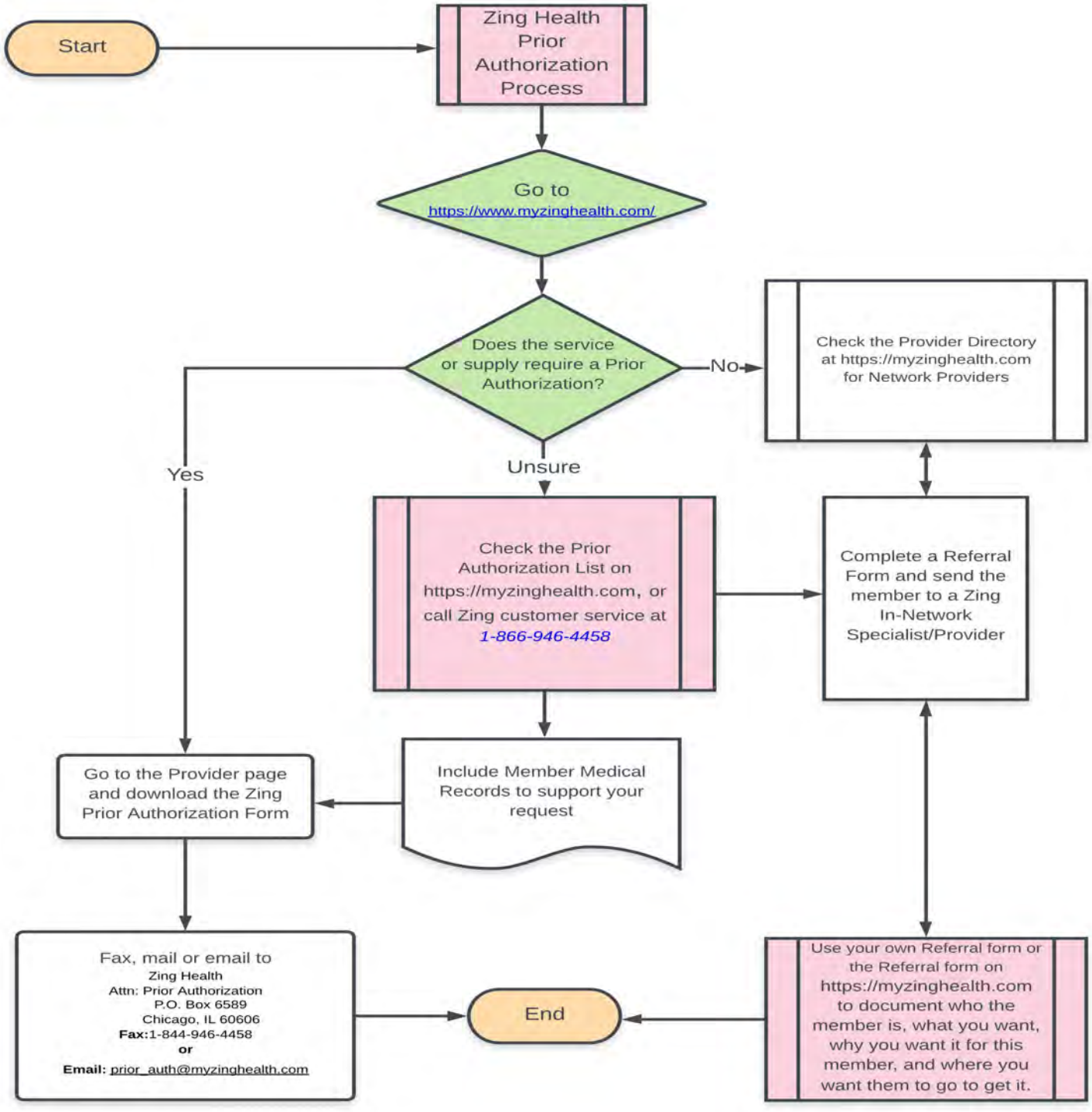
Prior Authorization 2021

IMPORTANT – Prior Authorization is not a guarantee of benefits or payment at the time of service. Benefits will vary between plans, so always verify benefits. This list is not intended to be all-inclusive. It includes tests that are most frequently requested and require prior authorization. [iii]

PRIOR AUTHORIZATION *NOT REQUIRED*	**HMO**	**HMO-POS**	**C-SNP**
Visits to the in-network primary care provider	none	none	none
Visits to the in-network specialty care provider	none	none	none
In-network Medicare-covered preventive care	none	none	none
PRIOR AUTHORIZATION *REQUIRED*	**HMO**	**HMO-POS**	**C-SNP**
ALL SERVICES provided by out of network (non-contracted) providers except for emergency services and use of out-of-network benefits in HMO, HMO-POS, and HMO C-SNP products. See Endnote[5]	x	x	x
The procedures/services below (in-network and out-of-network)	x	x	x
Acute admissions to in-network hospitals (medical, surgical, behavioral health) and admissions to LTAC, acute rehabilitation, and SNF facilities **(the admission may be subject to concurrent review)**	x	x	x
Notification required for DISCHARGE from all facilities	x	x	x
PRIOR AUTHORIZATION REQUIRED: ELECTIVE SERVICES AND SURGERIES	**HMO**	**HMO-POS**	**C-SNP**
Abdominoplasty	x	x	x
Ablation (bone marrow, liver, kidney, prostate)	x	x	x
Back surgery (spinal fusion, laminectomy, disc replacement, vertebroplasty, kyphoplasty)	x	x	x
Balloon sinuplasty	x	x	x
Breast procedures (breast cancer biopsy, lumpectomy, simple mastectomy, gynecomastia surgery)	x	x	x
Cardiac ablation	x	x	x
Cardiac catherization	x	x	x
Cardiac external counterpulsation (EECP)	x	x	x
Cardiac left atrial occlusion procedure (Watchman)	x	x	x
Cardiac transaortic or transapical valve insertion or replacement (TAVR or TMVR)	x	x	x
Cardiac ventricular assist devices (VAD)	x	x	x
Cochlear and auditory implants	x	x	x
Elective surgeries (cardiovascular, CNS, ENT, integument, GI, gynecologic,	x	x	x

ophthalmologic, orthopedic, podiatric, pulmonary, spinal, urologic)			
ENT surgeries (otoplasty, nasal and sinus endoscopic procedures)	x	x	x
Neurological procedures (Deep brain stimulator placement, intrathecal pain pump implantation)	x	x	x
Ophthalmologic surgeries	x	x	x
Oral, orthognathic, temporomandibular joint surgeries	x	x	x
Prosthetic devices	x	x	x
Spinal stimulator trial and placement	x	x	x
Transplantation (solid organ and stem cell transplants; pre-transplant evaluation; transplant; post-transplant care)	x	x	x
Urological surgeries (bladder sling surgery)	x	x	x
Varicose veins (surgical treatment and/or sclerotherapy)	x	x	x
Weight loss (bariatric) surgeries	x	x	x
PRIOR AUTHORIZATION REQUIRED: OUTPATIENT DIAGNOSTIC TESTS AND THERAPEUTIC SUPPLIES	**HMO**	**HMO-POS**	**C-SNP**
Cardiac computed tomography angiography (CCTA)	x	x	x
CT scan	x	x	x
Electrophysiology (EPS) with 3D mapping	x	x	x
Electrophysiology study (EPS)	x	x	x
Genetic/genomic testing (except for testing performed in-house)	x	x	x
MRA	x	x	x
MRI	x	x	x
Myocardial perfusion imaging single-photon emission computed tomography (MPI SPECT)	x	x	x
PET scan/National Oncology PET Registry (NOPR)	x	x	x
SPECT scan	x	x	x
Transesophageal echocardiogram (TEE)	x	x	x
PRIOR AUTHORIZATION REQUIRED: TRANSPORTATION	**HMO**	**HMO-POS**	**C-SNP**
Ambulance transport (fixed wing or jet medical transports and non-emergent helicopter, non-emergent)	x	x	x
PRIOR AUTHORIZATION REQUIRED: THERAPIES	**HMO-**	**HMO-POS**	**C-SNP**
Applied behavioral analysis (ABA) therapy	x	x	x
Electroconvulsive Therapy (ECT)	x	x	x
Hyperbaric Therapy	x	x	x
IVIG therapy (some)	x	x	x
Proton Beam Therapy	x	x	x
Transcranial Magnetic Stimulation for Depression	x	x	x
Ventricular Assist Devices	x	x	x

PRIOR AUTHORIZATION REQUIRED: PART B DRUGS	HMO	HMO-POS	C-SNP
Please reference Part B list on myzinghealth.com	x	x	x
PRIOR AUTHORIZATION REQUIRED: DME	**HMO**	**HMO-POS**	**C-SNP**
Bone growth stimulators	x	x	x
Breast implants (unless status post medically indicated mastectomy)	x	x	x
Custom made and specially sized wheelchairs and related equipment	x	x	x
Defibrillators (external) and related equipment (includes chest/vest defibrillators)	x	x	x
Electric, semi-electric, air fluidized, and advanced technology beds and related equipment	x	x	x
External ambulatory pumps (e.g. insulin)	x	x	x
High frequency chest wall oscillation air-pulse generator system; including vest, hose, and related equipment	x	x	x
High frequency chest compression vests	x	x	x
Implantable Infusions Pumps	x	x	x
Lower and upper limb prosthetics (including myoelectric and microprocessor controlled) and related equipment/supplies	x	x	x
Non-specific, miscellaneous, and unlisted prosthetic and DME codes	x	x	x
Power operated vehicles and related equipment	x	x	x
Sacral nerve stimulator	x	x	x
Spinal cord stimulators	x	x	x
Vagal nerve stimulators	x	x	x


Start
Zing Health Prior Authorization Process
Go to https://www.myzinghealth.com/
Does the service or supply require a Prior Authorization?
No
Check the Provider Directory at https://myzinghealth.com for Network Providers
Yes
Unsure
Check the Prior Authorization List on https://myzinghealth.com, or call Zing customer service at 1-866-946-4458
Complete a Referral Form and send the member to a Zing In-Network Specialist/Provider
Go to the Provider page and download the Zing Prior Authorization Form
Include Member Medical Records to support your request
Fax, mail or email to
Zing Health
Attn: Prior Authorization
P.O. Box 6589
Chicago, IL 60606
Fax:1-844-946-4458
or
Email: prior_auth@myzinghealth.com
End
Use your own Referral form or the Referral form on https://myzinghealth.com to document who the member is, what you want, why you want it for this member, and where you want them to go to get it.

[i] **Zing Health HMO, Zing Health HMO-POS and Zing Health C-SNP:** The above services rendered by participating providers require prior authorization by Zing Health. We also request notification for certain other services so that we may assist you and your patients with discharge planning, care coordination, and case management. All services must be medically necessary and appropriate, meet traditional Medicare coverage criteria where applicable, and be rendered by in-network physicians/providers (unless otherwise authorized in advance) to be eligible for payment. All services rendered by Out of Network providers (except Out of Network Pathology, Anesthesiology, Radiology, Emergency Department and Assistant Surgeon physicians providing services in a In-Network inpatient facility) must be prior authorized to receive full benefits. Claims will be reviewed to determine member eligibility at the time of service, benefit availability, evidence of coverage provisions, and claims payment agreements. Benefits are determined by each Member's plan. Authorization is not a guarantee of payment. Newly published/assigned codes and new/emerging therapy services or technology not listed may require prior authorization to determine medical necessity. Any service, therapy, medication, or procedure or medication that is experimental, investigational, unproven, or not FDA approved will be stopped for review and may be denied. Check with us before providing these types of services. This list is generally updated bi-annually but may change at any time. Please refer to the version currently in effect by visiting our website at https://www.myzinghealth.com clicking on the "Providers" tab and then clicking on the "Prior Authorization Lists".

[ii] There are services and procedures which are not covered by Medicare. These are NOT on the prior authorization list since they are never covered.