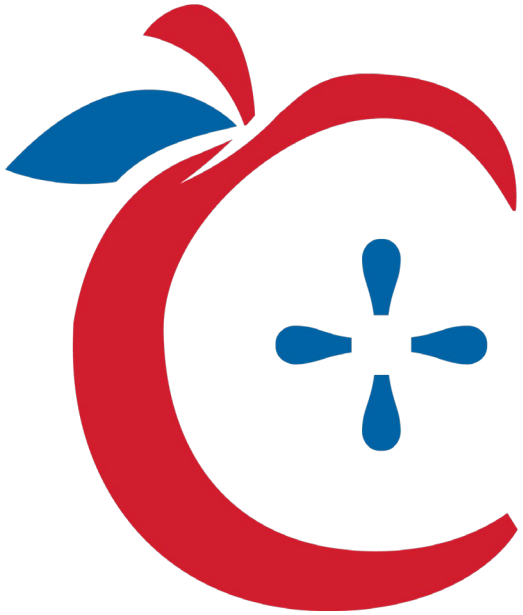


Provider's Guide

Learning & Development | 2025

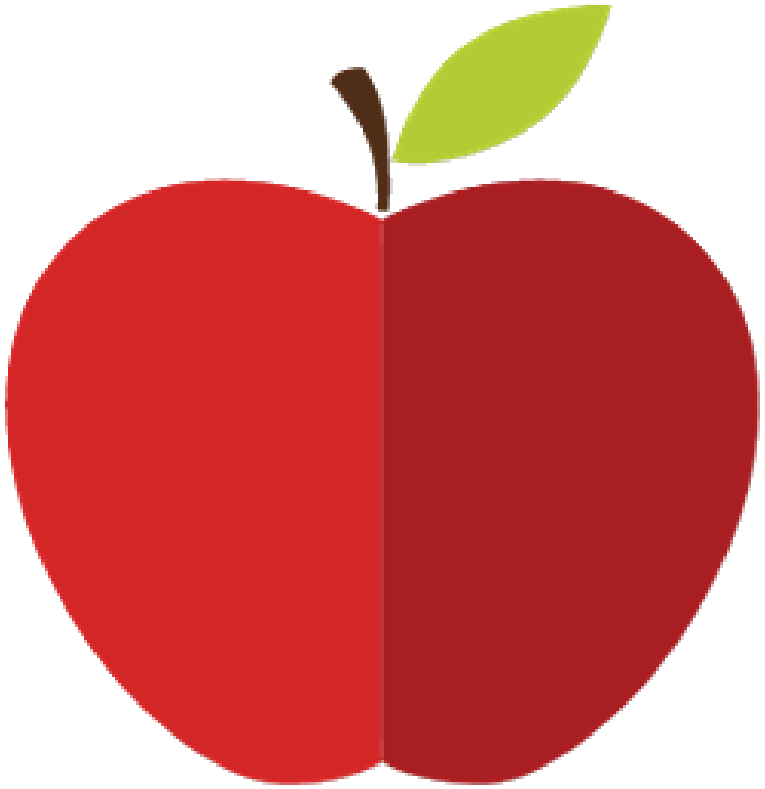
We will begin in a few minutes.

CarePlus HEALTH PLANS®

Objectives

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

- Understand the timeframes CarePlus (CPHP) has after a submission is received
- Distinguish the dos and don’ts of submitting a request
- Use of web portals 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



Important Information

CarePlus HEALTH PLANS®

Inpatient Only List

The Inpatient (IP) Only List contains codes of service that are to be performed only in an inpatient setting. CarePlus will conduct outreach to confirm accuracy of request for IP only codes at an outpatient facility.

Best practices for providers:

- Verify the Inpatient Only List to confirm presence of codes being requested
- If services are on the Inpatient Only List, request should include an inpatient facility

Note: Submitting IP Only codes at an outpatient setting can cause delay in care and/or potential for administrative denials.

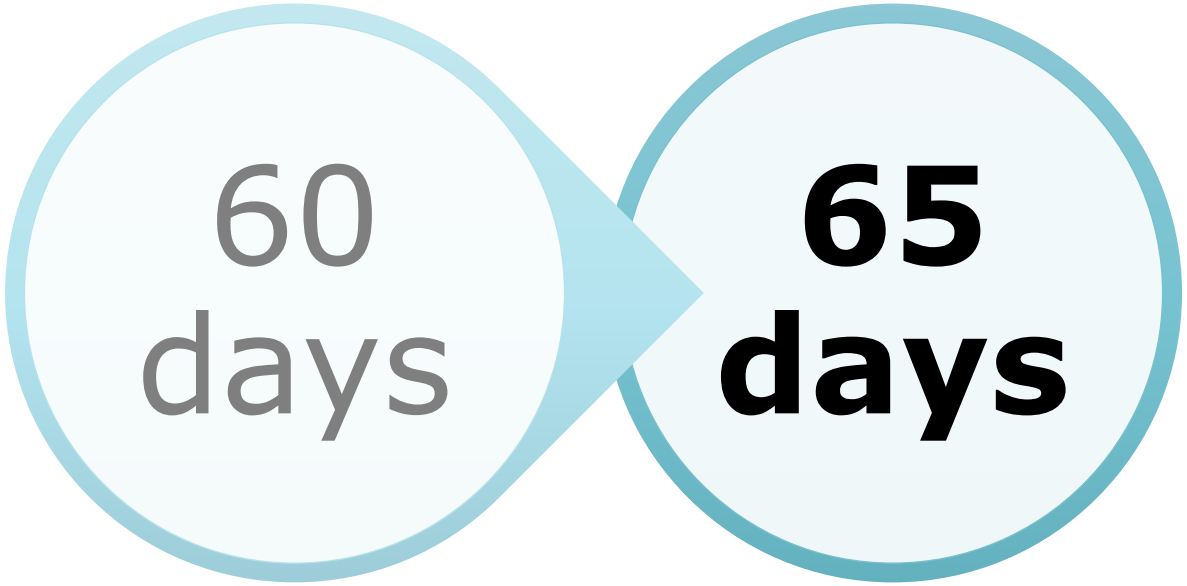
For more information, visit: Quarterly Addenda Updates | CMS

Inpatient Only List Example

If a code is on the Inpatient Only List, CarePlus will not authorize the service for an outpatient level of care.

Appeals Time Frame

Per Centers for Medicare & Medicaid Services (CMS) Final Rule, the appeals timeframe is now 65 days (previously 60), allowing providers, members, and their representatives additional days to appeal a denial.



Turnaround Times

CarePlus works to decision auth requests as soon as possible, but generally you can expect a decision no later than these timeframes:

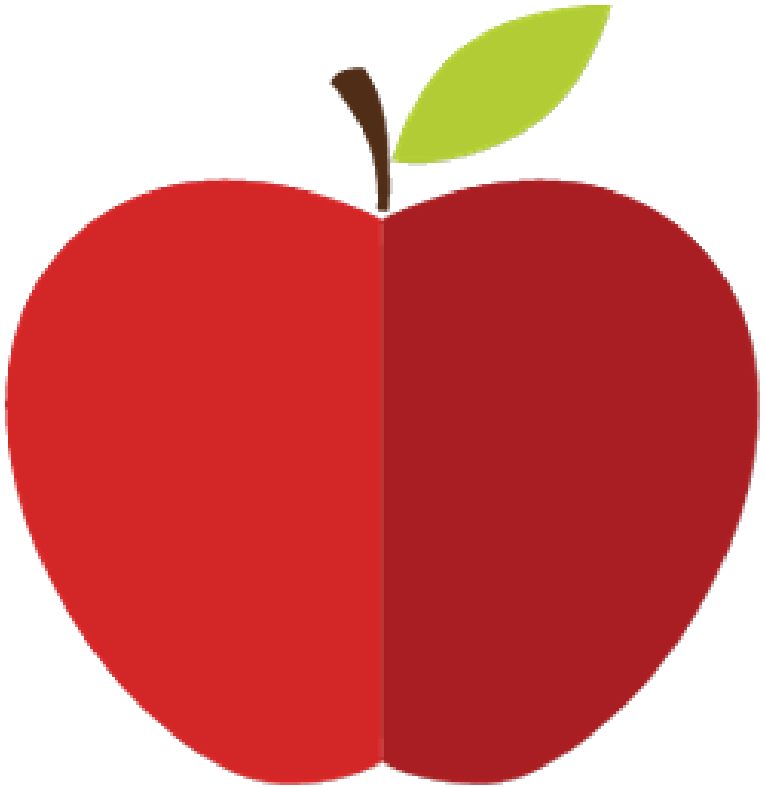
Current state:

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

---

Future state (2026):

- **Standard requests** → Part C: **7 calendar days**, Part B: 72 hours
- **Expedited requests** → Part C: 72 hours, Part B: 24 hours



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.

- Find additional information from the Quick Reference Preauthorization Guide on our website

Double-check all information for accuracy and verify that there are no duplicate submissions to avoid delays or denials.

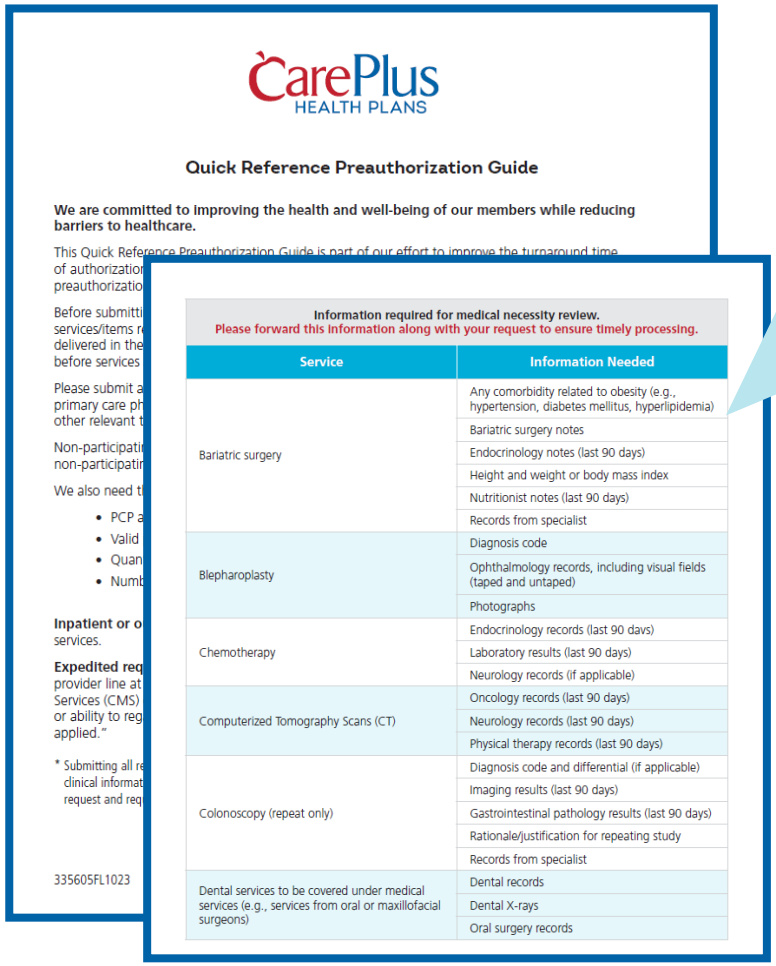
Submit requests within appropriate timeframes. If urgent, please ensure requests meet CMS-expedited criteria.

Note: You can only submit expedited requests by phone or fax. You cannot submit expedited requests in the portals.

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

Services Requiring Clinical Documentation

The Quick Reference Preauthorization Guide provides an overview of the required clinical documentation needed for an appropriate medical necessity review to take place.



CarePlus HEALTH PLANS

Quick Reference Preauthorization Guide

We are committed to improving the health and well-being of our members while reducing barriers to healthcare.

This Quick Reference Preauthorization Guide is part of our effort to improve the turnaround time of authorizatio preauthorizatio

Before submitti services/items r delivered in the before services

Please submit a primary care ph other relevant t

Non-participati non-participatir

We also need t

- PCP a
- Valid
- Quan
- Numb

Inpatient or o services.

Expedited req provider line at Services (CMS) or ability to reg applied."

* Submitting all r clinical informat request and req

335605FL1023

Information required for medical necessity review.
Please forward this information along with your request to ensure timely processing.

Service	Information Needed
Bariatric surgery	Any comorbidity related to obesity (e.g., hypertension, diabetes mellitus, hyperlipidemia)
	Bariatric surgery notes
	Endocrinology notes (last 90 days)
	Height and weight or body mass index
	Nutritionist notes (last 90 days)
	Records from specialist
Blepharoplasty	Diagnosis code
	Ophthalmology records, including visual fields (taped and untaped)
	Photographs
Chemotherapy	Endocrinology records (last 90 davs)
	Laboratory results (last 90 days)
	Neurology records (if applicable)
Computerized Tomography Scans (CT)	Oncology records (last 90 days)
	Neurology records (last 90 days)
	Physical therapy records (last 90 days)
Colonoscopy (repeat only)	Diagnosis code and differential (if applicable)
	Imaging results (last 90 days)
	Gastrointestinal pathology results (last 90 days)
	Rationale/justification for repeating study
	Records from specialist
Dental services to be covered under medical services (e.g., services from oral or maxillofacial surgeons)	Dental records
	Dental X-rays
	Oral surgery records

Information required for medical necessity review.
Please forward this information along with your request to ensure timely processing.

Service	Information Needed
Chemotherapy	Endocrinology records (last 90 davs)
	Laboratory results (last 90 days)
	Neurology records (if applicable)
Computerized Tomography Scans (CT)	Oncology records (last 90 days)
	Neurology records (last 90 days)
	Physical therapy records (last 90 days)
Colonoscopy (repeat only)	Diagnosis code and differential (if applicable)
	Imaging results (last 90 days)
	Gastrointestinal pathology results (last 90 days)
	Rationale/justification for repeating study
	Records from specialist

Referral vs. Preauthorization

Referral

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

Preauthorization

A preauthorization is 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.

Referral vs. Preauthorization

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?

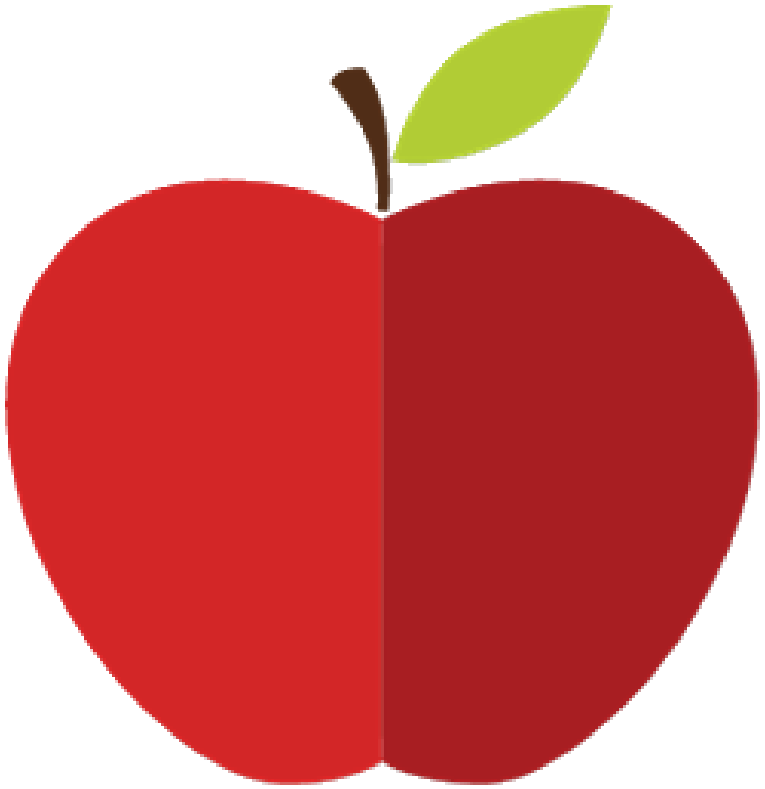
When you become a member of our plan, you must choose a network provider within your plan's service area to be your PCP. Your PCP is a provider who meets state requirements and is trained to give you basic medical care. Your *Provider Directory* will indicate which providers may act as your PCP. As we 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).

PCP (the gatekeeper)

Referrals / preauthorizations

Specialist

For more information, visit [Medicare Plan Documents | CarePlus Health Plans]



Pre-Authorization List (PAL)

CarePlus HEALTH PLANS®

Preauthorization List

The Preauthorization List (PAL) details services and medication (i.e., medication that is delivered in the physician's office, clinic, outpatient or home setting) that requires preauthorization prior to being provided or administered.

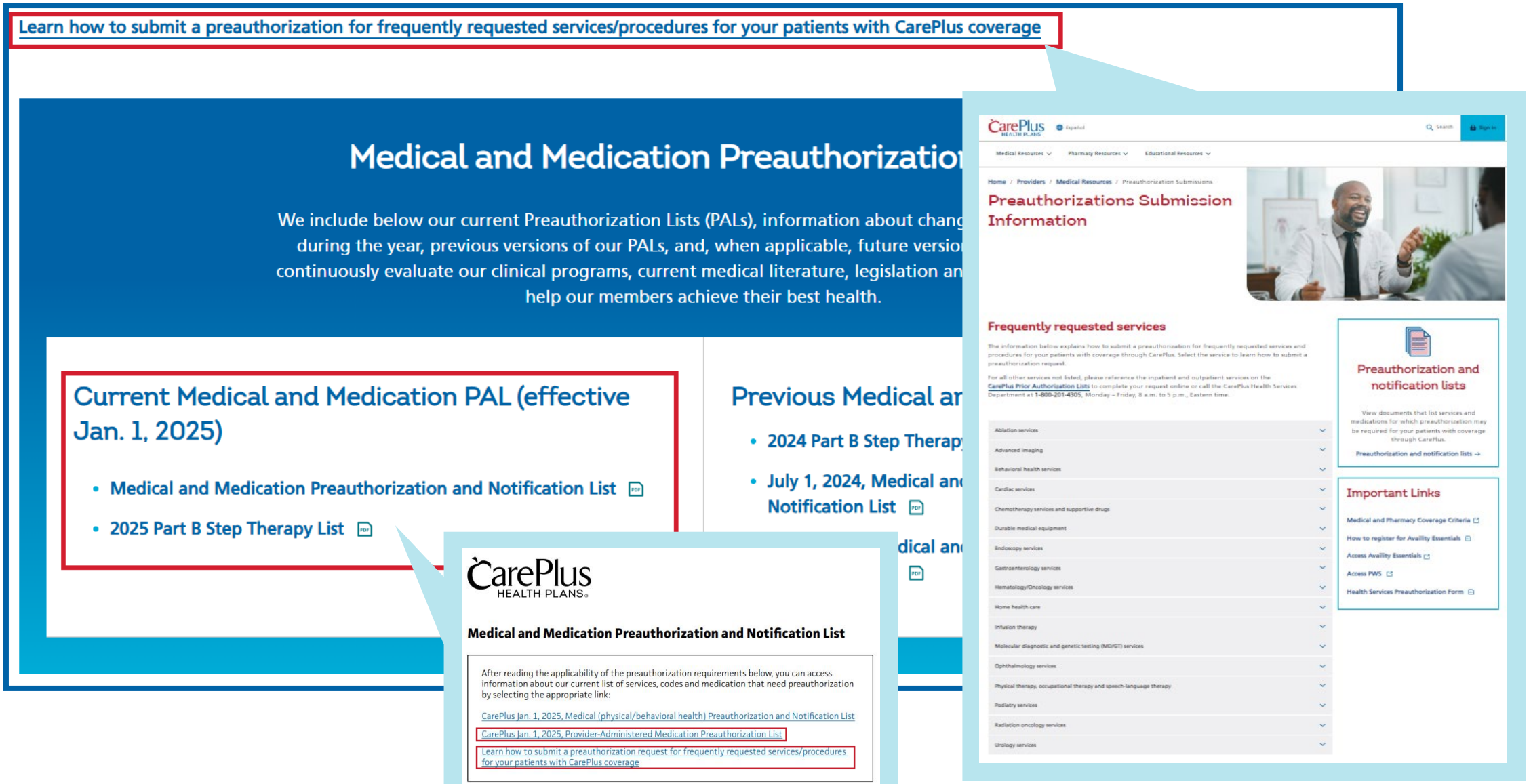
The current CarePlus PAL can be found here

For more information on PAL, please visit CarePlusHealthPlans.com/PAL

PAL Site

Learn how to submit a preauthorization for frequently requested services/procedures for your patients with CarePlus coverage
Medical and Medication Preauthorization Lists
We include below our current Preauthorization Lists (PALs), information about changes made to the PALs during the year, previous versions of our PALs, and, when applicable, future versions of our PALs. We continuously evaluate our clinical programs, current medical literature, legislation and coding practices to help our members achieve their best health.
Current Medical and Medication PAL (effective Jan. 1, 2025)
Medical and Medication Preauthorization and Notification List
2025 Part B Step Therapy List
Previous Medical and Medication PAL
2024 Part B Step Therapy List
July 1, 2024, Medical and Medication Preauthorization and Notification List
Jan. 1, 2024, Medical and Medication Preauthorization and Notification List

PAL Site


Learn how to submit a preauthorization for frequently requested services/procedures for your patients with CarePlus coverage
Medical and Medication Preauthorizatio
We include below our current Preauthorization Lists (PALs), information about chang
during the year, previous versions of our PALs, and, when applicable, future versio
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Current Medical and Medication PAL (effective Jan. 1, 2025)
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July 1, 2024, Medical an
Notification List
dical an
CarePlus
HEALTH PLANS
Medical and Medication Preauthorization and Notification List
After reading the applicability of the preauthorization requirements below, you can access information about our current list of services, codes and medication that need preauthorization by selecting the appropriate link:
CarePlus Jan. 1, 2025, Medical (physical/behavioral health) Preauthorization and Notification List
CarePlus Jan. 1, 2025, Provider-Administered Medication Preauthorization List
Learn how to submit a preauthorization request for frequently requested services/procedures for your patients with CarePlus coverage
CarePlus
Home / Providers / Medical Resources / Preauthorization Submissions
Preauthorizations Submission Information
Frequently requested services
Preauthorization and notification lists
Important Links
Medical and Pharmacy Coverage Criteria
How to register for Availity Essentials
Access Availity Essentials
Access PWS
Health Services Preauthorization Form

PAL, Continued

CarePlus HEALTH PLANS®

Medical and Medication Preauthorization and Notification Lis

After reading the applicability of the preauthorization requirements below, you can ac
information about our current list of services, codes and medication that need preau orization
by selecting the appropriate link:

CarePlus Jan. 1, 2025, Medical (physical/behavioral health) Preauthorization and Notification List

CarePlus Jan. 1, 2025, Provider-Administered Medication Preauthorization List

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

CarePlus HEALTH PLANS®

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

Effective date: 01/01/2025
Revision date: 05/01/2025

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, 51721*, 53850, 53852, 53854, 55873, 55881*, 55882*, 0421T, 0582T, 0947T*
	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	
Bladder slings		
Blepharoplasty		

CarePlus HEALTH PLANS®

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

Effective Date: 01/01/2025
Revision Date: 05/05/2025

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 PAL Site 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	J7171
Akynzeo IV	fosnetupitant and palonosetron	J1454

Requests for Service not on PAL

Any Medicare-covered CPT codes not found on the PAL do not need an authorization.

For more information on billing procedures, visit CPHP Provider Manual.

Preauthorization Request Options

Preferred preauthorization request options:

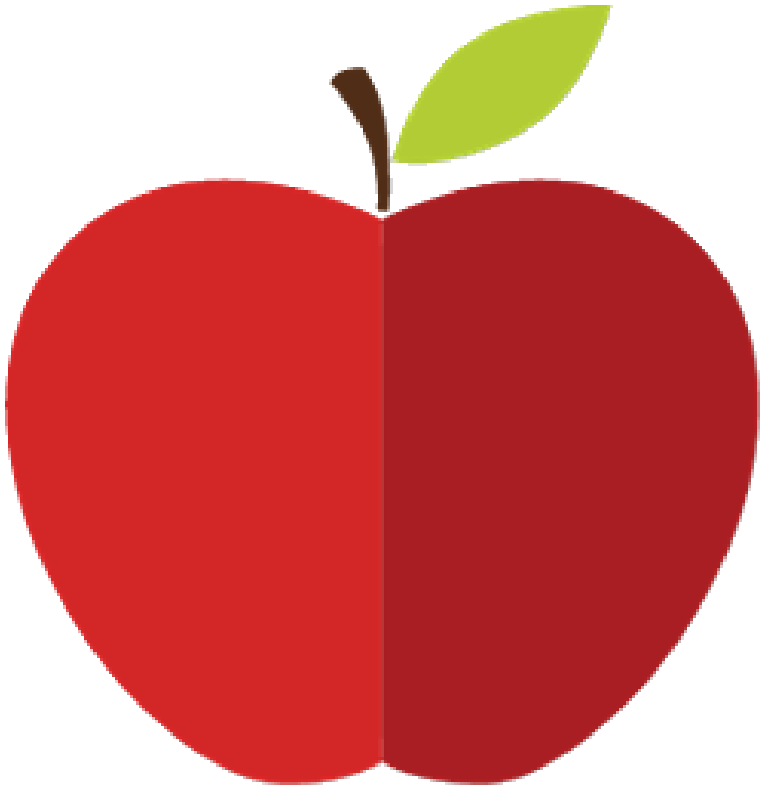
Check patient eligibility, submit preauthorization requests and more online.
Availity offers more options and flexibility when submitting preauthorization requests.
Learn more about the benefits of using Availity

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

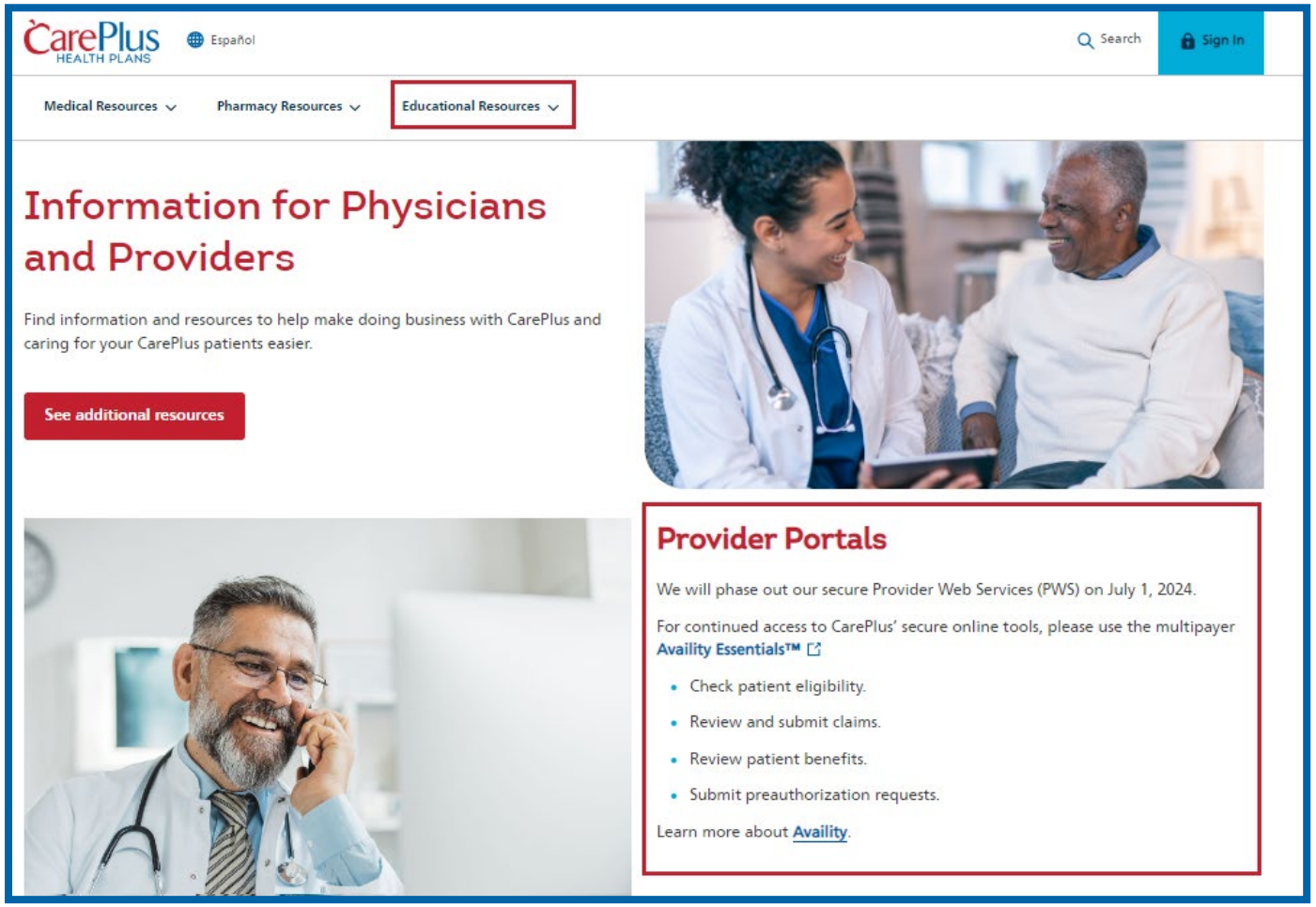
CarePlus HEALTH PLANS®

Availity Essentials

You can submit preauthorization requests and view member benefits, eligibility information, claims status, and more with Availity Essentials. Information about Availity Essentials can be found at CarePlusHealthPlans.com/Availity.

For Availity technical support:

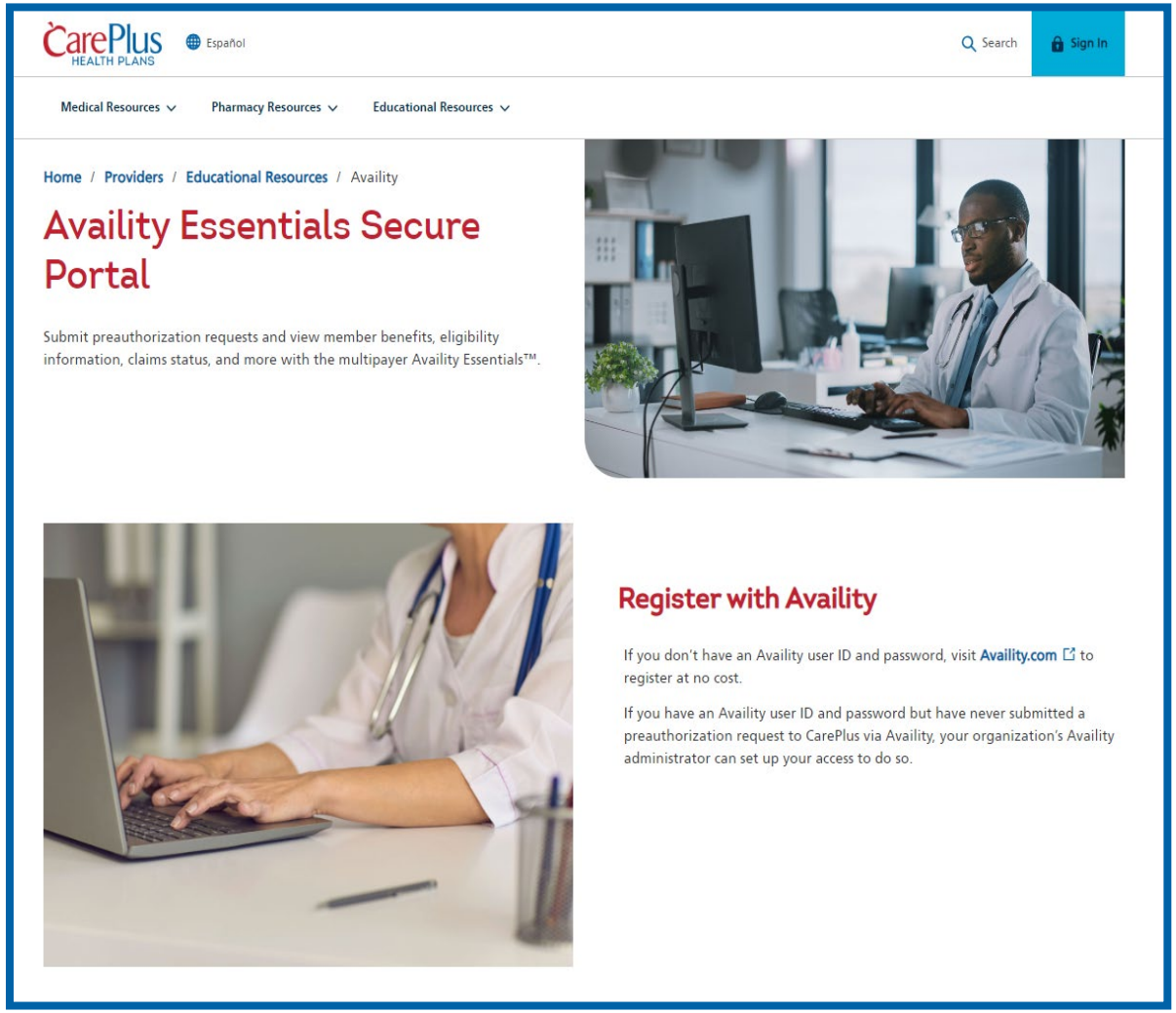
Call **1-800-282-4548**.



For more information, visit CarePlusHealthPlans.com/Availity.

Availity Essentials Resources

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



Training and Assistance

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

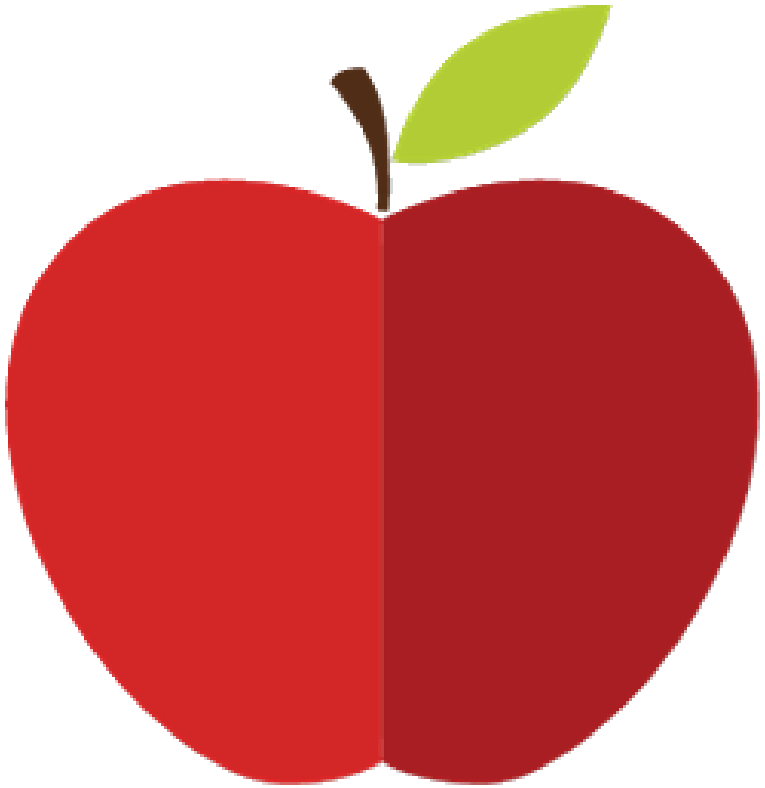
Availity Essentials Submission

Many preauthorization requests submitted via Availity will be automatically 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 counties: 1-866-832-2678, Miami Dade County: 1-888-790-9999, all others: 1-888-634-3521



Fax Submission Requests

CarePlus HEALTH PLANS®

Best Practices for Fax Submissions

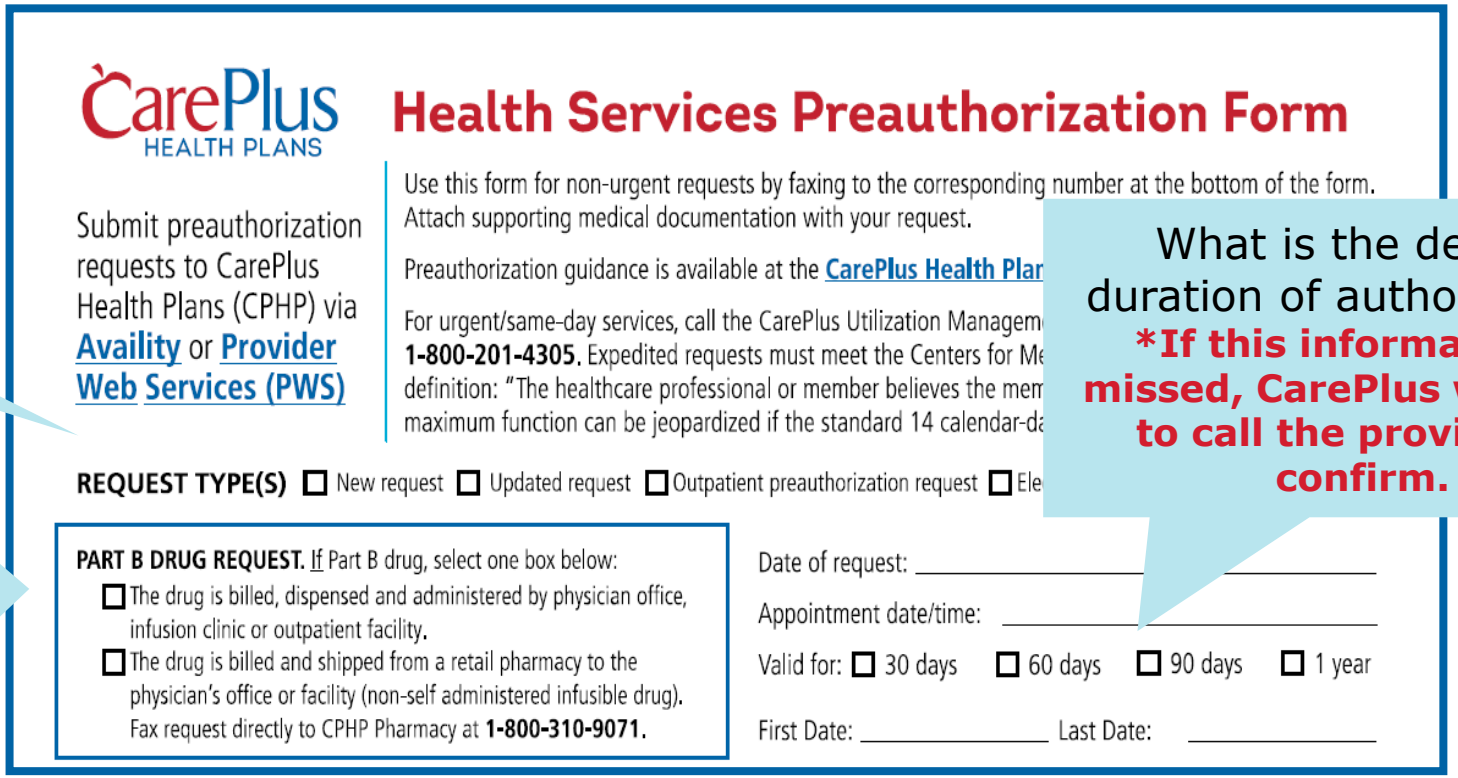
Providers are highly encouraged to use this form when faxing a request to ensure all pertinent information is included.

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 Plar

For urgent/same-day services, call the CarePlus Utilization Managem **1-800-201-4305**. Expedited requests must meet the Centers for Me definition: "The healthcare professional or member believes the mem maximum function can be jeopardized if the standard 14 calendar-da

REQUEST TYPE(S) ☐ New request ☐ Updated request ☐ Outpatient preauthorization request ☐ Ele

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: _____

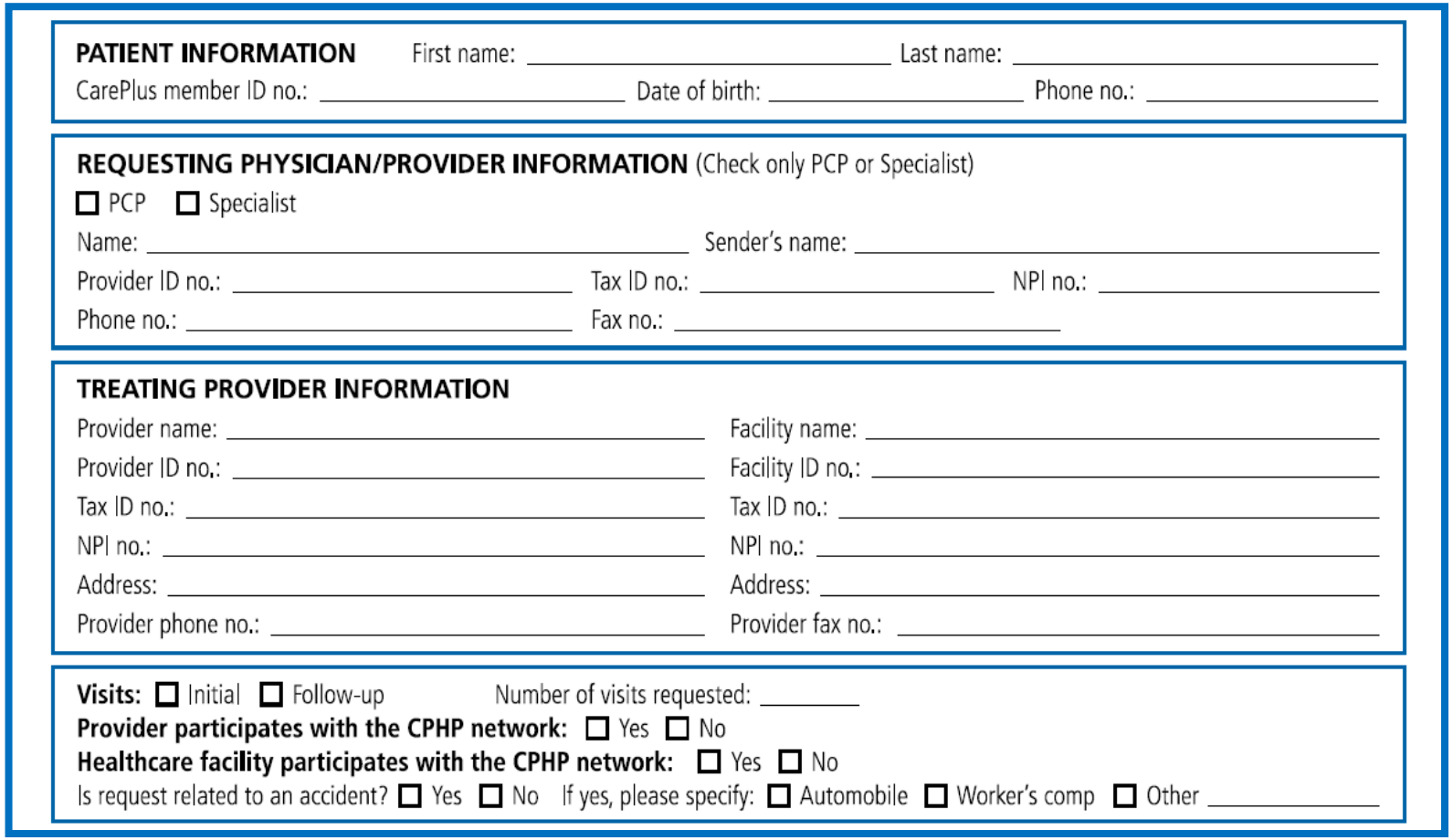
Appointment date/time: _____

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.**

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 patient information entered?

Is all PCP/specialist information entered?

Is all rendering physician/facility information entered?

Is all information regarding the service being requested entered?

How many visits are being requested?

Health Services Preauthorization Form

Request cannot be completed without diagnosis/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

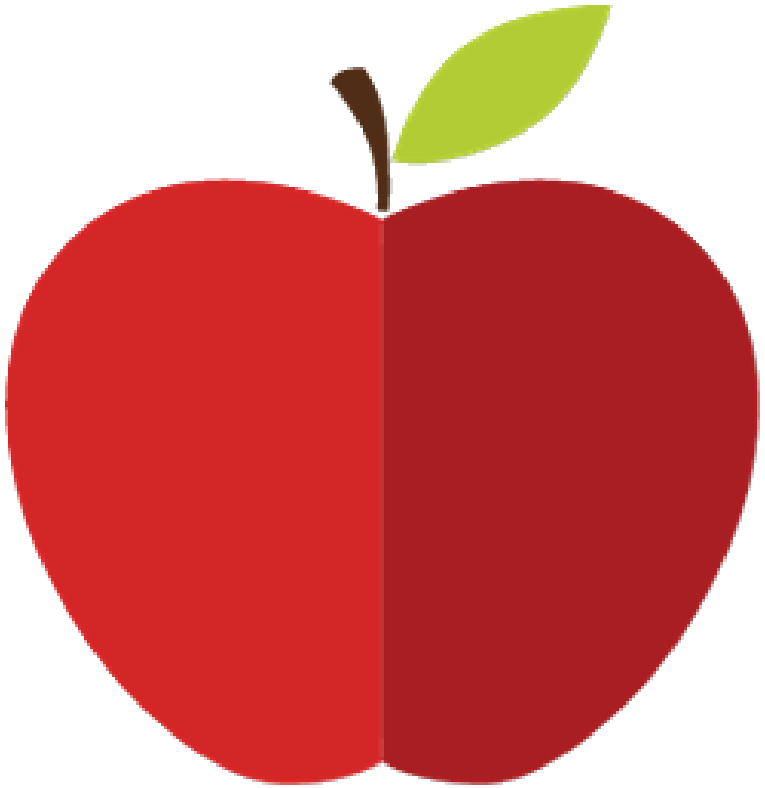
It is important to educate the member on the authorization process.

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.



Examples

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.

Duplicates Example

Please be mindful of sending duplicate requests.

Example:

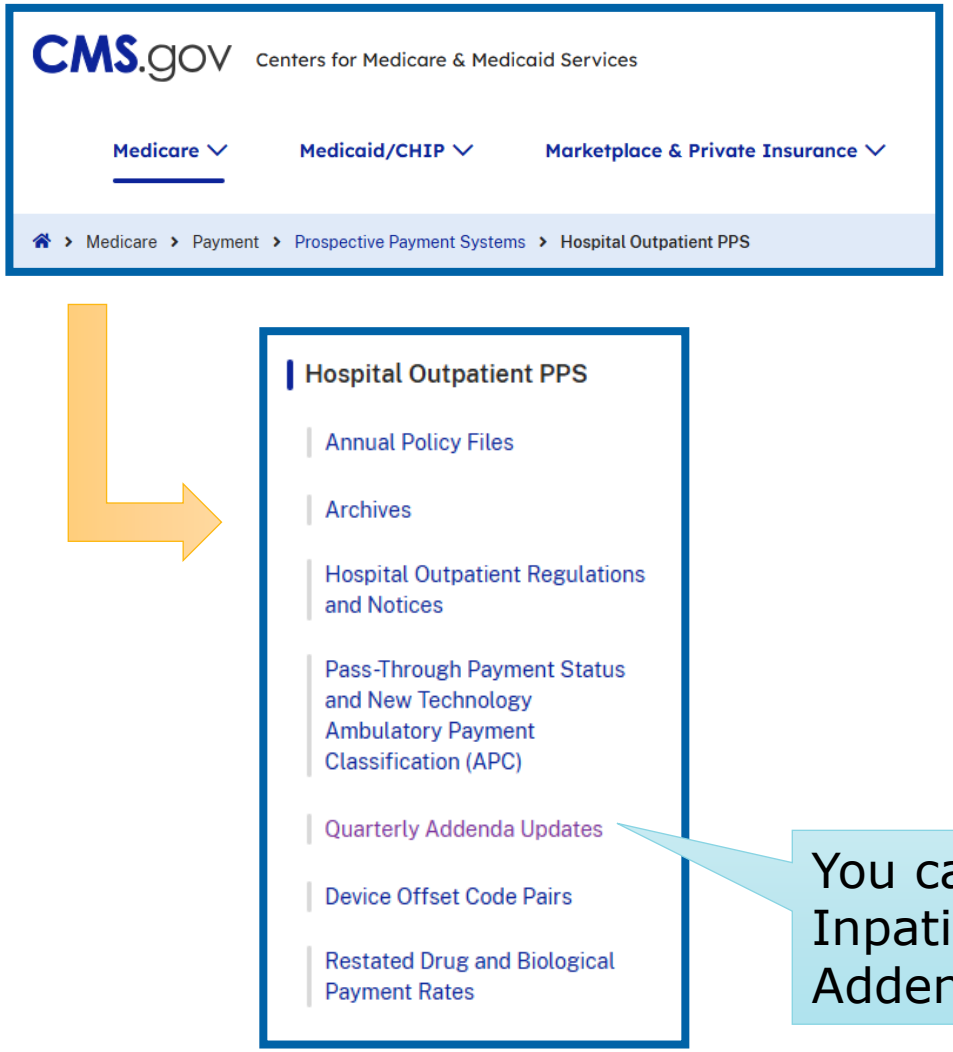
Dr. Smith submitted a prior authorization request to CarePlus for a member's medication. The request was submitted multiple times, leading to:

- CarePlus spent time and resources reviewing the same request multiple times.
- The provider's office is confused by multiple responses from CarePlus.

How can we avoid duplicate requests?

- If a request is submitted via Availity, check for a reference No.
- If a fax was submitted, check on the portal if already on file.

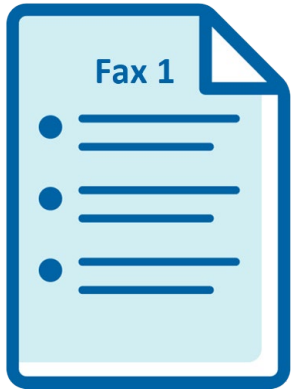
Inpatient-Only Example



You can check the Inpatient-Only List using Addendum B

Example:

Dr. Smith, a cardiothoracic surgeon, is preparing to submit an outpatient surgery request for a patient who needs a coronary artery bypass graft (CABG) with CPT codes **33533** and **33518**. Dr. Smith finds that both codes are on the Inpatient-Only List.



For more information, visit Quarterly Addenda Updates | CMS

Resources

- CarePlus Website
- CMS - Quarterly Addenda Updates - Inpatient Only List
- CMS - Organization Coverage Determinations and Appeals Guidance
- CarePlus Provider - Quick Reference Preauthorization Guide
- CarePlus - Medicare Plan Documents
- CarePlus Provider - Preauthorization List
- CarePlus - Provider Manual
- CarePlus – Providers
- CarePlus – Availity
- Availity Essentials
- CarePlus - Health Services Preauthorization Form
- CarePlus - Provider Forms and Resource Library

Thank you!

CPHP-ProviderTraining Survey

CarePlus HEALTH PLANS®

CarePlus
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