Perennial Advantage Strive (HMO I-SNP) - Ohio (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. Auto-approval for initial In-network SNF requests for the first 5 days following a post-acute hospitalization. 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. 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. 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: 8b2: Therapeutic Radiological Services Notes: 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 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 Authorization Required (In-Network and Out-of-Network)
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 Brain HQ, an online subscription for the year that offers brain/mental exercises and games.
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)