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Wellcare By Allwell Changing Peer-to-Peer Review Request and Elective Inpatient Prior Authorization Requirements for Medicare Advantage Plans

To reduce administrative burden on our provider partners, Wellcare By Allwell is making the following changes to both our peer-to-peer review request requirements and elective medical inpatient authorization process. This will impact peer-to-peer and elective medical inpatient authorization requests received on or after the elective dates outlined below.

Peer-to-Peer Review Requests Change Effective 10/1/2022

In order to ensure accurate delivery and reimbursement for medically necessary services to our members, Wellcare By Allwell is updating our requirements for peer-to-peer review effective 10/1/2022 to the following:

- Peer-to-peer review requests will be allowed up to two (2) business days after integrated denial notice *or* day of discharge, whichever is later.
- Peer-to-peer outreach will be completed within 2 business days of peer-to-peer review request.
- If provider is not reached, a voice mail will be left (if possible) giving provider one business day to respond.
- If the provider does not respond within the stipulated timeframe, Wellcare By Allwell will be unable to proceed with peer-to-peer request.

No changes are being made to existing peer-to-peer timeframes or processes for pre-service requests.

Elective Medical Inpatient Authorization Process Change Effective 11/1/2022

To provide increased flexibility and better align with industry best practices, we are making the following changes to our elective medial inpatient authorization process effective 11/1/2022:

- The prior authorization span for elective inpatient admissions will be increased to 60 (sixty) days for dates of service on or after 11/1/2022.
- If the planned admission date exceeds the authorized date span of 60 days, a new authorization span is required.
- Elective Inpatient Prior Authorization numbers will now start with the prefix of **OP** instead of **IP.**
- Notification of admission is required within one (1) business day of admit. At the time of admission notification, a new authorization number for the admission will be provided with the **IP** prefix. Failure to provide timely notification may result in a denial of payment.

As a reminder, all planned/elective admissions to the inpatient setting require ***prior authorization***. Prior authorization should be requested at least five (5) days before the scheduled service delivery date or as soon as

need for service is identified. If prior authorization is not on file at the time of elective admission, the service is considered retrospective, and provider should follow the appropriate retrospective request process as communicated in the provider notice. Emergent admissions do not require prior authorization.

Thank you for continuing to provide our Medicare members with high quality and compassionate care. If you have questions about any of this information, please contact Provider Services at 1-877-647-4848.