



Provider News Alert

AUTHORIZATIONS

CARE IMPROVEMENT PLUS HAS RECENTLY ELIMINATED THE PREAUTHORIZATION REQUIREMENT FOR OUTPATIENT REHABILITATION SERVICES. A COMPLETE LIST OF OUR UTILIZATION MANAGEMENT REQUIREMENTS IS ENCLOSED FOR YOUR REFERENCE.

PLEASE REMEMBER THAT MANY SERVICES REQUIRE AUTHORIZATIONS IN APPROPRIATE CASES AND FAILURE TO OBTAIN SUCH NECESSARY AUTHORIZATIONS WILL RESULT IN DENIED OR DELAYED PAYMENTS.

CARE IMPROVEMENT PLUS IS COMMITTED TO PROVIDING SAFE AND EFFECTIVE CARE TRANSITIONS FOR OUR MEMBERS. CARE COORDINATION BY THE HEALTH PLAN IS REQUIRED BY CMS AND NCQA FOR CSNPs. THUS WE HAVE INCREASED DISCHARGE PLANNING ACTIVITY AND SEEK TO PARTNER WITH PROVIDERS THROUGH THE AUTHORIZATION PROCESS.

HOSPICE

WHEN A MEDICARE ADVANTAGE MEMBER BECOMES ENROLLED IN A HOSPICE PROGRAM, ORIGINAL MEDICARE BECOMES THE PRIMARY PAYOR FOR ALL MEDICARE-COVERED SERVICES. AS ORIGINAL MEDICARE IS RESPONSIBLE FOR PAYMENT OF ALL COVERED SERVICES FOR HOSPICE ENROLLED MEMBERS YOU SHOULD SUBMIT CLAIMS DIRECTLY TO THEM FOR PAYMENT. CLAIMS SUBMITTED TO CARE IMPROVEMENT PLUS WILL BE DENIED WITH THE REASON CODE 747 (SERVICES COVERED UNDER HOSPICE) AND SHOULD BE FILED WITH MEDICARE.

TIMELY FILING

PLEASE REFER TO YOUR CARE IMPROVEMENT PLUS CONTRACT FOR TIMELY FILING AND CLEAN CLAIM SUBMISSION REQUIREMENTS.

PLEASE VISIT THE PROVIDER PAGES OF OUR WEB SITE AT
www.careimprovementplus.com
for additional information on our policy and procedures.

Provider Portal

If you need claims and eligibility information visit our provider portal by logging onto our Website at www.careimprovementplus.com In the blue Provider Portal box, highlight your state. Click "Select". This will route you to the appropriate Provider Portal.

For additional information about joining our network, or to assist you with billing questions, member eligibility or any other issues requiring assistance, call **Provider Relations at 1-866-679-3119**.

Additional Questions?

Call 1-866-679-3119 or email your local provider representative at:

AR/MO: ARprovider@careimprovementplus.com
MOprovider@careimprovementplus.com

SC/GA: SCprovider@careimprovementplus.com
GAprovider@careimprovementplus.com

MD: MDprovider@careimprovementplus.com

TX: TXprovider@careimprovementplus.com

This is not an advertisement. However, if you have received this transmission in error or wish to no longer receive faxes from us, please (1) call 1-888-681-5252, enter document #700014 and follow the prompt; or (2) send us a fax at 1-866-248-5116 requesting to no longer receive faxes. You must include in your request the fax/phone numbers for which you are requesting to no longer receive faxes from Care Improvement Plus. We will comply with your request within 30 days after receiving it. Your opt-out request will be overridden if you subsequently expressly request Care Improvement Plus to send you faxes at the fax/ phone numbers for which your opt-out request was made.

2009 PROVIDER AUTHORIZATION REQUIREMENTS – Revised 05/29/09
Arkansas, Georgia, Missouri, South Carolina, Texas



*These rules are designed to promote effective and efficient care management for the benefit of Medicare beneficiaries, and will be applied consistent with CMS and contractual requirements.
 *All services are subject to plan eligibility. **Authorization does not guarantee payment.** Medical necessity will need to be established.
***Failure to obtain authorizations beyond emergency and post-stabilization services in appropriate cases will result in delays or denials of payment or additional administrative requirements.**
 * The Care Improvement Plus Utilization Management office is closed on weekends/holidays for routine requests. Clinical information is due on the next business day.
 * Providers must be Medicare certified to provide services.

Emergency Inpatient Hospital Admissions: Medical and Psychiatric	No preauthorization is required for emergency services. However, all inpatient admissions require authorization . Under new NCQA guidelines, the plan must have a report of all admissions within 1 business day of the admission, and all requests must be submitted within that time. The authorization is pended until clinical information has been received, reviewed and a medical determination made. Please fax the admission face sheet and all appropriate information including ICD-9 codes to the number below.
Elective Inpatient Admissions and Elective Inpatient Surgical Procedures	All inpatient elective admissions and elective inpatient surgical procedures require preauthorization in advance of the admission. Requests should be submitted at least 5 days prior to the scheduled procedure. Requests must include the complete name and location of the procedure being performed (i.e. left knee, L1-L4, etc.), CPT codes, ICD-9 codes, facility, surgeon, proposed procedure date, and appropriate clinical information supporting the request.
Skilled Nursing Facility, Comprehensive Inpatient Rehab (Acute Rehab) and Long Term Acute Care (LTAC)	All skilled nursing facility, comprehensive inpatient rehab facility and long term acute care facility admissions require preauthorization in advance of the admission. An updated authorization is required in advance of a continued inpatient stay beyond the authorization period previously approved by the Plan. Initial requests must include discharge summary/MD Order from hospital and PT/OT evaluations. The Plan will notify the provider of the determination within 1 business day of receipt of all necessary clinical and other requested information.
Home Health Services	All home health services require authorization . Provider must seek authorization during the first week of services. Requests must include number of visits and services requested (skilled nursing, PT/OT, medical social work, etc.), ICD-9 codes, start of care date and MD order. No additional clinical information is required unless requested. Plan will notify provider of determination within 3 business days of receipt of all necessary clinical and other requested information.
Transplants and Weight Loss Procedures	All transplants and weight loss procedures require preauthorization . Requests should be submitted at least 30 days prior to procedure/service. Experimental procedures (not FDA approved) are not generally covered.
Power Operated Vehicle (POV): Power Wheelchair or Scooter (MAE)	Require preauthorization in advance. Submit MD order, completed physical therapy eval, face to face exam, applicable physician office notes, and any other pertinent clinical information. Include HCSPCS codes, and ICD-9 codes.
Prosthetics	Require preauthorization in advance. Submit MD order, clinical documentation denoting the member's past medical history, reason for amputation, current condition, status of residual limb, desire to ambulate, and clinical assessment of rehabilitation potential. Include HCSPCS codes, and ICD-9 codes.
Negative Pressure Wound Therapy (Wound Vac)	Require preauthorization in advance. Submit MD order, clinical documentation of wound history including measurements, staging, complete description of wounds and past treatment plans. Include HCSPCS codes, and ICD-9 codes.
Bone Growth Stimulators (Ultrasonic Osteogenesis Stimulators), Spinal Cord Stimulators (Dorsal Column Stimulators)	Require preauthorization in advance. Submit MD order, clinical documentation which details prior treatment plan, diagnostic results which confirms non-union of fracture (for long bones) or for spinal devices documentation of failed fusion surgeries and/or recent multilevel fusion procedures. Include HCSPCS, diagnoses, and ICD-9 codes.
Pressure Reducing Support Surfaces (Low air loss & air fluidized beds, Air/ water mattresses, gel pads, sheepskins etc)	Require preauthorization in advance. Submit MD order, clinical documentation of wound history including measurements, staging, complete description of wounds, past treatment plans, neuro status, mobility status, nutritional status. Include HCSPCS, and ICD-9 codes.
Lymphedema Pumps (Pneumatic Compression Devices)	Require preauthorization in advance. Submit MD order, H&P, diagnostic test results. Include HCSPCS, and ICD-9 codes.

IMPORTANT PHONE NUMBERS

Preauthorization for, SNF, Home Health, Acute Rehab, LTAC, DME and elective hospital admissions. Authorization for emergency inpatient hospital admissions (medical/surgical and psychiatric)	SC/GA – 1-888-625-2204 TX/AR/MO – 1-877-625-2201	
Member Services	1-800-204-1002	
MTM Transportation Services	1-888-240-6435	
AVESIS Vision/Dental Services	1-800-828-9341	
Provider Services/Claims Inquiries	1-866-679-3119	MEDICAL CLAIMS ADDRESS: CARE IMPROVEMENT PLUS, PO BOX 4347 SCRANTON PA 18505 EDI Claims: Emdeon payer ID 77082
Pharmacy Services/MEDCO Health Solutions Inc	1-866-673-3561	PHARMACY CLAIMS ADDRESS: MEDCO Health Solutions Inc, PO Box 14718 Lexington, KY 40512
Pharmacy Preauth for certain Part B drugs administered in a doctor's office	1-866-904-6561	
Appeals and Retrospective Review	Expedited and Medical Necessity Appeals (for denied medical claims) 1-800-213-0672 Pharmacy Appeals 1-866-683-3275 UM Retrospective Review for Pended Claims 1-866-683-2073	