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 authorizations. The guide specifies the required information to review for medical necessity for preauthorization requests.

Before submitting a preauthorization request, visit **CarePlusHealthPlans.com/PAL** to verify that the services/items require a preauthorization. The list details services and medications (e.g., medications delivered in the physician's office or clinic or an outpatient or home setting) that require preauthorization before services are provided or administered.

Please submit all clinical documentation to support the medical necessity of the request, in addition to primary care physician (PCP) and specialist notes, orders/prescription (if applicable), lab/imaging, and other relevant test results.

Non-participating provider requests: Please provide the reason for the preauthorization to the non-participating provider and/or facility (i.e., continuity of care).

We also need the following information for all requests listed on the PAL:

- PCP and/or specialist notes from the last 90 days
- Valid procedure and diagnosis code(s)
- Quantity of requested services
- Number of visits

Inpatient or outpatient requests: Please indicate whether the request is for inpatient or outpatient services.

Expedited requests: For urgent/same-day services, you can call the CarePlus Utilization Management provider line at 1-800-201-4305. All expedited requests must meet the Centers for Medicare & Medicaid Services (CMS) definition: ''The healthcare professional or member believes the member's health, life or ability to regain maximum function can be jeopardized if the standard 14 calendar-day time frame is applied."

* 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.

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.**	
Dental services to be covered under medical services (e.g., services from oral or maxillofacial surgeons) *cont.*	Rationale for dental service to be covered under medical services
	Justification whether outpatient ambulatory center or inpatient stay is required
Epidurals/facet joint injections	Conservative treatments tried (e.g., physical therapy)
	History and physical (last 90 days)
	Pain management clinical notes
Esophagogastroduodenoscopy (EGD)	History and physical (include signs and symptoms)
Magnetic resonance imaging (MRI)	Records from specialist (last 90 days)
	Radiology results (last 90 days)
Myocardial perfusion imaging SPECT	Cardiology records (last 90 days)
	Electrocardiogram results (last 90 days)
	History and physical (last 90 days)
Requests from non-participating 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 non-participating status
	Rationale for non preferred
Positron emission tomography (PET) scan	Neurology/oncology/physical therapy records (last 90 days)

Information required for medical necessity review. Please forward this information along with your request to ensure timely processing.	
Radiation therapy	Endocrinology records (last 90 days)
	Laboratory results (last 90 days)
	Neurology records if applicable
	Oncology records (last 90 days)
Transthoracic Echocardiography (TEE) with Cardiology records (last 90 days) doppler	Cardiology records (last 90 days)
	Diagnosis code and differential (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 (explaining why items on the evidence of coverage cannot meet member's needs)
Heavy-duty DME (wheelchair, scooter, power chair, hospital bed, etc.)	Orders/prescription with settings
	PCP records with member's height and weight
	If member is not within the qualifying weight criteria, include a letter of medical necessity
	Face to face - mainly directed toward mobility needs; if unable, state why
Hospital bed	Orders/prescription with diagnosis

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.

Mobility aids (power mobility device, power wheelchair, scooter, custom wheelchair, etc.)	Orders/prescription with diagnosis
	Face to face - 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
	Orders/prescription
	Diagnosis code(s)
	Clear explanation of medical necessity for the request
Patient lift/Hoyer lift	Orders/prescription with diagnosis
	Orthopedic records (last 90 days)
Registered nurse, aide, physical therapy/ occupational therapy / respiratory therapy / speech therapy at home	Orders/prescription with diagnosis specifying skilled services required
	Clear rationale of medical necessity for the home health services
	History and physical
Suction pump	Orders/prescription with settings
Ventilator	Orders/prescription with diagnosis and settings for vent
	Pulmonology records (last 90 days)
	Arterial blood gas results