43651	63040	64569	21275	52601	64493	21242	61885	64681	22634	33231	26121
22101	43652	63042	64575	23802	57156	64610	25442	50080	63685	25907	36470	26123
22102	43653	63044	67900	26508	43774	43999	26536	64462	63688	27427	64530	29868
22103	43870	63045	67901	27437	64410	48550	27442	33224	64479	27884	69806	43772
22505	43886	63046	67902	30130	33218	48999	30465	33264	64480	31660	67912	55899
22514	43887	63047	67903	36482	33244	58578	37226	64505	21245	37650	69711	63266
22515	43888	63048	67904	52450	64492	21240	53445	64680	22633	55860	69714	63268
22551	61796	63055	67906	57155	64605	21299	61880	63057	25446	63043	21110	33216
22554	61797	63056	67908	43773	37780	25441	64461	63064	27415	50592	21249	33241
22612	61798	63076	67909	64408	37785	26535	33223	63066	27700	32701	23455	36473
22614	61799	63620	67911	33217	37790	27441	33263	63075	30802	33230	25929	64585
22856	61800	63621	69717	64490	37799	3062	64495	21244	37247	36466	28429	69715
22899	62281	63650	69718	64491	21209	37225	64630	22585	23899	64520	29806	

27446	62282	63655	69720	64600	21296	53440	63017	25444	61888	69805	43659	
36479	62320	63661	69725	27447	24925	58674	63020	27412	50590	21085	55875	
37700	62321	63662	69740	36475	26531	47382	63030	27594	31830	21248	63265	
37718	62326	63663	69745	36476	27440	64416	63035	30801	33226	23334	63267	
37722	62327	63664	69799	36478	30460	33222	21243	37246	36465	25922	33215	
37735	63001	64483	69930	21208	37224	33262	22552	53852	64517	27428	33240	
37760	63003	64484	69949	21295	52648	64494	25443	61886	64999	27889	36471	
37761	63005	64553	22510	23921	57425	64620	27130	50081	64580	31661	64566	

**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 line item)

Prosthetics/Medical Supplies purchases exceeding **\$500.00 (billed amount)** per line 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

1 continuous glucose monitor 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

J0135	J7330	J0883	J0888	J1556	J1595	J2502	J7999	J1559	J1561	J3490	J1569	
J0364	J9260	J0885	J1212	J1599	J1826	J2505	J2507	J2170	J1568	J9999	J9250	
J0887	J0586	J1439	J1410	J7599	J1675	J1459	J2796	J9255	J2354	J0485		
J1562	J0587	J1573	J1438	J1557	J7799	J1566	J2941	J7686	J9266	J0881		
J1572	J0588	J7513	J1447	J1575	J1830	J1744	J7639	J9400	J0585	J0882		

**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 – SNP Plans Only**

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

