## How to Submit Prior Authorization Requests

<table>
<thead>
<tr>
<th>Method</th>
<th>Information</th>
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<tbody>
<tr>
<td><strong>Email</strong></td>
<td><a href="mailto:inmedmgt@caresource.com">inmedmgt@caresource.com</a></td>
</tr>
<tr>
<td><strong>Phone</strong></td>
<td>1-844-607-2831</td>
</tr>
<tr>
<td><strong>Fax</strong></td>
<td>Fax the prior authorization form to 844-432-8924 including supporting clinical documentation. The prior authorization request form can be found on <a href="http://CareSource.com">Caresource.com</a>.</td>
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</tbody>
</table>
| **Mail**  | CareSource  
            Attn: IN Utilization Management  
            P.O. Box 44493  
            Indianapolis, IN  46244 |
For prior authorization requests, please use the Indiana Health Coverage Programs (IHCP) Prior Authorization Request Form. It is located on the Forms page on CareSource.com:

- Hover over the Providers tab and click on Forms.
- Select your plan (Indiana Medicaid) in the dropdown menu.
Prior Authorization Checklist

When you request prior authorization (PA), be sure to include the following:

- Member/patient name and Medicaid RID number
- Referring and Servicing Provider name and NPI
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-network provider, if applicable
- Clinical information to support the medical necessity of the service
- Inpatient services need to include whether the service is elective, urgent, or emergency, admitting diagnosis, symptoms & plan of treatment

We do not require a referral to see a participating specialist. However, prior authorization may still be required for services provided by specialists.

Where do I find more information?
Find more information in our Health Partner Manual on CareSource.com.
## Prior Authorization Timeframes

<table>
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<tr>
<th>Authorization Type</th>
<th>Decision</th>
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<tr>
<td>Standard pre-service</td>
<td>7 calendar days</td>
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<tr>
<td>Urgent pre-service</td>
<td>72 hours</td>
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<tr>
<td>Urgent concurrent</td>
<td>24 hours</td>
</tr>
<tr>
<td>Post service (retrospective review)</td>
<td>30 calendar days</td>
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To check the status of a prior authorization request, call 1-844-607-2831.
Dental Authorizations

CareSource partners with Scion Dental to administer dental benefits. Dental authorization requests may be submitted via paper or online at https://pwp.sciondental.com/PWP/Landing.

ONLINE:
Participating providers may contact the web portal team at ProviderPortal@scion.com to get registered for the Scion Provider Web Portal and request a demonstration.

Some of the time-saving features of the dental Provider Web Portal include:
• View member service history, covered benefits and fee schedules.
• Create a member eligibility calendar and view real-time eligibility for multiple members.
• View authorization guidelines and required documentation prior to submitting authorizations.
• Submit authorizations with attachments for faster determinations.

PAPER:
Paper dental authorization requests may be sent to:

CareSource IN: Authorizations
P.O. Box 745
Milwaukee, WI, 53201

Please reference our Dental Health Partner Manual at CareSource.com/documents/in-med-dental-health-partner-manual for a list for services that require prior authorization.
Services Requiring Prior Authorization

- All services provided out-of-network, except self referral services
- Inpatient services
- Partial hospitalization programs
- All surgical services
- Advanced diagnostic imaging through NIA Magellan (i.e. PET, MRI, MRA, CT etc.)
- Certain outpatient procedures and tests as specified by PA list on our website
- Purchase or rental of specified medical supplies, durable medical equipment (DME) supplies or appliances, as well as items exceeding $750
- Skilled nursing facilities
- Home infusion therapy
- Accidental dental (reconstruction due to accident)
- Contact lens
- Pain management services
- Inpatient and residential behavioral health services
Important Information

• Providers are responsible for verifying eligibility and benefits before providing services, except in an emergency situation.
• Failure to obtain a prior authorization may result in a denial for reimbursement.
• Authorization is not a guarantee of payment for services.
• CareSource does not require prior authorization for unlisted CPT codes.
  • However, we require a signed, clinical record be submitted with your claim to review the validity of the unlisted CPT code.
  • Claims submitted without clinical records for unlisted CPT codes will be denied.
  • Denials will be reconsidered through the claims dispute/appeal process with pertinent clinical records and should be sent directly to claims for consideration.
• Services beyond any benefit limit for members 20 years of age and under require a prior authorization.
Self-Referral Services

CareSource includes self-referral health partners in our network. For both Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP), members may self-refer to Indiana Health Coverage Programs (IHCP) active providers for the services eligible for self-referral.

**HHW Members**

May receive self-referral services from Indiana Health Coverage Programs (IHCP) enrolled self-referral health partners who are not in the CareSource network.

CareSource reimburses self-referral services up to the applicable benefit limits and at IHCP Fee For Service (FFS) rates.

**HIP Members**

Must go to an in-network health partner; OR receive PA from CareSource to go to an out-of-network health partner.

**Exceptions:** Family planning & emergency services

CareSource reimburses self-referral services up to the applicable benefit limits and at a rate not less than the Medicare rate, or at 130% of Medicaid if no Medicare rate is available.
Self-Referral Services

The following services are eligible for self-referral:

- Psychiatric services
- Family planning services

The following services are eligible for self-referral, but may only be provided to members receiving services through Hoosier Healthwise, HIP State Plan Basic/Plus and HIP Plus OR while receiving the additional HIP pregnancy-only benefits:

- Chiropractic services
- Eye care services, except surgical services
- Routine dental services
- Podiatry services

The Indiana Administrative Code 405 IAC 5 (Hoosier Healthwise) and 405 IAC 9-7 (Healthy Indiana Plan) provide further detail.
NIA Magellan Imaging

CareSource partners with NIA Magellan to implement a radiology benefit management program for outpatient advanced imaging services.

<table>
<thead>
<tr>
<th>Procedures requiring prior authorization through NIA Magellan:</th>
<th>Services NOT requiring prior authorization through NIA Magellan:</th>
<th>NIA Magellan authorization phone number:</th>
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<tbody>
<tr>
<td>• CT/CTA</td>
<td>• Inpatient advanced imaging services</td>
<td>• 1-800-424-4883</td>
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<tr>
<td>• MRI/MRA</td>
<td>• Observation setting advanced imaging services</td>
<td></td>
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<tr>
<td>• PET Scans</td>
<td>• Emergency room imaging services</td>
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<tr>
<td>• Myocardial Perfusion Imaging (MPI)</td>
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<tr>
<td>• MUGA Scan</td>
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<tr>
<td>• Echocardiography</td>
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<tr>
<td>• Stress Echocardiography</td>
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Authorizations are accepted at [https://www1.radmd.com/radmd-home.aspx](https://www1.radmd.com/radmd-home.aspx).

Authorization requests are approved at intake in most cases. If an approval cannot be issued during the initial intake, more information may be required.

**Note:** Imaging procedures performed during an inpatient admission, hospital observation stay or emergency room visit are not included in this program.
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Thank you!