Prior Authorization Requirements

Medical Procedures

Updated: 08-01-2022

- 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**.**
- The 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 for the member as expeditiously as the member's health condition requires.

Non-Urgent/ Standard pre-service request – request is made in advance of the patient obtaining medical care or services. Decision and notification will be made ***no later than 15 calendar days*** after receipt of request for commercial plans and ***14 calendar days for the Medicare plans***.

Urgent/Expedited pre-service request – medical care provided for illness or injuries which require prompt attention based on the definition of urgent /expedited. An expedited request is if the Member's life, health, or ability to regain maximum function could be seriously harmed by waiting for the non-urgent/standard time-period. The decision and notification will be made ***no later than 72 hours*** after receipt of 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 – Any request for approval of care or treatment that has already been received by the patient. The Decision and notification will be made ***no later than 30 calendar days*** of receipt of the request for commercial plans and ***14 calendar days*** for Medicare Plans.

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

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 Click Here
        - Prior authorization requirements for specialty drugs Click Here

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**.

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 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 Surgical CPT codes

    - **The following non-HN1 providers below will continue to require an authorization** for both procedure and facility **through AvMed for Medicare Advantage Members**.
        - 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),
    - State of Florida Self-Insured
    - SantaFe Healthcare Self-Insured (AvMed)
    - 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 authorized 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

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 Resource Document

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 Emergent Urgent Direct Admissions
  - Emergency room visits without an overnight stay will not require an 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 advanced 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

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

- Except for emergency care, an authorization is required for all Out of Network (OON) services for Commercial, Medicare and Individual plan members
- Second Medical Opinions by an out of network, non-contracted provider
- Members with POS and Choice benefits may not require prior authorization for some out-patient services.
    - **Please verify coverage prior to services being rendered.**

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

- **Habilitative Therapy:** Physical, occupational and speech therapies provided in an outpatient or home care setting are covered when provided to help a person keep, learn, or improve skills and functioning for daily living.
    - Autism Services are authorized by Optum (see contact information above **Page 2**)
- **Physical Therapy modalities that are considered investigational** and not covered include, but are not limited to:
    - 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. Refer to member's plan for benefit limits.
    - See **Page three (3**) for Home Health Rehab needs.

- **Rehabilitative therapy** (Speech, Occupational, Physical/Lymphedema) **for Medicare Advantage** members is managed by **(HN1) Health Network One.** See Directory for exceptions.
  Visit their website https://www.ataflorida.com
  Provider contact #: 1-888-550-8800 option 1,
  Provider Fax: 855-410-0121

Pain Management

- When service is provided by an in-network outpatient provider /facility (ambulatory surgery center/hospital setting) including surgical procedures.
- Pain Management provided by a contracted Specialist in an office setting does not require prior authorization.

- **Acupuncture**
  - Covered **with a prior authorization for Medicare Members**.
  - Submit auth request to AvMed **via the web portal or fax to 800.552.8633**
  - **Covered for select ASO plans with out of network (POS) benefits**. Refer to member's specific plan for coverage and benefit limitations. No prior authorization is required for the ASO plans with this benefit. Benefit is only available from an Out of network provider for ASO plan members with POS benefit.

Reconstructive/Procedures That May Be Considered Cosmetic (not a complete list of procedures)

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

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: 877.454. 2858, 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 Ophthalmology above Code List Ophthalmology codes - AvMed / Health Network One / EMI See **page three (3)** for details.
- **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 carry out normal activities of daily living. **Verify individual plan benefits and authorization requirements.**
- **Podiatry**: Contact PNS (Podiatry Network Services) 844.222.3939
- **Prosthetic Devices**: Designed to restore bodily function or replace a physical portion of the body. Coverage for Prosthetic Devices is limited to artificial limbs, artificial joints, ocular prostheses, and cochlear implants.
- **Radiation Oncology** contact www.my.newcenturyhealth.com
- Medicare Advantage, Fully Insured Commercial Products (incl. Exchange), State of Florida Self-Insured Commercial Products, and SantaFe Healthcare Self-Insured Commercial Products
- 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)
    - For Radiation Oncology – **select Option 2**
- 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.

Supplies

- Ostomy, urostomy and wound care supplies are covered when Medically Necessary.
    - Provision of ostomy and urostomy supplies is subject to applicable Copayments and Coinsurance. Items which are not medical supplies, or which could be used by the Member or a family member for purposes other than ostomy care are not covered.
    - Wound care supplies are covered as part of an approved treatment plan, when one of the following criteria is met: treatment of a wound caused by, or treated by, a surgical procedure; or treatment of a wound that requires debridement.
    - See **page two (2)** for Home Health Care providers.

Surgical Procedures in 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

- Pre-transplant, transplant and discharge services for all major organ transplant evaluations and transplants
- Including but not limited to, Kidney, Liver, Heart, Lung and Pancreas, Small Bowel and Bone Marrow replacement or stem cell transfer after high dose chemotherapy.

Wound Care

- Hospital Inpatient and Outpatient setting requires prior authorization.
- In office (location 11) procedures by an in-network provider does not require prior authorization
- Wound Vacuums/Negative Therapy Wound Management Systems requires prior authorization.
- HBO (**Hyperbaric Oxygen Therapy**) requires prior authorization.

Other resources:

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