

2024 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 Renapy: ation

- Ambulance Services (Medicare covered nonemergency Ambulance transportation services NOTE: No authorization is needed for nonemergency 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

