Authorization and Referral Process Overview

Physician Referrals - The Primary Care Provider (PCP) is the Members' "Medical Home." PCPs may refer members to plan participating Specialists, clinics and free-standing facilities by writing or faxing a script to the Specialist **(except for Pain Management which requires Prior Authorization**). The Specialist must document receipt of this request and the reason for the referral (No additional communication with the plan is needed). The Specialist must coordinate with the PCP for any additional services that will require prior authorization.

Referrals by a Specialist to another Specialist are not permitted.

MEMBER SELF-REFERRALS	
Members may "self-refer", meaning no documented referral from the PCP is necessary, for the following services:	
➢ Routine women's health care ▪ *Breast Exams* ▪ *Screening Mammograms* ▪ *Breast Exams* ▪ *Pelvic Exams* ➢ Behavioral Health/Substance Abuse ➢ Emergent/Urgently needed care ➢ Dialysis when member is temporarily out-of-area	➢ Dermatology ▪ *Minor procedures and testing allowed during visit* *(limit 5 visits per year without authorization)* ➢ Chiropractic ➢ Flu shots, Hepatitis B and Pneumonia vaccinations ➢ Optometry

PLACE OF SERVICE CODES		
Note: Place of service codes are specific for some services. Please complete the Authorization Request Form in its entirety to prevent a delay in approval.		
02 – Telehealth	11 - Office	12 - Home
15 - Mobile Unit	19 - Off Campus-Outpatient Hospital	20 - Urgent Care Facility
21 - Inpatient Hospital	22 - On Campus-Outpatient Hospital	23 - Emergency Room
24 - Ambulatory Surgery Center	31 - Skilled Nursing Facility	32 - Nursing Facility
34 - Hospice	49 – Independent Clinic	61 - Comprehensive Inpatient Rehabilitation Facility
62 - Comprehensive Outpatient Rehabilitation Facility	65 - ESRD Clinic Treatment Facility	81 - Independent Laboratory

STANDARD AUTHORIZATIONS			
Procedures and Services	**Authorization Required**	**No Authorization Required**	**Comments**
Elective Inpatient Admissions (21)	x		Clinical updates required for continued length of stay
Unplanned Inpatient Admissions (21)	x		Notification by next business day with clinical updates required for continued length of stay
Skilled Nursing Admissions (31 & 32)	x		Clinical updates required for continued length of stay
Rehabilitation Facility Admissions (61)	x		Clinical updates required for continued length of stay
Long Term Acute Care Hospital (LTACH) Admission	x		Clinical updates required for continued length of stay
Home Health and Drug Infusion (12)	x		-Evaluation and first 3 visits DO NOT require authorization. PCP authorization required thereafter. -Antibiotics with HH are not subject to the 20% coinsurance ($0 copay). G0179 and G0180 DO NOT require prior authorization.
Emergency Room Services (23)		x	Notification Only – No authorization required
Pain Management Services	**x**		**All services, including office visit codes**
Emergency Transportation Services		x	
Dialysis (65)	x		Notification Only: Dialysis out of the service area; No authorization required.
Therapy; physical, occupational, speech & language	x		Evaluation and first 3 visits do not require an auth in POS 11, 12, 22; thereafter auth is required
Non-Emergency Transportation Services	x		
Emergency Behavioral Health and Substance Abuse Services		x	**PsychCare/Beacon Health Options** See Contracted Networks Phone: **800-627-1259** to access these services.
Hospital Observations (22)	x		Clinical updates required for continued length of stay.
Ambulatory Surgery Center Procedures (24)	x		A referral or PA is required for some services.
Wound Care/Wound Care Centers	x		A referral or prior authorization is required for some services. Please contact the plan for more information.
Disposable Medical Supplies	x		Ostomy, urological, and incontinence supplies
BiPAP/CPAP Machines, Nebulizers	x		

Procedures and Services	Authorization Required	No Authorization Required	Comments
DME Non-Standard equipment (11, 12)	x		Such as custom or motorized wheelchair/ scooter, special mattresses, insulin pumps, overnight pulse oximetry and bone growth stimulators.
DME Standard equipment (11, 12)	x		DME greater than $300 (billed amount) per line item require authorization.
Orthotics and Prosthetics	x		Excluding basic stabilizing splints and casts applied in an office.
Laboratory (Routine) Testing (11, 22, & 81)		x	Lab services performed in POS 81 should be directed to LabCorp.

OUT-OF-NETWORK AUTHORIZATION REQUESTS
Out-of-network services require prior authorization. Emergency care and/or urgently needed care when our network is not available, or dialysis out of the service area, do not require prior authorization and are always covered at the in-network benefit level, even when obtained from out-of-network providers. ***Prior authorization is required*** **when the level of care changes from Emergent Treatment to Post Stabilization Care Treatment.**

NOTE: **This guide is not intended to be an all-inclusive list of covered services by Ultimate Health Plans, but it substantially provides current referral and prior authorization instructions. This guide can be used as a reference in conjunction with Prior Authorization List document. Authorization does not guarantee claims payment. All services/procedures are subject to benefit coverage, limitations, and exclusions as described in the applicable plan coverage guidelines.*