## Quick Reference Guide
<https://www.getempowerhealth.com>

### Key Contact Information

<table>
<thead>
<tr>
<th>Provider Services</th>
<th>(855) 429-1028</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility verification, Claims/Billing, Network/Contracting, Utilization Management/Prior Authorizations (Medical, BH/DD, Vision, Pharmacy)</td>
<td></td>
</tr>
<tr>
<td>TTY/TDD and Language Line</td>
<td>711</td>
</tr>
<tr>
<td><strong>Utilization Management Fax Numbers:</strong></td>
<td></td>
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<tr>
<td>BH/DD/HCBS Services (800) 886-6839</td>
<td></td>
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<tr>
<td>Medical Services</td>
<td>(800) 878-8264</td>
</tr>
<tr>
<td><strong>Member Services</strong></td>
<td>(866) 261-1286</td>
</tr>
<tr>
<td>Care Coordination, Clinical Appeals, Complaints/Grievances, Member Benefits, Eligibility, and Authorizations</td>
<td></td>
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<tr>
<td>TTY/TDD and Language Line</td>
<td>711</td>
</tr>
<tr>
<td><strong>Fraud, Waste, and Abuse</strong></td>
<td>(844) 478-0329</td>
</tr>
<tr>
<td>empower.ethix360.com</td>
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</tbody>
</table>

### Claims

<table>
<thead>
<tr>
<th>Claims Questions</th>
<th>(855) 429-1028</th>
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<tbody>
<tr>
<td>EDI Clearinghouse</td>
<td>Change Healthcare</td>
</tr>
<tr>
<td>Empower Payer ID</td>
<td>12956</td>
</tr>
<tr>
<td><strong>Mail paper claim submissions to:</strong></td>
<td></td>
</tr>
<tr>
<td>Empower Healthcare Solutions</td>
<td></td>
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<tr>
<td>PO BOX 211446</td>
<td></td>
</tr>
<tr>
<td>Eagan, MN 55121</td>
<td></td>
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<tr>
<td><strong>Portal Submission</strong> (Professional Only)</td>
<td><a href="http://www.getempowerhealth.com">www.getempowerhealth.com</a></td>
</tr>
</tbody>
</table>

**Note:** You may also check claims status, authorizations, and eligibility through the portal

### Notification of Denial

When a claim is denied because of missing or invalid mandatory information, the claim should be corrected, marked as a second submission or a corrected claim, and resubmitted within ninety (90) days of notification of payment/denial either electronically or to the general claim address:

Empower Healthcare Solutions
PO BOX 211446
Eagan, MN 55121

### Correct Claims and Appeals Requests

Providers have the right to appeal the outcome of a claim. The appeal must be submitted in writing and received within one (1) year of the last process date and include supporting documentation. Empower will respond to the appeal within thirty (30) days from the receipt date with a determination or status of the review.

Resubmitted claims should be resubmitted on paper. Corrected claims can be sent electronically. All corrected claims should have the corrected claim indicator (a 7) on the claim and the original claim number that you are correcting. Resubmitted claims should be sent to the claims address referenced above.

### Pharmacy

<table>
<thead>
<tr>
<th>Pharmacy Benefits Manager (PBM)</th>
<th>CVS Caremark</th>
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<tbody>
<tr>
<td><strong>Pharmacy Help Desk</strong> (800) 364-6331</td>
<td>(Pharmacies Only)</td>
</tr>
<tr>
<td><strong>Pharmacy PA Requirements</strong></td>
<td></td>
</tr>
<tr>
<td>PA is necessary for some medications to establish medical necessity and to ensure eligibility for coverage per State and/or Federal regulations. This may be due to specific Food and Drug Administration (FDA) indications, the potential for misuse or overuse, safety limitations, or cost- benefit justifications.</td>
<td></td>
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</table>
Pharmacy BIN/PCN/Group

<table>
<thead>
<tr>
<th>BIN</th>
<th>PCN</th>
<th>RXGroup</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>004336</td>
<td>ADV</td>
</tr>
<tr>
<td>Medicaid Duals</td>
<td>012114</td>
<td>COBADV</td>
</tr>
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</table>

**PDL Exception Requests**

Providers may request an exception to Empower’s PDL verbally or in writing. For written requests, providers should complete a Prior Authorization Request Form, supplying pertinent Member medical history and information.

A Prior Authorization Request can be located on the Empower website at: [www.getempowerhealth.com](http://www.getempowerhealth.com)

To submit a request, orally, call (855) 429-1028 to speak with a pharmacy specialist.

If Authorization cannot be approved or denied, and the drug is Medically Necessary as defined by DHS, up to a 5 day emergency supply of the non-preferred drug can be supplied to the Member.

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### Appeals & Grievances

**Complaint and Grievances Process**

Any member or provider may submit a complaint regarding issues other than those related to the terms of the provider agreement and/or performance under the provider agreement. Assistance with filing grievances and appeals is available. For complaints or grievances contact:

Empower Healthcare Solutions, LLC  
Compliance Officer  
PO BOX 211446  
Eagan, MN 55121  
Email: complaintsandgrievance@empowerhcs.com  
Phone: (866) 261-1286

**Appeal Process**

The following individuals may file an appeal:

- The enrolled member;
- The enrolled member’s parent or legal guardian;
- An attorney authorized to represent the enrolled member;
- Another authorized representative of the enrolled member, including the representative of the enrolled member’s estate if that member is deceased;
- A direct service provider that is the subject of the adverse action/adverse decision, or the direct service provider’s legal representative or attorney.

Appeals may be submitted to the address or via phone number below:

Empower Healthcare Solutions, LLC  
PO BOX 211446  
Eagan, MN 55121  
Phone (866) 261-1286
# Services that Require Prior Authorization

## Medical Services

### Advanced Imaging:
- CT/CTA
- MRI/MRA
- PET/SPECT
- Nuclear Medicine Studies
- Gastrointestinal Tract Imaging with Endoscopy Capsule

Exclusions:
- Imaging rendered in the following settings DOES NOT require prior authorization:
  - Emergency department
  - Inpatient setting
  - Observation unit

(Contact number provided, CPT code list include - If not carved out)

### Admissions:
- Elective Procedures/Surgery
- LTAC, Rehabilitation, SNF
- Observation Stays Extending Beyond 48 hours
- Radiology Procedures Requiring Inpatient or Observation
- All Bariatric Procedures
- All Transplants, excluding cornea
- Intermediate Care Facility

- All elective admissions require PA
- Admission to any long-term acute care, rehabilitation or skilled nursing facility, requires PA.
- Observation Stays Extending Beyond 48 hours

### All Cosmetic Procedures
Limited to the following procedures:
- Reduction Mammoplasty
- Otoplasty and Rhinoplasty

### All non-participating providers (All OON services)
- Inpatient
- Outpatient
- All OON services require prior authorization excluding emergency room services

### Allergy Testing
- For Children Under the age of 5

### Any Experimental / Investigational

### Chiropractic Services
- ONLY to correct a subluxation of the spine
- 21 years and older-12 visits per
- Under 21-No benefit limit

### Dental Procedures
- Those services that fall under the medical benefit (eg. Orthognathic surgery)

### Drugs & Immunizations
- Chemotherapy and immunosuppressive drugs, Allergy Injections, other injections that are covered for specific diagnoses and/or conditions
- >$1000

### Durable Medical Equipment (DME)/External Prosthetic Appliances (EPA) and Supplies
- DME >$1000
- Orthotics/Prosthetics >$750
- Ostomy Supplies – Exceeding quantity limits require PA
- Enterals for ages 0-4; infusion pumps & supply kits (under 21)
- All DME with E1399 codes

### Pharmacy/High Dollar Meds (excluding medications administered in an inpatient setting)
Over $1000 requires PA

### Home Health
- For Nurse (RN or LPN), Aid or SW requests (PA required after initial eval)

### Home Infusion / IVT

### Hyperalimentation

### Hysterectomies

### Injections, Radiopharmaceuticals and Therapeutic Agents
- IP services only require PA
### Inpatient Acute Hospital Admissions:
- Medical
- Surgical

- Notification required within 24 hours of emergency room or direct admission from a clinic or provider office or next business day.
- Clinical updates required with continued stay

### Intensive Cardiac and Pulmonary Rehabilitation Services
- Inpatient
- Outpatient

### Molecular Diagnostics Testing

### OB Services
- Induction of labor- if prior to 39 weeks gestation
- OB ultrasound over 2 per pregnancy
- Stays over 2 days for Vaginal delivery
- Stays over 4 days for Cesarean
- Termination of pregnancy
- Genetic testing
- Certified Nurse-Midwife (for IP services based on MNC)

### Outpatient Bariatric Procedures

### Pain Management; Outpatient

### Private Duty Nursing
- Private duty
- Personal care services Clinical updates required with continued review, incorporate review requirements during review process

### Rehabilitative Hospital

### Retisert Implantation
- Fluocinolone Acetonide Intravitreal Implant

### Sleep studies
- Facility based only

### Behavioral Health Services & Development Disability Services

#### Autism Treatment under EPDST (ABA)
- Under 21

#### Inpatient Psychiatric Treatment

#### Intermediate Care Facility

#### Partial Hospitalization

#### Planned Respite
- Under 21

#### Psychiatric Residential Treatment
- Under 21

#### Residential Community Reintegration
- Under 21

#### Substance Abuse Detox (IP or OP-Obs only)
- Adults Only

#### Therapeutic Communities
- Adults Only (18+)

#### Therapeutic Host Home
- Under 21

*All out-of-network physicians and hospital and ancillary service requests will require prior authorization.*

** Unlisted procedure codes that are manually priced require prior authorization.

*** DDS & OBHS Community and Employment Support Services (1915C & 1915I) will be prior authorized as a final outcome of the PCSP process after full review of medical necessity.*
Excluded Services

The following services are excluded in the PASSE program:

a. Nonemergency medical transportation (NET) provided through the Prepaid Ambulatory Health Plan (PAHP);

b. Transportation to and from an EIDT and ADDT

c. Dental benefits in a capitated program;

d. School-based services provided by school employees;

e. Skilled nursing facility services;
   a. Limited Rehabilitation Stay is not considered an excluded skilled nursing facility service.

f. Assisted living facility services;

g. Human Development Center (HDC) services;
   a. This means full admission to a HDC.
   b. Respite stays and conditional admission at HDCs are not excluded services.
   Exclude HDC for PASSE program based on Medicaid IDs (Not all HDCs will be excluded, only the 5 providers listed below):

h. Waiver services provided to the elderly and adults with physical disabilities through the ARChoices in Homecare program or the Arkansas Independent Choices program, or a successor waiver for the elderly and adults with physical disabilities; and

i. Abortions, unless:
   a. The pregnancy is the result of incest or rape; or
   b. The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition that manifests during pregnancy, which would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

Excluded Programs- the following programs are not applicable to the PASSE program. Beneficiaries within these programs will not be a part of the PASSE:

a. ARChoices in Home Care Home and Community-Based 2176 Waiver

b. Children's Services Targeted Case Management

c. IndependentChoices

d. Living Choices Assisted Living

e. Patient-Centered Medical Home (PCMH)

f. Program of All-Inclusive Care for the Elderly (PACE)

g. Rehabilitative Services for Persons with Mental Illness (RSPMI)

h. Rehabilitative Services for Youth and Children (RSYC)

i. School-Based Mental Health Services

j. Episodes of Care

k. Area Health Education Center (AHEC)
l. ARKids First-B