CarePlus HEALTH PLANS

Quick reference prior authorization guide

Our goal is to provide excellent service to you and promote prompt access to care for your CarePlus-covered patients.

The lists below include the information we need for services and durable medical equipment (DME). Please be advised that this list is not all-inclusive of services and/or items that may require prior authorization. Before submitting a prior authorization request, visit CarePlusHealthPlans.com/PAL to verify that the services/items require a prior authorization.

In addition to the information listed, we need the following information for **all** requests:

- Outpatient or inpatient prior authorization request
- Primary care physician (PCP) notes from the last 90 days
- Valid procedure and diagnosis code(s) and number of visits/quantity of services being requested
- Authorization duration required for the course of treatment
- Phone number to reach you in the event further clarification is needed or for peer-to-peer conversations

Nonparticipating provider requests: Please provide the reason for the referral to the nonparticipating provider and/or facility (e.g., continuity of care). As a health maintenance organization (HMO) PCP-gated plan, PCP consent is required for nonparticipating provider visits.

Medicare Part B drug requests: All Medicare Part B (injectable, non-self-administered) medication requests **must be** accompanied by clinicals.

Information required for medical necessity review.	
Please forward this information with your request to ensure timely processing. Reminder: For requests for services not specified on this list, please submit all clinical documentation to support the medical necessity of the request, including orders, PCP and specialist notes, lab/imaging, and other relevant test results.	
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 (BMI)
	Nutritionist notes (last 90 days)
	Records from specialist

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Service	**Information needed**
Blepharoplasty	Diagnosis code
	Ophthalmology records, including visual fields (taped and untaped)
	Photographs
Chemotherapy	Endocrinology records (last 90 days)
	Laboratory results (last 90 days)
	Oncology records (last 90 days) with treatment plan
	Neurology records (if applicable)
Computed Tomography (CT) scans	Oncology records (last 90 days) (if applicable)
	Neurology records (last 90 days) (if applicable)
	Physical therapy records (last 90 days) (if applicable)
Dental services to be covered under medical services (e.g., services from oral or maxillofacial surgeons)	Dental records
	Dental X-rays
	Oral surgery records
	Rationale for dental service to be covered under medical services
	Information required regarding need for outpatient ambulatory center or inpatient stay
Diagnostic esophagogastroduodenoscopy or esophagoscopy (EGD)	Medical records (last 90 days)
	Radiology reports (if applicable)
	Laboratory reports (if applicable)
Epidurals/facet joint injections	Conservative treatments tried (e.g., physical therapy)
	History and physical (last 90 days)
	Pain management clinical notes
Magnetic resonance imaging (MRI)	Neurology/oncology/orthopedic records (last 90 days) (as applicable)

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Service	**Information needed**
Requests from nonparticipating providers	Continuity of care
	Gap in network/no participating provider available
	Patient request
	Rare or uncommon disease
	Second opinion
	Super subspecialist
	Transition of coverage
Nonpreferred specialist services	Diagnosis code(s)
	Participating or nonparticipating status
Physical and occupational therapy	Signed orders, including diagnosis, frequency of treatment; signed plan of care
Positron emission tomography (PET) scan	Neurology/oncology/physical therapy records (last 90 days) (as applicable)
Radiation therapy	Endocrinology records (last 90 days)
	Laboratory results (last 90 days)
	Neurology records (if applicable)
	Oncology records (last 90 days)
Transesophageal (TEE) and transthoracic (TTE) echocardiography	Cardiology records (last 90 days)
	Radiology reports (if applicable)
	Laboratory reports (if applicable)

Information needed for medical necessity review – durable medical equipment (DME) and home health	
Please submit all DME and home health requests with orders and clinicals to the CarePlus-delegated vendors. **Reminder:** For requests for services not specified on this list, please submit **all** clinical documentation to support the medical necessity of the request, including orders, PCP and specialist notes, lab/imaging, and other relevant test results.	
Bone growth stimulators	Diagnosis code(s)
	Imaging to support lack of healing of fracture 90-plus days after initial diagnosis
	Lab results (last 90 days)
	Oncology records (if applicable)
	Surgery records/operative report
Brand-specific DME	Orders with diagnosis
	Letter of medical necessity (Please explain why items on the Evidence of Coverage cannot meet the member's needs.)
Continuous positive airway pressure (CPAP), bilevel positive airway pressure (Bipap), auto-adjusting airway pressure (Auto-pap)	Orders with settings for CPAP machine and diagnosis
	Pulmonology records (last 90 days)
	Sleep study (polysomnogram and titration – both parts of the study)
Enteral nutrition	Orders/prescription with diagnosis, brand, route of administration and quantity
	PCP records (last 90 days)
Heavy-duty DME (wheelchair, scooter, power chair, hospital bed, commode, shower chair, etc.)	Medical records with orders
	PCP records with member's height and weight
	If member is not within the qualifying weight criteria, include a letter of medical necessity.
Lymphedema pump and lymphedema therapy	Orders with settings
	PCP records, treatment plan

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Mobility aids (power mobility device, power wheelchair, scooter, custom wheelchair, etc.)	Orders with codes identifying equipment and diagnosis codes
	Face-to-face evaluation mainly directed toward mobility needs; if unable, state why
	Functional mobility evaluation form must be completed
	Functional assessment
	History of prior repair to the device (if applicable)
	In-home DME evaluations
	Neurology records (if applicable)
	Orthopedic records
	Physical therapy records
Mobility aids continued (manual wheelchair, transport wheelchair, cane, crutches, walker, commode, bath/shower chair, etc.)	Orders with codes identifying equipment
	Diagnosis code(s)
	Clear explanation of medical necessity for the request
Oxygen home concentrator with portable tanks and/or liquid oxygen	Orders with settings (liter flow, route of administration and hours of usage) and diagnosis
	Oxygen saturation test on room air at rest and during exercise
	Oximetry testing (if available)
	Pulmonology records
Patient lift/Hoyer lift	Orders with diagnosis
	Orthopedic records (last 90 days)

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Portable oxygen concentrator	Orders with settings
	Letter of medical necessity (Please explain why tanks are not sufficient for the member.)
	Oxygen saturation test at rest and during exercise
	Pulmonology records (last 90 days)
	PCP/pulmonology records (last 90 days)
Registered nurse, aide, physical therapy/occupational therapy/ respiratory	Orders with diagnosis specifying skilled services required
	Medical records supporting medical necessity
ROHO® cushions for wheelchair and pressure-reducing mattress	Orders with diagnosis
	Records of any ulcer's stage, size and location
Transcutaneous electrical nerve stimulation (TENS) unit	Orders with diagnosis
	Orthopedic records (if applicable)
	Physical therapy records
Ventilator	Orders with diagnosis and settings for ventilator
	Pulmonology records (last 90 days)
	Arterial blood gas results