Hawai'i Medicare Quick Reference Guide

July 2023

https://www.wellcare.com/en/Hawaii/Providers/Medicare

OFFICE LOCATIONS

ISLAND OF OAHU (MAIN OFFICE)
949 Kamokila Blvd., Suite 350
Kapolei, HI 96707

ISLAND OF HAWAI'I
88 Kanoelehua Ave. Suite A105
Hilo, HI 96720

IMPORTANT NOTE

Please refer to the member ID card to determine appropriate authorization and claims submission process. Please see below for additional information.

IMPORTANT PHONE NUMBERS

BEHAVIORAL HEALTH CRISIS LINE: 1-800-411-6485
Members may call this number **24 hours** a day for a Behavioral Health Crisis. For non-crisis related concerns, please call Member Services.

NURSE ADVICE LINE: 1-800-581-9952
Members may call this number to speak to a nurse **24 hours** a day, **7 days** a week.

CONVENIENT SELF-SERVICE

Wellcare By 'Ohana Health Plan offers robust technology options to save you time. The fastest ways to get what you need are shown below.

	Portal	Chat	(IVR) Interactive Voice Response
Authorization Requirements*	**Fastest Result**	**Available**	Available
Authorization Status*	**Fastest Result**	**Available**	Available
Authorizations Request*	**Fastest Result**	**Available**	N/A
Benefit Information	**Fastest Result**	**Available**	Available
Claims Status	**Fastest Result**	**Available**	Available
Co-payment	**Fastest Result**	**Available**	Available
Eligibility Verification	**Fastest Result**	**Available**	Available
Submit Appeals	**Fastest Result**	**Available**	N/A
Appeals Status	**Fastest Result**	**Available**	N/A
Submit Claim Disputes	**Fastest Result**	**Available**	N/A
Submit Claims	**Fastest Result**	**Available**	N/A
Submit Corrected Claims	**Fastest Result**	**Available**	N/A

Wellcare understands that having access to the right tools can help you and your staff streamline day-to-day administrative tasks. The Provider Portal will help with those routine tasks.

Provider Portal Registration – click here

Provider Portal Training – click here

ⓘ*Note: Includes Pharmacy Medical Requests supplied by Physician.
For Pharmacy Benefit related questions please see the below Pharmacy page.

Provider Services: Interactive Voice Response System Phone: 1-888-505-1201 TTY: 711

For your convenience, when viewing online, items on this QRG in bold, underlined fonts are hyperlinks to supporting Provider Job Aids, resource guides and forms. NOTE: This guide is not intended to be an all-inclusive list of covered services under the Health Plan, but it substantially provides current referral and prior authorization instructions. All services/procedures are subject to benefit coverage, limitations and exclusions as described in the applicable plan coverage guidelines.

PRO_134098E Internal Approved 07212023

WELLCARE PHONE NUMBERS

CARE AND DISEASE MANAGEMENT REFERRALS

Phone: **1-866-635-7045** TTY: **711** Fax: **1-866-287-3286**
Hours: M–F 8 a.m.–7 p.m. Hawai'i Standard Time

FRAUD, WASTE & ABUSE HOTLINE

1-866-685-8664

CLAIM SUBMISSION INFORMATION

SUBMISSION INQUIRIES:

Support from Provider Services: 1-888-505-1201
For inquiries related to your electronic submissions to Wellcare, please contact our EDI team at **EDIBA@centene.com**.

ELECTRONIC FUNDS TRANSFER AND ELECTRONIC REMITTANCE ADVICE:

Register online using the simplified, enhanced provider registration process at **payspanhealth.com** or call **1-877-331-7154**. For more details on PaySpan, please refer to your **Provider Manual**.

CLEARINGHOUSE CONNECTIVITY:

WellCare has partnered with Availity as our preferred EDI Clearinghouse. You may connect directly to Availity or continue to use your existing vendor/biller/clearinghouse. If you need assistance in making a connection with Availity or have any questions, please contact Availity client services at **1-800-282-4548**.

FREE DIRECT DATA ENTRY (DDE)

Availity Essentials offers providers a web portal for direct data entry (DDE) claims that will submit to Wellcare electronically at no cost to you. To register, submit the request to **https://www.availity.com/Essentials-Portal-Registration**.

PAYER IDs

- **Fee-for-Service (FFS) is defined in the Transaction Type Code BHT06 as CH, which means Chargeable, expecting adjudication.**
- **Encounters (ENC) is defined in the Transaction Type Code BHT06 as RP, which means Reportable only, NOT expecting adjudication.**

Claim Type	FFS (CH – Chargeable) Submissions	Encounter (RF – Reporting only) Submissions
Professional or Institutional	14163	59354

PAPER SUBMISSION GUIDELINES:

We follow the Centers for Medicare & Medicaid Services (CMS) guidelines for paper claim submissions. Since October 28, 2010, Wellcare accepts only the original "red claim" form for claim and encounter submissions.

Wellcare does not accept handwritten, faxed or replicated claim forms. Wellcare does not accept media storage devices such as CDs, DVDs, USB storage devices or flash drives.

Click here to locate claim forms and guidelines.

MAIL PAPER CLAIM SUBMISSIONS TO:

Wellcare By 'Ohana Health Plan
Attn: Claims Department
P.O. Box 31372
Tampa, FL 33631-3372

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CLAIM PAYMENT DISPUTES

The Claim Payment Dispute Process is designed to address claim denials for issues related to untimely filing, unlisted procedure codes, non-covered codes etc. Examples include Explanation of Payment Codes DN001, DN004, DN038, DN039, VSTEX, DMNNE, HRM16 and KYREC. However, this is not an all-encompassing list of Appeals codes. Claim payment disputes must be submitted in writing to Wellcare within the time frame as indicated in the Provider Manual or as specified in your Provider Contract. Submit all claims payment disputes with supporting documentation at **https://provider.wellcare.com/ohanacare**.

Click here to locate Provider Administrative Review Request form.

NOTE: Wellcare does not accept media storage devices such as CDs, DVDs, USB storage devices or flash drives.

MAIL ALL CLAIM PAYMENT DISPUTES WITH SUPPORTING DOCUMENTATION TO:

Wellcare By ʻOhana Health Plan
Attn: Claim Payment Disputes
P.O. Box 31370
Tampa, FL 33631-3370
Fax: 1-877-277-1808

***NOTE:** Any appeals related to a claim denial for lack of prior authorization, services exceeding the authorization, insufficient supporting documentation or late notification must be sent to the Appeals (Medical) address in the section below. Anything else related to authorization or medical necessity that is in question should be sent to the Appeals P.O. Box. Include all substantiating information (please do not include image of claim) like a summary of the appeal, relevant medical records and member-specific information.*

CLAIM PAYMENT POLICY DISPUTES

The Claims Payment Policy Department has created a new mailbox for provider issues related strictly to payment policy issues. Disputes for payment policy-related issues must be submitted to us in writing within the time frame indicated in the Provider Manual or as specified in your Provider Contract. Please provide all relevant documentation (please do not include image of Claim), which may include medical records, in order to facilitate the review. Submit all Claims Payment Policy Disputes related to Explanation of Payment Codes beginning with IH###, CE###, CCV### (Medical records required) or PD### at: **https://provider.wellcare.com/ohanacare**.

Click here to locate Provider Administrative Review Request form.

NOTE: Wellcare does not accept media storage devices such as CDs, DVDs, USB storage devices or flash drives.

MAIL ALL DISPUTES RELATED TO EXPLANATION OF PAYMENT CODES BEGINNING WITH IH###, CE###, CCV### (MEDICAL RECORDS REQUIRED) OR PD### TO:

Wellcare By ʻOhana Health Plan
Attn: Payment Policy Disputes Department
P.O. Box 31426
Tampa, FL 33631-3426

MAIL ALL MEDICAL RECORDS AND INITIAL REVIEWS AND 1ST LEVEL APPEALS RELATED TO EXPLANATION OF PAYMENT CODES BEGINNING WITH CPI##:

BY MAIL (U.S. POSTAL SERVICE)
Optum
P.O. Box 52846
Philadelphia, PA 19115
Phone: 1-844-458-6739 | Fax: 1-267-687-0994

BY DELIVERY SERVICES (FEDEX, UPS)
Optum
458 Pike Road
Huntingdon Valley, PA 19006

BY SECURE INTERNET UPLOAD
Refer to Optum's Medical Record Request letter for further instructions

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CLAIM PAYMENT POLICY DISPUTES CONTINUED

MAIL ALL DISPUTES RELATED TO EXPLANATION OF PAYMENT CODES LT###, RVLT# AND CPI## 2ND LEVEL APPEALS TO:

Wellcare By 'Ohana Health Plan
Attn: CCR
P.O. Box 31394
Tampa, FL 33631-3394

MAIL ALL DISPUTES RELATED TO EXPLANATION OF PAYMENT CODES RVPI# TO:

PICRA
P.O. Box 31416
Tampa, FL 33631-3416

RECOVERY/COST CONTAINMENT UNIT (CCU)

REFUND(S) in response to a Wellcare overpayment notification should include a copy of the overpayment notification as well as a copy of attachment(s) and sent to:

Wellcare – Comprehensive Health Management
Attn: Recovery/Cost Containment Unit (CCU)
PO Box 947945
Atlanta, GA 30394-7945

NOTE: Wellcare does not accept media storage devices such as CDs, DVDs, USB storage devices or flash drives.

If you do not agree with this proposed Wellcare overpayment notification related to adjustments **RVXX (Except RV059**, which should refer to the **Claim Payment Disputes** section above), you may request an Administrative Review by submitting a dispute in writing within **40 days** of the recovery letter date. Your request should detail why you disagree with these findings and must include any supporting evidence/documentation you believe is pertinent to your position.

MAIL OR FAX YOUR ADMINISTRATIVE REVIEW REQUEST TO:

Wellcare Initiated Recovery
Attn: CCU Recovery
P.O. Box 31658
Tampa, FL 33631-3658
Fax: 1-813-283-3284

Additional documentation received after your initial Administrative Review request will not be considered. A Final Determination will be rendered within **30 days** of the date of Wellcare's receipt of your request. If you do not submit a dispute or render payment within the time period referenced above, we will take action to recover the amount owed as allowed by law, or as outlined within the contract between you and Wellcare.

ADMINISTRATIVE REVIEWS RELATED TO EXPLANATION OF PAYMENT CODES AND COMMENTS BEGINNING WITH DN227, DN228 OR RV213 must be submitted in writing and include at a minimum: a summary of the review request, the member's name, member's identification number, date(s) of service, reason(s) why the denial should be reversed, copies of related documentation and all applicable medical records related to both stays to support appropriateness of the services rendered.

YOUR DISPUTE SHOULD BE SENT TO:

Cotiviti
Attn: Wellcare Clinical Chart Validation
HillCrest III Building
731 Arbor Way, Suite 150
Blue Bell, PA 19422
Fax: 1-203-202-6607
Phone: 1-203-202-6107 (Inquiries Only)

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RECOVERY/COST CONTAINMENT UNIT (CCU) CONTINUED

PROVIDER-IDENTIFIED REFUND(S) without receiving overpayment notification should include the reason for overpayment as well as any details that assist in identifying the member and Wellcare Claim ID.

Wellcare – Comprehensive Health Management
Attn: Recovery/Cost Containment Unit (CCU)
PO Box 947945
Atlanta, GA 30394-7945

NOTE: For single-claim checks, please use the **Refund Check Informational Sheet** to help Recovery post accurately and timely. For checks in excess of 25 claims, please complete the **Refund Referral Grid** and email all supporting documentation, including the grid, to **OverpaymentRefunds@wellcare.com** to assist with expedited posting. Please note that only check referrals will be accepted by this email box; anything other than check referrals will not be responded to and will be closed.

APPEALS AND RECONSIDERATIONS (MEDICAL)

APPEALS (NON-PARTICIPATING PROVIDERS AND MEMBERS): Procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes they are entitled to receive.

RECONSIDERATIONS (PARTICIPATING PROVIDERS): A reconsideration is the first appeals process level. Reconsiderations involved an MA plan reviewing an adverse organization determination, the findings they based them on, along with other evidence.

All non-participating Medicare provider appeals must be submitted within **60 calendar days from the date of the notice of the initial determination** and they must also submit a signed waiver of liability (WOL) with their request for processing. Accompanying the WOL, an Appointment of Representative form is needed for the WOL process whenever a vendor (such as a billing entity) is appealing on behalf of a non-participating provider. When submitting an appeal, the specific code or service being appealed must be listed on the appeal form. Anything else related to authorization or medical necessity that is in question should be sent to the Appeals P.O. Box. Include all substantiating information (please do not include image of claim) like a summary of the appeal, relevant medical records and member-specific information.

Wellcare Non-Participating Provider Appeal Request Form

Participating providers must seek a reconsideration through the Appeals Department within **90 calendar days** of a claim denial for lack of prior authorization, services exceeding the authorization, insufficient supporting documentation or late notification. When submitting a reconsideration, the specific code or service being reconsidered must be listed on the appeal form. Anything else related to authorization or medical necessity that is in question should be sent to the Appeals P.O. Box. Include all substantiating information (please do not include image of claim) like a summary of the appeal, relevant medical records and member-specific information.

Wellcare Participating Provider Reconsideration Request Form

APPOINTMENT OF REPRESENTATIVE (AOR): With the Member's written consent, an appeal for denial of an authorization for medical service/Part B Drug can be filed on the Member's behalf by a participating Provider who has or is currently treating the Member. If the Member wishes to use a representative, they must complete a Medicare AOR form, and the Member and representative must sign the AOR form.

- **Pre-service appeals:** AORs are not required when providers are submitting pre-service appeals on behalf of Members.
- **Direct member reimbursements:** A provider must submit an AOR when submitting an appeal for a direct Member reimbursement on behalf of the Members. In this instance, the provider would be acting as an appointed representative.

NOTE: For both Appeals and Reconsiderations, Wellcare does not accept media storage devices such as CDs, DVDs, USB storage devices or flash drives.

MAIL OR FAX ALL MEDICAL APPEALS AND RECONSIDERATIONS WITH SUPPORTING DOCUMENTATION TO:

Wellcare By 'Ohana Health Plan
Attn: Appeals Department
P.O. Box 31368
Tampa, FL 33631-3368
Fax: 1-866-201-0657

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GRIEVANCES

Member grievances may be filed verbally by contacting Customer Service or submitted in writing via mail, email or fax. Providers may also file a grievance on behalf of the member with the member's written consent.

NOTE: Wellcare does not accept media storage devices such as CDs, DVDs, USB storage devices or flash drives.

MAIL, EMAIL OR FAX ALL MEMBER GRIEVANCES TO:

Wellcare By 'Ohana Health Plan
Attn: Grievance Department
949 Kamokila Blvd., Suite 350
Kapolei, HI 96707
Phone: 1-877-902-6784 | Fax: 1-866-388-1769
Email: Operationalgrievance@wellcare.com
or pdpgrievance@wellcare.com

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HEALTH PLAN PARTNERS

Contracted Networks

HEARING	VISION	DENTAL
HearUSA	**Premier Eye Care**	**HDSl**
Phone: **1-855-828-4146**	Phone: **1-855-879-1448**	Phone: **1-808-529-9237**

New Century Health®

Wellcare has partnered with **New Century Health** (NCH) to implement a new oncology prior authorization program, **Oncology Pathway Solutions**. Effective April 1, 2023, NCH will manage prior authorization requests for Medical Oncology and Radiation Oncology treatments provided in an outpatient setting. This includes all oncology-related chemotherapeutic drugs and supportive agents and radiation oncology treatments. This requirement applies for your Medicare members 18 years of age and older.

Wellcare has partnered with **New Century Health**(NCH) to implement a new cardiology prior authorization program, the **Cardiology Management Program**. This program is intended to help providers easily and effectively deliver quality patient care. **Effective July 1, 2023**, cardiology services rendered in a physician's office, in an outpatient hospital ambulatory setting, or in an inpatient setting (planned professional services only) must be submitted to NCH for prior authorization. Approvals issued by Wellcare before July 1, 2023, are effective until the authorization end date, but all prior authorization requests needed after July 1, 2023, must be submitted to NCH. This requirement applies to all of your Medicare members ages 18 and older.

Prior authorization can be requested by:

- Visiting NCH's Web portal at **my.newcenturyhealth.com**, or
- Calling **1-888-999-7713, Option 1** (Monday–Friday, 8 a.m.–8 p.m. EST)

TurningPoint®

TurningPoint is our in-network Surgical Quality & Safety Management Program vendor for the following programs **Orthopedic Surgery** and **Spinal Surgery**. The provider resources can be accessed through the vendor portal, link listed below. Contact TurningPoint for all authorization-related submissions for the services listed above rendered in any inpatient and outpatient places of service. Please click on the link below for a listing of the specific services and related resources included in the TurningPoint programs.

Member eligibility and authorization request materials may be accessed via the **TurningPoint Portal**.
A searchable **authorization lookup** is also available online to check the status of your authorization request, and criteria can be accessed through the program link.

For Urgent Authorizations and Provider Services, please contact 1-866-596-7279

SERVICE COORDINATION AND DISEASE MANAGEMENT

Click here to locate Referral for Service Coordination/Disease Management forms, or call Customer Service at **1-888-505-1201**.

Refer a member to a **Service Coordination Program** for assistance with medication compliance, adherence to a medical treatment plan, coordination of services, screening for home-based services, accessing Behavioral Health Services or placement in a foster home or long-term care setting.

Refer a member to our **Disease Management Program** for health education and coaching for Diabetes, Coronary Artery Disease, Asthma, and/or Smoking Cessation.

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PHARMACY SERVICES

PHARMACY SERVICES: 1-888-505-1201

Including after-hours, weekends and holidays – CVS Caremark® Provider Enrollment and Contract Inquiries **1-480-391-4623**

Rx BIN	Rx PCN	Rx GRP
004336	MEDDADV	788257

Click here to locate CVS Caremark® Mail Order Info: **1-866-808-7471**
TTY: **1-866-236-1069**
Fax: **1-800-378-0323**

ACARIAHEALTH™

AcariaHealth is a national comprehensive specialty pharmacy focused on improving care and outcomes for patients living with complex and chronic conditions. AcariaHealth is comprised of dedicated healthcare professionals who work closely with physician offices, including support with referral and prior authorization processes. This collaboration allows our patients to receive the medicine they need as fast as possible.

Representatives are available from Monday–Thursday, 8 a.m. to 7 p.m., and Friday, 8 a.m. to 6 p.m. ET.

***AcariaHealth™ Pharmacy #26, Inc.**
8715 Henderson Rd.
Tampa, FL 33634
Phone: 1-866-458-9246 (TTY 1-855-516-5636)
Fax: 1-866-458-9245
Website: www.acariahealth.com

***Effective on or about July 2021**

MEDICATION APPEALS: Fax: 1-866-388-1766

Click here to locate Medication Appeal Request (form) and mail with supporting documentation to:

Wellcare
Attn: Pharmacy Appeals Department
P.O. Box 31383
Tampa, FL 33631-3383

Medication appeals may also be initiated by contacting Provider Services. Please note that all appeals filed verbally also require a signed, written appeal.

NOTE: Wellcare does not accept media storage devices such as CDs, DVDs, USB storage devices or flash drives.

FORMULARY INCLUSIONS:

To request consideration for inclusion of a drug to the formulary, providers may submit a medical justification to us in writing to:

Wellcare, Clinical Pharmacy Department
Director of Formulary Services
Pharmacy and Therapeutics Committee
P.O. Box 31577
Tampa, FL 33631-3577

COVERAGE DETERMINATION REQUESTS: Fax: 1-866-388-1767

Click here to locate Coverage Determination Request (form) to be submitted for the exceptions listed below:

- Medications not listed on the formulary
- Drugs listed on the formulary with a prior authorization (PA)
- Duplication of therapy
- Prescriptions that exceed the FDA daily or monthly quantity limit (QL)
- Most self-injectable and infusion medications (including chemotherapy administered in a physician's office)
- Drugs that have a step edit (ST) and the first-line therapy is inappropriate
- Drugs that have an age limit (AL)
- Drugs listed on the formulary with a quantity limit (QL)

Click here to locate **the Medication Guide/Formulary**

Click here to locate **Pharmacy Request forms** such as Injectable Infusion, CVS Caremark Mail Order Service, etc.

Click here to locate **AcariaHealth™ Pharmacy Solutions – Specialty**

New Century Health will manage Medical Oncology Services.

New Century Health
Phone: **1-888-999-7713, Option 1**

FOR HOME INFUSION/ENTERAL SERVICES:

Once Authorization Approval is obtained through Wellcare, if required, please contact our providers below to initiate services:

Coram®:
Phone: **1-800-423-1411** or Fax: **1-866-462-6726**

Option Care Health™ aka Option Care:
Phone: **1-833-466-0358**

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PRIOR AUTHORIZATION (PA) LIST

PRIOR AUTHORIZATION (PA) REQUIREMENTS

This Prior Authorization list supersedes any lists that have been distributed to our providers. Please ensure that older lists are replaced with this updated version. Authorization changes will be denoted with a symbol for easy identification. Requirements that have been edited for clarification only with be denoted with an ⓘ symbol.

Wellcare supports the concept of the Primary Care Physician (PCP) as the "medical home" for its members. PCPs may refer members to network specialists when services will be rendered at an office, clinic or freestanding facility. The specialist must document receipt of the consultation request and the reason for the referral in the medical record. **No communication with the health plan is necessary.**

All services rendered by non-participating providers and facilities require authorization. Specialists must coordinate all services with the member's PCP. It is the responsibility of the provider rendering care to verify that the authorization request has been approved before services are rendered.

***Urgent* Authorization Requests and Admission Notifications: Call 1-888-505-1201 and follow the prompts.**

- Notification is required for Inpatient Hospital admissions **by the next business day** (except normal maternity delivery admissions). Phone authorizations must be followed by a fax submission of clinical information.
- Outpatient authorizations for urgent and time-sensitive services may be submitted by phone when warranted by the member's condition.
- Please include **CPT and ICD-10 codes** with your authorization request. Standard authorization requests may be submitted **online** or via fax to the numbers listed on the associated forms located **here**.
- **Wellcare does not accept media storage devices such as CDs, DVDs, USB storage devices or flash drives.**
- **Web submissions** are faster, and if the procedure requested meets clinical criteria, the Web provides an approval that can be printed for easy reference.
- Obtaining prior authorization does not guarantee payment, but rather only confirms whether a service meets the health plan's determination criteria at the time of the request. Wellcare retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, the medical necessity of services and correct coding and billing practices.
- Wellcare Health Plan may delegate Prior Authorization to the contracted MSO, IPA or Medical Groups who then determine prior authorization requirements for their assigned members.
  - IPAs must make every attempt to authorize services that are the financial responsibility of Wellcare to a provider within Wellcare's contracted network. If a member requires out-of-network services because Wellcare is not contracted with a provider of like specialty, the IPA is required to notify Wellcare's Utilization Management Department prior to issuing an authorization. The Utilization Management Department will discuss the case with the Wellcare Contracting Department and notify the IPA accordingly such that an authorization may be issued. For services that are the financial responsibility of the IPA, the IPA is required to follow its organization's policy in reference to authorization of out-of-network providers.
  - Emergency admissions that are outside the IPA/Group's service area are monitored by the Wellcare Utilization Management Department. Wellcare's Medical Management Department will be responsible for issuing an authorization, performing concurrent review, and working with the IPA to coordinate transfer of the member to an in-network facility once the member has been stabilized.
  - For specific authorization requirements, please follow your group's direction.

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BEHAVIORAL HEALTH SERVICES

SECURE PROVIDER PORTAL

For Urgent and Inpatient Hospitalization Authorizations and Provider Services Phone: 1-888-505-1201

Please **log in** to submit your Outpatient Authorization Requests and Inpatient Clinical Submissions.

To fax a request, please access our forms **here**

Web-based information: **https://www.wellcare.com/Hawaii/Providers/Medicare/Behavioral-Health**

- **To obtain authorization, notification of an Inpatient admission is required on the next business day following admission.**
- Inpatient concurrent review is generally done by phone, but a fax option is available and the forms and fax numbers can be found **here**.
- Psychological testing requests are to be submitted via fax. All other levels of care requiring authorization, including outpatient services, may be submitted online.
- For more information on Authorization Requirements, **click here** and select the **"Behavioral Health Authorization List"** PDF under **Resources**.

Procedures and Services	Authorization Required	Comments
Emergency Behavioral Health Services	**No**	
Non-contracted (non-participating) Provider Services	**Yes**	All services from non-participating providers require prior authorization.
Behavioral Health Services	**See Comments**	Please refer to the **Behavioral Health Authorization List** under **Resources** for authorization requirements. **Secure Provider Portal**

EMERGENCY SERVICES

Procedures and Services	Authorization Required	Comments
Emergency Behavioral Health Services	**No**	
Emergency Care Services	**No**	
Emergency Transportation Services (excluding Air and Water Ambulances)	**No**	
Urgent Care Services	**No**	

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INPATIENT SERVICES & DISCHARGE PLANNING

SECURE PROVIDER PORTAL

Please **log in** to submit your Authorization Requests & Inpatient Clinical Submissions.

To fax a request, please access our forms **here**

Discharge planning requests for Home Health and DME should be submitted separately using one of the methods outlined above.

Procedures and Services	Authorization Required	Comments
Acute Behavioral Health, Alcohol or Substance Abuse Admissions	**Yes**	Clinical updates required for continued length of stay (LOS). No authorization required for Physician consults.
Elective Inpatient Procedures	**Yes**	Clinical updates required for continued length of stay (LOS).
Hospice	**Yes**	
Inpatient Hospital Admissions	**Yes**	Clinical updates required for continued length of stay (LOS).
Long-Term Acute Care Hospital (LTACH) Admissions	**Yes**	Clinical updates required for continued length of stay (LOS).
Observations	**Yes**	Notification and Clinical updates required for continued length of stay (LOS).
Orthopedic Surgery	**Yes – See Comments**	Contact TurningPoint for prior authorization: **TurningPoint Portal** Phone: **1-866-596-7279** Fax: **1-808-824-3357**
Rehabilitation Facility Admissions	**Yes**	Clinical updates required for continued length of stay (LOS).
Skilled Nursing Facility Admissions	**Yes**	Clinical updates required for continued length of stay (LOS).
Spinal Surgery	**Yes – See Comments**	Contact TurningPoint for prior authorization: **TurningPoint Portal** Phone: **1-866-596-7279** Fax: **1-808-824-3357**

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OUTPATIENT SERVICES & DISCHARGE PLANNING

SECURE PROVIDER PORTAL

Please **log in** to submit your Outpatient Authorization Requests & Clinical Submissions.

To fax a request, please access our forms **here**

Pharmacy Medical Requests Fax: **1-888-871-0564**

Discharge planning requests for Home Health and DME should be submitted separately using one of the methods outlined above.

Procedures and Services	Authorization Required	Comments
Select Outpatient Procedures	**Yes – See Comments**	Please refer to the **Authorization Lookup Tool** for prior authorization requirements. **Web Submission Portal**
Dialysis	**No**	
Durable Medical Equipment Purchases and Rentals	**Yes – See Comments**	Please refer to the **Authorization Lookup Tool** for prior authorization requirements. ***For Home Infusion/Enteral Services, please refer to the Pharmacy section above for the preferred provider if the authorization is required.**
Hospice Care Services	**No**	
Investigational & Experimental Procedures and Treatment	**Yes**	**Refer to Clinical Coverage Guidelines** **Secure Provider Portal**
Medical Oncology Services	**Yes**	Contact New Century Health for authorization: **New Century Health Portal** Phone: **1-888-999-7713, Option 1** **Medical Oncology Program Services**
Non-contracted (non-participating) Provider Services	**Yes**	All services from non-participating providers require prior authorization.
Orthopedic Surgery	**Yes – See Comments**	Contact TurningPoint for prior authorization: **TurningPoint Portal** Phone: **1-866-596-7279** Fax: **1-808-824-3357**
Orthotics and Prosthetics	**Yes – See Comments**	Please refer to the **Authorization Lookup Tool** for prior authorization requirements.
Radiation Therapy Management	**Yes – See Comments**	Contact New Century Health for authorization: **New Century Health Portal** Phone: **1-888-999-7713, Option 1** **Radiation Therapy Management Program Resources**

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OUTPATIENT SERVICES & DISCHARGE PLANNING CONTINUED

Procedures and Services	Authorization Required	Comments
Skilled Therapy (PT/OT/ST) services	**Yes**	Includes Occupational, Physical and Speech therapy. No authorization is required for initial evaluations. PA is required for continued services. **Secure Provider Portal**
Spinal Surgery	**Yes – See Comments**	Contact TurningPoint for prior authorization: **TurningPoint Portal** Phone: **1-866-596-7279** Fax: **1-808-824-3357**
Wound Care	**See Comments**	**For CPT's 11004, 11005, 11008, 11011, 11012, 11042, 11043, 11044, 11045, 11046 and 11047** No authorization is required for the first 12 visits. After 12 combined visits or paid claims, authorization would be required.

For your convenience, when viewing online, items on this QRG in bold, underlined fonts are hyperlinks to supporting Provider Job Aids, resource guides and forms.