# Perennial Advantage Premier (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 the 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 or 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 | 15-2: Medicare Part B Chemotherapy/Radiation Drugs Notes: NA<br>15-3: Other Medicare Part B 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 |

| SERVICE TYPE | REQUIREMENT |
|---|---|
| 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) |
| 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 $50/month pre-loaded onto a flex card to spend on OTC products, fitness classes/supplies, personal training, dining packages, massage therapy sessions, or beauty/barber shop services from preferred providers. |
| 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 | The Plan provides members with a subscription to an online fitness and exercise platform.Members also 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 Authorization Required (In-Network and Out-of-Network) |
| 14c18: Therapeutic Massage Notes | Members may use their pre-loaded flex card ($50/month) towards massage therapy services from preferred providers (Combined with other benefit categories. See Combined Supplemental Benefits section). |
| 14c19: Adult Day Health Services | No Benefit |

| SERVICE TYPE | REQUIREMENT |
|---|---|
| 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) |
| 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** | |

| SERVICE TYPE | REQUIREMENT |
| --- | --- |
| 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) |