

Ohio Medicare Quick Reference Guide

wellcare

March 2022

<https://www.wellcare.com/Ohio/Providers/Medicare>

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 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*	<u>Fastest Result</u>	<u>Available</u>	Available
Authorization Status*	<u>Fastest Result</u>	<u>Available</u>	Available
Authorizations Request*	<u>Fastest Result</u>	<u>Available</u>	N/A
Benefit Information	<u>Fastest Result</u>	<u>Available</u>	Available
Claims Status	<u>Fastest Result</u>	<u>Available</u>	Available
Co-payment	<u>Fastest Result</u>	<u>Available</u>	Available
Eligibility Verification	<u>Fastest Result</u>	<u>Available</u>	Available
Submit Appeals	<u>Fastest Result</u>	<u>Available</u>	N/A
Appeals Status	<u>Fastest Result</u>	<u>Available</u>	N/A
Submit Claim Disputes	<u>Fastest Result</u>	<u>Available</u>	N/A
Submit Claims	<u>Fastest Result</u>	<u>Available</u>	N/A
Submit Corrected Claims	<u>Fastest Result</u>	<u>Available</u>	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: 1-855-538-0454 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 Wellcare, a plan offered by WellCare Health Plans, Inc., 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. (Revised Mar 2022).

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.
Eastern Standard Time

**RISK MANAGEMENT
FRAUD, WASTE &
ABUSE HOTLINE**
1-866-685-8664

**COMMUNITY CONNECTIONS
HELP LINE**
1-866-775-2192

CLAIM SUBMISSION INFORMATION

SUBMISSION INQUIRIES:

Support from Provider Services: 1-855-538-0454

For inquiries related to your electronic or paper submissions to Wellcare, please contact our EDI team at **EDI-Master@wellcare.com**.

ELECTRONIC FUNDS TRANSFER AND ELECTRONIC REMITTANCE ADVICE:

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

CLEARINGHOUSE CONNECTIVITY:

Wellcare has partnered with Change Healthcare as our preferred EDI Clearinghouse. You may connect directly to Change Healthcare, or in some cases, your existing clearinghouse, billing service or trading partner may maintain existing reciprocal agreements with Change Healthcare. We encourage you to contact your claims vendor and determine if they have connectivity to Change Healthcare. If not, you may want to consider contacting Change Healthcare to establish free connectivity to Wellcare for your EDI transactions. Change Healthcare offers Submitter/Client Connectivity Services at **1-877-411-7271**. All Clearinghouses, Practice Management Vendors, or Billing Services may call Change Healthcare at **1-800-527-8133** for connectivity services.

CHANGE HEALTHCARE CLEARINGHOUSE PAYER IDS (CPIDS)

Claim Type	Fee-for-Service (CH - Chargeable) Submissions	Encounter (RF - Reporting only) Submissions
Professional	1844	3211
Institutional	8551	4949

PAYER IDS – If your clearinghouse or billing system is not connected to Change Healthcare and requires a 5-digit Payer ID, please use the following according to the file type (Fee-for-Service or Encounters):

- **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

FREE DIRECT DATA ENTRY (DDE) AND SMALL BATCH FILE SOLUTIONS (USE SAME WELLCARE PAYER IDS DEFINED ABOVE):

AdminisTEP offers a web browser for single submission direct data entry (DDE) or batch upload for professional and institutional submissions, claim status and reporting and inquiry functions **at no cost to you**. To sign up, go to **<http://www.administep.com/Signup.aspx>** or call **1-888-751-3271**.

ConnectCenter™ for physicians offers a web browser for direct data entry (DDE) or batch upload capability at no cost to you. To sign up, go to: **<https://physician.connectcenter.changehealthcare.com>**.

For registry questions, submitter/clients may contact Payer Connectivity Services at **1-877-411-7271**. Direct questions regarding functionality of ConnectCenter to Change HealthCare at **1-800-527-8133, opt 2**.

- Providers will be required to **enter a credit card** upon initial enrollment to verify them as a valid submitter.
- Only our submissions are free of charge and please ensure you **use vendor code 212750** when you register.

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.

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.

Wellcare does not accept handwritten, faxed or replicated claim forms.

Click here to locate claim forms and guidelines.



MAIL PAPER CLAIM SUBMISSIONS TO:

**Wellcare
Attn: Claims Department
P.O. Box 31372
Tampa, FL 33631-3372**

DATE OF SERVICE GUIDE TO DETERMINE CORRECT PAYER:

- If billing a **fee for service (FFS) institutional submission with the bill types 18x, 21x or 32x**, please use the **through date to perform the date of service evaluation**. Institutional (837I) statement date is located in: Loop 2300 (DTP*434*from-through~) and for paper box FL-06 of the UB-04 standard paperform.
- If billing a **fee for service (FFS) professional or institutional submission with an outpatient bill type**, please use the **earliest from date to perform date of service evaluation**. Professional (837P) earliest service date in all claim lines which is located in Loop 2400 (DTP*472*from-through~) or FL-24a unshaded area on the CMS1500 02/12 form. Institutional statement date is located in Loop 2300 (DTP*434*from-through~) or FL-06 of the UB-04 paper form.
- If billing a **fee for service (FFS) institutional inpatient bill type (DRG pricing included)**, please use **the admit date to perform date of service evaluation**. Institutional (837I) statement date is located Loop 2300 (DTP*435*date~) or FL-06 of the UB-04 paper form.

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. Claim payment disputes must be submitted in writing to Wellcare **within 90 calendar days** of the date on the EOP. Submit all claims payment disputes with supporting documentation at **<https://provider.wellcare.com/>**



MAIL ALL CLAIM PAYMENT DISPUTES WITH SUPPORTING DOCUMENTATION TO:

**Wellcare
Attn: Claim Payment Disputes
P.O. Box 31370
Tampa, FL 33631-3370**

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. 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. 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 **90 calendar days** of the date on the EOP. 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: **<https://provider.wellcare.com/>**.

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



**Wellcare
Attn: Payment Policy Disputes Department
P.O. Box 31426
Tampa, FL 33631-3426**

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CLAIM PAYMENT POLICY DISPUTES CONTINUED

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)**

Phone: 1-844-458-6739

Fax: 1-267-687-0994

Optum

P.O. Box 52846

Philadelphia, PA 19115

**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

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

Wellcare

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**

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 **45 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:

Fax: 1-813-283-3284

Wellcare

Attn: CCU Recovery

P.O. Box 31658

Tampa, FL 33631-3658

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:

Fax: 1-203-202-6607

Cotiviti

**Attn: Wellcare Clinical Chart Validation
HillCrest III Building
731 Arbor Way, Suite 150
Blue Bell, PA 19422**

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 (MEDICAL)

All non-participating Medicare provider appeals must be submitted within **60 calendar days** and they must also submit a signed waiver of liability (WOL) with their request for processing. Participating providers also can seek an appeal 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. 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. 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.

MAIL OR FAX ALL MEDICAL APPEALS WITH SUPPORTING DOCUMENTATION TO:

Fax: 1-866-201-0657

Wellcare

**Attn: Appeals Department
P.O. Box 31368
Tampa, FL 33631-3368**

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.

MAIL, PHONE, EMAIL OR FAX ALL MEMBER GRIEVANCES TO:

Phone: 1-877-902-6784

Fax: 1-866-388-1769

Wellcare

Attn: Grievance Department

P.O. Box 31384

Tampa, FL 33631-3384

**Email: Operationalgrievance@wellcare.com
or pdpgrivance@wellcare.com**

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HEALTH PLAN PARTNERS

Contracted Networks

HEARING

HCS

Phone: **1-866-344-7756**

VISION

Premier

Phone: **1-888-285-2826**

DENTAL

DentaQuest

Phone: **1-844-822-8113**

TRANSPORTATION

Access2Care

Phone: **1-866-393-2162**

eviCore

eviCore is our in-network vendor for the following programs and clinical criteria can be accessed through the corresponding program links: **Lab Management**, and **Sleep Diagnostics**.

Contact eviCore for **all authorization-related** submissions for the services listed above rendered in outpatient places of service (including the home setting*). Please click on the hyperlinks above for a listing of the specific services and related criteria included in the eviCore programs.

Web submissions are faster, and if the procedure requested meets clinical criteria, the web provides an immediate approval that can be printed for easy reference. Member eligibility and authorization requests may be submitted via the **eviCore Provider Web Portal**. A searchable **Authorization Lookup and Eligibility Tool** is also available online, and criteria can be accessed through the program links above.

Urgent Authorizations and Provider Services: **1-888-333-8641**

*Excluding Episode of Care Requests. Please contact Wellcare for all services rendered during an Episode of Care

National Imaging Associates aka NIA

NIA (National Imaging Associates) is our in-network vendor for the following programs and clinical criteria can be accessed through the corresponding program links: **Advanced Radiology**, **Advanced Cardiology**, **Pain Management**, **Physical Occupational and Speech Therapy**.

Contact NIA for all authorization-related submissions for the services listed above rendered in outpatient places of service (including the home setting*). Please click on the hyperlinks above for a listing of the specific services and related criteria included in the NIA program. Web submissions are faster and if the procedure requested meets clinical criteria, the web provides an immediate approval that can be printed for easy reference. Member eligibility and authorization requests may be submitted via the **NIA Provider Web Portal**. A searchable **Authorization Lookup tool** is also available online and criteria can be accessed through the program links above.

Urgent Authorization and Provider Services: **1-800-424-5388**

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HealthHelp®

HealthHelp is our in-network vendor for the following programs, and provider resources can be accessed through the corresponding program links: **Radiation Therapy** and **Medical Oncology**.

Contact HealthHelp for all **authorization-related** submissions for the services listed above rendered in all outpatient places of service. Please click on the links above for a listing of the specific services and related resources included in the HealthHelp programs.

Member eligibility and authorization request materials may be accessed via the **HealthHelp 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 links above.

Urgent Authorizations and Provider Services: 1-888-210-3736

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 1-866-611-6951

PHARMACY SERVICES

PHARMACY SERVICES:

1-855-538-0454

Including after-hours and weekends –
CVS Caremark®

Rx BIN
004336

Rx PCN
MEDDADV

Rx GRP
788257

Click here to locate CVS Caremark®
Mail Order Info:

1-866-808-7471
TTY: **1-866-236-1069**
Fax: **1-866-892-8194**

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

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.

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**

HealthHelp will manage Medical Oncology Services. Please see below for HealthHelp Contact Information.

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

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 will 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.**

For members enrolled in a PPO plan, authorization is not required for nonparticipating 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.
- 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**.
- **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 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: 1-855-538-0454

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/Ohio/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. *Excluding members enrolled in a PPO plan
Behavioral Health Services	See Comments	Please refer to the <u>Behavioral Health Authorization List</u> under Resources for authorization requirements.

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
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	Elective procedures that convert to an Observation stay are subject to outpatient authorization requirements. Authorization Lookup Tool Services performed during an urgent or emergent Observation stay, such as Advanced Radiology or Cardiology, do not require authorization. Clinical updates required for continued length of stay (LOS).
Orthopedic Surgery	Yes – See Comments	Contact TurningPoint for prior authorization: TurningPoint Portal Phone: 1-866-611-6951 Fax: 1-216-302-3880
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: 1-866-611-6951 Fax: 1-216-302-3880

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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 <u>Authorization Lookup Tool</u> for prior authorization requirements.
Advanced Radiology Services: CT, CTA, MRA, MRI, Nuclear Cardiology, Nuclear Medicine, PET & SPECT Scans	Yes – See Comments	Contact National Imaging Associates for authorization: <u>National Imaging Associates Provider Web Portal</u> Phone: 1-800-424-5388 <u>Advanced Radiology Program Criteria Radiology Request Forms</u>
Cardiology Services: Cardiac Imaging, Cardiac Catheterization, Diagnostic Cardiac Procedures and Echo Stress Tests	Yes – See Comments	Contact National Imaging Associates for authorization: <u>National Imaging Associates Provider Web Portal</u> Phone: 1-800-424-5388 <u>Cardiology Program Criteria Cardiology Worksheets</u>
Dialysis	No	
Durable Medical Equipment Purchases and Rentals	Yes – See Comments	All DME rentals require authorization. DME purchase items reimbursed at OR below \$500 per line item do NOT require authorization. *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	<u>Refer to Clinical Coverage Guidelines Secure Provider Portal</u>

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OUTPATIENT SERVICES & DISCHARGE PLANNING CONTINUED

Procedures and Services	Authorization Required	Comments
Laboratory Management (Certain Molecular and Genetic Tests)	Yes – See Comments	Contact eviCore for authorization: <u>eviCore Provider Web Portal</u> Phone: 1-888-333-8641 <u>Wellcare Lab Management Program Criteria</u> <u>Molecular and Genetic Testing Quick Reference Guide</u>
Medical Oncology Services	Yes	Contact HealthHelp for authorization: <u>HealthHelp Portal</u> Phone: 1-888-210-3736 <u>Medical Oncology Program Services</u>
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: <u>TurningPoint Portal</u> Phone: 1-866-611-6951 Fax: 1-216-302-3880
Orthotics and Prosthetics	Yes – See Comments	Purchase items reimbursed at OR below \$500 per line item do NOT require authorization.
Pain Management Treatment (Certain Pain Management Treatments)	Yes – See Comments	Contact National Imaging Associates for authorization: <u>National Imaging Associates Provider Web Portal</u> Phone: 1-800-424-5388 <u>Pain Management Program Criteria</u> <u>Musculoskeletal Management Request Forms</u>
Physical and Occupational Therapy (including home-based therapy) *Excluding Episode of Care Requests. Please contact Wellcare for all services rendered during an Episode of Care	Yes – See Comments	Contact National Imaging Associates for authorization: <u>National Imaging Associates Provider Web Portal</u> Phone: 1-800-424-5388 <u>Physical and Occupational Therapy Program Criteria</u> <u>PT/OT Worksheets</u>
Radiation Therapy Management	Yes – See Comments	Contact HealthHelp for authorization: <u>HealthHelp Portal</u> Phone: 1-888-210-3736 <u>Radiation Therapy Management Program Resources</u>

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.

OUTPATIENT SERVICES & DISCHARGE PLANNING CONTINUED

Procedures and Services	Authorization Required	Comments
Sleep Diagnostics	Yes – See Comments	Contact eviCore for authorization: <u>eviCore Provider Web Portal</u> Phone: 1-888-333-8641 <u>Sleep Diagnostics Program Criteria</u> <u>Sleep Management Worksheets</u>
Speech Therapy	Yes	Contact National Imaging Associates for authorization: <u>National Imaging Associates</u> <u>Provider Web Portal</u> Phone: 1-800-424-5388
Spinal Surgery	Yes – See Comments	Contact TurningPoint for prior authorization: <u>TurningPoint Portal</u> Phone: 1-866-611-6951 Fax: 1-216-302-3880
Transplant Services	Yes	Please submit clinical records for prior authorization for all transplant phases.

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