AGERIGHT ADVANTAGE

AgeRight Advantage Health Plan (HMO I-SNP) - Oregon (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: 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	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
8a: Outpatient Diagnostic Procedures Tests and Lab Services Notes	8a1: Diagnostic Procedures/Tests Notes: 8a2: Lab Services Notes: Authorization required for genetic testing.

SERVICE TYPE	REQUIREMENT
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 authorization.
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 chemotherapy, the initial administration only requires authorization.
16b: Comprehensive Dental	Authorization Required

SERVICE TYPE	REQUIREMENT
16b: Comprehensive Dental Notes	Authorization is for Medicare-covered comprehensive dental only.
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 Authorization Required (In-Network and Out-of-Network)
10b1: Transportation Services - Plan Approved Health-related Location Notes	Trips not to exceed 20 miles (one-way limit) and subject to $550 limit.
10b2: Transportation Services - Any Health-related Location	No Benefit
13: Other Services - Supplemental	
13a: Acupuncture	No Benefit
13b: Over-the-Counter (OTC) Items	No Benefit
13c: Meal Benefit	No Benefit
14c: Other Defined Supplemental Benefits - Supplemental	
14c2: Nutritional/Dietary Benefit	No Benefit
14c4: Fitness Benefit	No Benefit
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 Benefit
16a4: Dental X-Rays	No Authorization Required (In-Network and Out-of-Network)
16a4: Dental X-Rays Notes	One bitewing radiograph is a covered benefit every year.One panoramic radiograph or One complete series is a covered benefit once every three years.Intraoral occlusal radiographs are a covered benefit twice every year.

SERVICE TYPE	REQUIREMENT
16b1: Non-routine Services	No Authorization Required (In-Network and Out-of-Network)
16b1: Non-routine Services Notes	Occlusal guard, analysis, and adjustments are covered once every three (3) years.Teledentistry covered two (2) every calendar years.
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	Fillings are covered;Â no duplicate surface per tooth for two (2) years.Fixed prosthodontic services are a covered benefit once per tooth every five (5) years.One (1) per tooth of the following restorative services are covered every five (5) years, core buildup, pin retention, post and core indirectly fabricated, and each additional prefabricated post.Prefabricated crown is a covered service once per tooth every year.
16b4: Endodontics	No Authorization Required (In-Network and Out-of-Network)
16b4: Endodontics Notes	Endodontic services are covered once per tooth per lifetime.
16b5: Periodontics	No Authorization Required (In-Network and Out-of-Network)
16b5: Periodontics Notes	Scaling and root planning once per quadrant every two (2) years. Periodontal maintenance is a covered benefit two (2) per year.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	Simple and Surgical extractions are a covered benefit once per tooth per lifetime. The extraction of an impacted tooth is a covered benefit.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	Prosthodontic services include complete and partial dentures once per arch every five (5) years.Denture adjustments and repairs are a covered benefit once per arch every year.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)

SERVICE TYPE	REQUIREMENT
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)