Prior Authorizations 101

2022 IHCP Works
Annual Seminar

Agenda

- Prior Authorization Services
- Submitting Prior Authorization Requests
- Provider Portal & Authorization
- Provider Authorization Timelines
- NIA Magellan
- Dental Authorization
- Appeal Process
- Denials and Retro Authorization
- Important Reminders
- Updates and Announcements

Prior Authorization Services

CareSource™

Prior Authorization Services

Prior authorization is how we decide if the health services will be covered by the CareSource plan.

- The services must be evidence-based and medically necessary for your care. They must also fall within the terms of the health plan.
- Emergency care does not need prior authorization.
- If the provider is not part of the CareSource network, a prior authorization must be obtained before services are rendered, not just those listed.

***Reminder – An authorization or notification is not a guarantee of payment, but is based on medical necessity, appropriate coding, and benefits.**

Prior Authorization Services

- All Inpatient Services (Skilled Nursing, Acute, Inpatient Rehab/Therapy, Long Term and Respite Care)
- Applied Behavior Analysis therapy Services (ABA)
- Elective Surgeries (Outpatient and Inpatient)
- Intensive Outpatient Program Services
- All Outpatient Therapies
- Genetic Testing
- Ambulance Transport – non-emergent
- Home Health Care Services
- Hearing Aids
- Prosthetic and Orthotic devices
- DME/All DME Miscellaneous Codes

***This is not an all-inclusive list, please verify authorization requirements via the Procedure Code Look-up Tool on our website.**

Prior Authorization Services

- Pain management
  - Facets
  - Epidurals
  - SI Joints
- Outpatient Services
  - Cosmetic/Plastic/Reconstructive Procedures
  - Spinal Cord Stimulators
  - Implantable Pain Pumps
- Organ Transplants
- Partial Hospitalization Program
- Residential Services
- Services beyond benefit limits for members 20 years of age or older.
  - ***PMP visits are limited to a max of 30 per calendar year without a PA**
- Gender Dysphoria Surgeries

***This is not an all-inclusive list, please verify authorization requirements via the Procedure Code Look-up Tool on our website.**

Procedure Code Look Up Tool

PRIOR AUTHORIZATION

CareSource evaluates prior authorization based on medical necessity, medical appropriateness, and benefit limits.

CareSource

Procedure Code Lookup

Complete Steps

Choose Line of Business

-- Line of Business --

2 Enter a CPT/HCPCS Code

ABC90 or 92507

https://procedurelookup.caresource.com

Submitting PA Requests

CareSource™

How to Submit PA Requests

Provider Portal	https://providerportal.caresource.com/IN/Provider/PriorAuth/PriorAuth.aspx
Fax	Fax the Medical prior authorization form to **844-432-8924** including supporting clinical documentation. The prior authorization request form can be found on **CareSource.com.**
Mail	CareSource Attn: IN Utilization Management P.O. Box 1307 Dayton, OH 45401-1307
Phone	**844-607-2831** Monday – Friday 8:00 a.m. to 6:00 p.m.

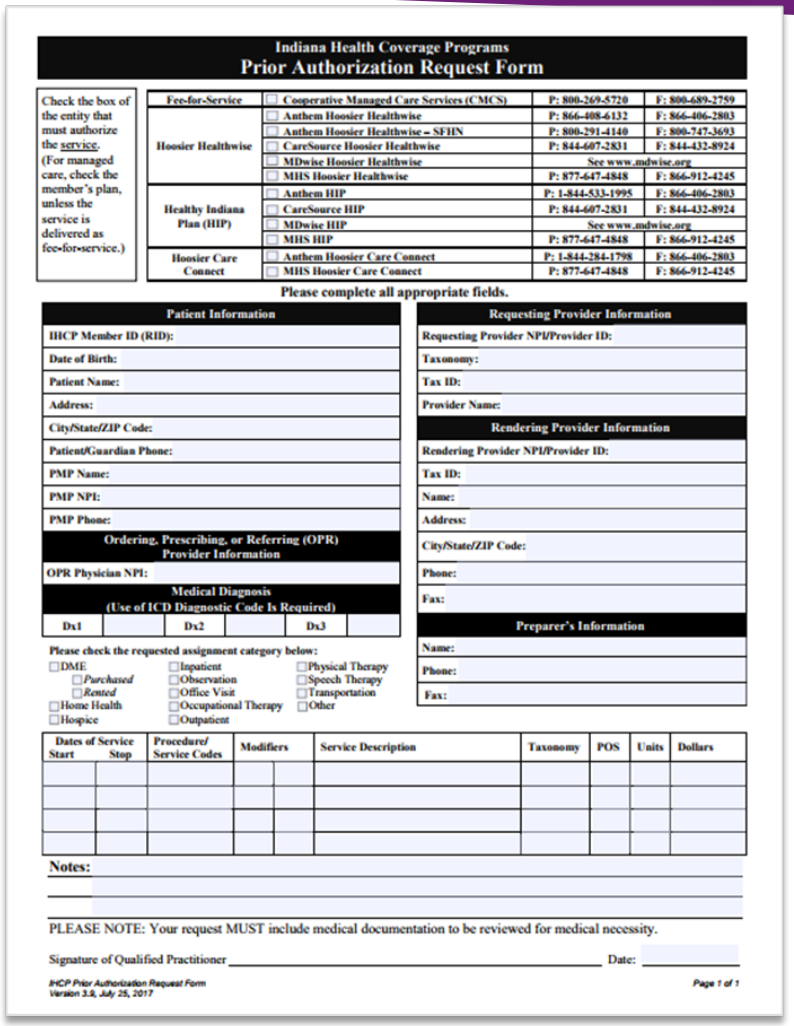
***Please include supporting clinical documentation with all submissions.**

Prior Authorization Form

For prior authorization requests, please use the IHCP Universal Prior Authorization Request Form.

Form 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.
- Please be sure if the service is for a surgical procedure that the rendering provider should be the ASC/Facility and not the surgeon.



Indiana Health Coverage Programs
Prior Authorization Request Form

Check the box of the entity that must authorize the service. (For managed care, check the member's plan, unless the service is delivered as fee-for-service.)

Fee-for-Service	☐ Cooperative Managed Care Services (CMCS)	P: 800-269-5720	F: 800-689-2759
Hoosier Healthwise	☐ Anthem Hoosier Healthwise	P: 866-408-6132	F: 866-406-2803
	☐ Anthem Hoosier Healthwise – SFHN	P: 800-291-4140	F: 800-747-3693
	☐ CareSource Hoosier Healthwise	P: 844-607-2831	F: 844-432-8924
	☐ MDwise Hoosier Healthwise	See www.mdwise.org	
	☐ MHS Hoosier Healthwise	P: 877-647-4848	F: 866-912-4245
Healthy Indiana Plan (HIP)	☐ Anthem HIP	P: 1-844-533-1995	F: 866-406-2803
	☐ CareSource HIP	P: 844-607-2831	F: 844-432-8924
	☐ MDwise HIP	See www.mdwise.org	
	☐ MHS HIP	P: 877-647-4848	F: 866-912-4245
Hoosier Care Connect	☐ Anthem Hoosier Care Connect	P: 1-844-284-1798	F: 866-406-2803
	☐ MHS Hoosier Care Connect	P: 877-647-4848	F: 866-912-4245

Please complete all appropriate fields.

Patient Information
IHCP Member ID (RID):
Date of Birth:
Patient Name:
Address:
City/State/ZIP Code:
Patient/Guardian Phone:
PMP Name:
PMP NPI:
PMP Phone:

Ordering, Prescribing, or Referring (OPR) Provider Information
OPR Physician NPI:

Medical Diagnosis (Use of ICD Diagnostic Code Is Required)
Dx1 | Dx2 | Dx3

Requesting Provider Information
Requesting Provider NPI/Provider ID:
Taxonomy:
Tax ID:
Provider Name:

Rendering Provider Information
Rendering Provider NPI/Provider ID:
Tax ID:
Name:
Address:
City/State/ZIP Code:
Phone:
Fax:

Preparer's Information
Name:
Phone:
Fax:

Please check the requested assignment category below:
☐ DME ☐ *Purchased* ☐ *Rented* ☐ Home Health ☐ Hospice
☐ Inpatient ☐ Observation ☐ Office Visit ☐ Occupational Therapy ☐ Outpatient
☐ Physical Therapy ☐ Speech Therapy ☐ Transportation ☐ Other

Dates of Service Start	Stop	Procedure/ Service Codes	Modifiers		Service Description	Taxonomy	POS	Units	Dollars

Notes:

PLEASE NOTE: Your request MUST include medical documentation to be reviewed for medical necessity.

Signature of Qualified Practitioner _____ Date: _____

IHCP Prior Authorization Request Form
Version 3.8, July 25, 2017
Page 1 of 1

Provider Portal & Authorizations

CareSource™

Prior Authorizations can be requested through the provider portal.

Provider Portal & Prior Authorizations

- Select **Provider Authorizations** and **Notifications** on left navigation
  - Enter **CareSource ID** and **Start Date of Service** & select **Search**
  - Select **Care Setting** and **type of Prior Auth**
  - Enter provider information **Name, NPI or CS Provider Number**
    - *Please be sure to look closely to choose the correct one, NPI's can return more than one choice.*
  - Complete **required fields** and select **Continue**
  - Select **Document Clinical** to continue
  - Click **Add** to choose **Guideline of Service**
  - Answer **Guideline questions**, hit **Save**, and **Submit Request**

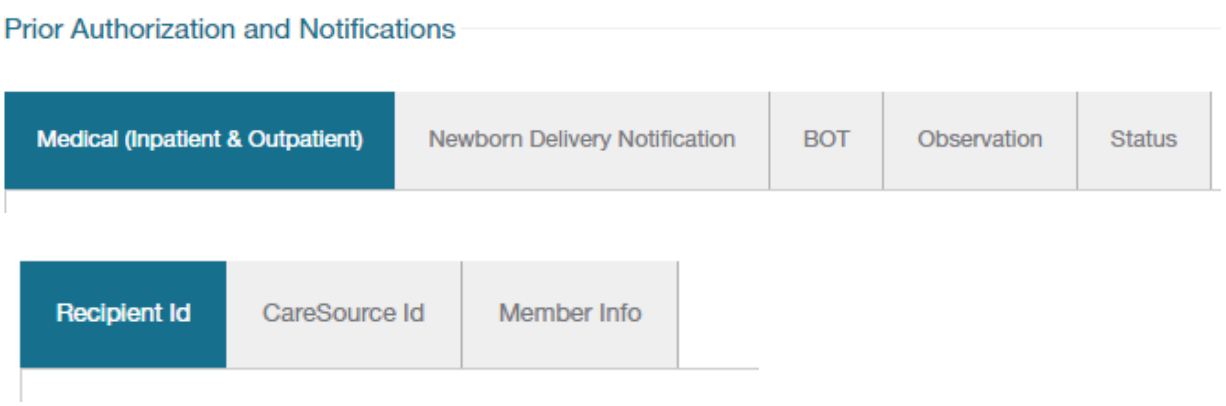
Provider Portal & PA's

PROVIDERS

- Care Management Referral
- Dental Provider Login
- ER Referral
- File Grievance
- HIP Provider Cost Estimator
- Pharmacy
- Prior Authorization and Notifications
- Provider Documents
- Provider Maintenance
- Quality Enhancer
- Radiology Benefits Manager

How Do I Access the Prior Authorizations in the Portal?

https://providerportal.caresource.com/IN/Provider/PriorAuth/PriorAuth.aspx



Update Authorizations

- **Did you know that you can update your authorizations?**

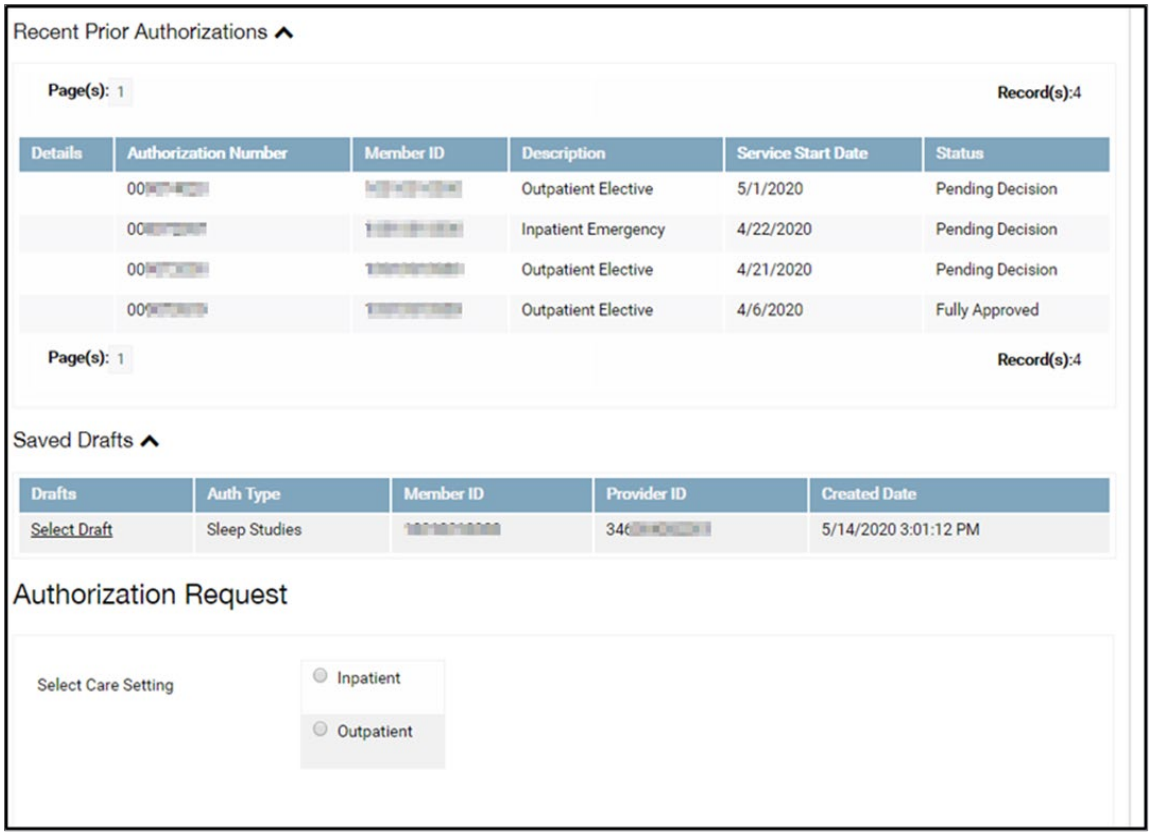
  - On the website, you can update a current authorization if your CPT Code has changed.
  - Add additional documentation.
  - The tip sheet is located on the provider portal under documents.

https://www.caresource.com/documents/in-p-0840-request-for-change-or-request-for-case-tip-sheet/

Provider Portal and PA's

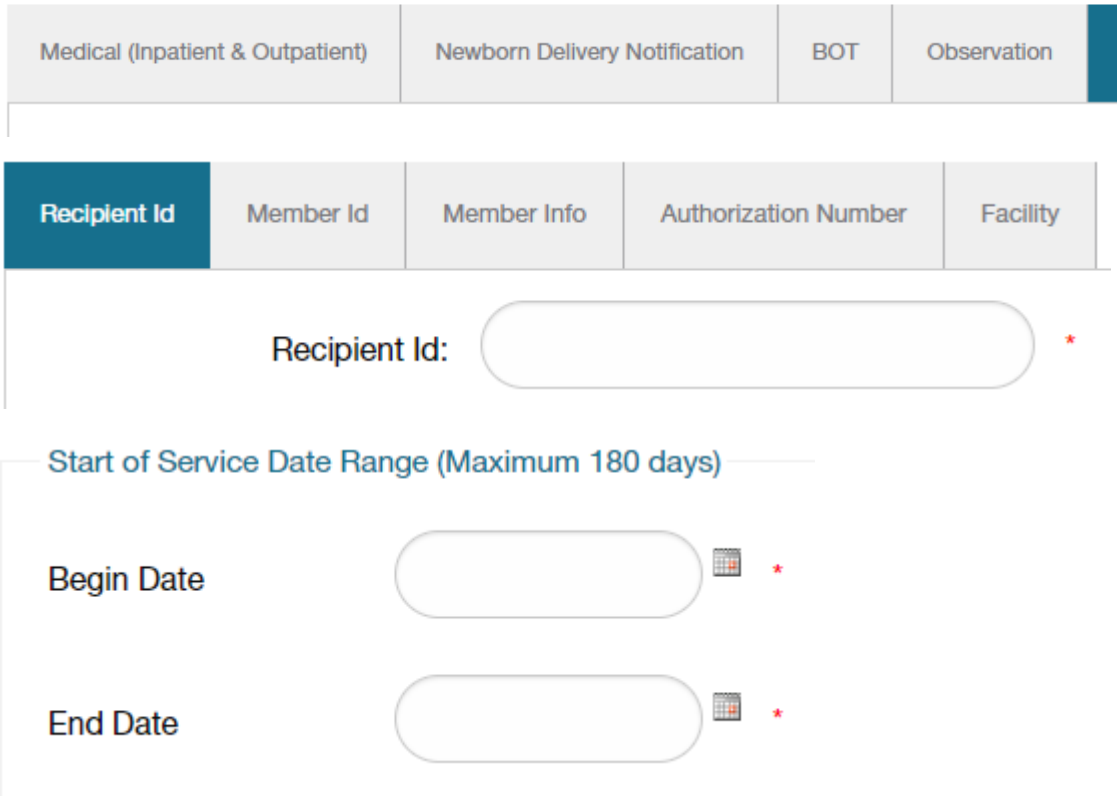
Authorization Recall

- Partially completed prior authorizations can now be saved for up to seven days!
- The prior authorization can be completed by anyone within the practice.



Provider Portal and PA's

Authorization Status by Facility ID

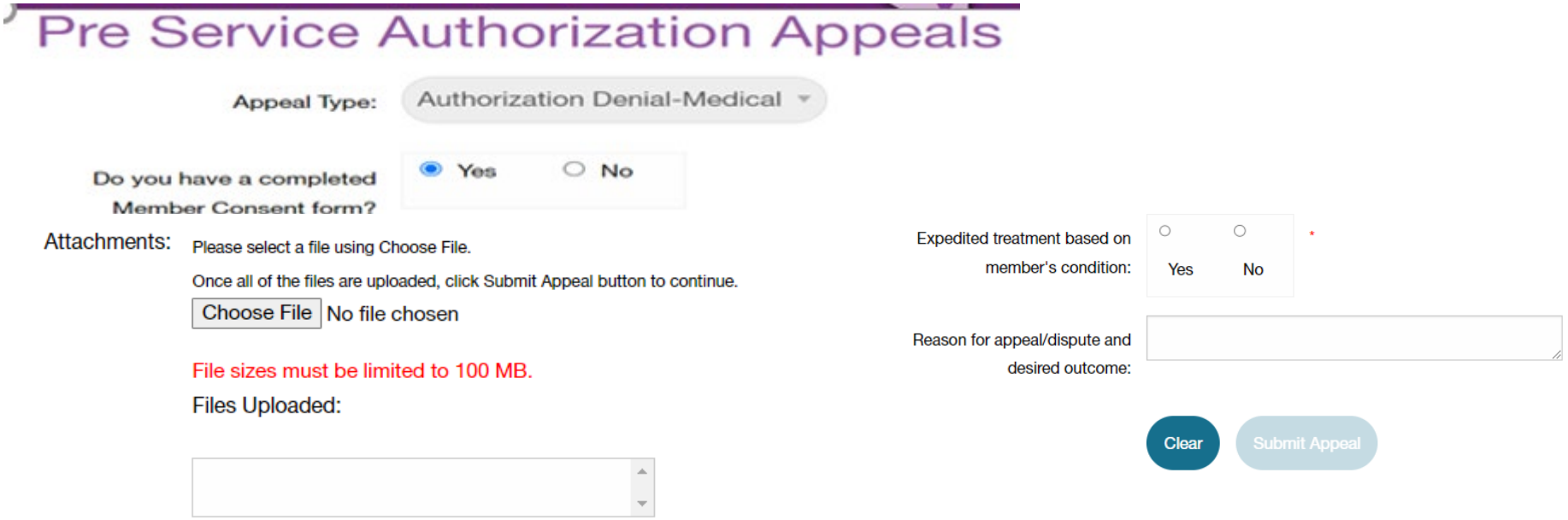


New search by Facility is available on the Prior Authorization and Notifications page.

Provider Portal and PA's

Pre-Service or Post Service Authorization Appeals

- Pre-Service Authorization Appeal for denied authorizations (new option)
- Click **View Details**
- Complete the Form
- **Attach** member consent and documentation
- Post Service Clinical Appeals
  - You have 60 days from DOS, discharge or authorization denial to submit a post-service appeal.



Enhancements

PROCEDURE CODES DISPLAY AUTHORIZATION CONFIRMATION

When submitting a prior authorization with multiple procedure codes, the **Confirmation** page now displays all relevant procedure codes submitted on the authorization.

ACCESS TO PRIOR AUTHORIZATION DOCUMENTATION AND LETTERS

Prior authorization documents and letters that are sent to providers are now available on the **Provider Documents** page as well as when checking the status of a prior authorization.

Prior Authorization Timeframes

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Prior Authorization Timeframes

Authorization Type	Decision
Standard pre-service	7 calendar days
Urgent pre-service	72 hours
Urgent concurrent	24 hours
Post service (retrospective review)	30 calendar days

To check the status of a prior authorization request, call **844-607-2831** or go through the provider portal.

Prior Authorization
Ancillary Providers

- Ancillary Services that require authorization: either the ancillary services or the primary services must be authorized.

- Facility will normally obtain prior authorization for inpatient stays; however, if they do not, the provider group or entity will need to obtain authorization.
  - Radiology
  - Anesthesiology
  - Pathology
  - Hospitalist services
  - Labs
  - Other professional services performed in an inpatient or outpatient setting.

NIA Magellan

CareSource™

NIA Magellan

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

Procedures requiring prior authorization through NIA Magellan:	Services NOT requiring prior authorization through NIA Magellan:	NIA Magellan authorization phone and website information:
• CT/CTA • MRI/MRA • PET Scans • Myocardial Perfusion Imaging (MPI) • MUGA Scan • Echocardiography • Stress Echocardiography	• Inpatient advanced imaging services • Observation setting advanced imaging services • Emergency room imaging services	• **800-424-4883** • https://www1.radmd.com/radmd-home.aspx

NIA Magellan

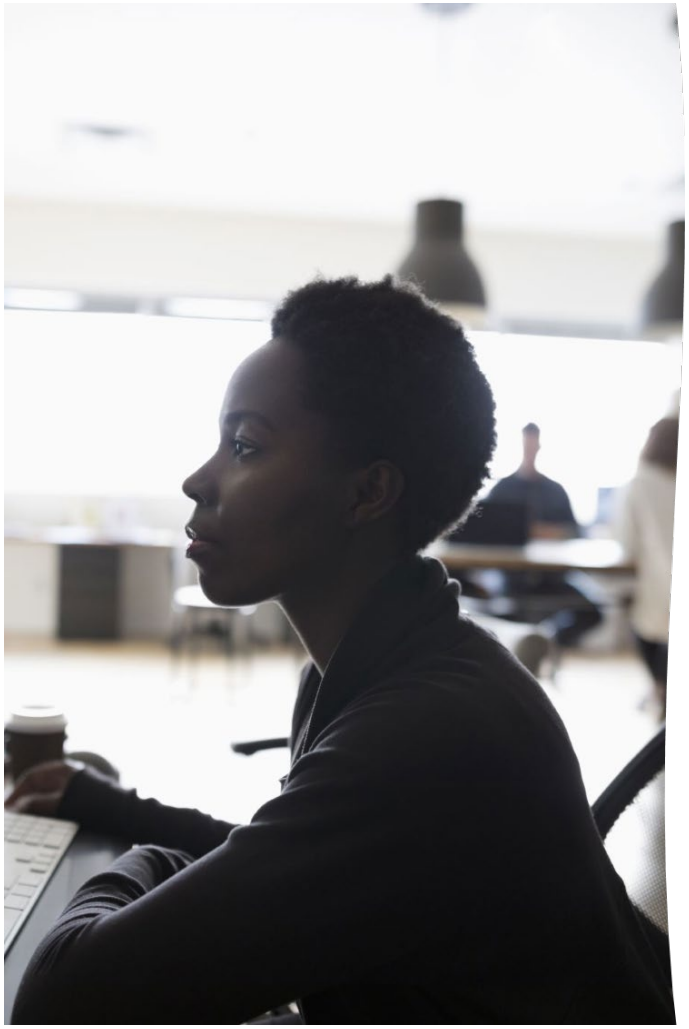
How to submit:

visit

https://www1.radmd.com/radmd-home.aspx

or **call 800-424-4883**

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



Dental

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Dental Authorizations

CareSource partners with SkyGen Dental to administer dental benefits. Dental authorization requests may be submitted via paper or online.

ONLINE:
Participating providers may contact the web portal team at https://pwp.sciondental.com/PWP/Landing to register 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.

PAPER:
Paper dental authorization requests may be sent to:

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

PHONE: 844-607-2831

Remember to always submit your authorizations with attachments for faster determination!

Appeal Process

CareSource™

Expedited Appeals

- Call us at **844-607-2831** to expedite a clinical appeal.
- Expedited appeals will be resolved, and verbal notification will be made within 48 hours.
- CareSource will decide whether to expedite an appeal within 24 hours.

Provider Clinical/Claim Appeal Form

CareSource

Provider Clinical/Claim Appeal Form

Please note the following to avoid delays in processing clinical/claim appeals:

Include supporting documentation • Incomplete submission will be returned for additional information • Applicable timely filing limits apply

Please indicate the following patient information:

Member Name _____
Member ID Number _____
Date of Service _____
Code/Service Not Covered _____
Place of Service _____

Please indicate the following provider information:

Provider Name _____
Provider NPI Number _____
Provider Telephone Number (____)_____
CareSource Provider ID _____
Claim Number _____
Requestor Name _____

Select the most appropriate appeal type:	Include required documentation:
❑ **Claim Appeal** — An adverse decision regarding payment for a submitted claim or a denied claim for services rendered to a CareSource member.	• Appeal form • Supporting documentation • Original remittance advice The provider/facility rendering services has 365 days from the date of service to file a claim appeal.
❑ **Clinical Appeal** — A request to review a determination not to certify an admission, extension or stay, or other health care service conducted by a peer review who was not involved in any previous adverse determination /non-certification decision pertaining to the same episode or care.	• Appeal form • Records supporting medical necessity • Original remittance advice The provider/facility rendering service has 180 days from the date of service to file a clinical appeal.
❑ **Corrected Claim** — Any correction of the date of service, procedure/diagnosis code, incorrect unit count, location code and/or modifier to a previously processed claim. Resubmit the entire claim with updated information as a **Corrected Claim**. If you disagree with the amount paid on a claim line, you will need to submit an appeal.	**Please send Corrected Claims to:** STOP CareSource ATTN: Claims Dept. P.O. Box 3607 Dayton, OH 45401-3607

Reason for appeal request:

Mail or fax all information to:

Claim Appeals Department	Clinical Appeals Department	Provider Claim Appeals Coordinator
P.O. Box 2008 Dayton, OH 45401-2008	P.O. Box 1947 Dayton, OH 45401-1947	Fax Number: 937-531-2398

IN-P-0088-V.2; Date Issued 10/17/2017 OMPP Approved 12/14/2016

https://www.in.gov/medicaid/providers/files/pa-form.pdf

Denials and Retro Authorizations

CareSource™

Administrative Denials

Examples

- Late notification of inpatient admission
- Member not eligible at time of request for authorization
- Late Retro Physician Denial
  - Needs to be submitted **within 60 days** from DOS
- Non-Covered Codes

Retro Authorizations

Upon written request, CareSource shall not permit retro authorization submission after the date of service or admission where a prior authorization was required but not obtained except in the following circumstances as outlined in the IAC rule below:

- **Prior authorization will be given after services have begun or supplies have been delivered only under the following circumstances:**

  - **Pending or retroactive member eligibility. The prior authorization request must be submitted within twelve (12) months of the date of the issuance of the member's Medicaid card.**
  - **Mechanical or administrative delays or errors by the office.**
  - **Services rendered outside Indiana by a provider who has not yet received a provider manual.**
  - **Transportation services authorized under 405 IAC 5-30. The prior authorization request must be submitted within twelve (12) months of the date of service.**

Retro Authorizations (cont.)

The provider was unaware that the member was eligible for services at the time services were rendered.

Prior authorization will be granted in this situation only if the following conditions are met:

- **The provider's records document that the member refused or was physically unable to provide the member ID (RID) number.**
- **The provider can substantiate that the provider continually pursued reimbursement from the patient until Medicaid eligibility was discovered.**
- **The provider submitted the request for prior authorization within sixty (60) days of the date Medicaid eligibility was discovered.**

Retrospective Authorization Timeframes

Retrospective Authorization (post service)

Provider has **30 calendar days** from the DOS to submit an update to a current/active Prior Authorization if there were any changes to the CPT codes.

- Submit a new PA form with the original auth number on the form.
- Note any additional services or CPT codes.
- Include any supporting clinical documentation.

Note: Dispute/appeal process may be required for a denied claim.

Peer-to-Peer Review

Upon request, CareSource will provide the clinical rationale or criteria used in making medical necessity determinations.

- You may request the information by calling or faxing the CareSource Medical Management Department
  - By Phone: **833-230-2168**
  - By Fax: **844-432-8924**

- If you would like to discuss an adverse decision with physician reviewer, please call the Provider services line.
  - By Phone: **833-230-2168**
  - Contact our provider services line within **seven** business days of the determination.

Important Reminders

CareSource™

Important Information

- Verify eligibility and benefits
- 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 claim's dispute/appeal process with pertinent clinical records and should be sent directly to claims for consideration.
- Services beyond applicable benefit limit for members 20 years of age and under require a prior authorization.
  - ***PMP visits are limited to a max of 30 per calendar year without a PA**

Updates and Announcements

CareSource™

Updates & Announcements

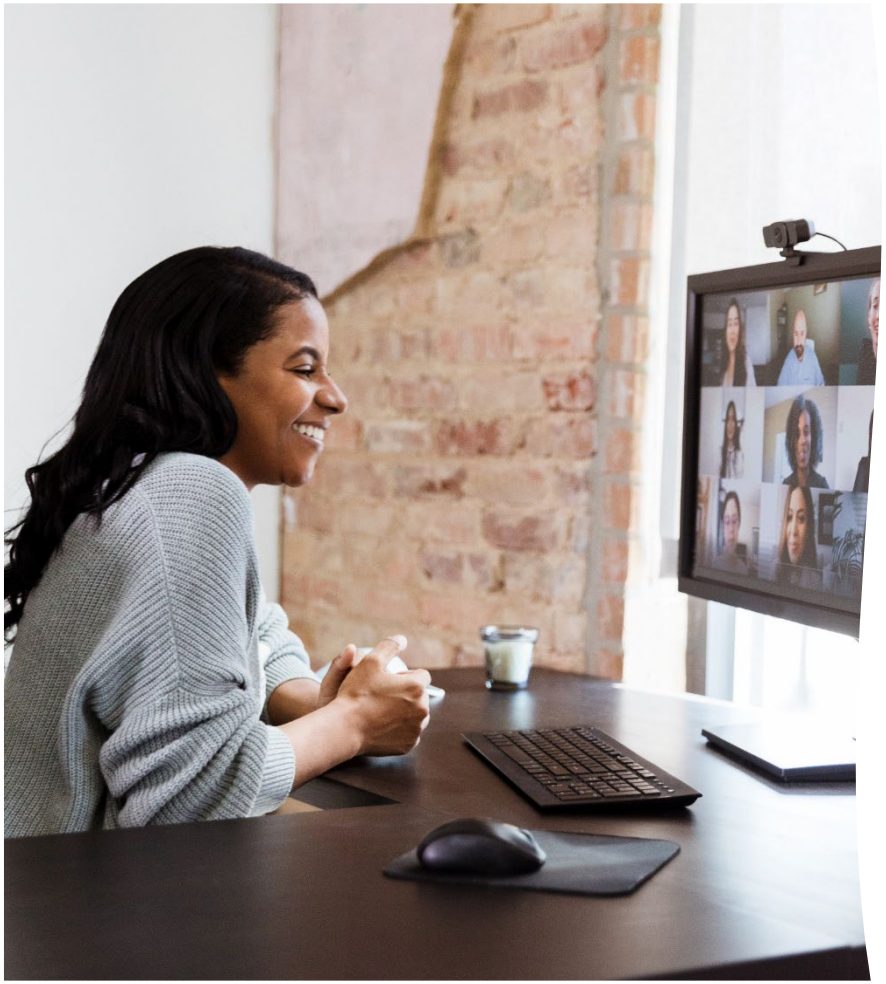
Visit the Updates and Announcements page located on our website for frequent network notifications.

Updates may include:

- Medical, pharmacy and reimbursement policies
- Authorization requirements

https://www.caresource.com/in/providers/tools-resources/updates-announcements/medicaid/

Quarterly Friday Forum



- Revenue cycle, contracting, credentialing, clinical operations, quality, or administrative staff are welcome to attend.
- Brief presentation covering updates
- Live Q&A follows presentation
- **Dec. 16, 2022 – 2 p.m. to 4 p.m. EST**
- Save the Date will be published on our Updates & Announcements page.
- Please reach out to your Health Partner Engagement Specialist for any topics you want to hear about.

Provider Resources

Visit the **CareSource.com** Plan Resources page to access the following resources**:**

- Printable health partner manual
- Printable orientation slides
- Newsletters & network notifications
- Formularies
- Covered benefits
- Quick reference guides
- And more

CareSource Provider Portal:
https://providerportal.caresource.com/IN

How To Reach Us

CareSource™

How to Reach Us

Provider Services	**844-607-2831**
Hours	Monday to Friday 8 a.m. to 8 p.m. (EST)
Member Services	**844-607-2829**
Hours	Monday to Friday 8 a.m. to 8 p.m. (EST)

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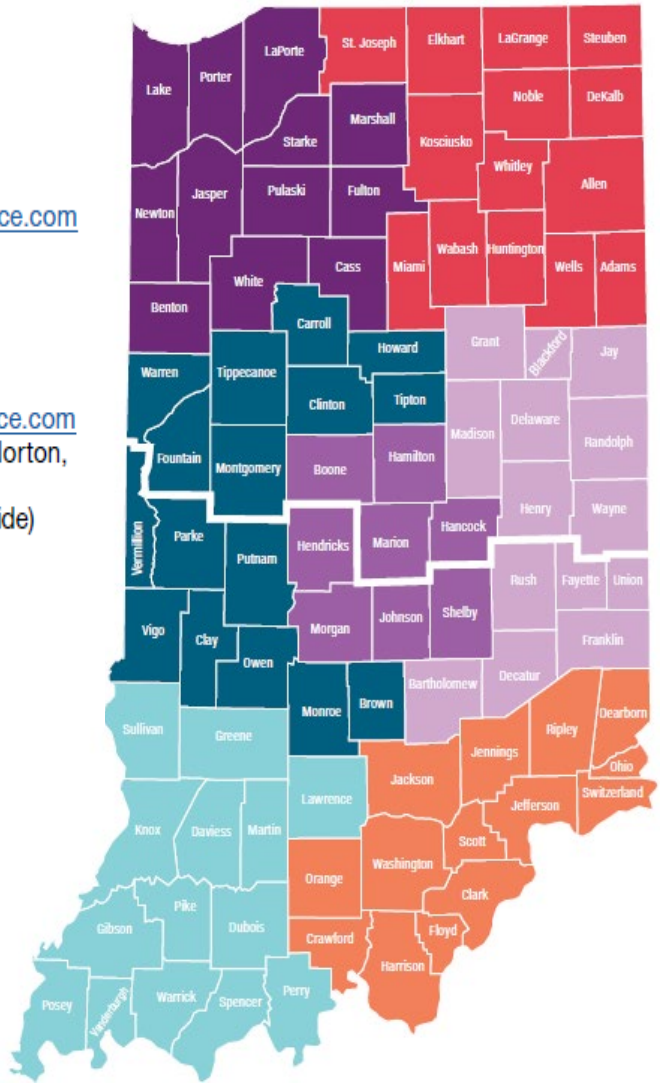

Contact Us | Indiana – Medicaid | CareSource

Thank You!