



HAWAII MEDICARE QUICK REFERENCE GUIDE
January 2012

Web Address: www.ohanahealthplan.com/provider/resources

Important Telephone Numbers

Provider Services (888) 505-1201
 Eligibility verification, Claims, Utilization Mgmt.,
 Language Line and Provider Complaints

Nurse Advice Line (800) 581-9952
 Members may call this number to speak to a
 Nurse 24 hours a day, 7 days a week.

TTY/TDD (877) 247-6272

'Ohana Fraud, Waste and Abuse Hotline (866) 678-8355

Provider "How To" Guide

Provider Resource Guide

Claim Submissions

Claim Payment Disputes

Provider Services (888) 505-1201
 Questions related to claim submissions

The Claim Payment Dispute Process is designed to address claim denials for issues related to untimely filing, unlisted procedure codes, non-covered codes, etc. Claim payment disputes must be submitted in writing to 'Ohana within 90 days of the date on the EOP.

For EDI questions and assistance, please contact our EDI team who will help identify, test and correct any issues: EDI-Master@wellcare.com.

Mail or fax all claim payment disputes with supporting documentation to:

Preferred EDI Partner **EDI Payor ID**
 RelayHealth (McKesson) 14163 (877) 411-7271

'Ohana Health Plan, Inc. **Fax (877) 277-1808**
 Attn: Claim Payment Disputes
 PO Box 31370
 Tampa, FL 33631-3370

'Ohana follows the Centers for Medicare and Medicaid Services' (CMS) guidelines for paper claim submissions. Since October 28, 2010, 'Ohana accepts only the original "red claim" form for claim and encounter submissions. 'Ohana does not accept handwritten, faxed or replicated claim forms.

Provider Administrative Review Request Form

Claim forms and guidelines may be found on our website at:
www.ohanahealthplan.com/provider/claims_updates

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 (Explanation of Payment Codes beginning with IHXXX, MKXXX or PDXXX) must be submitted to 'Ohana in writing within 90 days of the date of denial on the EOP.

Mail paper claim submissions to:

Mail all disputes related to payment policy issues to:

'Ohana Health Plan, Inc.
 Claims Department
 PO Box 31372
 Tampa, FL 33631-3372

'Ohana Health Plan, Inc. **Fax (877) 277-1808**
 Payment Policy Disputes Department
 PO Box 31426
 Tampa, FL 33631-3426

Appeals (Medical)

For pre-service appeals, providers may file an appeal on the member's behalf with the member's consent. A signed appointment of representative may be required. Providers may also seek an appeal through the Appeals department within 120 calendar days of a claims denial for lack of prior authorization, services exceeding the authorization, insufficient supporting documentation or late notification.

Mail or fax medical appeals with supporting documentation to:

'Ohana Health Plan, Inc. **Fax (866) 201-0657**
 Attn: Appeals Department
 PO Box 31368
 Tampa, FL 33631-3368

Grievances

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

Mail or fax member grievances to:

'Ohana Health Plan, Inc. **Fax (866) 388-1769**
 Attn: Grievance Department
 PO Box 31384
 Tampa, FL 33631-3384

Medicare Appointment of Representative Form

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Pharmacy Services

Pharmacy Services (866) 653-0976
Including After Hours/Weekends

Specialty Pharmacy (866) 458-9246
wsp@wellcare.com Fax (866) 458-9245

Medication Appeals Fax (866) 388-1766

Mail all [medication appeal request forms](#) with supporting documentation to:

‘Ohana Health Plan, Inc.
Attn: Pharmacy Appeals Department
PO Box 31383
Tampa, FL 33631-3383

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

PDL Inclusions

To request consideration for inclusion of a drug to ‘Ohana’s PDL, providers may write ‘Ohana explaining the medical justification.

Ohana Health Plans, Clinical Pharmacy Department
Director of Formulary Services
Pharmacy and Therapeutics Committee
PO Box 31577
Tampa, FL 33631

Coverage Determination Review Fax (866) 388-1767

Submit [Coverage Determination Request Forms](#) for:

- 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 limits
- Most self-injectable and infusion drugs (including chemotherapy) administered in a physician’s office
- Drugs listed on the Formulary with a quantity limit (QL)
- Drugs that have a step edit (ST) and the first line therapy is inappropriate

Web-Based Information:

- Pharmacy Services Overview
- Pharmacy Updates
- Preferred Drug List (PDL)
- Drug Evaluation Review Forms
- Participating Pharmacies

[Injectable Infusion Prescription Order Form](#)

[Medical Injectables – No Authorization Required List](#)

[Preferred Drug List – Dual Eligible Members](#)

[WellDyneRx Medicare Order Prescription Form](#)

Contracted Networks

Transportation

Logisticare (Customer Service)

Reservations (866) 814-6405
Ride Assist (866) 814-6442

A three business day notification is required for routine non-emergent transportation reservations. Representatives are available Monday through Friday from 8:00 am to 6:00 pm HST.

Dental

Liberty Dental Plan

Utilization Management and Customer Service (888) 704-9837

Care Management

To refer a member to Case or Disease Management Programs, please complete the [Care Management Referral Form](#) and fax it to: (888) 881-8220.

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Prior Authorization (PA) Requirements

This 'Ohana Prior Authorization list supersedes any lists that have been distributed to our providers. Please ensure that older lists are replaced with this updated version. Changes to authorization requirements on this list will be denoted by a **Pa** symbol for easy identification. Requirements that have been edited for *clarification only* will be denoted with an **i** symbol.

All services rendered by non-participating providers and facilities require authorization unless the member's Point-of-Service benefit is utilized. No authorization is required when the member's POS Benefit is utilized for office visits and/or treatment considered by the Plan to be part of a routine office visit. All other requests to utilize Point-of-Service benefits must be submitted and reviewed for authorization. The POS benefit is a HMO option that allows members of designated Plans the ability to receive care from non-participating providers for additional costs. With the exception of emergent/urgent services, the member will pay more to access services outside of the network.

Specialists should 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.

'Ohana supports the concept of the 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 free-standing facility (11, 50, 71 & 72)*. The specialist must document receipt of the request for a consultation and the reason for the referral in the medical record. **No communication with the Plan is necessary.**

'OHANA'S PRIOR AUTHORIZATION (PA) LIST:

Urgent Authorization Requests and Admission Notifications – Call (888) 505-1201 and follow the prompts.

- Notify the Plan of unplanned inpatient hospital admissions and observations within the next business day (except normal maternity delivery admissions). Telephone authorizations must be followed by a fax submission of clinical information – within the next business day.
- Outpatient authorizations may be requested by phone for urgent and time sensitive services when warranted by the member's condition. Please add **CPT and ICD-9 codes** with your authorization request.

NOTE: [Place of service codes \(POS\)* are specified for some services.](#)

***Place of Service Codes**

11 – Office	23 – Emergency Room	50 – FQHC	72 – Rural Health Clinic
12 – Home	24 – Ambulatory Surgery Center	61 – Inpatient Rehab	81 – Laboratory
20 – Urgent Care Facility	31 – Skilled Nursing Facility	62 – Outpatient Rehab	99 – Other
21 – Inpatient Hospital	32 – Nursing Facility	65 – ESRD	
22 – Outpatient Hospital	33 – Custodial Care Facility	71 – Public Health Clinic	

PROCEDURES and SERVICES	Auth Required	No Auth Required	Comments
Pa = New or changed requirement i = Clarification of current requirement			
<u>Ancillary Services Authorization Request Form</u>			Fax (888) 881-8225
Durable Medical Equipment purchases	X		Purchases billed for less than \$200 do not require an authorization.
Durable Medical Equipment rentals	X		<u>Refer to Clinical Coverage Guidelines</u>
Hearing Aids and Devices	X		Purchases billed for less than \$200 do not require an authorization.
Home health care services	X		
Orthotics and Prosthetics	X		Purchases billed for less than \$200 do not require an authorization.
Respiratory therapy services	X		
Skilled therapy services (11 & 22)*	X		Includes Occupational, Physical and Speech therapy

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📄 = New or changed requirement ⓘ = Clarification of current requirement			
Outpatient Services Authorization Request Form			Fax (877) 892-8215
Acupuncture		X	
Advanced Radiology services: CT, CTA, MRA, MRI, Nuclear Cardiology, Nuclear Medicine, PET & SPECT scans (11, 22 & 24)*	X		
Ambulance transportation (non-emergent)	X		
Ambulatory surgery center services (24)*	X		No authorization is required for CPT code ranges: 43200 – 43258, 44360 – 44397, 45300 - 45392
Cardiac and pulmonary rehabilitation programs	X		Refer to Clinical Coverage Guidelines
Court-ordered services	X		
Cytogenetic, reproductive and molecular diagnostic laboratory testing	X		Refer to Clinical Coverage Guidelines
Diagnostic laboratory services (Routine) (11, 22 & 81)		X	No authorization is required for routine lab services. Testing must be consistent with CLIA guidelines.
Diagnostic tests and procedures considered by the Plan to be routine office treatment (11)*		X	No authorization is required for non-participating providers if the member's Point-of-Service benefit is utilized. See page three for details.
Diagnostic ultrasounds		X	
Domiciliary, rest home & custodial services (32 & 33)*	X		
Investigational & experimental procedures and treatment	X		Experimental and Investigational Procedures and Devices Clinical Coverage Guideline
Mammograms (ALL)*		X	
Nursing Facility services (31 & 32)*	X		
Outpatient Hospital procedures (22)*	X		No authorization is required for CPT code ranges: 43200 – 43258, 44360 – 44397, 45300 - 45392
Pain Management treatment (11, 22 & 24)*	X		
Primary Care Physician office visits and treatment		X	
Potentially Cosmetic procedures (ALL)*	X		
Radiology Anesthesia		X	No Authorization is required for CPT codes 01916 - 01936
Rehabilitation facility services (62)*	X		
Routine radiology services (11, 22 & 24)*		X	
Specialist office visits and treatment (11)*		X	No authorization is required for non-participating providers if the member's Point-of-Service benefit is utilized. See page three for details.
Urgent care services (20)*		X	

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