CARE IMPROVEMENT PLUS

Specialized Care for Medicare Beneficiaries

Care Improvement Plus
4350 Lockhill-Selma Road 3rd Floor
San Antonio, TX 78249

Re: Medical Necessity Review for Acute Hospital Inpatient Stays and CMS Two Midnight Rule for Participating Providers

Effective **June 27,2015**, Care Improvement Plus (CIP) will begin to perform a concurrent medical necessity review for acute hospital stays for participating providers and integrate the Center for Medicare and Medicaid Services (CMS) Two Midnight Rule as patt of the clinical criteria for the concurrent medical necessity review.

As part of the concurrent medical necessity review, CIP will review inpatient admissions to determine whether inpatient level of care is medically necessary. The concurrent medical necessity review process will allow the facility to receive a medical necessity determination pre-claim.

No preauthorization is required for emergency services. However, **all inpatient admissions require notification within one business day of admission.** Participating providers should submit a notification for inpatient admission and fax the admission face sheet, admitting H&P and diagnosis with ICD-9 diagnosis codes. The facility will receive a reference number acknowledging the receipt of the request. NOTE - The reference number is not an authorization for services. Once the CIP beneficiary is admitted, the facility is expected to fax all supporting clinical documentation, including but not limited to the inpatient admission order.

Consistent with Medicare regulations, CIP will conduct a medical necessity review of the reasonableness of the physician's expectation that the stay will cross two or more midnights and will utilize evidence-based guidelines to determine the medical necessity and duration of the stay. CIP will advise the facility of the detennination once CIP has received and reviewed the relevant information.

The requirement that certain elective hospital services require preauthorization has not changed. Refer to the CIP Provider Manual at https://www.careimprovementplus.com/pdf/20 15_CIP_Provider_Manual.pdf for the list of services requiring preauthorization and for more information about the relevant procedures.

Care providers are encouraged to work with Care Improvement Plus medical directors to support the provision of evidence-based and medically necessaty care for our members.

For More Information
To submit your requests for inpatient, please call 1-888-625-2204 or fax to 1-800-211-6490. For more **infonnation, please visit us at www.careimprovementplus.com.**

References:
l. Centers for Medicare & Medicaid Services. (2014). ***cms.gov.*** **Retrieved from http://www.cms.gov/MedicarefMedicare-Fee-for-Service-Payment/AcutelnpatientPPS/FY20 14-IPPS-Fina!-Rule-Home-Page.html**

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Re: Effective June 30, 2015, the Ability to Submit an Authorization Request Retrospectively Will No Longer Be Available

Effective June 30, 2015, the ability to submit an authorization request retrospectively will no longer be available. All authorization requests must be submitted pre-service. Accordingly, such retrospective requests received by fax to the retrospective line (1-866-683-2073), or any other way, will not be available.

As you know, your participation agreement sets forth various requirements, including adhering to the Provider Manual's requirements. The Provider Manual provides services for which you are required to request a pre-service organization determination before rendering service to a Medicare Advantage member. If a required pre-service organization determination is not issued prior to service being rendered, then your claim will be denied and you will be required to follow the appeal process. The Provider cannot bill a member for services in cases in which you do not comply with the protocols set forth in the Provider Manual and for claims that are administratively denied. Please note, you are not required to submit authorization for emergent services.

Care Improvement Plus accepts both paper and electronically submitted claim forms from providers. All claims and encounter data must be submitted on either a form CMS 1500 or UB-04, or on electronic media in an approved HIPAA compliant format. Care Improvement Plus uses Availity, Emdeon and Xerox EDI Direct as our clearinghouse options. The unique Electronic Payor ID is: **77082. Call-866-679-3119** for assistance.

For more detailed information regarding Care Improvement Plus claims payment policies, please go online to www.careimprovementplus.com to our provider self-service center and access the quick links for more information.

Thank you for your attention to this matter. We look forward to working with you to improve efficiency in providing quality and timely care for the members of Care Improvement Plus.