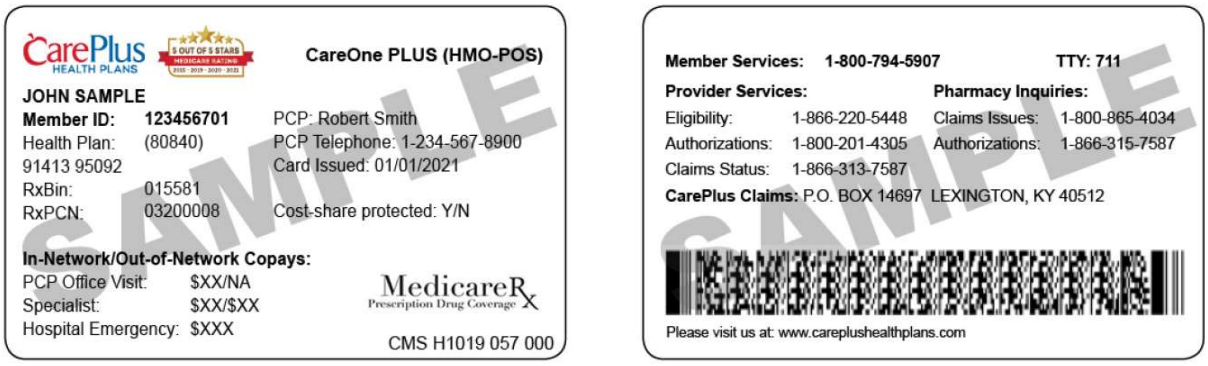
FAQ: New Medicare Advantage HMO-POS benefit plan for providers in Orlando

For 2021, CarePlus has added a new Medicare Advantage (MA) health maintenance organization point-of-service (HMO-POS) benefit plan, CareOne PLUS (HMO-POS) H1019-057, for Orlando. Under this new plan:

- Patients will have an assigned primary care physician.
- Certain out-of-network services will be covered for members visiting Puerto Rico. If noncontracted providers do not agree to provide those services to plan members when they are neither emergency nor urgent, CarePlus is prepared to coordinate medically necessary care with those providers.
- Excluded services will include those not covered under Original Medicare, such as routine vision, hearing and dental.

Patients with CareOne PLUS (HMO-POS) H1019-057 coverage should present this identification card:



Answers to general and operational questions providers might have about the new plan begin on the next page.

General Questions

1. What does HMO-POS mean on the patient's ID card?

A: HMO-POS means that the patient is in a traditional HMO plan with some out-of-network benefits. Benefit and eligibility information is available at www.availity.com or www.changehealthcare.com (registration required). Healthcare providers also can contact our Provider Services Department at 866-313-7587, Monday−Friday, 8 a.m.−5 p.m., Eastern time.

---

2. How are noncontracted healthcare providers reimbursed?

A: Non-contracted healthcare providers are reimbursed according to Original Medicare's fee schedule for the service area.

---

3. Q: Are National Provider Identifiers (NPIs) required on claims submitted to CarePlus?

A: Yes. NPIs, as well as taxonomy numbers and Tax Identification Numbers, are required so that CarePlus can price and process claims appropriately. Facilities should use subunit identifiers with their facility ID when submitting claims.

---

4. What happens if a patient disenrolls from CareOne PLUS (HMO-POS) H1019-057 and enrolls in a different benefit plan? How are the patient's cost-shares calculated?

A: If a patient were to enroll in a different CarePlus benefit plan, the copayments and deductibles specified in the patient's Evidence of Coverage for the new benefit plan would apply.

---

5. Can healthcare providers go online to review their claim status or to verify patient eligibility?

A: Yes. Healthcare providers who want to review claims or verify eligibility for patients covered by CareOne PLUS (HMO-POS) H1019-057 can do so at www.availity.com or www.changehealthcare.com (registration required). Providers also can contact our Provider Services Department at 866-313-7587, Monday−Friday, 8 a.m.−5 p.m., Eastern time, for assistance.

---

6. What format is required for claims?

A: Claims submitted for processing should be in a HIPAA-compliant 837 file format and filed electronically with Availity at Availity.com using the CarePlus payer ID 95092 (specific to Availity), or with Change Healthcare at ChangeHealthcare.com using the CarePlus payer ID 65031 (specific to Change Healthcare). Healthcare providers should work with their practice management system, system vendor or billing service to ensure CarePlus Health Plans is enabled for electronic claim submission. If unable to submit electronically, providers can submit professional claims on a properly completed CMS 1500 form

within the time frame specified in their contracts. Providers also may use the revised 1500 claim form (version 02/12). This approved, updated 1500 claim form accommodates reporting needs for ICD-10 and aligns with requirements in the Accredited Standards Committee X12 (ASC X12) Health Care Claim: Professional (837P) Version 5010 Technical Report Type 3.

If unable to submit facility claims electronically, providers can submit them on a properly completed UB-04/CMS 1450 form within the time frame specified in their contracts.

If all electronic data interchange methods fail and the CarePlus provider services executive has been unable to assist, providers can submit a paper claim and claim-related correspondence to this address:

CarePlus Health Plans
Attn: Claims Department
P.O. Box 14697
Lexington, KY 40512-4697

Claims and medical records also can be faxed to 855-811-0408.

---

7. What should a physician do if he/she suspects that a service might not be covered under CareOne PLUS (H1019-057)?

A: Healthcare providers who think a service might not be covered should contact CarePlus for a formal determination of coverage. If a provider performs a service that might not be covered, and the plan has not made a determination that the service is not covered, the provider can collect only the cost-sharing that would apply for the service if it were covered. That is, the provider must not balance bill a CareOne PLUS (H1019-057) patient for a noncovered service if the plan has not issued the patient a formal, written determination that the service will not be covered.

For more information, refer to Medicare Managed Care Manual, Chapter 4 – Benefits and Beneficiary Protections, Sections: 160, 170 and 170.2.

Operational Questions

1. For CareOne PLUS (HMO-POS) H1019-057, does CarePlus follow Medicare guidelines promulgated in National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)?

A: Yes. CarePlus applies NCDs and LCDs in accordance with federal regulations and the Centers for Medicare & Medicaid Services (CMS) guidance.

---

2. Does CareOne PLUS (HMO-POS) H1019-057 follow all Medicare rules for readmissions?

A: Yes. CareOne PLUS (HMO-POS) H1019-057 follows all Medicare rules for readmissions.

---

3. What are the enrollment and disenrollment guidelines?

A: Enrollment and disenrollment guidelines are determined by CMS. Please visit the CMS website at cms.gov for more information.

---

4. Does CareOne PLUS (HMO-POS) H1019-057 provide for an on-site reviewer?

A: On-site nurses are available in some markets. Certain cases are identified for case management on an outpatient basis through post-discharge calls to patients. Depending on their conditions, certain patients are identified for further case management. Case management is handled by phone.

---

5. Does CareOne PLUS (HMO-POS) H1019-057 offer case management services?

A: Case management services are available for a specific set of chronic conditions. You can find information about CarePlus' Health and Wellness, Disease Management and Case Management programs and how to refer patients to the programs by contacting our Case Management Department at 866-657-5625, Monday−Friday, 8 a.m.−5 p.m., Eastern time.

---

6. Does CareOne PLUS (H1019-057) provide for on-site associates who can present letters to doctors and patients explaining the appeal process?

A: Because CarePlus has a limited number of on-site associates to deliver letters, please coordinate with hospital employees for delivery of appeal rights letters for patients.

---

7. What kind of criteria does CareOne PLUS (HMO-POS) H1019-057 use for medical necessity?

A: All CarePlus' MA HMO-POS plans use Medicare coverage guidelines, nationally accepted guidelines and peer-reviewed literature to determine medical necessity.

---

8. Does CareOne PLUS (HMO-POS) H1019-057 assist with discharge planning?

A: Under the plan, CarePlus' case managers will work with facility discharge planners to create, implement and follow up on discharge plans. In addition, CarePlus collaborates on and coordinates discharge planning with the patient and/or the patient's representative and physician.

---

9. Who can I call if my question isn't listed here?

A: Please contact our Provider Services Department at 866-313-7587 Monday−Friday, 8 a.m.−5 p.m., Eastern time.