Perennial Advantage Freedom (HMO-POS) - Ohio (partial)
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	Prior authorization is only required for services provided by non-capitated providers. Auto-approval for initial In-network SNF requests for the first 7 days following a post-acute hospitalization if one of the following are met: IP stay greater than 5 days, ICU admission, status post operation. Clinical documentation required.
2: Skill-In-Place (SIP)	Authorization Required
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 Pathology and Occupational Therapy Services	Authorization Required
7c,i: Therapy: Physical Therapy, Speech-Language Pathology and Occupational Therapy Services Notes	Prior authorization is only required for services provided by non-capitated providers.
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 Services	Authorization Required

SERVICE TYPE	REQUIREMENT
8a: Outpatient Diagnostic Procedures Tests and Lab Services Notes	8a1: Diagnostic Procedures/Tests Notes: No Authorization 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, except for Genetic Testing, which does require authorization.
8b: Outpatient Diagnostic and Therapeutic Radiological Services	Authorization Required
8b: Outpatient Diagnostic and Therapeutic Radiological Services Notes	8b1: Diagnostic Radiological Services Notes: 8b2: Therapeutic Radiological Services Notes: 8b3: Outpatient X-Ray Services Notes: x-rays do not require authorization when service rendered in a nursing facility or physician office. All other diagnostic and therapeutic radiological services require auth.
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)	Authorization Required
11a: Durable Medical Equipment (DME)	Authorization Required
11b: Prosthetics/Medical Supplies	Authorization Required
11c: Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts	No Authorization Required (In-Network and Out-of-Network)
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)
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 Notes	Prior authorization is required for some medications. For chemo therapy authorization is required for the initial drug approval only.
16b: Comprehensive Dental	Authorization Required
16b: Comprehensive Dental Notes	Prior authorization is only required for Medicare-covered comprehensive dental
17a: Eye Exams	No Authorization Required (In-Network and Out-of-Network)

SERVICE TYPE	REQUIREMENT
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	
7b: Chiropractic Services - Supplemental	
7b1: Routine Chiropractic Care	No Authorization Required (In-Network and Out-of-Network)
7b1: Routine Chiropractic Care Notes	Prior authorization is only required for Medicare-covered chiropractic services.
7f: Podiatry Services - Routine Foot Care	No Authorization Required (In-Network and Out-of-Network)
10b: Transportation Services - Supplemental	
10b1: Transportation Services - Plan Approved Health-related Location	No Benefit
10b2: Transportation Services - Any Health-related Location	No Benefit
13: Other Services - Supplemental	
13a: Acupuncture	No Benefit
13b: Over-the-Counter (OTC) Items	No Authorization Required (In-Network and Out-of-Network)
13c: Meal Benefit	No Benefit
14c: Other Defined Supplemental Benefits - Supplemental	
14c2: Nutritional/Dietary Benefit	No Benefit
14c4: Fitness Benefit	No Authorization Required (In-Network and Out-of-Network)
14c4: Fitness Benefit Notes	Members have access to an online physical fitness and exercise class subscription for the year. Members also have access to Brain HQ, an online subscription for year that offers brain/mental exercises and games. Members receive $150 towards the purchase of a Fitbit activity tracker.
14c5: Enhanced Disease Management	No Benefit
14c6: Telemonitoring Services	No Benefit
14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)	No Benefit
14c11: Personal Emergency Response System (PERS)	No Benefit
14c12: Medical Nutrition Therapy (MNT)	No Benefit
14c13: Post discharge In-Home Medication Reconciliation	No Benefit
14c18: Therapeutic Massage	No Benefit
14c19: Adult Day Health Services	No Benefit
14c21: In-Home Support Service	No Benefit
16a: Preventive Dental Services - Supplemental	
16a1: Oral Exams	No Authorization Required (In-Network and Out-of-Network)
16a2: Prophylaxis (Cleaning)	No Authorization Required (In-Network and Out-of-Network)
16a3: Fluoride Treatment	No Authorization Required (In-Network and Out-of-Network)

SERVICE TYPE	REQUIREMENT
16a4: Dental X-Rays	No Authorization Required (In-Network and Out-of-Network)
16b1: Non-routine Services	No Authorization Required (In-Network and Out-of-Network)
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	1 per tooth of the following restorative services are covered every 5 years, core buildup, pin retention, post and core indirectly fabricated, and each additional prefabricated post. Prefabricated crown are a covered service once per tooth every year.
16b4: Endodontics	No Authorization Required (In-Network and Out-of-Network)
16b5: Periodontics	No Authorization Required (In-Network and Out-of-Network)
16b5: Periodontics Notes	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	Alveoloplasty services are covered once per site/quad 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, Other Services Notes	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	
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)