KeyCare ADVANTAGE

# KeyCare Advantage Community (HMO I-SNP) Maryland

## 2025 Prior Authorization Chart

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

| Service Type | Details |
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| MEDICARE OFFERINGS | |
| Inpatient Services | |
| Inpatient Hospital-Acute Auth | Authorization Required |
| Inpatient Hospital Psychiatric Auth | Authorization Required |
| Skilled Nursing Facility (SNF) Auth | Authorization Required |
| Skilled Nursing Facility (SNF) Notes | Authorization is required for services provided by non-capitated providers. |
| Skill-In-Place (SIP) Auth | Authorization Required |
| Partial Hospitalization Auth | Authorization Required |
| Observation Services Auth | Authorization Required |
| Outpatient Services | |
| Cardiac and Pulmonary Rehabilitation Services Auth | Authorization Required |
| Emergency Services Auth | No Authorization Required (In-Network and Out-of-Network) |
| Home Health Services Auth | Authorization Required |
| Primary Care Physician Services Auth | No Authorization Required (In-Network and Out-of-Network) |
| Chiropractic Services Auth | Authorization Required |
| Chiropractic Services Notes | Prior authorization is only required for Medicare-covered chiropractic services. |
| Therapy | Authorization Required |
| Therapy | Authorization is required for services provided by non-capitated providers. |
| Physician Specialist Services Auth | No Authorization Required (In-Network and Out-of-Network) |
| Mental Health Specialty Services Auth | No Authorization Required (In-Network and Out-of-Network) |
| Podiatry Services Auth | No Authorization Required (In-Network and Out-of-Network) |
| Other Health Care Professional Auth | No Authorization Required (In-Network and Out-of-Network) |
| Psychiatric Services Auth | No Authorization Required (In-Network and Out-of-Network) |
| Additional Telehealth Benefits Auth | No Authorization Required (In-Network and Out-of-Network) |
| Opioid Treatment Program Services Auth | Authorization Required |
| Outpatient Diagnostic Procedures Tests and Lab Services Auth | Authorization Required |

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| 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 requires authorization. |
| Outpatient Diagnostic and Therapeutic Radiological Services Auth | Authorization Required |
| 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, physician office or mobile X-Ray. All other diagnostic and therapeutic radiological services require authorization. |
| Outpatient Hospital Services Auth | Authorization Required |
| Outpatient Hospital Services Notes | $0 copay for diagnostic colonoscopy and polyp removal. 20% coinsurance for surgeries and $225 copay for all other outpatient hospital services |
| Ambulatory Surgical Center (ASC) Services Auth | Authorization Required |
| Outpatient Substance Abuse Services Auth | Authorization Required |
| Outpatient Blood Services Auth | No Authorization Required (In-Network and Out-of-Network) |
| Ambulance Services Auth | Authorization Required |
| Durable Medical Equipment (DME) Auth | Authorization Required |
| Prosthetics/Medical Supplies Auth | Authorization Required |
| Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Auth | No Authorization Required (In-Network and Out-of-Network) |
| Dialysis Services Auth | No Authorization Required (In-Network and Out-of-Network) |
| Medicare-covered Zero Dollar Preventive Services Auth | No Authorization Required (In-Network and Out-of-Network) |
| Kidney Disease Education Services Auth | No Authorization Required (In-Network and Out-of-Network) |
| Glaucoma Screening Auth | No Authorization Required (In-Network and Out-of-Network) |
| Diabetes Self-Management Training Auth | No Authorization Required (In-Network and Out-of-Network) |
| Barium Enemas Auth | No Authorization Required (In-Network and Out-of-Network) |
| Digital Rectal Exams Auth | No Authorization Required (In-Network and Out-of-Network) |
| EKG following Welcome Visit Auth | No Authorization Required (In-Network and Out-of-Network) |

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| Medicare Part B Insulin Drugs Auth | No Authorization Required (In-Network and Out-of-Network) |
| Medicare Part B Rx Drugs and Home Infusion Drugs Auth | Authorization Required |
| 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. |
| Medicare Dental Services Auth | Authorization Required |
| Eye Exams Auth | No Authorization Required (In-Network and Out-of-Network) |
| Eyewear Auth | No Authorization Required (In-Network and Out-of-Network) |
| Hearing Exams Auth | No Authorization Required (In-Network and Out-of-Network) |
| SUPPLEMENTAL OFFERINGS | |
| Routine Chiropractic Care Auth | No Authorization Required (In-Network and Out-of-Network) |
| Podiatry Services - Routine Foot Care Auth | No Authorization Required (In-Network and Out-of-Network) |
| Transportation Services - Plan Approved Health-related Location Auth | No Benefit |
| Transportation Services - Any Health-related Location Auth | No Benefit |
| Acupuncture Auth | No Benefit |
| Enhanced Disease Management Auth | No Benefit |
| In-Home Support Service Auth | No Authorization Required (In-Network and Out-of-Network) |
| In-Home Support Service Notes | In-home support services may include support with ADLs or IADLs including personal hygiene needs, light housekeeping, laundry tasks, meal preparation, feeding, bathing, and toileting.30 hours annually (Companion Care) |
| Oral Exams Auth | No Authorization Required (In-Network and Out-of-Network) |
| Oral Exams Notes | Two preventive oral exams, x-ray coverage, two prophylaxis services, and two fluoride treatments are carved out from the benefit maximum.Plan will only cover 2 of periodic, limited, periodontal or comprehensive oral evaluation every calendar year. |
| Dental X-Rays Auth | No Authorization Required (In-Network and Out-of-Network) |
| Dental X-Rays Notes | Two bitewing radiograph is a covered benefit every year.One (1) panoramic radiograph or One (1) complete series is a covered benefit once every three years.Intraoral occlusal radiographs are a covered benefit twice every year. |
| Other Diagnostic Dental Services Auth | No Authorization Required (In-Network and Out-of-Network) |

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| Other Diagnostic Dental Services Notes | Plan will cover cone beam CT capture and interpretation, pulp vitality tests and caries risk assessments. |
| Prophylaxis (Cleaning) Auth | No Authorization Required (In-Network and Out-of-Network) |
| Flouride Treatment Auth | No Authorization Required (In-Network and Out-of-Network) |
| Other Preventative Dental Services Auth | No Benefit |
| Restorative Services Auth | No Benefit |
| Restorative Services Notes | Fillings are covered; 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. |
| Endodontics Auth | No Authorization Required (In-Network and Out-of-Network) |
| Endodontics Notes | Endodontic services are covered once per tooth per lifetime. |
| Periodontics Auth | No Authorization Required (In-Network and Out-of-Network) |
| 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. |
| Periodontics removable Auth | No Authorization Required (In-Network and Out-of-Network) |
| Periodontics removable 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. |
| Maxillofacial Prosthetics Auth | No Benefit |
| Implant Services Auth | No Benefit |
| Prosthodontics Fixed Auth | No Authorization Required (In-Network and Out-of-Network) |
| Prosthodontics Fixed Notes | Fixed prosthodontic services are a covered benefit once per tooth every five (5) years.One (1) pontic/retainer crown (bridge) per tooth every 5 calendar years. |
| Oral and Maxillofacial Surgery Auth | No Authorization Required (In-Network and Out-of-Network) |

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| Oral and Maxillofacial Surgery Notes | Plan will cover Simple and Surgical extractions, and removal of impacted tooth one per tooth in a lifetime. Alveoloplasty services are covered once per site/quad in a lifetime.Bone replacement graft for ridge preservation, per site one (1) per site in a lifetime. Frenuloplasty one every 5 years. Incision and drainage of an abscess, Excision of benign lesion, Removal of benign odontogenic cyst/tumor. |
| Orthodontics Auth | No Benefit |
| Adjunctive General Services Auth | No Authorization Required (In-Network and Out-of-Network) |
| Adjunctive General Services Notes | Adjunctive General Services include Deep sedation, intravenous conscious sedation, consultation. Occlusal guard, analysis, and adjustments are covered once every three (3) years. Teledentistry covered two (2) every calendar years. |
| Routine Eye Exams Auth | No Authorization Required (In-Network and Out-of-Network) |
| Contact Lenses Auth | No Authorization Required (In-Network and Out-of-Network) |
| Eyeglasses (lenses and frames) Auth | No Authorization Required (In-Network and Out-of-Network) |
| Eyeglass lenses Auth | No Benefit |
| Eyeglass frames Auth | No Benefit |
| Upgrades Auth | No Benefit |
| Routine Hearing Exams Auth | No Authorization Required (In-Network and Out-of-Network) |
| Fitting/Evaluation for Hearing Aid Auth | No Benefit |
| Hearing Aids (all types) Auth | No Authorization Required (In-Network and Out-of-Network) |