MDX Hawai'i

Prior Authorization List for Medicare Advantage Plans

effective January 1, 2024

This list of services requiring PRIOR authorization applies to MDX Hawaii's Medicare Advantage Programs. Refer to MDX Hawaii's Prior Authorization (PA) Look up tool, which has a list of specific procedure or service codes that require authorization. The MDX Humana PA Drug List and MDX UHC PA Drug List contain a list of drugs (J codes) that also require authorization. Please refer to these lists quarterly for any updates.

APPLIES TO THE FOLLOWING HEALTH PLANS:

Humana Medicare Advantage Plans

PPO Plan	Humana Choice	H5216-232/233/313
PPO Plan	Humana USAA Honor	H5216-234/ Oahu only: 314 (with RX)
HMO Plan	Humana Gold Plus	H0028-048

UnitedHealthcare (UHC) Medicare Advantage Plans (PPO Plans)

Oahu

AARP Medicare Advantage	HI-0001	H2406-040
AARP Medicare Advantage	HI-0002	H2406-058
Medicare Advantage Patriot		H2406-041

Kauai & Maui

AARP Medicare Advantage	HI-0003	H2406-059
Medicare Advantage Patriot		H2406-041

INPATIENT SERVICES	DETAILS
Admissions	All scheduled inpatient admissions including acute hospital, rehabilitation facilities, hospice and skilled nursing facilities require PRIOR authorization. Admissions through the emergency room require notification within 24 hours.
Behavioral Health (BH) or Detoxification	All scheduled admissions require PRIOR authorization. BH hospital, psychiatric hospital, subacute facility, and substance abuse admissions through the emergency room require notification within 24 hours. Partial hospital/ residential treatment requires PRIOR authorization.
Changes to Level of Care (LOC) or Health Plan Examples: - Observation to Admission - Level of Care changes - Member changes health plan during a hospital stay	If a member changes primary health plan coverage and MDX Hawai'i becomes responsible during the hospitalization, notification to MDX Hawai'i with a revised face sheet is required. If a member changes LOC, notification is required if admitted to a hospital. Face sheet is not required when transmitting an electronic daily census. Failure to notify MDX Hawai'i within one (1) business day of the change may result in denial of coverage.
Elective Surgeries/Admission	All scheduled admissions require PRIOR authorization. This includes any pre-scheduled inpatient hospitalization and/or Ambulatory Surgery Center conversion to inpatient. For Outpatient Surgeries that require authorization, please use the PA Look-Up Tool on the secured portal at www.CAPCMS.com for authorization requirements.
Observation Servies when members are admitted to acute care.	No notification is required UNLESS member's LOC is changed to inpatient.

OUTPATIENT SERVICES, PROCEDURES OR EQUIPMENT	DETAILS
All non-participating and/or out-of-area services (excludes ER visit)	No Prior Authorization (PA) is required for PPO members. PA is required for HMO members to use non-participating or out-of-area services.
All Outpatient Procedures and Surgeries	Routine procedures/surgeries do not require PA.
Acupuncture	Contact the member's Health Plan for benefits.
Brachytherapy	Medicare-covered brachytherapy does not require PA.
Chiropractic Services	No PA is required up to the member's Health plan benefit.
Clinical trials	Submit requests directly to the health plan to ensure that selected services are covered during the clinical trial period.
Diagnostic Tests including PET scans, etc.	Routine diagnostic tests do not require PA.
Drugs and Medications	See MDX Humana PA Drug List and MDX UHC PA Drug List for the list of Drugs and Medication requiring PA.
Durable Medical Equipment (DME) includes CPAP, NPPV, specialty wheelchair, orthotics, prosthetics, oxygen tank and oxygen concentrator, etc.	Medicare-covered DME does not require PA, however certain specialty equipment such as a specialty wheelchair may require PA.
Drugs and Medications	See MDX Humana PA Drug List and MDX UHC PA Drug List for the list of Drugs and Medication requiring Prior Auth.
Enteral/parenteral services and supplies and commercial oral nutritional supplements	Medicare-covered enteral/parenteral services do not require PA.
Genetic Testing and Counseling	Medicare has limited coverage of genetic testing.
Home Health Services (includes Home Health Care)	Home Health coverage is warranted for skilled care and if a member is homebound.
Hospice Care/ Supportive Care	Notify MDX when a member enrolls in Hospice or Palliative Care.
Hyperbaric Oxygen (HBO) Therapy	Medicare-covered HBO does not require PA.
Infusion Services	Medicare-covered Infusion Service does not require PA.
Medical Nutrition Therapy (MNT)	Medicare-covered MNT does not require PA.
Outpatient Services, Surgeries and Procedures	Routine services, surgeries/procedures do not require PA.
Pain Management Surgeries and Procedures	Medicare-covered pain management treatment does not require PA.
Parenteral Nutrition	Medicare-covered parental nutrition does not require PA.
Podiatry Services	Medicare-covered podiatry care does not require PA.

OUTPATIENT SERVICES, PROCEDURES OR EQUIPMENT	DETAILS
Proton Beam Therapy (PBT) & Radiation Therapy	Medicare-covered PBT and Radiation therapy does not require PA.
Radiology: Outpatient Imaging	Routine outpatient imaging does not require PA.
Reconstructive Surgery, including but not limited to: • Blepharoplasty • Breast Reconstruction • Vein Stripping/Varicose Vein • Sclerotherapy • Bariatric Surgery	Medically necessary Medicare-covered reconstructive surgery does not require PA.
Rehabilitation Services (PT/OT)	Routine outpatient rehabilitation services do not require PA.
Skin Grafts	Medicare-covered skin grafts do not require PA.
Transplant services	Review the Member's benefit summary guide on what is covered and whom to contact when submitting a transplant evaluation request. Transplant requests are screened for eligibility, benefits, Centers of Excellence criteria, in addition to medical necessity based on nationally approved clinical criteria.

IMPORTANT NOTES:

Please refer to your current contract to determine compliance with the terms defined in this document. This list represents services and medications (i.e., medications that are delivered in the physician's office, clinic, outpatient, or home setting through home health or infusion companies). Services must be provided according to the Medicare Coverage Guidelines, established by the Centers for Medicare & Medicaid Services (CMS) and are subject to review. According to the guidelines, all medical care, services, supplies, and equipment must be medically necessary. You may review the Medicare Coverage Guidelines online at: https://www.medicare.gov/coverage.

- investigational and experimental procedures are not usually covered benefits. Please consult the member's Evidence of Coverage or contact the Health Plan for confirmation of coverage.
- Failure to obtain prior authorization for a service could result in payment reductions for the provider and benefit reductions for the member based upon the provider's contract and the member's Evidence of Coverage.
- This is not a comprehensive list. For a current list, check the PA Look-Up Tool at least quarterly on the secured portal at www.CAPCMS.com. For Medication and Drugs that require prior authorization, please refer to MDX Humana PA Drug List and/or MDX UHC PA Drug List for specific J codes requiring prior authorization.
- There may be exceptions to this list. Not all procedures and medications are covered by all health plans. Since a single document cannot reflect all possible exceptions, individual practitioners making specific requests for services are encouraged to verify benefits and authorization requirements prior to providing services.

REFERRAL PROCESS FOR HUMANA GOLD PLUS MEMBERS (HMO PLAN ONLY)

Primary Care Physician (PCP) Referring an HMO Member to a Specialist

If you need to refer your HMO member to a specialist, refer your patient to a provider who participates in MDX Hawai'i's Preferred Provider Network for Humana's HMO Medicare Advantage Plan. Refer to your current contract to determine needed compliance with the terms defined in this document. All referrals to a non-participating specialist or out-of-state services require PA.

1. A Specialist Referral is required before you refer your patient for specialty services. Submit the Referral Request PA Form before the patient is referred to a specialist. If the request is medically urgent, please submit the PA within the next business day.

2. Submit the request through the Conifer portal. Register by going to www.capcms.com

For PA Approved Specialists

If an HMO member has been referred to you and needs to have a service that is on PA Look up tool (or the MDX Humana or UHC PA Drug List), either you or the PCP may submit the Prior Authorization Request Form to www.capcms.com.

Once the Specialty Referral is approved, the Specialist may submit a prior authorization request for any medically necessary services until the referral expires. The Specialist must have a valid Specialty referral on file in order to request prior authorization for services.

1. Submit the request through the Conifer portal. Register by going to www.capcms.com

2. When you submit your claim, be sure to enter the name of the referring physician in Box 17 and NPI in Box 17b on your claim form (CMS 1500).