MDX Hawai'i

Prior Authorization List for Medicare Advantage Plans

effective January 1, 2024

This list of services requiring PRIOR authorization applies to Humana's Medicare Advantage Plans and UnitedHealthcare's Medicare Advantage Plans contracted with MDX Hawai'i. This list applies to CONTRACTED and NON-CONTRACTED health care providers. See IMPORTANT NOTES on page 3.

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: • OBS now is admitted to IP • ICF now changes to SNF or IP • Member changes health plan during a hospital admission	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 if 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/Admissions	All scheduled admissions require PRIOR authorization. This includes any pre-scheduled inpatient hospitalizations and Ambulatory Surgery Center conversions to inpatient. For Outpatient Surgeries, please use our PA Look-Up Tool on the secured portal at www.CAPCMS.com for authorization requirements.
Observation Services when members are admitted	No notification required UNLESS member's LOC is changed to inpatient in a hospital without e-census.

OUTPATIENT SERVICES, PROCEDURES OR EQUIPMENT	DETAILS
All non-participating and/or out-of-area services (excludes ER visit)	No Authorization Required for PPO. Required for HMO
All Outpatient Procedures and Surgeries	See PA Look up Tool for specific codes
Acupuncture	Please contact the member's Health Plan.
Brachytherapy	See PA Look up Tool for specific codes
Outpatient Specialty Drugs	See PA Look-Up Tool for specific codes
Chiropractic Services	No Authorization Required up to Health plan benefit
Clinical trials	Please submit PRIOR authorization requests directly to the health plan to ensure that selected services are covered during the clinical trial period.
Diagnostic Tests includes PET scans, etc.	See PA Look up tool for specific codes
Durable Medical Equipment (DME) includes CPAP, NPPV, specialty wheelchair, orthotics, prosthetics, oxygen tank and oxygen concentrator, etc.	See PA Look up tool for specific codes
Drugs and Medications	See MDX Humana Drug List and MDX UHC Drug List on portal for list of Drugs and Medication requiring Prior Auth
Enteral/parenteral services and supplies and commercial oral nutritional supplements	See PA Look up toolfor specific codes
Genetic Testing and Counseling	See PA Look up tool for specific codes. May not be covered
Home Health Services (includes Home Health Care)	See PA Look up tool for specific codes
Hospice Care/ Supportive Care	Notification required
Hyperbaric Oxygen Therapy	See PA Look up tool for specific codes
Infusion Services	See PA Look up tool for specific codes
Medical Nutrition Therapy (MNT)	See PA Look up tool for specific codes
Outpatient Services, Surgeries and Procedures	See PA Look up tool for specific codes
Pain Management Surgeries and Procedures	See PA Look up tool for specific codes
Parenteral Nutrition	See PA Look up tool for specific codes
Podiatry Services	See PA Look up tool. Covered for Diabetes

(continued)

OUTPATIENT SERVICES, PROCEDURES OR EQUIPMENT	
Proton Beam Therapy & Radiation Therapy	See PA Look up tool for specific codes
Radiology: Outpatient Imaging	See PA Look up tool for specific codes
Reconstructive Surgery, including but not limited to: • Blepharoplasty • Breast Reconstruction • Vein Stripping/Varicose Vein • Sclerotherapy • Bariatric Surgery	See PA Look up tool for specific codes
Rehab Services (PT/OT)	See PA Look up tool for specific codes
Skin Grafts	See PA Look up tool for specific codes
Transplant services	Providers should 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 your needed 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 preauthorization 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 Drug List and/or MDX UHC 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)

For Primary Care Physician (PCP) Referring Humana Gold Plus Member to a Specialist

If you need to refer your Humana Gold Plus member to a specialist, please refer your patient to a provider who participates in MDX Hawai'i's Preferred Provider Network for Humana's HMO Medicare Advantage Plan. Please refer to your current contract to determine your needed compliance with the terms defined in this document.

1. A Specialist Referral is required before you refer your patient for specialty services. Please submit the Referral Request Form before the patient is referred to a specialist.
2. Submit the request through the Conifer portal. Register by going to www.capcms.com

For Specialists

If a Humana Gold Plus member has been referred to you and needs to have a service that is on MDX Hawai'i's Prior Authorization Look up tool for Medicare Advantage Plans, 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).