



## Align Kidney Care (HMO-POS C-SNP) - Michigan (partial) 2024 Prior Authorization Chart

\*Detailed limits and exclusions can be found in the member's Evidence of Coverage (EOC).

| SERVICE TYPE   | REQUIREMENT  |
|--|--|
| <b>MEDICARE OFFERINGS</b>  |  |
| <b>Inpatient Services</b>  |  |
| 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  | 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   |
| <b>Outpatient Services</b>   |  |
| 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)  |
| 7d: Physician Specialist Services Notes  | \$0 cost share for in-network nephrologists. 20% coinsurance for all other physician specialist visits.  |
| 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   |

| SERVICE TYPE  | REQUIREMENT   |
|---|---|
| 8a: Outpatient Diagnostic Procedures Tests and Lab Services                   | Authorization Required  |
| 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 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:<br>8b2: Therapeutic Radiological Services Notes:<br>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)   |

| SERVICE TYPE  | REQUIREMENT   |
|---|---|
| 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:<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  |
| 16b: Comprehensive Dental Notes   | Prior authorization only required for Medicare-covered comprehensive dental services.   |
| 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)   |
| <b>SUPPLEMENTAL OFFERINGS</b>   |   |
| <b>7b: Chiropractic Services - Supplemental</b>   |   |
| 7b1: Routine Chiropractic Care  | No Benefit  |
| 7f: Podiatry Services - Routine Foot Care   | No Authorization Required (In-Network and Out-of-Network)   |
| <b>10b: Transportation Services - Supplemental</b>  |   |
| 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)   |
| 10b2: Transportation Services - Any Health-related Location Notes                             | 75-mile limit on each one-way trip.   |
| <b>13: Other Services - Supplemental</b>  |   |
| 13a: Acupuncture  | No Benefit  |
| 13b: Over-the-Counter (OTC) Items   | No Authorization Required (In-Network and Out-of-Network)   |
| 13c: Meal Benefit   | No Authorization Required (In-Network and Out-of-Network)   |
| 13c: Meal Benefit Notes   | The Plan provides up to two meals per day for seven days following a discharge from an inpatient hospital or rehabilitation stay. The benefit is limited to four weeks of meals annually. The Plan also provides up to 2 meals per day for 30 days to members with a diagnosis of ESRD. |
| <b>14c: Other Defined Supplemental Benefits - Supplemental</b>                                |   |
| 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 exercise and wellness platform that offers exercise classes and recommendations.   |
| 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  |

| SERVICE TYPE   | REQUIREMENT  |
|--|--|
| 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   |
| <b>16a: Preventive Dental Services - Supplemental</b>                        |  |
| 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)  |
| 16a4: Dental X-Rays Notes  | Intraoral occlusal radiographs are a covered benefit twice every year.   |
| 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  | Alveoplasty 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.   |
| <b>17a: Eye Exams - Supplemental</b>   |  |
| 17a1: Routine Eye Exams  | No Authorization Required (In-Network and Out-of-Network)  |
| <b>17b: Eyewear - Supplemental</b>   |  |

| SERVICE TYPE                             | REQUIREMENT   |
|--|---|
| 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) |
| <b>18a: Hearing Exams - Supplemental</b> |   |
| 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) |
| <b>18b: Hearing Aids - Supplemental</b>  |   |
| 18b1: Hearing Aids (all types)           | No Authorization Required (In-Network and Out-of-Network) |