CarePlus HEALTH PLANS®

Provider's Guide

Learning & Development | 2024

We will begin in a few minutes

537701FL0824

Objectives

By the end of the module, you will be able to:

- Determine the appropriate processing timeframes for submissions
- Distinguish the dos and don’ts of submitting a request
- Use of Availity and Provider Web Services (PWS) to:
  - View member benefits and eligibility
  - Submit, review, and update preauthorization requests
  - Identify network specialty and ancillary providers
  - Submit and view claims information (including pharmacy claims information)
- Understand how and when to submit preauthorization requests
- Identify expedited requests and member requests

CarePlus HEALTH PLANS®

Turnaround Times

CarePlus HEALTH PLANS®

CMS Expedited Definition

Expedited requests are appropriate when the standard time frame for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function. 42 C.F.R. § 422.570(c)(2).

Turnaround Times (TAT)

Compliance guidelines – TAT for processing authorization request:

Standard requests	Expedited requests
Part C: 14 calendar days	**Part C: 72 hours**
Part B: 72 hours	**Part B: 24 hours**

"Organization Determinations," Centers for Medicare & Medicaid Services, last accessed March 13, 2024, https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/parts-c-and-d-enrollee-grievances-organization-coverage-determinations-and-appeals-guidance.pdf

CarePlus HEALTH PLANS®

Best Practices

CarePlus HEALTH PLANS®

Best Practices

Complete a new request form for each member.

Inform your patient that you/your practice submitted the preauthorization request.

All requests must be accompanied by clinical documentation.

- Get additional information in our Quick Reference Prior Authorization Guide on our website

Check to ensure all information in the request is accurate.

Submit requests with appropriate timeframes. If urgent, please ensure requests meet CMS expedited criteria.

Note: You can only submit expedited requests by phone or fax. You cannot submit expedited requests in PWS or Availity.

Provide the reason for the referral to the nonparticipating provider and/or facility (e.g., the member is established with the provider, etc.).

Referral vs. Preauthorization

Referral

A written or verbal approval **provided by the primary care physician (PCP)** to see a specialist or to receive other healthcare services

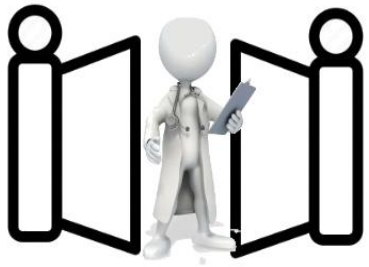
Preauthorization

A decision by the health plan that a service, treatment plan, prescription drug or durable medical equipment is medically necessary

Note: CarePlus will process requests via any method a provider uses, such as phone, fax, or web, to submit a referral to a specialist or request a preauthorization.

CarePlus HEALTH PLANS®

Referral vs Preauthorization



PCP (the gatekeeper)

Availity

Referral/Preauthorizations

Specialist

The Evidence of Coverage (EOC) explains how referrals work.

SECTION 2 **Use providers in the plan's network to get your medical care**

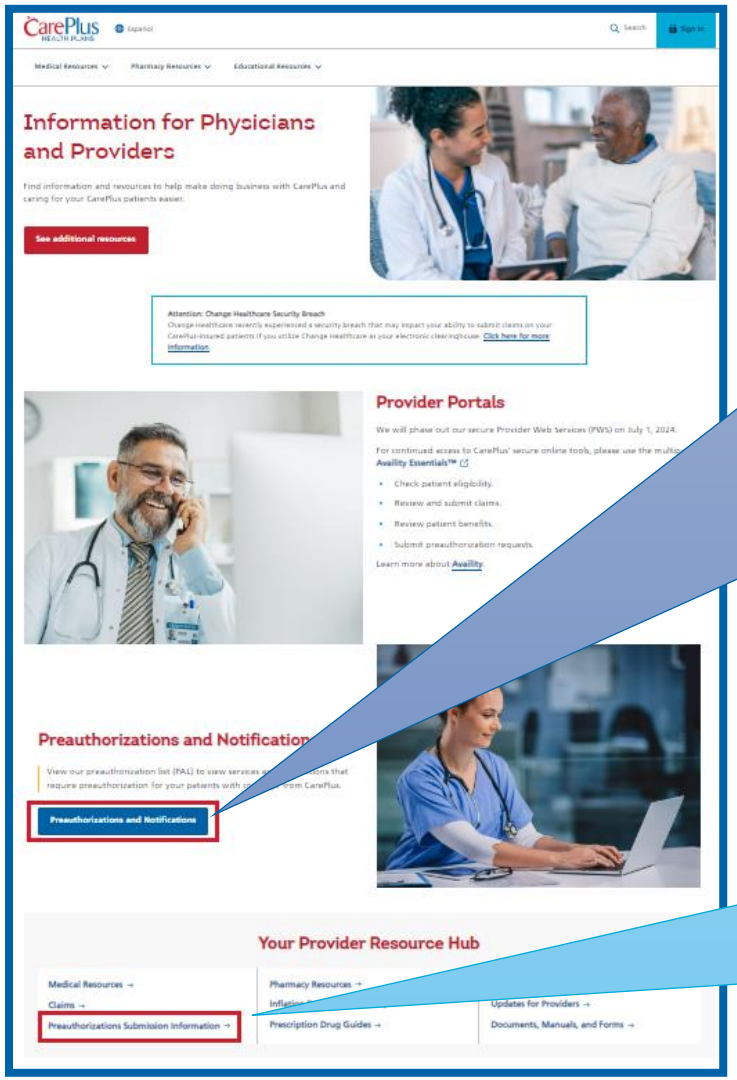
Section 2.1 **You must choose a Primary Care Provider (PCP) to provide and oversee your medical care**

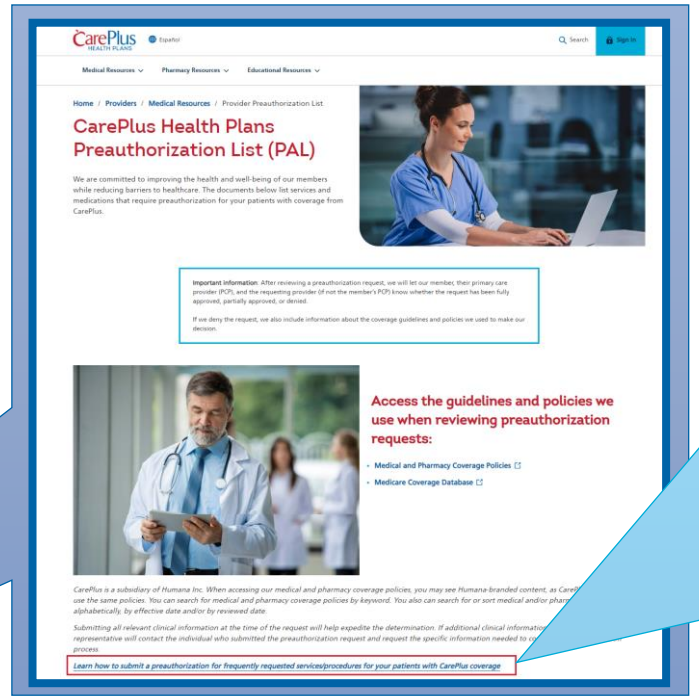
What is a PCP and what does the PCP do for you?

When you become a member of our plan, you must choose a network provider within your plan's service area to be your PCP. Your PCP is a provider who meets state requirements and is trained to give you basic medical care. Your *Provider Directory* will indicate which providers may act as your PCP. As we explain below, you can get your routine or basic care from your PCP. Your PCP can also coordinate the rest of the covered services you get as a plan member. For example, in order to see a network specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist).

"Medicare Advantage Plans," CarePlus Health Plans, last accessed March 13, 2024, https://www2.careplushealthplans.com/medicare/medicare-advantage-plans-2023

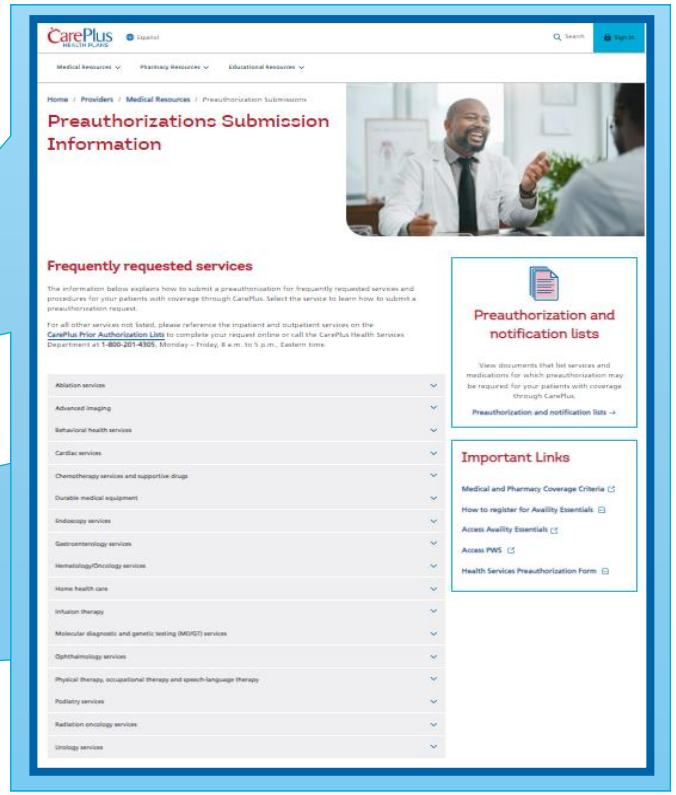
Provider Page (PAL)



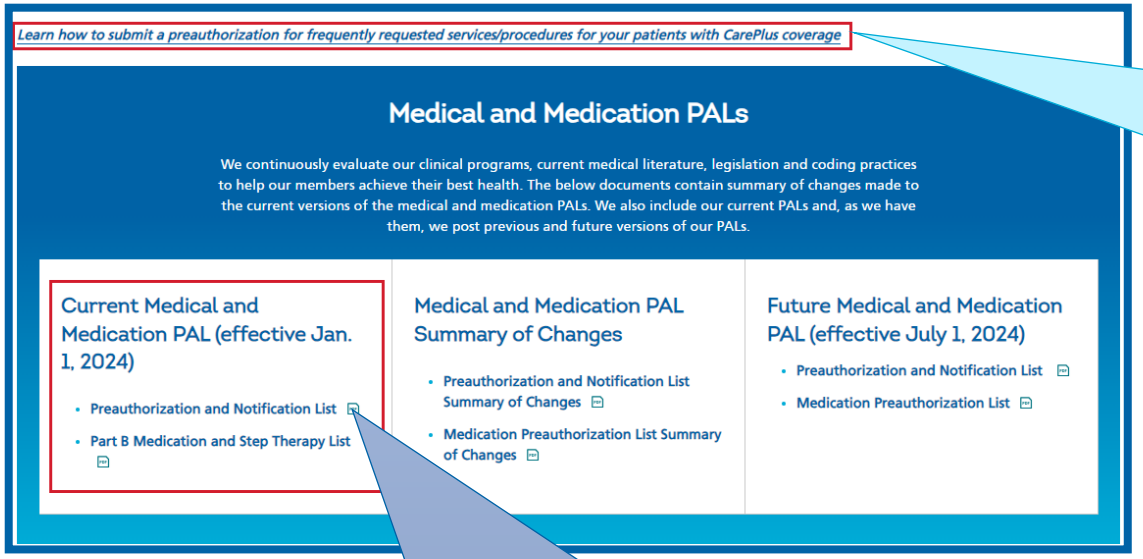


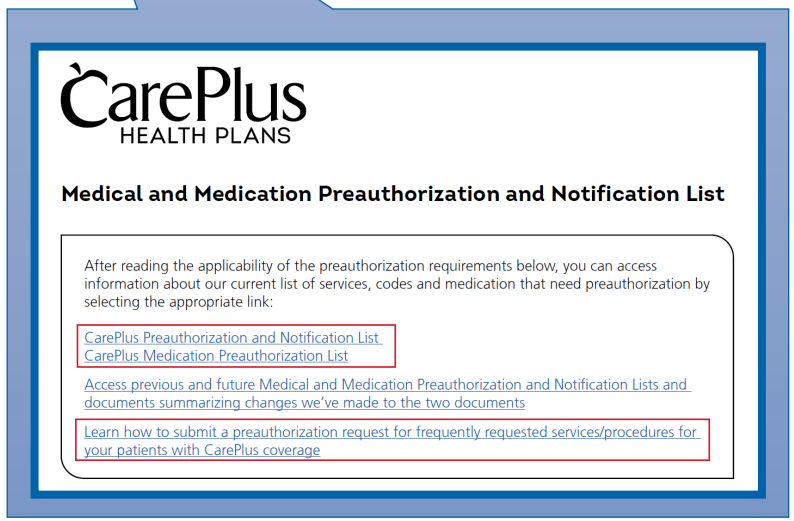
PAL List

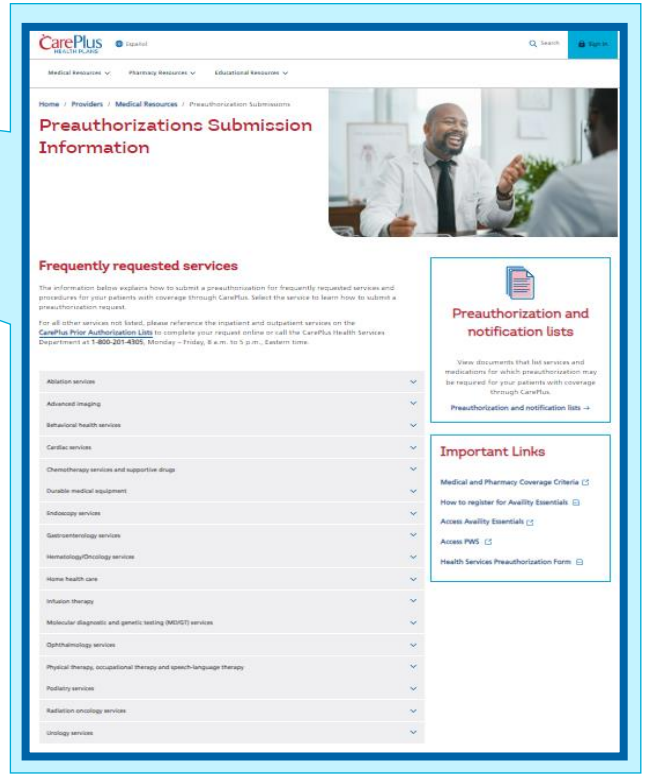
- There are thousands of codes that will no longer require an authorization.
- This will mirror Humana's PAL process.



Preauthorization List (PAL) Site







Preauthorization List (PAL)

CarePlus HEALTH PLANS

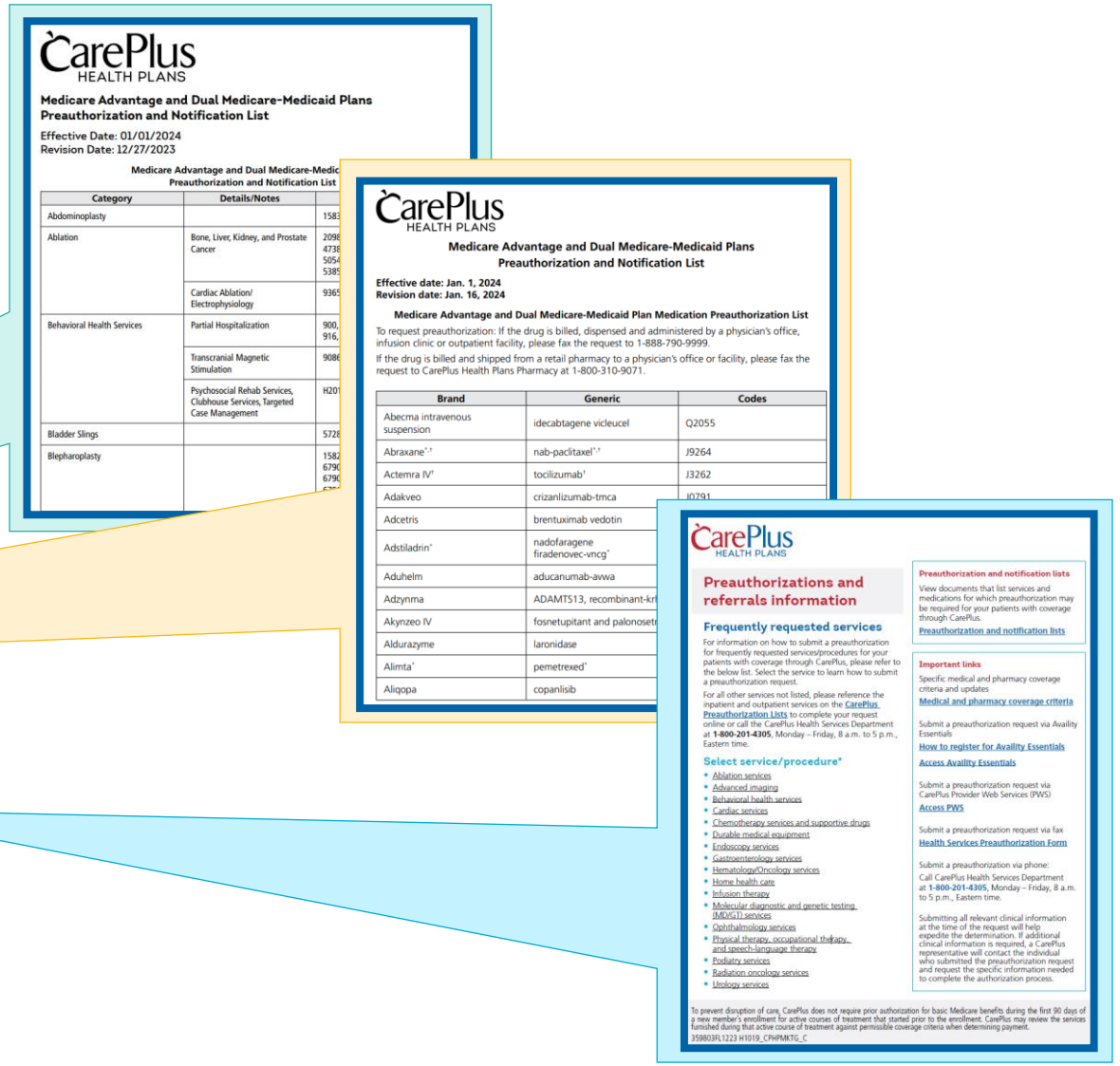
Medical and Medication Preauthorization and Notificati

After reading the applicability of the preauthorization requirements b… access information about our current list of services, codes and medic… need preauthorization by selecting the appropriate link:

CarePlus Preauthorization and Notification List
CarePlus Medication Preauthorization List

Access previous and future Medical and Medication Preauthorization and Notification Lists and documents summarizing changes we've made to the two documents

Learn how to submit a preauthorization request for frequently requested services/procedures for your patients with CarePlus coverage


CarePlus HEALTH PLANS

Medicare Advantage and Dual Medicare-Medicaid Plans Preauthorization and Notification List

Effective Date: 01/01/2024
Revision Date: 12/27/2023

Medicare Advantage and Dual Medicare-Medic… Preauthorization and Notification List

Category	Details/Notes	
Abdominoplasty		1583
Ablation	Bone, Liver, Kidney, and Prostate Cancer	2098 4738 5054 5385
	Cardiac Ablation/ Electrophysiology	9365
Behavioral Health Services	Partial Hospitalization	900, 916,
	Transcranial Magnetic Stimulation	9086
	Psychosocial Rehab Services, Clubhouse Services, Targeted Case Management	H201
Bladder Slings		5728
Blepharoplasty		1582 6790 6790

CarePlus HEALTH PLANS

Medicare Advantage and Dual Medicare-Medicaid Plans Preauthorization and Notification List

Effective date: Jan. 1, 2024
Revision date: Jan. 16, 2024

Medicare Advantage and Dual Medicare-Medicaid Plan Medication Preauthorization List

To request preauthorization: If the drug is billed, dispensed and administered by a physician's office, infusion clinic or outpatient facility, please fax the request to 1-888-790-9999.

If the drug is billed and shipped from a retail pharmacy to a physician's office or facility, please fax the request to CarePlus Health Plans Pharmacy at 1-800-310-9071.

Brand	Generic	Codes
Abecma intravenous suspension	idecabtagene vicleucel	Q2055
Abraxane*,†	nab-paclitaxel*,†	J9264
Actemra IV†	tocilizumab†	J3262
Adakveo	crizanlizumab-tmca	J0791
Adcetris	brentuximab vedotin	
Adstiladrin*	nadofaragene firadenovec-vncg*	
Aduhelm	aducanumab-avwa	
Adzynma	ADAMTS13, recombinant-krt	
Akynzeo IV	fosnetupitant and palonoset	
Aldurazyme	laronidase	
Alimta*	pemetrexed*	
Aliqopa	copanlisib	

CarePlus HEALTH PLANS

Preauthorizations and referrals information

Frequently requested services

For information on how to submit a preauthorization for frequently requested services/procedures for your patients with coverage through CarePlus, please refer to the below list. Select the service to learn how to submit a preauthorization request.

For all other services not listed, please reference the inpatient and outpatient services on the CarePlus Preauthorization Lists to complete your request online or call the CarePlus Health Services Department at **1-800-201-4305**, Monday – Friday, 8 a.m. to 5 p.m., Eastern time.

Select service/procedure*

- Ablation services
- Advanced imaging
- Behavioral health services
- Cardiac services
- Chemotherapy services and supportive drugs
- Durable medical equipment
- Endoscopy services
- Gastroenterology services
- Hematology/Oncology services
- Home health care
- Infusion therapy
- Molecular diagnostic and genetic testing (MD/GT) services
- Ophthalmology services
- Physical therapy, occupational therapy, and speech-language therapy
- Podiatry services
- Radiation oncology services
- Urology services

Preauthorization and notification lists

View documents that list services and medications for which preauthorization may be required for your patients with coverage through CarePlus.

Preauthorization and notification lists

Important links

Specific medical and pharmacy coverage criteria and updates

Medical and pharmacy coverage criteria

Submit a preauthorization request via Availity Essentials

How to register for Availity Essentials

Access Availity Essentials

Submit a preauthorization request via CarePlus Provider Web Services (PWS)

Access PWS

Submit a preauthorization request via fax

Health Services Preauthorization Form

Submit a preauthorization via phone:

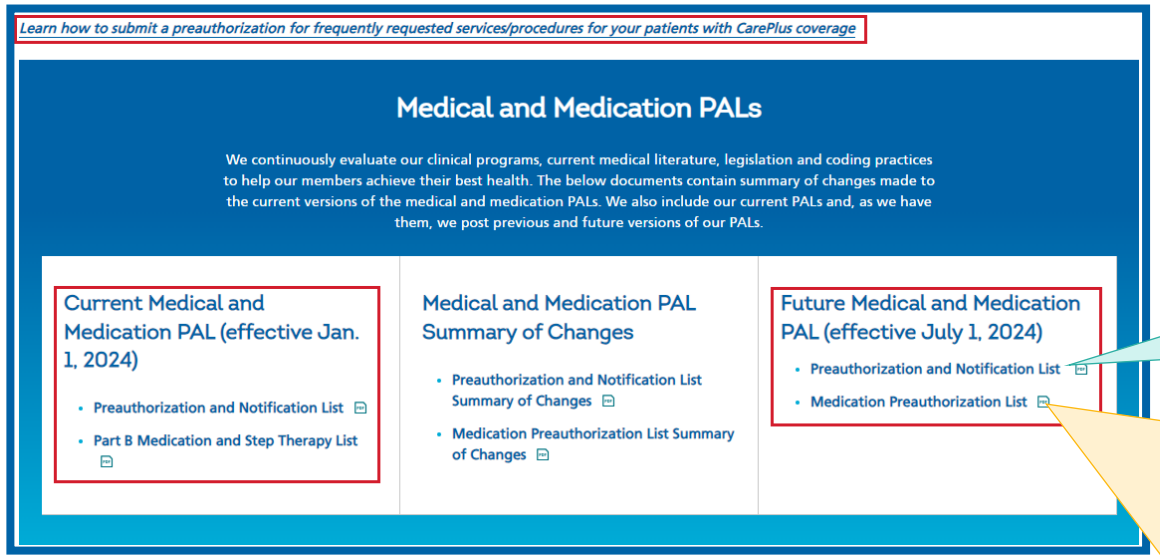
Call CarePlus Health Services Department at **1-800-201-4305**, Monday – Friday, 8 a.m. to 5 p.m., Eastern time.

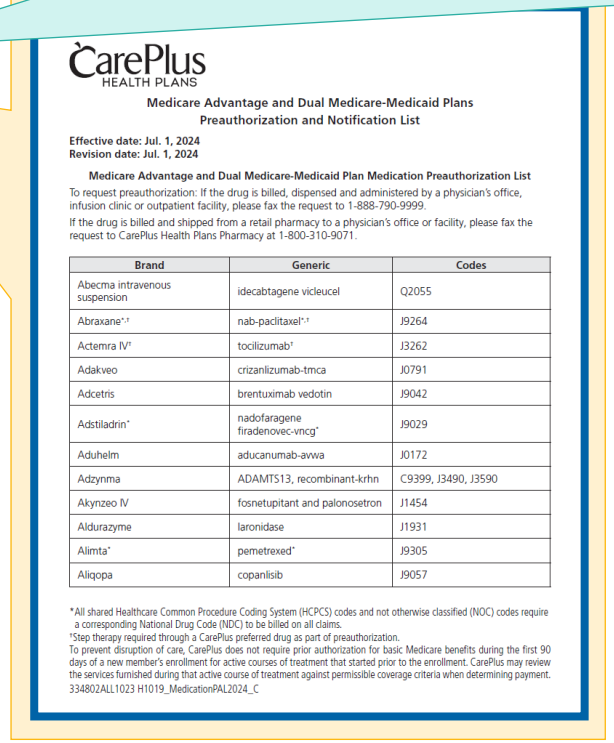
Submitting all relevant clinical information at the time of the request will help expedite the determination. If additional clinical information is required, a CarePlus representative will contact the individual who submitted the preauthorization request and request the specific information needed to complete the authorization process.

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

359803FL1223 H1019_CPHPMKTG_C

Preauthorization List (PAL) Site




CarePlus HEALTH PLANS

Medicare Advantage and Dual Medicare-Medicaid Plans Preauthorization and Notification List

Effective date: Jul. 1, 2024
Revision date: Jul. 1, 2024

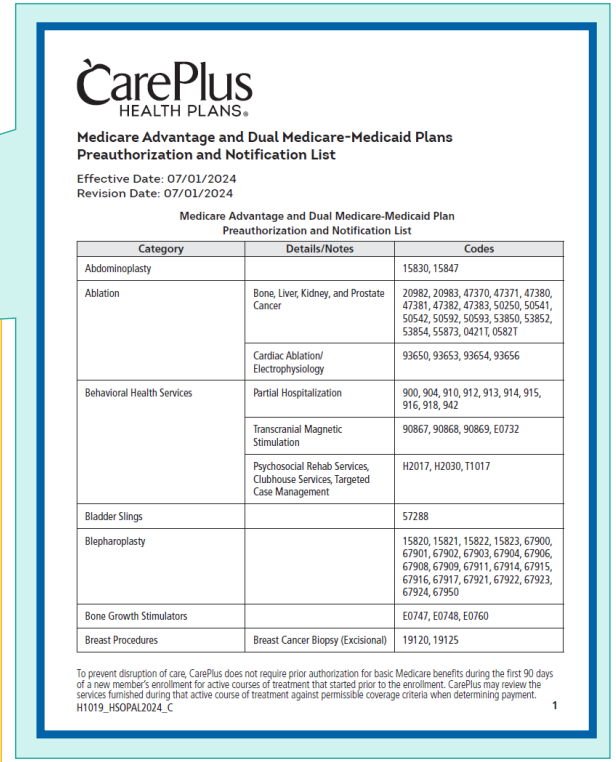
Medicare Advantage and Dual Medicare-Medicaid Plan Medication Preauthorization List

To request preauthorization: If the drug is billed, dispensed and administered by a physician's office, infusion clinic or outpatient facility, please fax the request to 1-888-790-9999.

If the drug is billed and shipped from a retail pharmacy to a physician's office or facility, please fax the request to CarePlus Health Plans Pharmacy at 1-800-310-9071.

Brand	Generic	Codes
Abecma intravenous suspension	idecabtagene vicleucel	Q2055
Abraxane*,†	nab-paclitaxel*,†	J9264
Actemra IV†	tocilizumab†	J3262
Adakveo	crizanlizumab-tmca	J0791
Adcetris	brentuximab vedotin	J9042
Adstiladrin*	nadofaragene firadenovec-vncg*	J9029
Aduhelm	aducanumab-avwa	J0172
Adzynma	ADAMTS13, recombinant-krhn	C9399, J3490, J3590
Akynzeo IV	fosnetupitant and palonosetron	J1454
Aldurazyme	laronidase	J1931
Alimta*	pemetrexed*	J9305
Aliqopa	copanlisib	J9057

*All shared Healthcare Common Procedure Coding System (HCPCS) codes and not otherwise classified (NOC) codes require a corresponding National Drug Code (NDC) to be billed on all claims.
†Step therapy required through a CarePlus preferred drug as part of preauthorization.
To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.
334802ALL1023 H1019_MedicationPAL2024_C


CarePlus HEALTH PLANS

Medicare Advantage and Dual Medicare-Medicaid Plans Preauthorization and Notification List

Effective Date: 07/01/2024
Revision Date: 07/01/2024

Medicare Advantage and Dual Medicare-Medicaid Plan Preauthorization and Notification List

Category	Details/Notes	Codes
Abdominoplasty		15830, 15847
Ablation	Bone, Liver, Kidney, and Prostate Cancer	20982, 20983, 47370, 47371, 47380, 47381, 47382, 47383, 50250, 50541, 50542, 50592, 50593, 53850, 53852, 53854, 55873, 0421T, 0582T
	Cardiac Ablation/ Electrophysiology	93650, 93653, 93654, 93656
Behavioral Health Services	Partial Hospitalization	900, 904, 910, 912, 913, 914, 915, 916, 918, 942
	Transcranial Magnetic Stimulation	90867, 90868, 90869, E0732
	Psychosocial Rehab Services, Clubhouse Services, Targeted Case Management	H2017, H2030, T1017
Bladder Slings		57288
Blepharoplasty		15820, 15821, 15822, 15823, 67900, 67901, 67902, 67903, 67904, 67906, 67908, 67909, 67911, 67914, 67915, 67916, 67917, 67921, 67922, 67923, 67924, 67950
Bone Growth Stimulators		E0747, E0748, E0760
Breast Procedures	Breast Cancer Biopsy (Excisional)	19120, 19125

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.
H1019_HSOPAL2024_C 1

CarePlus HEALTH PLANS®

Preauthorization Request Options

Preferred Preauthorization Request Options

Skip the paperwork!

Check patient eligibility, submit preauthorization requests and more online. Availity offers more options and flexibility when submitting preauthorization requests. **Learn more about the benefits of using Availity**

Availity Essentials™:
Availity does not require an authorization to check benefits for CarePlus members.
Access Availity

Submit via phone: CarePlus Health Services department:
1-800-201-4305

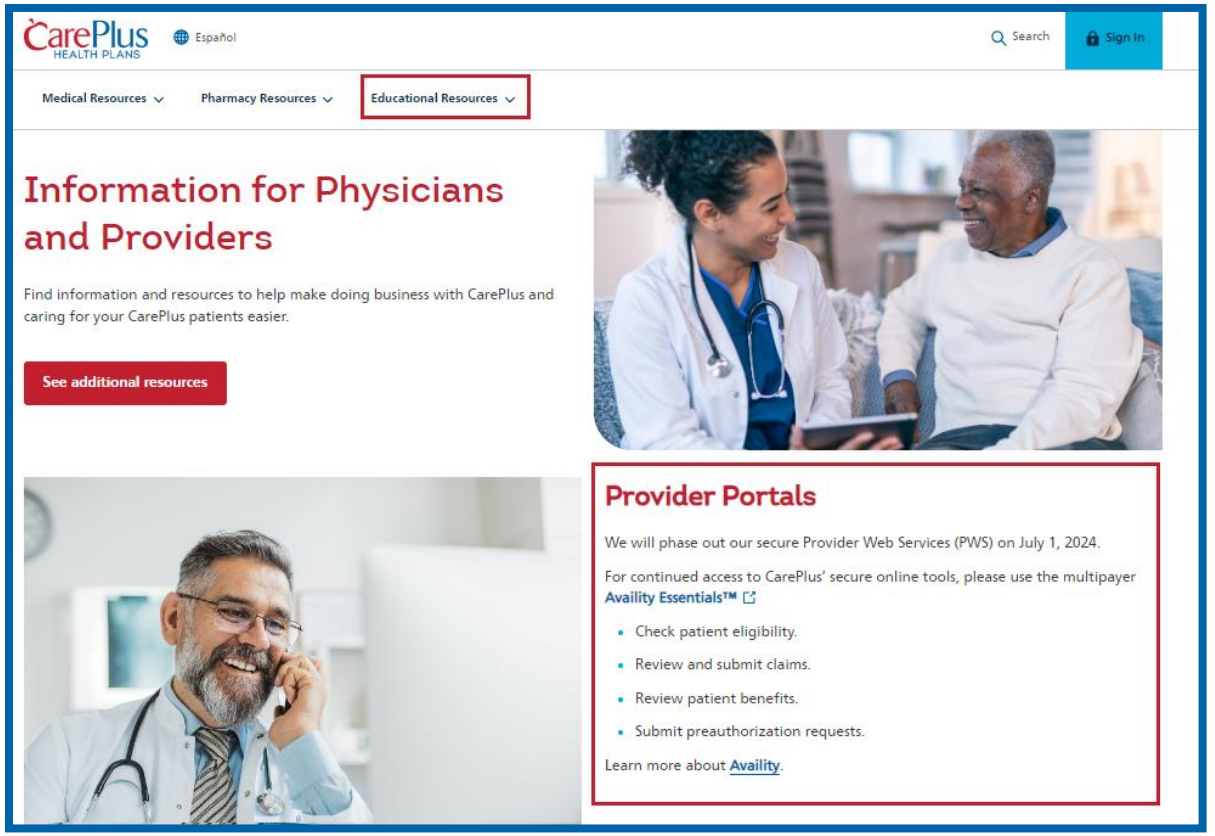
Submit via fax: Health Services Preauthorization Form

CarePlus Provider Operations Helpline: **1-866-220-5448**
Monday – Friday, 8 a.m. to 5 p.m., Eastern time

Availity Essentials

You can submit preauthorization requests and view member benefits, eligibility information, claims status, and more with Availity Essentials. Visit the providers page on the CarePlus website to view the Availity Resources.

Hover over “Educational Resources” and select Availity or simply select Availity within the “Provider Portals” section.

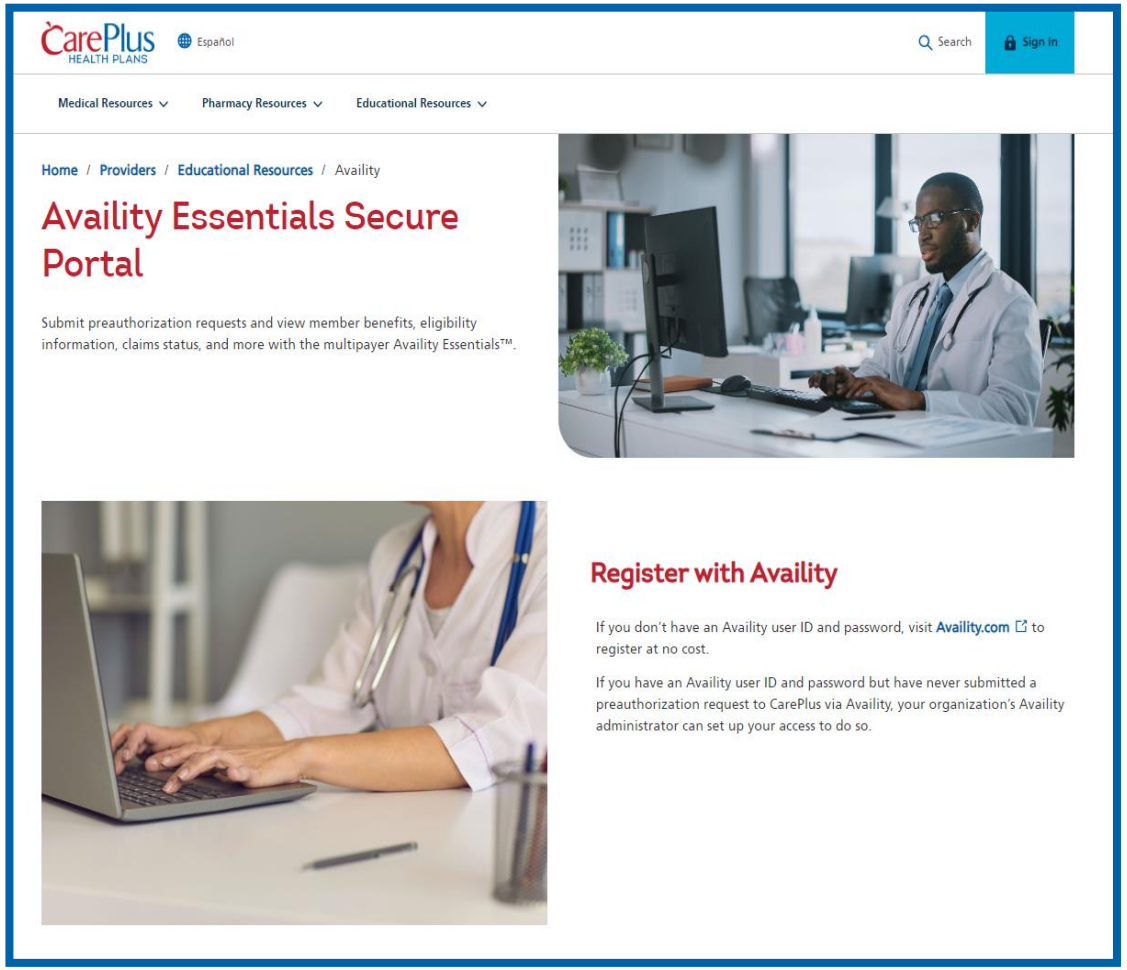


https://www.careplushealthplans.com/providers

CarePlus HEALTH PLANS

Availity Essentials Resources

You can find various resources on the CarePlus website to assist you with Availity.



Help and Additional Support

To access the Availity Learning Center, please sign in to your account, select "Help & Training" in the upper right corner, and then select "Get Trained."

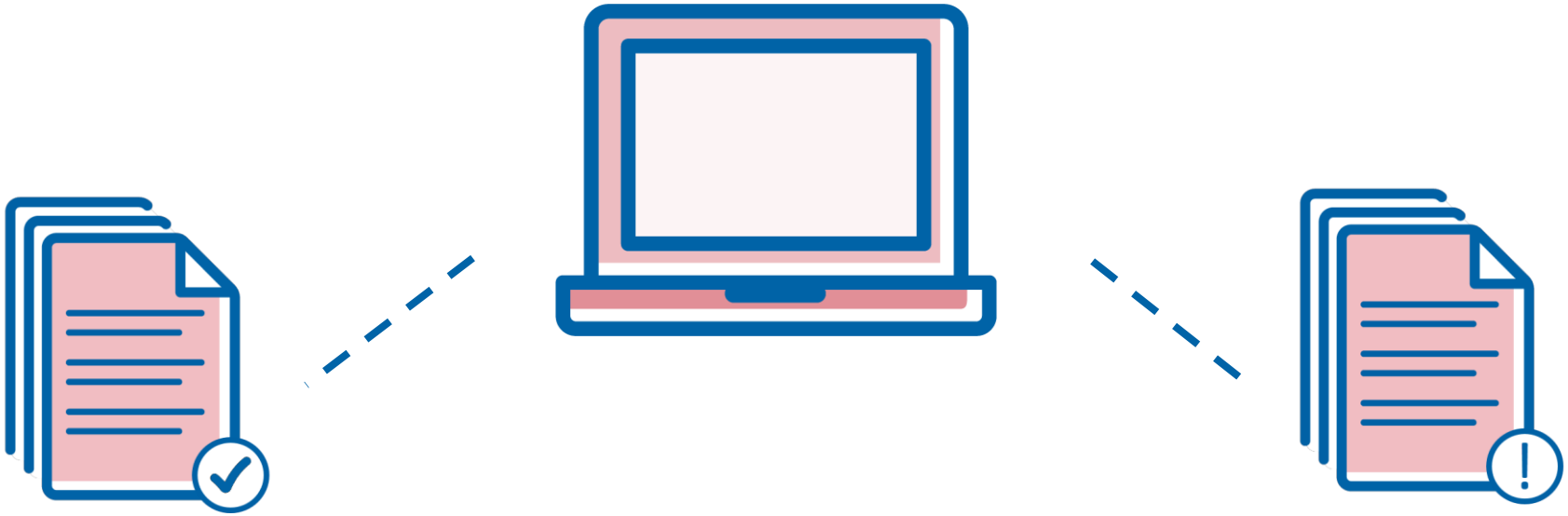
Availity also makes a training video library available after you log in. Training videos include:

- **Availity Claim Status - Recorded Webinar**
- **Claim Status - Training Demo**
- **Eligibility and Benefits Inquiry - Training Demo**
- **Preauthorization/Referral Inquiry - Training Demo**
- **Preauthorizations Training Site**
- **Professional Claim (new) - Training Demo**
- **Remittance Solutions - Training Demo**

For Availity technical support:

- Call 1-800-282-4548
- Open a supprt ticket by selecting "Help & Training" in the upper right corner, and then selecting "Availity Support."
- Submit a tech support ticket once you sign in to Availity Essentials.

Availity Essentials Submission



Many preauthorization requests submitted via Availity will be auto-approved.

Your request may appear as pending. If this occurs, fax supplemental information and your reference number to CarePlus.

CarePlus fax numbers:

Broward and Palm Beach: 1-866-832-2678, Miami Dade: 1-888-790-9999, all others: 1-888-634-3521

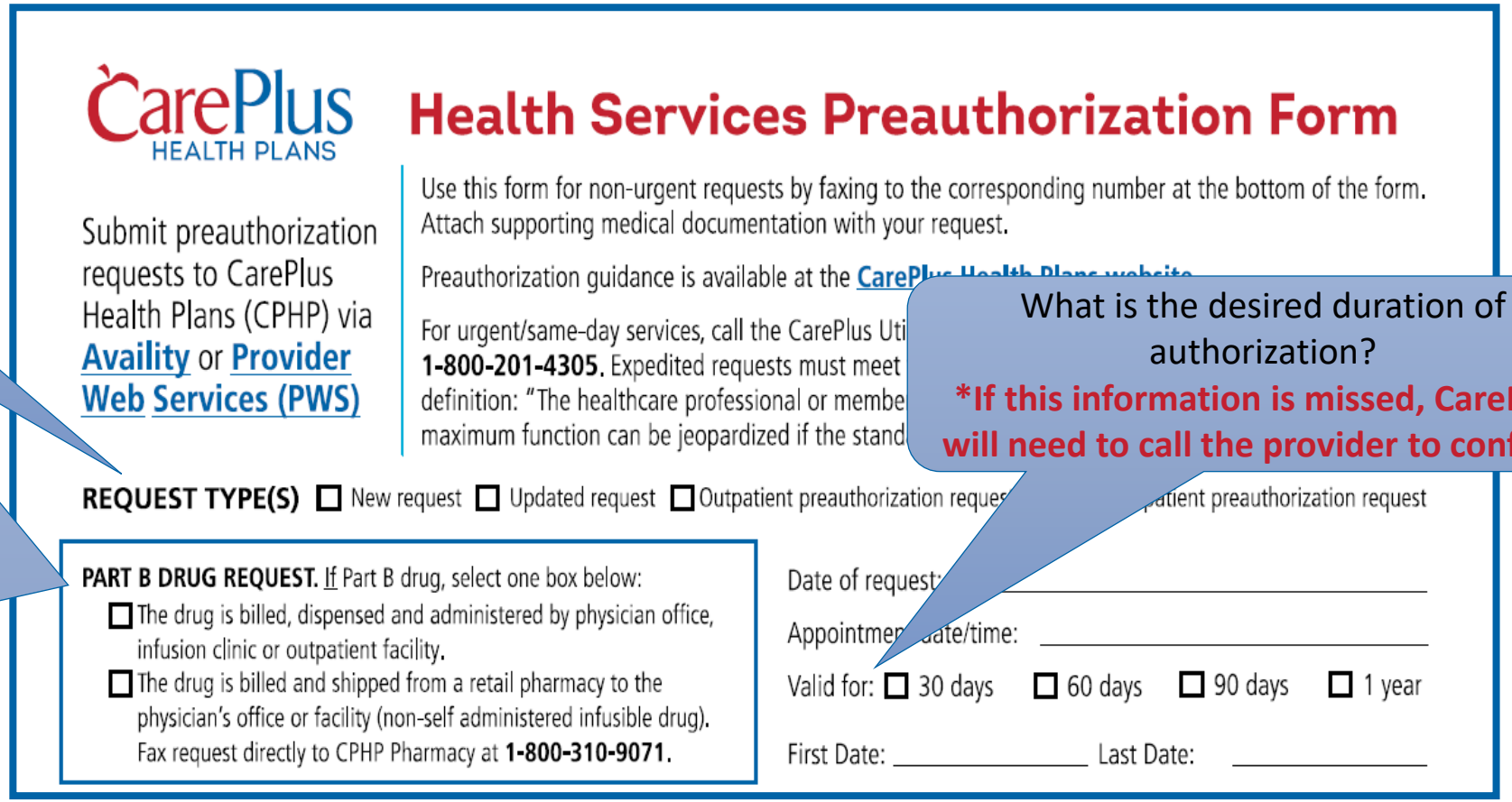
Best Practices for Fax Submissions

What type of request is it?

Part B drug requests:

Is this drug billed, dispensed, and administered by provider?

Is this drug billed and shipped from retail pharmacy to provider?



CarePlus HEALTH PLANS

Health Services Preauthorization Form

Submit preauthorization requests to CarePlus Health Plans (CPHP) via **Availity** or **Provider Web Services (PWS)**

Use this form for non-urgent requests by faxing to the corresponding number at the bottom of the form. Attach supporting medical documentation with your request.

Preauthorization guidance is available at the CarePlus Health Plans website

For urgent/same-day services, call the CarePlus Uti **1-800-201-4305**. Expedited requests must meet definition: "The healthcare professional or membe maximum function can be jeopardized if the stand

REQUEST TYPE(S) ☐ New request ☐ Updated request ☐ Outpatient preauthorization reques ☐ patient preauthorization request

PART B DRUG REQUEST. If Part B drug, select one box below:

- ☐ The drug is billed, dispensed and administered by physician office, infusion clinic or outpatient facility.
- ☐ The drug is billed and shipped from a retail pharmacy to the physician's office or facility (non-self administered infusible drug). Fax request directly to CPHP Pharmacy at **1-800-310-9071**.

Date of request: _____

Appointmen ate/time: _____

Valid for: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 1 year

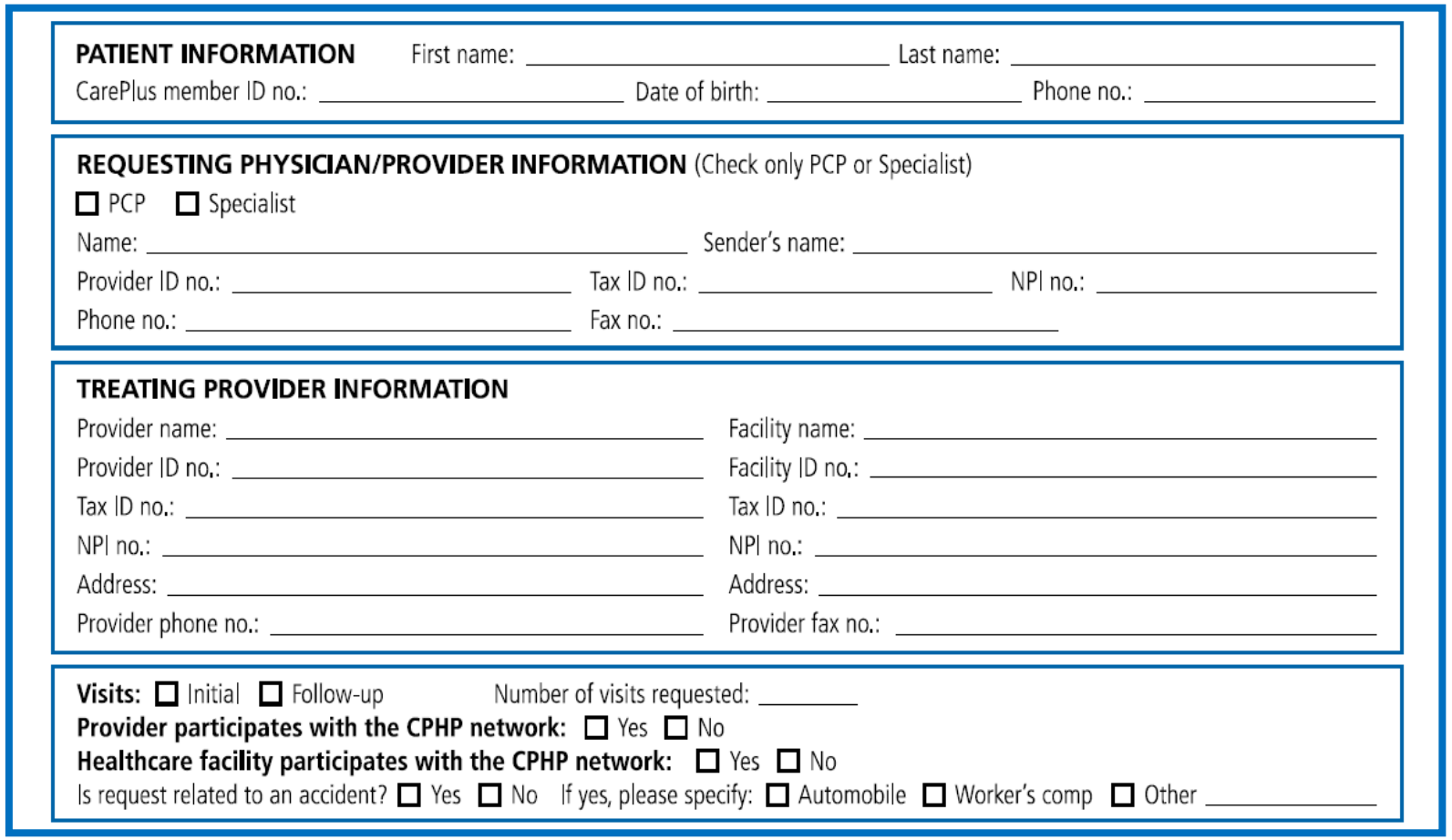
First Date: _____ Last Date: _____

What is the desired duration of authorization?

***If this information is missed, CarePlus will need to call the provider to confirm.**

Providers are highly encouraged to use this form when faxing a request to ensure all pertinent information is included.

Health Services Preauthorization Form



PATIENT INFORMATION First name: _____ Last name: _____
CarePlus member ID no.: _____ Date of birth: _____ Phone no.: _____

REQUESTING PHYSICIAN/PROVIDER INFORMATION (Check only PCP or Specialist)
☐ PCP ☐ Specialist
Name: _____ Sender's name: _____
Provider ID no.: _____ Tax ID no.: _____ NPI no.: _____
Phone no.: _____ Fax no.: _____

TREATING PROVIDER INFORMATION
Provider name: _____ Facility name: _____
Provider ID no.: _____ Facility ID no.: _____
Tax ID no.: _____ Tax ID no.: _____
NPI no.: _____ NPI no.: _____
Address: _____ Address: _____
Provider phone no.: _____ Provider fax no.: _____

Visits: ☐ Initial ☐ Follow-up Number of visits requested: _____
Provider participates with the CPHP network: ☐ Yes ☐ No
Healthcare facility participates with the CPHP network: ☐ Yes ☐ No
Is request related to an accident? ☐ Yes ☐ No If yes, please specify: ☐ Automobile ☐ Worker's comp ☐ Other _____

Is all the patient information entered?

Is all the PCP/specialist information entered?

Is all the rendering physician/facility information entered?

Is all information regarding the service being requested entered?

How many visits are being requested?

CarePlus HEALTH PLANS®

Health Services Preauthorization Form

Request cannot be completed without the diagnoses/CPT codes.

Specify the quantity requested for each code.

ICD-10 diagnosis code/description*	Procedure code/description*	Quantity

* required field(s)

The transmitted information is intended only for the person or entity to which it is addressed. It might contain confidential material. If you receive this document in error, please contact the sender, and delete or destroy the material/information.

336803FL1023 | H1019 HS PrvdPreAuthReqForm 2024

CarePlus Health Plans fax numbers:

Broward and Palm Beach counties: **1-866-832-2678**

Miami-Dade county: **1-888-790-9999**

All others: **1-888-634-3521**

Note: Keep in mind CarePlus may request additional information on certain services.

Member Requests

CarePlus HEALTH PLANS®

Member Requests

Members may contact CarePlus directly to request prior authorization for services/items.

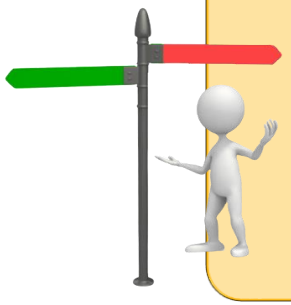
Member calls CarePlus requesting services.

CarePlus documents and processes the request in the system.

CarePlus contacts the PCP for additional information. PCP's office reviews and submits/confirms the request to CarePlus.

CarePlus reviews the request.

CarePlus makes a determination.

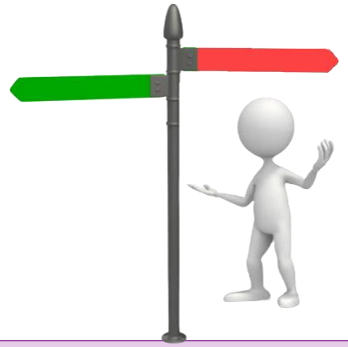


Provider Requests

Member has an appointment with a provider.

The provider's office submits the request to CarePlus.

CarePlus receives and processes the request.



CarePlus makes a determination.

CarePlus HEALTH PLANS®

Example

CarePlus HEALTH PLANS®

Expedited vs. Standard Example

	J Code	Drug Name	Directions for use	Dose	Purchase Type	No. of Cycles	No. Of Doses
Bone Mets							
Part B Non Oral	J0897	DENOSUMAB PROLIA INJECTION (Forwarded to Health Plan)	EVERY 6 MONTHS	60 mg	Buy and Bill	1	1

Site of Administration:	**Provider's Office**	Type of Treatment:		Request Type:	**EXPEDITED**
Primary Diagnosis:	**M81.0**	ECOG/Performance Status:	**Unknown**	Testing Values Applicable:	**No**
Disease Category:	**Bone Disease**	Medication Type:	**Bone Agents**		
		Clinical Staging:			
Treatment Start Date:		Intent to Treat:			
Est Duration of Treatment:		Clinical Trial?	**No**		
Continuous Infusions of IV Pump Required?					

✗ Request submitted as expedited. The service/item does not meet criteria for an expedited request, as injection is given routinely every 6 months.

✓ Request should have been submitted as a standard Part B request.

Resources

- CarePlus Website
- Organization Determinations | CMS
- Parts C&D Enrollee Grievances, Organization/Coverage Determination, and Appeals Guidance
- CarePlus Provider Forms and Resource Library
  - Medicare Plan Documents | CarePlus Health Plans
  - CarePlus Quick Reference Preauthorization Guide
  - Availity Essentials
  - Health Services Preauthorization Form

Questions?

https://www.surveymonkey.com/r/CPHP2024ProviderTraining

Thank you!

CarePlus HEALTH PLANS®