

PruittHealth Premier Advantage (HMO I-SNP) - Georgia (partial) 2024 Prior Authorization Chart

*Detailed limits and exclusions can be found in the member's Evidence of Coverage (EOC).

SERVICE TYPE	REQUIREMENT
MEDICARE OFFERINGS	
Inpatient Services	
1a: Inpatient Hospital-Acute	Authorization Required
1b: Inpatient Hospital Psychiatric	Authorization Required
2: Skilled Nursing Facility (SNF)	Authorization Required
2: Skilled Nursing Facility (SNF) Notes	Authorization required (notification/request within 2 business
	days of SNF start).
2: Skill-In-Place (SIP)	No Benefit
5: Partial Hospitalization	Authorization Required
9a2: Observation Services	Authorization Required
Outpatient Services	
3: Cardiac and Pulmonary Rehabilitation Services	Authorization Required
4a: Emergency Services	No Authorization Required (In-Network and Out-of-Network)
6: Home Health Services	Authorization Required
7a: Primary Care Physician Services	No Authorization Required (In-Network and Out-of-Network)
7b: Chiropractic Services	Authorization Required
7b: Chiropractic Services Notes	Prior authorization is only required for Medicare-covered
	chiropractic services.
7c,i: Therapy: Physical Therapy, Speech-Language	Authorization Required
Pathology and Occupational Therapy Services	
7c,i: Therapy: Physical Therapy, Speech-Language	7c: Occupational Therapy Services Notes: Authorization is not
Pathology and Occupational Therapy Services Notes	required when service is provided in PruittHealth Skilled Nursing Facilities.
	7i: Physical Therapy and Speech-Language Pathology Services
	Notes: Authorization is not required when service is provided in
	PruittHealth Skilled Nursing Facilities.
	All evaluations do not require an authorization (In-Network and
	Out of Network)
7d: Physician Specialist Services	No Authorization Required (In-Network and Out-of-Network)
7e: Mental Health Specialty Services	No Authorization Required (In-Network and Out-of-Network)
7f: Podiatry Services	No Authorization Required (In-Network and Out-of-Network)
7g: Other Health Care Professional	No Authorization Required (In-Network and Out-of-Network)
7h: Psychiatric Services	No Authorization Required (In-Network and Out-of-Network)
7j: Additional Telehealth Benefits	No Authorization Required (In-Network and Out-of-Network)
7k: Opioid Treatment Program Services	Authorization Required
8a: Outpatient Diagnostic Procedures Tests and Lab	Authorization Required
Services	

SERVICE TYPE	REQUIREMENT
8a: Outpatient Diagnostic Procedures Tests and Lab	8a1: Diagnostic Procedures/Tests Notes: No Authorization
Services Notes	required when services are rendered in a Nursing Facility or
	Physician Office.
	8a2: Lab Services Notes: No authorization required for lab services
	rendered in any place of service. Authorization required for
	genetic testing only.
8b: Outpatient Diagnostic and Therapeutic Radiological	Authorization Required
Services	
8b: Outpatient Diagnostic and Therapeutic Radiological	8b1: Diagnostic Radiological Services Notes: Ultrasounds do not
Services Notes	required authorization.
	8b2: Therapeutic Radiological Services Notes:
	8b3: Outpatient X-Ray Services Notes: X-Rays do not require
	authorization in nursing facility, physician office, or hospital.
	detronzation in harsing reently, physician office, or hospital.
9a1: Outpatient Hospital Services	Authorization Required
9b: Ambulatory Surgical Center (ASC) Services	Authorization Required
9c: Outpatient Substance Abuse Services	Authorization Required
9d: Outpatient Blood Services	No Authorization Required (In-Network and Out-of-Network)
10a: Ambulance Services (Non-Emergent)	No Authorization Required (In-Network and Out-of-Network)
11a: Durable Medical Equipment (DME)	Authorization Required
11b: Prosthetics/Medical Supplies	Authorization Required
11c: Diabetic Supplies and Services and Diabetic	No Authorization Required (In-Network and Out-of-Network)
Therapeutic Shoes or Inserts	
12: Dialysis Services	No Authorization Required (In-Network and Out-of-Network)
14a: Medicare-covered Zero Dollar Preventive Services	No Authorization Required (In-Network and Out-of-Network)
14d: Kidney Disease Education Services	No Authorization Required (In-Network and Out-of-Network)
14e1: Glaucoma Screening	No Authorization Required (In-Network and Out-of-Network)
14e2: Diabetes Self-Management Training	No Authorization Required (In-Network and Out-of-Network)
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14e3: Barium Enemas	No Authorization Required (In-Network and Out-of-Network)
14e4: Digital Rectal Exams	No Authorization Required (In-Network and Out-of-Network)
14e5: EKG following Welcome Visit	No Authorization Required (In-Network and Out-of-Network)
15-1-I: Medicare Part B Insulin Drugs	No Authorization Required (In-Network and Out-of-Network)
15: Medicare Part B Rx Drugs and Home Infusion Drugs	Authorization Required
15: Medicare Part B Rx Drugs and Home Infusion Drugs	Prior authorization is required for some medications. For
Notes	chemotherapy, only the initial use requires authorization.
16b: Comprehensive Dental	Authorization Required
16b: Comprehensive Dental Notes	Authorization is for Medicare-covered comprehensive dental only.
17a: Eye Exams	No Authorization Required (In-Network and Out-of-Network)

17b: Eyewear No Authorization Required (In-Network and Out-of-Network) 18a: Hearing Exams No Authorization Required (In-Network and Out-of-Network) SUPPLEMENTAL OFFERINGS Authorization Required (In-Network and Out-of-Network) 51: Routine Chropractic Care Authorization Required (In-Network and Out-of-Network) 10b: Transportation Services - Supplemental No Authorization Required (In-Network and Out-of-Network) 10b: Transportation Services - Any Health-related No Authorization Required (In-Network and Out-of-Network) 10b: Transportation Services - Any Health-related No Benefit 102: Charge Care No Benefit 103: Over-the-Counter (OTC) Items No Benefit 13: Over-the-Counter (OTC) Items Notes OTC benefit list of approved items provided by the Plan. 13: Chear Benefit No Benefit 14c2: Nurtional/Dictary Benefit No Benefit 14c4: Fitness Benefit Notes Members will receive an annual subscription to BrainHQ. Brain	SERVICE TYPE	REQUIREMENT
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	16a2: Prophylaxis (Cleaning)	No Authorization Required (In-Network and Out-of-Network)
16a4: Dental X-Rays No Authorization Required (In-Network and Out-of-Network)	16a3: Fluoride Treatment	No Authorization Required (In-Network and Out-of-Network)
	16a4: Dental X-Rays	No Authorization Required (In-Network and Out-of-Network)

SERVICE TYPE	REQUIREMENT
16a4: Dental X-Rays Notes	One bitewing radiograph is a covered benefit every year.One
	panoramic radiograph or One complete series is a covered benefit
	once every three years.Intraoral occlusal radiographs are a
	covered benefit twice every year.
16b1: Non-routine Services	No Authorization Required (In-Network and Out-of-Network)
16b1: Non-routine Services Notes	Occlusal guard, analysis, and adjustments are covered once every
	three (3) years.Teledentistry covered two (2) every calendar years.
16b2: Diagnostic Services	No Authorization Required (In-Network and Out-of-Network)
16b3: Restorative Services	No Authorization Required (In-Network and Out-of-Network)
16b3: Restorative Services Notes	Fillings are covered; no duplicate surface per tooth for two (2)
	years.Fixed prosthodontic services are a covered benefit once per
	tooth every five (5) years.One (1) per tooth of the following
	restorative services are covered every five (5) years, core buildup,
	pin retention, post and core indirectly fabricated, and each
	additional prefabricated post.Prefabricated crown is a covered
	service once per tooth every year.
16b4: Endodontics	No Authorization Required (In-Network and Out-of-Network)
16b4: Endodontics Notes	Endodontic services are covered once per tooth per lifetime.
16b5: Periodontics	No Authorization Required (In-Network and Out-of-Network)
16b5: Periodontics Notes	Scaling and root planning once per quadrant every two (2) years.
	Periodontal maintenance is a covered benefit two (2) per
	year.Gingival irrigation is a covered benefit once per quadrant
	every two (2) years.Covered periodontal services include
	gingivectomy one (1) per quadrant every three (3) years; osseous
	surgery once per site/quadrant every five (5) years; full mouth
	debridement once every two (2) years.Periodontal grafting
	services one (1) per site/quadrant every three (3) years.
16b6: Extractions	No Authorization Required (In-Network and Out-of-Network)
16b6: Extractions Notes	Simple and Surgical extractions are a covered benefit once per
	tooth per lifetime. The extraction of an impacted tooth is a
	covered benefit. Alveoloplasty services are covered once per
	site/guad per lifetime.
16b7: Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	No Authorization Required (In-Network and Out-of-Network)
16b7: Prosthodontics, Other Oral/Maxillofacial Surgery,	Prosthodontic services include complete and partial dentures once
Other Services Notes	per arch every five (5) years.Denture adjustments and repairs are
	a covered benefit once per arch every year. Denture relines are a
	covered benefit once per arch every two (2) years.
17a: Eye Exams - Supplemental	
17a1: Routine Eye Exams	No Authorization Required (In-Network and Out-of-Network)
17b: Eyewear - Supplemental	
170 Evewear - Supplemental	

SERVICE TYPE	REQUIREMENT
17b1: Contact Lenses	No Authorization Required (In-Network and Out-of-Network)
17b2: Eyeglasses (lenses and frames)	No Authorization Required (In-Network and Out-of-Network)
17b3: Eyeglass lenses	No Authorization Required (In-Network and Out-of-Network)
17b4: Eyeglass frames	No Authorization Required (In-Network and Out-of-Network)
17b5: Upgrades	No Authorization Required (In-Network and Out-of-Network)
18a: Hearing Exams - Supplemental	
18a1: Routine Hearing Exams	No Authorization Required (In-Network and Out-of-Network)
18a2: Fitting/Evaluation for Hearing Aid	No Authorization Required (In-Network and Out-of-Network)
18b: Hearing Aids - Supplemental	
18b1: Hearing Aids (all types)	No Authorization Required (In-Network and Out-of-Network)