Hawaiʻi Medicare Quick Reference Guide

April 2024

wellcare.com/en/Hawaii/Providers/Medicare

CONVENIENT SELF-SERVICE

Wellcare By ʻOhana Health Plan understands that having access to the right tools can help you and your staff streamline day-to-day administrative tasks. **The Provider Portal is the fastest way to get the help with those routine tasks.**

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

Provider Portal Registration
click here
The portal is not accessible to non-participating providers. Please visit our website for information on **Joining our Network**.

Provider Portal Training
click here

Provider Services Phone (IVR):
1-888-505-1201 (TTY: **711**)

OFFICE LOCATIONS

ISLAND OF OAHU (MAIN OFFICE)

820 Mililani Street, Suite 200
Honolulu, HI 96813

ISLAND OF HAWAIʻI

88 Kanoelehua Ave. Suite A105
Hilo, HI 96720

OTHER 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. Hawaiʻi Standard Time

RISK MANAGEMENT FRAUD, WASTE & ABUSE HOTLINE

1-866-685-8664

COMMUNITY CONNECTIONS HELP LINE

1-866-775-2192

BEHAVIORAL HEALTH CRISIS LINE

1-800-411-6485
24 hours a day for a Behavioral Health Crisis.
For non-crisis related concerns, members should call Member Services.

NURSE ADVICE LINE

1-800-581-9952 (24 hours)

HEALTH PLAN PARTNERS

Contracted Networks

HEARING	VISION	DENTAL
HearUSA	**Premier**	**HDS**
Phone: **1-877-541-0556**	Phone: **1-855-879-1448**	Phone: **1-808-529-9237**

NOTE: Please refer to the member ID card to determine appropriate authorization and claims submission process.
This guide is not intended to be an all-inclusive list of covered services under the Health Plan.

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CLAIM SUBMISSION INFORMATION

SUBMISSION INQUIRIES:

Support from Provider Services: 1-888-505-1201

For inquiries related to your electronic or paper 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 **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

Visit our **Claims** page to locate claim forms and guidelines.

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.

MAIL PAPER CLAIM SUBMISSIONS TO:

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

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, DN038, DN039, VSTEX, HRM16 and KYREC. However, this is not an all-encompassing list of Appeals codes. Claim payment disputes must be submitted in writing to Wellcare By ʻOhana Health Plan 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 provider.wellcare.com/ohanacare or by mail.

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

CLAIM PAYMENT DISPUTES WITH SUPPORTING DOCUMENTATION MAY ALSO BE MAILED 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###, CV### (Medical records required) or PD### at provider.wellcare.com/ohanacare or by mail.

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

IH###, CE###, CV### (MEDICAL RECORDS REQUIRED) OR PD### TO:

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

CPI## 1ST LEVEL (INCLUDE ALL MEDICAL RECORDS AND INITIAL REVIEWS) APPEALS TO:

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.

LT###, RVLT# AND CPI## 2ND LEVEL APPEALS TO:

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

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 By ʻOhana Health Plan
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)

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.

Participating providers must seek a reconsideration through the Appeals Department within **90 calendar days** (required timing is listed in your contract) 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.

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 Physician 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.

Non-Physician (Practitioner): Per CMS and the Social Security Act, a non-physician is not a qualified physician (e.g.).

Type of Practitioner*	AOR Needed	No AOR Needed
Certified Nurse Midwife (CNM)	X	
Certified Registered Nurse Anesthetist (CRNA)	X	
Clinical Nurse Specialist (CNS)	X	
Surgeon Assistant	X	
Anesthesiology Assistant	X	
Audiologist	X	
Licensed Clinical Social Worker (LCSW)	X	
Clinical Psychologist	X	
Non-Clinical Psychologist	X	
PT, OT, Speech Pathologist	X	
Registered Dietician or Nutrition Professional	X	
Advanced Registered Nurse Practitioner (ARNP)	X	
Nurse Practitioner (NP)	X	
Physician Assistant (PA)	X	

Physician: A person skilled in the art of healing; specifically, one educated, clinically experienced, and licensed to practice medicine as usually distinguished from surgery. A person licensed to practice medicine; a medical director (e.g.).

Type of Physician*	AOR Needed	No AOR Needed
Doctor of Medicine (MD)		X
Doctor of Osteopathic Medicine (DO)		X
Doctor of Dental Surgery (DDS) or Dental Medicine (DMD)		X
Doctor of Optometry (OD)		X
Doctors of Obstetrics and Gynecology (OB-GYN)		X
Chiropractor (Doctor of Chiropractor)		X
Psychiatrist		X

Provider: Any physician, hospital, facility, or other Health Care Professional who is licensed or otherwise authorized to provide Health Care services in the State or jurisdiction in which they are furnished.

Type of Facility*	AOR Needed	No AOR Needed
Inpatient		X
Behavioral Inpatient		X
Home Health Agency	X	
Skilled Nursing Facility on own behalf		X
Skilled Nursing Facility (PT, OT & ST)	X	
Physician Group on own behalf		X
Physician Group (PT, OT & ST)	X	
Rehabilitation Facility (i.e., LTAC)		X
Durable Medical Equipment	X	

*The above lists of Non-Physicians, Physicians and Providers is not intended to be an all-inclusive list, they are the most common identified on an appeal.

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

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, AOR forms are available **here**.

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 ʻOhana Health Plan
Attn: Grievance Department
820 Mililani Street, Suite 200
Honolulu, HI 96813
Fax: 1-866-388-1769
Email: Please visit the Contact Us page on the website.

PHARMACY SERVICES

PHARMACY SERVICES: 1-888-505-1201

Including after-hours and weekends

Rx BIN	Rx PCN	Rx GRP
610014	MEDDPRIME	2FFA
610014	MAC	2FHU (MA Only)

MAIL ORDER:

Click here to locate Express Scripts® Mail Order info:

Phone: **1-833-750-0201** (TTY: **711**)
24 hours a day, 7 days a week

SPECIALTY PHARMACY:

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: acariahealth.com

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.

COVERAGE DETERMINATION REQUESTS:

Fax: **1-866-388-1767**

Electronic Prior Authorization (ePA):
account.covermymeds.com

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 formulary 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, Express Scripts Mail Order Service, etc.

New Century Health (NCH) 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**
Fax: **1-866-462-6726**

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

PRIOR AUTHORIZATION (PA) LIST

PRIOR AUTHORIZATION (PA) REQUIREMENTS

Use the Pre-Auth Needed tool on our website to determine if prior authorization is required. This Prior Authorization list is provided as a quick reference. Most current information can be found within the Pre-Auth tool.

For fastest results, submit requests online at our **website**. If the procedure requested meets clinical criteria, the Web provides an approval that can be printed for easy reference. The health plan supports the concept of the Primary Care Physician (PCP) as the "medical home" for its members.

For members enrolled in a PPO plan, authorization is not required for non-participating providers and facilities, however, services on the medical necessity/authorization required list below must be covered services within the benefit plan and considered medically necessary for the plan to pay a portion of the out-of-network claim.

For members enrolled in a non-PPO plan, all services rendered by non-participating providers and facilities require authorization, including requests to use the member's Point-of-Service benefits. 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 1-855-538-0454 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.
- Standard authorization requests may be submitted **online** or via fax to the numbers listed on the associated forms located **here**.

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 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.

Procedures and Services	Auth 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 **Other Resources** for authorization requirements.

EMERGENCY SERVICES

Emergency Services for the following procedures and service do NOT require prior authorization:

- **Emergency Behavioral Health Services**
- **Emergency Care Services**
- **Emergency Transportation Services (excluding Air & Water Ambulances)**
- **Urgent Care Services**

CARDIOLOGY MANAGEMENT PROGRAM

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. This requirement applies to all of your Medicare members ages 18 and older.

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.

Prior authorization can be requested by:

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

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.

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	Auth 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**	Contact **National Imaging Associates** for authorization: Phone: **1-800-424-5388**
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**	Contact **National Imaging Associates** for authorization: Phone: **1-800-424-5388**

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	Auth Required	Comments
Select Outpatient Procedures	**Yes**	Please refer to the **Authorization Lookup Tool** for prior authorization requirements.
Dialysis	**No**	
Durable Medical Equipment Purchases and Rentals	**Yes**	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**	Contact **National Imaging Associates** for authorization: Phone: **1-800-424-5388**
Orthotics and Prosthetics	**Yes**	Please refer to the **Authorization Lookup Tool** for prior authorization requirements.
Radiation Therapy Management	**Yes**	Contact New Century Health for authorization: **New Century Health Portal** Phone: **1-888-999-7713, Option 1** **Radiation Therapy Management Program Resources**
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**

OUTPATIENT SERVICES & DISCHARGE PLANNING CONTINUED

Procedures and Services	Auth Required	Comments
Spinal Surgery	**Yes**	Contact **National Imaging Associates** for authorization: Phone: **1-800-424-5388**
Transplant Services	**Yes**	Please submit clinical records for prior authorization for all transplant phases.
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.