# Perennial Advantage Strive (HMO I-SNP) - Colorado (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 | Prior authorization is only required for services provided by non-capitated providers.<br>Auto-approval for initial In-network SNF requests for the first 5 days following a post-acute hospitalization.<br>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.<br>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 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 of Physician office.<br>8a2: Lab Services Notes: No authorization required for lab services 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:<br>8b2: Therapeutic Radiological Services Notes:<br>8b3: Outpatient X-Ray Services Notes: Authorization exception: 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) | 10a1: Ground Ambulance Services Auth: N<br>10a2: Air Ambulance Services Auth: Y |
| 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 chemotherapy, authorization is required on the initial drug approval only. |
| 16b: Comprehensive Dental | Authorization Required |
| 16b: Comprehensive Dental Notes | Prior authorization is only required for Medicare-covered comprehensive dental |

| SERVICE TYPE | REQUIREMENT |
|---|---|
| 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** | |
| **7b: Chiropractic Services - Supplemental** | |
| 7b1: Routine Chiropractic Care | No Benefit |
| 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) |
| 13b: Over-the-Counter (OTC) Items Notes | Members receive $175/quarterly pre-loaded on a flex card to spend on OTC products. $125/quarter may be spent on any OTC products. $50/quarter may be spent specifically on incontinence products. One wheelchair cushion is available to each member free of cost once per year. |
| 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 annual subscription of Brain HQ, which offers online brain exercises and games to improve memory and brain elasticity. |
| 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 Benefit |
| 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) |