

Prior Authorization Requirements

Benefits described below are for "Covered Services" only. (Please refer to the Martin's Point Generations Advantage Evidence of Coverage for a listing of covered benefits, limitations, and exclusions.)

- ▶ In order to determine if a provider is a network provider or a non-network provider, please refer to the Provider Directory, or contact a Martin's Point Generations Advantage Provider Inquiry Representative at 1-888-732-7364.
- ▶ For authorization of mental health and substance abuse services, please call Behavioral HealthCare Program (BHCP) toll-free at 1-888-812-7335.
- ▶ Network Providers—Prime (HMOPOS), Select (PPO) and Value (HMO) plans authorization is required for those services on this grid. There is a 90-day grace period for retro-authorizations.
- ▶ Non-Network Providers— Prime (HMOPOS) and Value (HMO) plans most services require authorization per the grid below. Select (PPO) plan no authorization required for any service out-of-network.

Service	Prior Auth Required (Network)	Prior Auth Required (Non-Network)	Comments
Abrasion Treatment, Dermabrasion, Salabrasion	Yes	Yes	Cosmetic services are not covered.
Allergy Injections	No	Yes	
Ambulance Services, Ground	No	No	Per Medicare guidelines, transportation home is not a covered benefit.
Ambulance Services, Air	Yes	Yes	
Audiological or Audiometric Testing	No	Yes	See also Hearing Exams.
Biofeedback	No	Yes	
Biopsy, Office Setting	No	Yes	
Biopsy, Outpatient Hospital Setting	No	Yes	
Capsule Endoscopies	No	Yes	
Cardiac Catheterization, Including Diagnostic Procedures, Stent Insertion, Drug Eluting Stent and Balloon Angioplasty	No	Yes	Status change to observation or inpatient admission requires Martin's Point Generations Advantage Plan authorization.
Cardiac Rehabilitation, Phase II	Yes	Yes	
Chemotherapy Regimen	Yes	Yes	
Chiropractic Services	No	Yes	
Colorectal Screening	No	Yes	
Colonoscopy, Diagnostic or Routine Screening, Office or Outpatient Setting	No	Yes	Status change to observation or inpatient admission requires Martin's Point Generations Advantage Plan authorization.

Medicare-covered services only

MARTIN'S POINT GENERATIONS ADVANTAGE

Service	Prior Auth Required (Network)	Prior Auth Required (Non-Network)	Comments
Contact Lens Fitting	Yes	Yes	Benefit is limited to patients who have had cataract surgery. Members enrolled in the Prime plan are eligible for reimbursement of \$100 towards eyeglasses or contacts once every two years. Members enrolled in the ValuePlus and Value plans are not eligible for this benefit.
CORF—Comprehensive Outpatient Rehabilitation Facility	No	Yes	
Dental Services—Medicare Covered Services	Yes	Yes	Members enrolled in the Prime plan are eligible for reimbursement of \$100 towards one preventive dental exam every six months. Members enrolled in the ValuePlus and Value plans are not eligible for this benefit.
Diabetes Education and Self Management (ADEF)	No	Yes	
Diabetic Equipment and Monitoring Supplies (e.g. monitor, test strips and lancets)	No	Yes	
Diagnostic Tests, Office or Outpatient Setting (e.g. lab work, x-rays, MRAs, MRIs, CAT Scans, PET Scans, SPECT, EEG, Cardiac Tests)	No	No	Network providers should be used for diagnostic testing whenever possible.
Diagnostic Procedures, Office or Outpatient Setting (e.g. EMG, Nerve Conduction Tests, Digestive Endoscopy, EGD, Urodynamic Studies, Endoscopic Ultrasound)	No	Yes	
Durable Medical Equipment	Refer to Separate List	Refer to Separate List	
Emergency Room Services	No	No	Status change to observation or inpatient admission requires authorization. Any follow up services to an ER visit require PCP referral.

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MARTIN'S POINT GENERATIONS ADVANTAGE

Service	Prior Auth Required (Network)	Prior Auth Required (Non-Network)	Comments
Eye Examinations, Annual Routine	No	Yes	Member may self refer to a participating provider without a PCP referral. Members enrolled in the Prime plan are eligible for reimbursement of \$100 towards eyeglasses or contacts once every two years. Members enrolled in the ValuePlus and Value plans are not eligible for this benefit.
Eye Examinations, Non-Routine (e.g. diabetic, cataract, glaucoma)	No	Yes	
Eye Glasses	Yes	Yes	Benefit is limited to patients who have had cataract surgery. Members enrolled in the Prime plan are eligible for reimbursement of \$100 towards eyeglasses or contacts once every two years. Members enrolled in the ValuePlus and Value plans are not eligible for this benefit.
Foot Care, Podiatry Non-Routine (e.g. treatment of injury or trauma to foot or toes)	No	Yes	
Foot Care, Podiatry Routine (e.g. paring corns or calluses, nails, debridement)	No	Yes	Routine foot care covered only for patients with systematic disease or lower extremity.
Fracture Care, Office Setting	No	Yes	
Gastric Bypass and all related services beyond initial consultation	Yes	Yes	Benefit limitations apply.
Hearing Exam, Diagnostic (e.g. to diagnose hearing loss)	No	Yes	Members enrolled in the Prime plan are eligible for reimbursement of \$500 towards hearing aid(s) once every three years. Members enrolled in the ValuePlus and Value plans are not eligible for this benefit.
Hearing Exam, Routine	No	Yes	One routine hearing exam is covered per year.
Home Health Services (e.g. skilled nursing, physical therapy, occupational therapy, speech therapy)	No	No	
Hospice Services	No	No	Hospice benefits are covered by original Medicare.

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Hospital Clinic (e.g. Pain Clinic, Wound Clinic, etc.)	Yes	Yes	
Immunizations and Vaccinations (influenza, pneumonia, Hepatitis B)	No	Yes	
Inpatient Hospital Facility Admissions	Yes	Yes	
IV Therapy, Outpatient Hospital	No	Yes	For weekend therapy, please coordinate with our Health Management Department.
IV Therapy, Office Setting	No	Yes	For weekend therapy, please coordinate with our Health Management Department.
IV Therapy, Home Setting	Yes	Yes	Medicare covered services only, medical review required.
Mammography, Medical Diagnosis	No	Yes	
Mammography Screening, Routine Annual	No	Yes	Covered every 12 months.
Neuropsychological Testing	Yes	Yes	
Observation Stay	Yes	Yes	Status change to inpatient admission requires additional authorization.
Occupational Therapy, Office or Clinic Setting	No	Yes	
Office Visit, Primary Care Provider	No	Not Applicable	
Office Visit, Specialist	No	Yes	
Oncology Services	Yes	Yes	
Pacemaker Checks	No	Yes	
Pap Smear Test	No	Yes	For all women, Pap tests covered once every 24 months. If member is at high risk of cervical cancer or has had an abnormal Pap test and are of childbearing age, Pap tests covered once every 12 months.
Physical Therapy, Office or Clinic Setting	No	Yes	
Pool Therapy	No	Yes	
Physician Visits Provided in Hospital Office Setting	No	Yes	
Proctosigmoidoscopy Diagnostic, Office or Outpatient Hospital Setting	No	Yes	
Physicals, Annual Routine	No	Not Applicable	
Prostate Cancer Screening	No	Yes	Covered every 12 months.

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Pulmonary Rehabilitation	Yes	Yes	
Radiation Therapy	Yes	Yes	
Sigmoidoscopy, Diagnostic or Routine Screening, Office or Outpatient Hospital Setting	No	Yes	
Skilled Nursing Facility, Sub-Acute and/or Rehabilitative Facility	Yes	Yes	
Surgery, Inpatient Hospital Setting	Yes	Yes	
Surgery, Office Setting	No	Yes	Network and Non-network providers: Surgery for oral, vision, plastic, cosmetic, reconstructive, or scar revision, you must receive prior authorization.
Surgery, Outpatient Hospital Setting and Ambulatory Surgical Setting	Yes	Yes	Status changes to observation or inpatient admission requires separate authorization.
Telemedicine	No	Yes	
Testosterone Shots	No	Yes	
Transplants	Yes	Yes	
Ultrasound, Diagnostic	No	No	Network providers should be used for diagnostic testing whenever possible.
Urgent Care Center	No	No	Any follow-up services received at an Urgent Care Center require authorization. Members should contact their PCP for a referral. The PCP office will should request authorization from Martin's Point Generations Advantage.

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