Provider FAQ

General

Who is WellSky and what is PAC Advance?

WellSky is a healthcare technology company leading the movement for intelligent, coordinated care. Our next-generation software, analytics, and services power better member outcomes and an improved provider experience across the post-acute care continuum.

PAC Advance aims to deliver a fully integrated, post-acute care (PAC) episode management program, inclusive of skilled nursing facilities (SNF), inpatient rehabilitation facilities (IRF), long-term acute care hospitals (LTAC), and skilled home health (HH) services, facilitating high-quality, end-to-end post-acute care management. WellSky aims to improve member satisfaction and outcomes.

How can providers submit prior authorization or continued stay authorizations?

Submissions can be made via:

- WellSky Discharge Planning tools*
  - CarePort Care Management
  - CarePort Discharge
- WellSky provider portal*
- Fax submission with the required forms and documentation
- Telephone, where you can provide the necessary details to a representative

*Preferred method(s) that yield the best turnaround time.

Who should be submitting requests?

- Acute providers and PCP as prior/initial authorization request for the following levels of care:
  - Skilled nursing facility
  - Inpatient rehabilitation facilities
  - Long term aute care hospitals
  - Skilled home health
- Skilled nursing facility
  - Community referral – Initial authorization request
  - Concurrent review authorization request
- Inpatient rehabilitation facilities
  - Community referral – Initial authorization request

- Concurrent review authorization request
- Long term aute care hospitals
  - Community referral – Initial authorization request
  - Concurrent review authorization request
- Skilled home health
  - Community referral – Initial authorization R\request
  - Recertification authorization requests

****Note: The prior authorization request will originate from the acute care setting unless it is a community referral or concurrent review.****

How long does it take to receive an authorization decision?

Processing times vary but when all required information is received, typical turnaround time to final decision will follow guidelines set forth by CMS. Although final determination will follow the CMS guidelines, the WellSky team aims to have an initial review of information received and response within the time allotted below.

- Initial response (not final determination): Within 24 hours of received date and time
- Urgent/expedited requests: 72 hours

****Expedited requests****: Per CMS, by submitting an urgent or expedited request, you are attesting the ordering physician has indicated that applying the standard timeframe for a decision could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. If the previous statement does not apply to your request, your authorization request should be submitted as a standard request.

What information is required to submit a prior authorization?

Details can be found within the Provider resources web page under 'Pre-authorization requirements.'

What happens if an authorization request is denied?

If you receive a denial:

- Review the denial notice for specific reasons
- Member appeal rights are contained within the notification

Can a post-acute authorization be extended?

Yes, if the member requires additional care beyond the initially approved period, you can request additional days by providing updated clinical information and justification through the defined authorization process. To assist with this process, WellSky will conduct progress checks for the members midway through the initial authorized period.

Where do I send extensions or requests for additional days?

Post-acute providers can obtain an extension or a concurrent review via the same process as the initial review -- including portal, fax, and phone. Required authorization details can be found on the Provider resources web page under "Pre-Authorization Requirements."

Acute providers

When should the post-acute authorization be submitted?

The WellSky Clinical team would like to understand the transition plan for a member as early as possible. Sending the authorization request as soon as the referral is sent to a provider allows our team to help identify quality in-network providers with the best outcomes as well as alternative transitions of care.

How long is an authorization valid for?

Approved authorization(s) based on medical necessity for the next level of care are valid for five calendar days. From the date the authorization is received, you will have five days to discharge the member to the approved level of care. The authorization period starts at the PAC admission date and is valid for the set number of days provided within the authorization. After the fifth day has elapsed from authorization approval notification without the member discharging from the hospital, you will need to obtain a new authorization with appropriate medical necessity documentation requirements.

PAC providers

Can I submit for the initial prior authorization if I receive a referral?

If the referral is coming from the community, you can submit the initial prior authorization via the portal, fax, or phone. If the referral is coming from acute providers, the acute provider should request the prior authorization.

Home health providers

Can I submit for the initial prior authorization if I receive a referral?
If the referral is coming from the community, you can submit the initial prior authorization via the portal, fax, or phone. If the referral is coming from acute providers, the acute provider should request the prior authorization.

Are authorizations episodic based or pay per visit (PPV)?
Requests will be authorized for 30-day episodes based on medical necessity. At the end of the first 30-day episode, the provider must request a medical necessity recertification.

Contact information

For questions regarding WellSky PAC Advance, please get in touch with our team.

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