Prior Authorization Requirements

Medical Procedures

Updated: April 04, 2024

- Benefits are determined by the Member's plan.
- This document applies to all AvMed Members and benefit products/line of business.
- Items listed may have limited or no coverage.
- An authorization is not a guarantee of payment.
- Payment is subject to member eligibility, benefit, and provider contract on the date of service.
- Providers both in and out of network are responsible for verifying eligibility and obtaining authorization for non-emergent services provided to AvMed Members when a prior authorization is needed.
- Members must be eligible on the date of service and the service must be a covered benefit.
- Authorizations processed by AvMed must be requested electronically on the AvMed Authorization and Referral Tool (AART) application via the Provider Portal, or on an Authorization Request form and submitted via fax.
- Services listed below require an authorization from AvMed or a contracted Vendor, (exceptions may apply)

Providers should submit authorization requests in accordance with *CMS/NCQA guidelines to allow for the Health Plan to make determination within the standard turnaround time, unless the member urgently needs care based on the below definition of an expedited/urgent request.

*CMS – Centers for Medicaid and Medicare Services (AvMed offers only the Medicare product)
*NCQA – National Committee for Quality Assurance

Authorization requests are processed promptly, based on the urgency dictated by the member's health condition.

Non-Urgent/ Standard pre-service request – A request submitted before a patient receives medical care or services. The decision and notification will be completed within fifteen (15) calendar days for commercial plans and fourteen (14) calendar days for Medicare plans.

Urgent/Expedited pre-service request – Urgent medical care provided for illnesses or injuries that require prompt attention. An expedited request is necessary when waiting for the non-urgent or standard time could seriously harm the member's life, health, or ability to regain maximum function. The decision and notification for urgent care will be made no later than 72 hours after receiving the request.

Urgent Concurrent - An on-going course of treatment. The decision and notification will be made ***no later than 24 hours*** after receipt of the request.

Post-Service – Decisions for care or treatment that the patient has already received will be made within thirty (30) calendar days for commercial plans and fourteen (14) calendar days for Medicare Plans.

Updated: 04/04/2024

How to Submit Authorization Requests

Behavioral Health

- **Behavioral Health and Substance Abuse Services** are authorized by **Optum Behavioral Health** effective January 1, 2021. Authorization may be requested by phone via AvMed's Behavioral Health Service Center powered by Optum at the numbers listed below.
    - AvMed Medicare Advantage: 866.284.6989
    - AvMed Commercial: 866.293.2689
    - You can also visit:
        - http://www.avmed.org/BehavioralHealth-Members
        - http://www.avmed.org/BehavioralHealth-Medicare
    - AvMed PCP Provider Communication form
        - PCP Behavioral health Coordination Form

Cardiology for Medicare Plan

- **Cardiology (non-complex diagnostic & surgical)** for Medicare Plan Members **–** please contact New Century Health (NCH) at **1-888-999-7713** or https://my.newcenturyhealth.com
- **Cardiology for Commercial Plans**
    - **See how to submit authorizations for All other prior authorizations.**

Chemotherapy

- **Chemotherapy Services (Outpatient) and Specialty Medications**
    - For **Medicare Advantage Plans** Chemotherapy and Hematology treatment requests along with supportive medications requested by all specialties will require review or an authorization by **New Century Health.**
        - Log into the New Century Health provider web portal: https://my.newcenturyhealth.com
        - Call 1-888-999-7713 (Monday–Saturday, 8 a.m. to 8 p.m. ET)
            - Medical Oncology – Option 1
- **Chemotherapy Services (Outpatient)**
    - Authorizations for AvMed members with coverage through either Fully Insured or Self-Insured Commercial Products will continue to be managed by AvMed.
    - For all other chemotherapy requests, complete a Medical Prior authorization request form and fax to **1-800-552-8633** Medical Prior Auth Request Form

- **Chemotherapy Services (Inpatient) and Specialty Medications**
    - **For all Members contact AvMed for Inpatient authorization requests.**

- **Chemotherapy Services Specialty Medications**
    - For all **Commercial and Self-Insured plans**, please contact NovoLogix via the web-based online preauthorization tool for providers. A list of all Medications (office and O/P facilities) reviewed by this vendor is available on the website.
    - For specialty drugs Log into Novologix via the AvMed Provider portal at www.avmed.org
        - To visit the Prescriptions page on the AvMed website Prescriptions | AvMed
        - Prior authorization requirements for specialty drugs
        - Pharmacy Resources | AvMed

Updated: 04/04/2024

Dermatology

- **Dermatology Services** for Medicare Plan Members are authorized by **(DNS) Dermatology Network Solutions**. You may contact **DNS** by phone at **305-667-8787** or by Fax at **(305) 402-2269**.
  - A referral is not required for in-network Dermatologists.

Dermatology cont.

- **Dermatology services** for all other benefit plans are managed by AvMed.
  - A referral is not required for in-network Dermatologists.
  - An auth may be required for certain surgical dermatology procedures.

Home Health and DME Services

- **Home Health and** certain **DME** items require prior authorization. Authorizations are processed by the following delegates based on what county the member lives in. See below for list of Medical Equipment and Prosthetics/Orthotics reviewed by AvMed.
  - **Integrated Home Care Services (IHCS)** for all counties except those listed below.
    - Call 844.215.4264 or FAX to 844.215.4265.
    - For Ostomy, Urology and Wound Care supplies [**new orders only**]
  - **BayCare Home Care**: Hillsborough, Hernando, Pasco, Polk, and Pinellas counties.
    - 800.940.5151
- **Advanced Care Solutions** for Ostomy, Urology and Wound Care supplies
  - Phone: 800.748.1977, Fax: 877.748.1985 [**Previously serviced members only; refer new orders to Integrated Home Care**]

Ophthalmology: HN1 providers and non HN1 providers have different authorizations requirements.

- Ophthalmology Codes - AvMed/Health Network One/EMI

- **Health Network One HN1 Ophthalmology services for the Medicare Advantage members are part of the Eye Management Inc. (EMI) network.**
  - **To initiate an authorization request,**
    - **Health Network One (HN1) EMI provider obtains authorization or a control number** to perform surgery for an AvMed Medicare Member through HN1.
    - Visit Health Network One website: www.myemifl.com
    - Call: 1.800.329.1152 option one (1).
    - Fax: 305.868.7640 or 800.922.4132
  - **AvMed In network Facility auth requirements**: None

Ophthalmology: Non-HN1 Providers for Medicare Advantage and Commercial Members.

- **Submit authorization requests through AvMed using one of the methods below:**
  - **Preferred:** Submit a referral or an authorization request via our new AvMed Authorization and Referral Tool **(AART).**
  - Complete a Medical Prior authorization request form and fax to **1-800-552-8633.**
    - Medical Prior Auth Request Form
      AvMed No Authorization Required List of Procedure Codes
  - **The following non-HN1 providers will continue to require an authorization** for both procedure and facility **through AvMed for Medicare Advantage Members**.

Updated: 04/04/2024

- All **non**-Health Network One EMI providers.
- University of Miami/Bascom Palmer doctors and facilities.
- All out of network doctors and facilities.
- All out of area and emergency related services.
- **All provider and facility claims** will continue to be processed by AvMed Claims Department.
- **Refer to the No Auth list for codes that will continue to not require an auth.**
  - AvMed No Authorization Required List of Procedure Codes

Podiatry:

- For All Members contact PNS (Podiatry Network Services) 844.222.3939
- Surgical procedures may require prior authorization.
  - AvMed No Authorization Required List of Procedure Codes

Radiation Therapy

- **Medicare Radiation oncology** is managed by **(NCH**) **New Century Health for the following plans:**
  - Medicare Advantage,
  - Fully Insured Commercial Products (incl. Exchange),
  - Sentara Health Plans
    - The requesting physician must complete an authorization request using one of the following methods:
      - Log into the New Century Health provider web portal: www.my.newcenturyhealth.com
      - Call 1-888-999-7713 (Monday–Saturday, 8 a.m. to 8 p.m. ET)
        - Radiation Oncology – Option 2

- **Commercial Radiation oncology** authorizations for AvMed members with coverage through Miami-Dade County, Jackson Health System, or City of Sunrise will continue to be managed by AvMed.
  - To submit a Radiation Therapy request to AvMed, complete a Medical Prior authorization request form and fax to **1-800-552-8633.**
    - Medical Prior Auth Request Form

Radiology authorizations for all AvMed Members are overseen by eviCore for In-office and Outpatient setting.

- **Diagnostic Testing List of codes Click Here**
- **Complex Radiology Services & Nuclear Medicine:** CAT Scan, MRI, PET Scan, CT Angiography
- **Nuclear and Cardiac Imaging**
  - Visit the website at http://www.evicore.com/,
  - Call **800-792-8790**
  - Fax **800-540-2406**
  - Access guidelines https://www.evicore.com/provider/clinical-guidelines

Referrals: For a list of Specialties requiring a referral Click Here
Visit our website Provider Education for AvMed Authorization and Referral Tool (AART)

- **Referral requirements by Plan type:**
  - **Medicare Advantage Plans:** Choice, Circle, Premium Saver
  - **Individual and Family:** Engage and Entrust (HMO)
  - **Small Group:** Focus (HMO)

Updated: 04/04/2024

ALL OTHER PRIOR AUTHORIZATIONS AND VENDORS

Preferred: Submit a referral or an authorization request via our new AvMed Authorization and Referral Tool **(AART).**

- To access AART, please log in to the **Provider Portal**
  - https://www.avmed.org/news/new-service-portals/ and review the following resources:
    - Quick reference guide
    - Video tutorial
    - List of specialties requiring a referral
      - Providers may also submit authorization requests via fax to **AvMed** prior authorization department at 1-800-552-8633. The prior authorization request form may be found on the forms tab on the AvMed website. Medical Prior Auth Request Form

- **AvMed Coverage Guidelines:** Click Here
- **Hospital/Skill Nursing Facilities Hospital Discharge Planning Resource**
- All procedures outlined on this list require prior authorization.
  - All Inpatient admissions and Observation stay for surgical and non-surgical stays require authorization notification. Hospital Use only - Emergent Urgent Direct Admissions
    - Emergency room visits without an overnight stay will not require authorization.
  - Maternity and Newborn confinements require authorization.
  - Inpatient SNF (Skilled Nursing), LTAC (Long Term Acute Care) and Acute Rehabilitation facilities require prior authorization.
  - **Behavioral Health/Substance Abuse Services** for both inpatient and outpatient hospital services (including Partial Hospitalization and Intensive Outpatient Programs) require authorization by Optum. See above for contact information.

Investigational/Experimental Items and Non-Covered Services

- **Any item or service potentially considered investigational or experimental** must be authorized in advance and may not be covered per members' plan.
- **Examples of Services** that may not be covered include but not limited to:
  - Magnetoencephalography (MEG),
  - Thermal Capsulorrhaphy,
  - Chronic Intermittent Intravenous Insulin Therapy (**CIIT**),
  - Platelet Rich Plasma & Fibrin Matrix (**PRP**),
  - Percutaneous Tibial Nerve stimulation (**PTNS**),
  - MLS Laser Therapy for Treatment of Pain,
  - Breast Thermography/Breast Care DTS,
  - Ligament Augmentation and Reconstruction **LARS.**
  - Acoustic Rhinometry
  - Cosmetic Services– surgical and non-surgical
  - Custodial Care
  -

Updated: 04/04/2024

Laboratory Services

- All Specialty Labs
- Genetic Testing: does not include standard Down Syndrome and Cystic Fibrosis Screening when performed by capitated /contracted laboratory listed below.
    - Quest Diagnostics All Florida Counties except as listed below 866-697-8378,
        - Quest Lab
    - Consolidated Laboratory Services for Clay, Duval, Nassau, and St Johns Counties
        - Contact 904-308-5600

Medical Equipment and Prosthetics/Orthotics (see above for DME items processed by delegate) includes but not limited to:

- Bone growth stimulators
- Dynasplint
- Home PT/INR Monitor
- External Defibrillator (The Vest)
- External prosthetic devices (excludes post-cancer breast prostheses)
- Implanted devices including cochlear device and /or implantation.
- Insulin Pumps, Continuous Glucose Monitors, and supplies.
- Lower limb prosthetics
- Myoelectric prostheses
- Negative Pressure Wound Therapy (Wound Vacuum Device)
- Neurostimulators trial or implantation
- Implanted Pain Pumps,
- Prefabricated Orthotics (please call to verify member's coverage and authorization requirements)
- Snore Guards (Oral appliances)

Out of Network Services

- **Authorization is mandatory for all Out of Network (OON) services**, except for emergency care, for Commercial, Medicare, and Individual plan members.
- Second Medical Opinions by an out of network, non-contracted provider
- Select out-patient services for members with POS (point of service) and Choice (out of network) benefits may not require prior authorization.
    - **Please verify coverage at www.avmed.org** or contact the Provider Service Center at 800.452.8633 prior to rendering service.

Outpatient Rehabilitative Services (Speech, Occupational, Physical and Habilitative Therapy)

- **Authorization is not necessary when the provider is in network.**
- **Habilitative Therapy** encompasses physical, occupational and speech therapies offered in an outpatient or home care setting and is a covered benefit when provided to help a person keep, learn, or improve skills and functioning necessary for daily living.
    - **Optum** oversees Autism Services (see **Page 2** for contact information)

- **The coverage for the following Physical Therapy modalities is currently unavailable due to their investigational status,** but this list is not exhaustive:
    - Interactive Metronome Program
    - Augmented Soft Tissue Mobilization
    - Kinesio Taping/Taping

  - MEDEK Therapy
  - Hands-Free Ultrasound and Low-Frequency Sound (Infrasound)
  - Hivamat Therapy (Deep Oscillation Therapy)

- **Rehabilitative physical, occupational and speech therapies** provided in an outpatient environment or home care setting are covered to improve or restore physical functioning following disease, injury or loss of a body part does not require prior authorization **when performed at non-hospital affiliated facilities or offices**. Refer to member's plan for benefit limits.
  - See **Page 3** for Home Health Rehab needs.

- **Rehabilitative therapy (outpatient)**
  - **Health Network One (HN1) oversees** speech, occupational and physical/lymphedema therapy benefits for **Medicare Advantage** Plan members.
  - For Outpatient free standing therapy centers visit **HN1** website https://www.ataflorida.com
  - Provider contact #: 1-888-550-8800 option one.
  - Provider Fax: 855-410-0121

Pain Management (PM)

- For in-network outpatient services, such as those provided by ambulatory surgery centers or hospitals, an authorization is necessary for pain management services, this includes surgical pain management procedures.
- Pain Management services provided by an in-network (PM) Specialist in an office setting does not require prior authorization.

  Acupuncture
  - Covered for **Medicare Members with diagnosis of chronic low back pain only.**
    - Verify member benefits for coverage requirements and limitations.
    - Acupuncture provided by an in-network Acupuncturist (**Medicare only**) will not require prior authorization.
  - Covered for **select ASO (Self-Funded) plans with (POS) out of network benefits**. Refer to member's specific plan for coverage and benefit limitations.
    - For ASO plans with this benefit, prior authorization is not necessary. However, the benefit is exclusively accessible from an out-of-network provider for ASO plan members with POS benefit.

Reconstructive Procedures performed to restore function or correct deformities after trauma or a medical condition such as cancer requires prior authorization. **Cosmetic surgeries are not a covered benefit.**

Examples below are not a complete list.

- Abdominoplasty/Panniculectomy (excision of excessive skin due to weight loss)
- Blepharoplasty/Canthoplasty
- Mammoplasty,
- Breast Reduction Reconstruction
- Rhinoplasty
- Panniculectomy
- Penile implant
- Surgery for Varicose veins
- Earlobe repair /Keloids/Scar revision

Updated: 04/04/2024

Select Items and Services

- **Ambulance Services:** Including air, land, and water for Emergency and Non-Emergency
- **Cardiac Rehabilitation:** Verify member benefits and coverage for authorization requirements.
- **Chiropractic:** Contact Chiro Alliance - HMO Members: 877-434-8258, POS and HSAQ Members: 888-693-3296
- **Dermatology** See No auth required list for codes that do not require prior auth.
    - AvMed No Authorization Required List of Procedure Codes
- **Diabetic Supplies –** Insulin pumps, Continuous Glucose Monitors
- **Dialysis and related services**
- **Drug Infusion Therapy** – Verify auth requirements as the requirements may be plan specific.
- **Gender Reassignment Procedures and Surgery**
- **Hyperbaric Oxygen treatments – may have limited treatments.**
- **Hospice**
- **Infertility Diagnostic Testing:** Hysteroscopy, Hysterosalpingogram, Sono-hysterogram, Laparoscopy
- **Lymphedema Therapy**
- **Neuropsychology Testing:** For all out of network providers
- **Neurostimulators:** Includes Trial and Implantation
- **Ophthalmology:** See **page three (3)** for details.
    - **See Ophthalmology Code List** Ophthalmology Codes - AvMed/Health Network One/EMI
- **Orthotic Devices:** Coverage for Orthotic Devices or Orthotic Appliances may be limited to custom-made leg, arm, back and neck braces when related to a surgical procedure or when used to avoid surgery and when necessary to conduct normal activities of daily living.
    - **Verify individual plan benefits and authorization requirements.**
- **Podiatry**: Contact PNS (Podiatry Network Services) 844-222-3939
- **Prosthetic Devices** are specifically designed to restore bodily function or replace a physical portion of the body. The coverage for prosthetic devices is limited to artificial limbs, artificial joints, ocular prostheses, and cochlear implants.
- **Radiation Oncology** contact **NCH** www.my.newcenturyhealth.com
    - Medicare Advantage, Fully Insured Commercial Products (incl. Exchange) and Sentara Health Plans.
    - Log into the NCH provider web portal: www.my.newcenturyhealth.com
    - Call 1-888-999-7713 (Monday–Saturday, 8 a.m. to 8 p.m. ET)
        - For Radiation Oncology – **select Option 2**
- **Radiation oncology:** AvMed reviews and makes decisions regarding radiation oncology authorizations for members with Miami-Dade County, Jackson Health System and City of Sunrise benefit plans.

Supplies

- When medically necessary, ostomy, urostomy and wound care supplies are covered.
    - The provision of ostomy and urostomy supplies is subject to applicable copayments and coinsurance. Items which are not medical supplies, or that could be used by the Member or a family member for purposes other than ostomy care are not covered.
    - Wound care supplies are included in an approved treatment plan if either of the following criteria is met:
        - treatment of a wound resulting from a surgical procedure; or treatment of a wound necessitating debridement.
        - See **page two (2)** for Home Health Care providers.

Updated: 04/04/2024

Surgical Procedures in a Hospital or Ambulatory Surgery Center

- All surgical procedures performed in the hospital or ambulatory surgery center setting require prior authorization EXCEPT those listed on the No Auth Required List.
  AvMed No Authorization Required List of Procedure Codes

Transplants

- Comprehensive services are offered for pre-transplant evaluations, organ transplants and post-transplant care. These services cover a wide range of major organs including Kidney, Liver, Heart, Lung, Pancreas, Small Bowel and Bone Marrow. Additionally, stem cell transfer is available after high dose chemotherapy.
  - For Case Management Programs:
    - Medicare Click here
    - Individuals and Families Click Here

Wound Care

- Hospital Inpatient and Outpatient setting requires prior authorization.
- Wound care procedures rendered by an in-network provider in an office setting do not require prior authorization.
- Wound Vacuums/Negative Therapy Wound Management Systems requires prior authorization.
- HBO (**Hyperbaric Oxygen Therapy**) requires prior authorization and is subject to benefit limitations.

Other resources:

- **New Member Transition of Service:** Designed To assist newly enrolled members in transitioning their medical services and prescription needs from their previous health plan to AvMed.
  - New Member Transition of Service form

- **Continuation of Care for existing members**: Use this form when a treating provider becomes out of network but needs to complete treatment already started for an existing member.
  Continuity of Care Authorization Form
- **Claims**
  - Submit New Claims: P.O. Box 569000 Miami, FL 33256
  - Claims Correspondence, Reviews, and Appeals: P.O. Box 569004 Miami, FL 33256
    - Fax: 1-800-452-3847

** **Services not included on the precertification list are subject to the coverage terms of the member's plan.**