



#### **Prior Authorizations**

IHCP Works Annual Seminar October 2023

# Agenda

- Prior Authorization Review
- Submitting Requests
- Portal Submission Tips
- Retro Authorizations
- Sterilization and Hysterectomy
- Mom and Baby Process
- Dental
- Behavioral Health
- NIA Magellan
- Important PA Reminders
- Updates and Announcements
- Contacts



#### **Prior Authorization Review**



# What is a Prior Authorization?

A prior authorization (PA) is the process of determining medical necessity for covered services under the CareSource plan.

- The services must be evidence-based and medically necessary for your care. They must also fall within the coverage 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 any 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, eligibility 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 <u>Procedure Code Look-up Tool</u> on our website.



#### **Prior Authorization Services Continued**

- Pain management
  - Facets
  - Epidurals
  - Sacroiliac 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 <u>Procedure Code Look-up Tool</u> on our website.



# **Procedure Code Look Up Tool**

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

CareSource			Procedure Code Lookup
Complete Steps			
Choose Line of Business		2 Enter a CPT/HCPCS Code	
Line of Business	•	ABC90 or 92507	Q

CareSource | Procedure Code Lookup https://procedurelookup.caresource.com



### Procedure Code Look-Up Tool

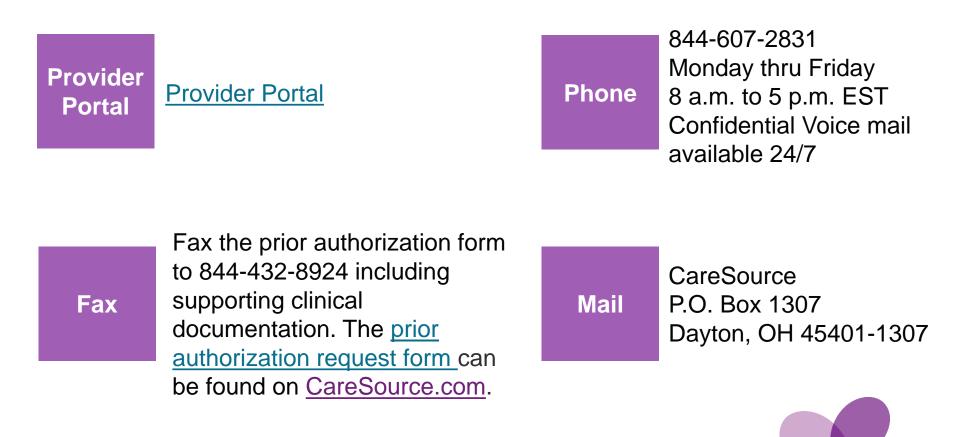
#### DISCLAIMER

- Results are provided "AS IS" and "AS AVAILABLE" and do not guarantee approval or payment for services.
- Approval or payment of services can be dependent upon the following, but not limited to:
  - Member eligibility
  - Members < 21 years old</li>
  - Medical necessity
  - Covered benefits
  - Modifiers
  - Diagnosis and revenue codes
  - Limits and number of visit variances
  - Provider contracts, Provider types
  - Correct coding and billing practices
- For specific details, please refer to the <u>Health Partner Provider Manual</u>

#### How to Submit Authorizations



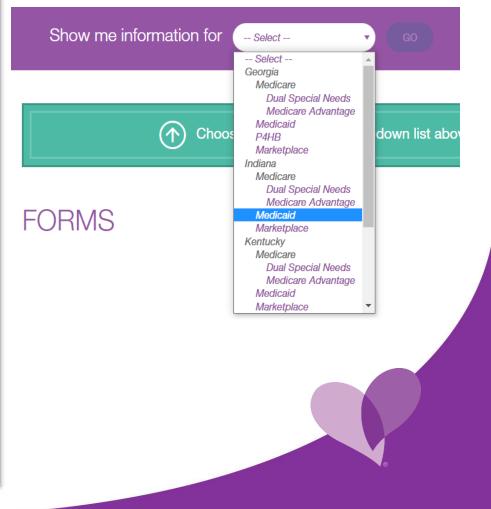
### How to Submit PA Requests



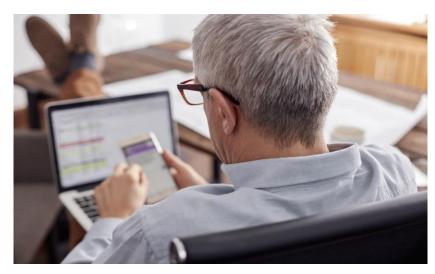
#### Medicaid Prior Authorization Form

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IHCP Member ID		ation		Requesting Provid			nation	
Date of Birth:	•			Taxonomy:	Jer INFI/FF0VD	uer ID:		
Patient Name:				Taxpayer Identifi		- CEND:		
Address:				Provider Name:	cation Numbe	r (113):		
City/State/ZIP Co	da			Provider Address				
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				Address:				
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							+	-
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Notes:			-			•		
ious.								
LEASE NOTE: Yo	ur request MUST	include med	lical documenta	tion to be reviewed for	medical neces	sity.		

#### IHCP Universal Prior Authorization Request Form



### **Prior Authorization Timeframes**



To check the status of a prior authorization request, please call **844-607-2831** or log into the <u>Provider</u> <u>Portal</u>.

Authorization Type	Decision
Standard pre-service	5 business days
Urgent pre-service	48 hours
Urgent concurrent	1 business day (after receiving all necessary information)
Post service (retrospective review)	30 calendar days

# Prior Authorization – Specialty Pharmacy

Refer to the provider portal for a complete list of forms.

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

Due to the complexity of Specialty Pharmacy, there are some drugs that will have their own form that should be used in place of the "Specialty Pharmacy Prior Authorization Form".

 Example of specialty pharmacy drugs that have a specific form is Growth Hormone, Mental health Medications and Cystic Fibrosis to name a few.

#### **Portal Submission Tips**



### **Prior Authorization Submission**

Access to the Prior Authorization form can be found by clicking **Providers > Prior Authorization and Notification** from the left navigation menu. <u>Prior Authorization and</u> <u>Notifications</u>

or Authorization and Notification

Medical (Inpatient & Outpatient)

#### PROVIDERS

Cardiac & Orthopedic Services Prior Authorization Care Management Referral Dental Provider Login + ER Referral File Grievance

HIP Provider Cost Estimator

Pharmacy

Prior Authorization and Notifications

vovider Documents

ovider Maintenance

diology Benefits Manager

ality Enhancer

An authorization or notification is not a guarantee of payment, but is based on medical necessity, appropriate coding

BOT

Observation

Status

For Physician Administered Pharmacy Codes, please click here to complete your Prior Authorization

Newborn Delivery Notification

Begin an authorization by searching for the CareSource member by Member ID, CareSource ID, or Member Information and the start date of service.

Once the member is located, click Verified.

Recipient Id

Provider ID:

Impersonation

Recipient Id:

Start Date of Service

Becipient Id:

Start Date of Service

Becipient Id:

Becipient Id:
<

# **Prior Authorization Type**

Complete the authorization form by filling out the following fields:

- Select if the service is <u>Inpatient</u> or <u>Outpatient.</u>
- Select the appropriate category.
- Select the type of prior authorization request.
- Select if the service will be completed in a Facility.

Select Care Setting		<ul><li>Inpatient</li><li>Outpatient</li></ul>	
Select Category		Outpatient Services	
Select Type of Prior Authorization	ו Request	Office Visit •	
	○ Yes		
Will service be performed in a Facility?	<ul><li>No</li></ul>		

#### **Prior Authorization Provider Info**

#### Requesting/Ordering Provider Information

Search: Provider Name	Locate the Requesting/Ordering and Servicing/Rendering Provider by searching:
Servicing/Rendering Provider Information	<ul> <li>Provider Name*</li> <li>Provider NPI*</li> <li>CareSource Provider ID</li> </ul>
If unable to locate the physician please use the facility. Search: Provider Name	Once searched criteria has been entered, select the appropriate provider from the available list.
Ordering, Prescribing, or Referring (OPR) Provider Information	
OPR NPI:	* Required Fields

#### **Prior Authorization Details**

Start Date: End Date:	4/	7/2023	Complete	e the following fields:
Treatment Type Treatment Type: Place Of Service		Choose One	<ul><li>Choos</li><li>Enter a</li></ul>	ate e a treatment type e a Place of Service all applicable diagnosis ocedure codes
Place Of Service:		Choose One		
Diagnosis Codes		Procedure Codes Code Type:	All Procedure Codes	Once a procedure code is
Code Type: Search By:	ICD10 Diagnosis Codes Code	Search By:	Code	entered, units and modifiers may be selected.

#### **Prior Authorization Contact Info**

Enter all required contact information fields.

Attest if clinical information documents will be completed with any additional notes.

Additional Information

Save Draft

Continue

Contact Information	
Contact name of person completing this request:	
Contact phone number:	
Contact phone number extension:	
Contact fax number:	
Contact email:	
Are you prepared to document clinical indications at this time?	⊖ Yes
Note: You will be able to attach clinical no matter	○ No
your selection	* Required
Click <b>Continue</b> . A draft authorization i	may be
saved to come back t	
by clicking Save Drat	F4

### **Prior Authorization Completion**

Authorization Request Form Porm Clinical Submit Request	∜mcg
Patient :       Name :       DOB :       Gender : Male         Authorization :       Type : Beyond Benefit Limits       Status : NoDecisionYet         Diagnosis Codes :       Procedure Codes : 80324(CPT/HCPCS)       primary         Disclaimers       80324 - CPT/HCPCS       • REVIEW REQUIRED: This request requires review. Select the 'Document Clinical' button to continue.	<ul> <li>The authorization will be processed through the Cite Auto (MCG) program.</li> <li>Complete any required clinical documentation by clicking Document Clinical and click Submit Request.</li> </ul>
Procedure Code: 80324 (CPT/HCPCS) Requested Units: 1	Q Document Clinical equest ★ Cancel Request ← Back

#### **Prior Authorization Response**

Reference #:	10.00 T # 30			
Reference #:				
Description:	Outpatient Elective			
Place Of Service:	11 Office			
Submitting Provider:			The status of	
Requesting/Ordering Provider:			The status of the authorization	as well as
Servicing/Rendering Provider:			a reference numb	
Facility:				
Member Information			be provided that	
Member Name:			used to review st	atus if
CareSource Id:			needed later.	
Birth Date:				
Gender:				
Service Event				
Diagnosis Code:	Z78 Other specified health status			
Procedure:	99215 Office or other outpatient visit for level	r the evaluation and management of an e	stablished patient, which requires a medically approp	riate history and/or examination and high
Line #1				
Requested Received Date:		4/6/2023 8:00:00 AM	Requested Units:	1
Start Date of Service:		4/7/2023	Authorized Units:	0
End Date of Service:		4/7/2023	Status:	Pending

#### **Prior Authorization Status**

Prior Authorization and Notifications		
Medical (Inpatient & Outpatient) Newborn Delivery Notification Marketplace and Medicaid lines of business only: To check the	Observation Status	Authorization, <u>click here</u>
Recipient Id     Member Id     Member Info     Authoriz       Recipient Id:	ation Number Facility  Reference #:  Reference #:  Pasce 10 Service: 22 On Campus-Odytatent Hospital  Submitting Provider:	<ul> <li>Prior authorization status may be viewed by searching:</li> <li>Member ID</li> <li>Member Info</li> </ul>
End Date	Summing rowder:  Requesting/Ordering Provider:  Servicing/Rendering Provider:  Facility:  Member Information  Member Name:  CareSource Id:  Birth Date:	<ul> <li>Authorization Number</li> <li>Facility</li> </ul>
Search	Gender:       Service Event       Diagnosis Code:     M47.816 Spondylosis without myekpathy or radiculopathy, lumbar region; M54.16 Radiculopathy, lumbar region; M	

### In Review

- 1. Select Provider Authorizations and Notifications on left navigation.
- 2. Enter CareSource ID and Start Date of Service and select Search.
- 3. Select Care Setting and type of Prior Auth.
- 4. 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.*
- 5. Complete required fields and select Continue.
- 6. Select **Document Clinical** to continue.
- 7. Click Add to choose Guideline of Service.
- 8. Answer Guideline questions, hit Save, and Submit Request.

### **Coordination of Benefits**

If CareSource requires a prior authorization for a service, and the member has additional insurance that is primary, the provider must follow the primary insurer requirement for obtaining a prior authorization and must also obtain a prior authorization for CareSource.

#### Updating an Approved PA Submission

Any changes to an existing prior authorization must be submitted:

Phone 844-607-2831

Fax 844-432-8924

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

Examples of Changes:

- Rendering provider
- CPT/HCPCS codes
- Location of service
- Dates of service
- Units (service and/or medication)



#### **Retro Authorizations**





#### **Circumstances for a Retrospective/Post-Service Review**

- Services are rendered outside of Indiana.
- Transportation services can be submitted within 12 months.
- Provider is unaware of member eligibility due to these possible reasons:
  - o Member refusal to provide insurance information.
  - Member was physically unable to provide Medicaid information.
  - Provider can substantiate reimbursement was continually pursued.



## **Administrative Denials**

#### Examples

- Late notification of inpatient admission
- Member not eligible at time of request for authorization
- Late Retro Physician Denial
  - Medicaid needs to be submitted within 60 days from DOS



Non-Covered Codes



#### Medicaid 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 <u>except</u> in the following circumstances as outlined in the IAC (Indiana Administrative Code) 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.



# Medicaid 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 (MID) 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.

#### **Retro Authorizations Timeframes**



Retrospective (postservice) reviews will be decided within **30** calendar days from the receipt of the request



#### **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

Phone: 833-230-2168 Fax: 844-432-8924

If you would like to discuss an adverse decision with a physician reviewer, please call the Provider Services line within the plan's specified timeframe.

• Medicaid: within **seven** business days of the determination.





#### Sterilizations and Hysterectomy



# **Sterilizations**

#### Sterilization renders a person unable to reproduce.

- When are sterilizations reimbursable?
  - Sterilizations are reimbursable for men and women only when a valid consent form accompanies all related claims.
- What is the timeframes for informed consent?
  - At least 30 days and no more than 180 days between consent and procedure.
- For sterilizations planned concurrent with delivery, what is the timeframes?
  - The patient must give the informed consent at least 30 days before the expected date of delivery.
- What requirements must the patient meet?
  - Voluntary Consent given and form signed.
  - 21 years or older at time of consent.
  - Is neither mentally incompetent nor institutionalized.
  - Medical need is identified.



#### Sterilization Prior Authorization Checklist

- Signed Consent Form
- Clinical Notes
- Member must be over 21 or have a medical reason for sterilization

#### **Consent for Sterilization Form**

Form Approved: OMB No. 0937-0166 Expiration date: 7/31/2025

#### CONSENT FOR STERILIZATION

. When I first asked

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

#### CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

#### Doctor or Clinic

for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that an move detine or for which I may become elicible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a The discomforts, risks

#### Specify Type of Operation

and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

Lunderstand that the operation will not be done until at least 30 days after 1 sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs. Jam at least 21 wars of ane and was horn or:

	Date
l	, hereby consent of my own
free will to be sterilized	by
	Doctor or Clinic
by a method called	. My
_	Specify Type of Operation
consent expires 180 da	ys from the date of my signature below.
	e release of this form and other medical records
about the operation to:	
	f the Department of Health and Human Services,
	programs or projects funded by the Department
I have received a co	ining if Federal laws were observed.
Thave received a co	py or this form.
Signs	ture Date
You are requested to	supply the following information, but it is not re-
	Race Designation) (please check)
Ethnicity:	Race (mark one or more):
Hispanic or Latino	American Indian or Alaska Native
Not Hispanic or Lati	no 🗌 Asian
	Black or African American
	Native Hawaiian or Other Pacific Islander
	White
	RPRETER'S STATEMENT
	vided to assist the individual to be sterilized: information and advice presented orally to the in-

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in

language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Date

Interpreter's Signature HHS-687 (07/2025) Before signed the Name of Individual signed the consent form, I explained to him/her the nature of sterilization operation

, the fact that it is Specify Type of Operation intended to be a final and irreversible procedure and the discomforts, risks

STATEMENT OF PERSON OBTAINING CONSENT

intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I connected the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is to the best of my knowledge and belief the individual to be sterilized is to the best of my knowledge.

at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Signature of Person Obtaining Consent	Date
Facility	
Address PHYSICIAN'S STATEMEN	T

Shortly before I performed a sterilization operation upon

							on	
Name of Individual							D	ate of Sterilization
explained	to	him/her	the	nature	of	the	sterilization	operation

Specify Type of Operation tended to be a final and irreversible procedure and the discomforts, risks

and benefits associated with it. I counseled the individual to be sterilized that alternative methods of

birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can

be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is I least 21 years old and appears mentally competent. He/She knowingly nd voluntarily requested to be sterilized and appeared to understand the ature and consequences of the procedure.

(Instructions for use of alternative final paragraph: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those scese, the second paragraph below must be used. Cross out the paragraph which is not used.) (1) At least 30 days have passed between the date of the individual's

signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

Premature delivery Individual's expected date of delivery:

Emergency abdominal surgery (describe circumstances):

Physician's Signature Date

#### Consent for Sterilization



#### IHCP Reference Module Family Planning Eligibility Program



## Hysterectomy

- IHCP covers hysterectomies when they are medically necessary.
- The member must give consent.
- IHCP does not cover this service to solely render a member permanently incapable of bearing children.
- Do <u>not</u> use the Consent for Sterilization Form.
- The Hysterectomy Consent Form must be submitted with the claim.
- PA is always required, unless Individual is already sterile or experiencing a life-threatening emergency.

## Acknowledgement of Receipt

#### Acknowledgement of Receipt of Hysterectomy Information

Member Name:
IHCP Member ID:
Physician Name:
NPI or IHCP Provider ID:
AMA Education Number:
It has been explained orally and in writing to
□ Signed before surgery
□ Signed after surgery (at the time of the hysterectomy, eligibility was not established).
(Member or Representative Signature) (Date)
Physician Statement
The hysterectomy in the above case is being done for medically necessary reason(s), and the resulting sterilization is incidental and is not, at any time ever, the reason for this surgical operation.

Diagnosis(ses)

(Physician Signature)

(Date)

#### IHCP Provider Reference Module: Obstetrical and Gynecological Services Provider Reference Module

The signed acknowledgement of receipt of hysterectomy information is required in all cases, except when the patient is already sterile or a life-threatening emergency exists for which the physician determines prior acknowledgement is not possible.

## Acknowledgement Not Required

The physician who performs the hysterectomy when the patient is already sterile or a life-threatening emergency exists for which the physician determines prior acknowledgement is not possible, must complete one of the following certification requirements:

- Certify in writing that the individual was already sterile at the time the hysterectomy was performed. The certification must state the cause of the sterility at the time of the hysterectomy.
- Certify in writing that the hysterectomy was performed under a life-threatening emergency in which the physician determined that prior acknowledgement was not possible. The physician must also include a description of the nature of the emergency.

#### Mom and Baby Process



# **Newborn Process**

Providers have 60 days to request retro-authorization.

- Include detailed information about the change in eligibility with the PA request.
- Copy of Retro-Authorization is submitted with claim.

### **Medicaid Mom and Baby**

CareSource does **NOT** require newborn notification. Deliveries only require authorization if:

- Inpatient stay exceeds 3 days for vaginal delivery.
- Inpatient stay exceeds 5 days for C-Section.
- Newborn remains inpatient after mother is discharged.







## **Dental Authorizations Online**

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 <u>https://pwp.sciondental.com/PWP/Landing</u> 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.

## **Dental Authorizations Paper**

#### PAPER:

Paper dental authorization requests may be sent to:

#### **CareSource IN: Authorizations**

P.O. Box 745 Milwaukee, WI, 53201 Remember to always submit your authorizations with attachments for faster determination!

#### **Behavioral Health**





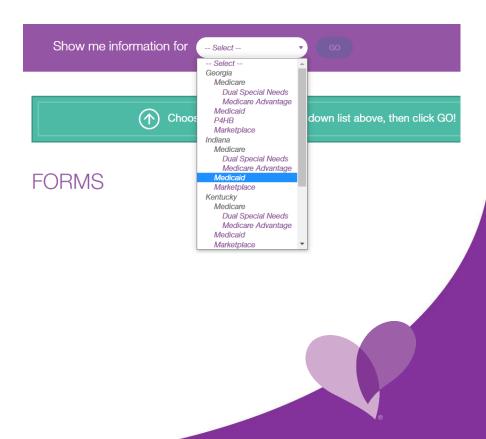
## Behavioral Health Prior Authorization List

- All Inpatient admissions
- Applied Behavioral Analysis (ABA therapy)
- Psychiatric inpatient admissions, including admissions for substance use and rehabilitation
- Medicaid Rehabilitation Option (MRO) services, except for crisis intervention
- Partial Hospitalization Program (PHP) services
- Intensive Outpatient Treatment (IOT)

#### Medicaid Prior Authorization Form

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#### <u>IHCP Universal Prior</u> <u>Authorization Request Form</u>



## **Prior Authorization Form - SUD**

#### Indiana Health Coverage Programs Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form

Please use this form and its associated attachment if you have a 3.1 or 3.5 American Society of Addiction Medicine (ASAM) residential designation or are an inpatient psychiatric facility/hospital.

Select the	Fee-for-Service	C Kepro	P: 866-725-9991	F: 800-261-2774
radio button of the entity		O Anthem Hoosier Healthwise	P: 866-408-6132	F: Inpatient: 877-434-7578 Outpatient: 866-877-5229
that must	Hoosier	CareSource Hoosier Healthwise	P: 844-607-2831	F: 844-432-8924
authorize the	Healthwise	MDwise Hoosier Healthwise	P: 888-961-3100	F: 888-465-5581
service based on the		MHS Hoosier Healthwise	P: 877-647-4848	F: Inpatient: 844-288-2591 Outpatient: 866-694-3649
member's enrollment/		Anthem HIP	P: 844-533-1995	F: Inpatient: 877-434-7578 Outpatient: 866-877-5229
benefits.	Healthy Indiana Plan (HIP)	CareSource HIP	P: 844-607-2831	F: 844-432-8924
		MDwise HIP	P: 888-961-3100	F: Inpatient 866-613-1631 Outpatient: 866-613-1642
		O MHS HIP	P: 877-647-4848	F: Inpatient: 844-288-2591 Outpatient: 866-694-3649
		O Anthem Hoosier Care Connect	P: 844-284-1798	F: Inpatient: 877-434-7578 Outpatient: 866-877-5229
	Hoosier Care Connect	MHS Hoosier Care Connect	P: 877-647-4848	F: Inpatient: 844-288-2591 Outpatient: 866-694-3649
		O UnitedHealthcare	P: 877-610-9785	F: Inpatient and Outpatient: 844-897-6514

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OPR Provider N	PI:			Phone:		
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				Name:		
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Inpatient	Residenti	al		Fax:		
Dates of Service Start Stop	Procedure/ Service Codes	Modifiers	Service Des	cription	The SUD universe	
	-				is located on the	

Include the Initial Assessment form and reassessment form when requesting SUD PAs.

The rendering provider is the facility when requesting these services, as specialty type 836 is a billing provider.

The <u>SUD universal standard PA</u> form a located on the CareSource Website





# 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:
<ul> <li>CT/CTA</li> <li>MRI/MRA</li> <li>PET Scans</li> <li>Myocardial Perfusion Imaging (MPI)</li> <li>MUGA Scan</li> <li>Echocardiography</li> <li>Stress Echocardiography</li> </ul>	<ul> <li>Inpatient advanced imaging services</li> <li>Observation setting advanced imaging services</li> <li>Emergency room imaging services</li> </ul>	<ul> <li>800-424-4883</li> <li><u>https://www1.radmd.co</u> <u>m/radmd-home.aspx</u></li> </ul>

## Important PA Reminders



# **Important Reminders**



- Verify eligibility.
- Failure to obtain a prior authorization may result in a denial.
- Authorization is not a guarantee of payment for services.
- CareSource does not require prior authorization for unlisted CPT codes, however:
  - A signed, clinical record must be submitted with your claim.
  - Claims submitted without clinical records for unlisted CPT codes will be denied.
  - Denials will be reconsidered through the claim's dispute/appeal process.
- Services beyond applicable benefit limit for members 20 years of age and under require a prior authorization.



#### **Updates and Announcements**





#### **Updates and Announcements**

Visit the **Updates and Announcements page** located on CareSource.com website for frequent network notifications.

Updates may include:

- Medical, pharmacy and reimbursement policies
- Authorization requirements

Updates & Announcements | Indiana – Medicaid | CareSource



## **Provider Communications Sign Up Form**

The **sign-up** form: <u>https://secureforms.caresource.com/ProviderCommunicationSignup</u>

The **unsubscribe** function at <u>https://secureforms.caresource.com/ProviderCommunicationSignup/unsubscribe</u>

### **Provider Resources**

Visit the <u>CareSource.com</u> Plan Resources page to access the following resources:

- Printable health partner manual
- Printable orientation slides
- Formularies
- Covered benefits
- Quick reference guides
- And more

**CareSource Provider Portal:** 

https://providerportal.caresource.com/IN

## **Quarterly Friday Forums**

- A Save the Date will be published on the Updates & Announcements page.
- Revenue cycle, contracting, credentialing, clinical operations, quality, or administrative staff are welcome to attend.
- Brief presentation covering updates.
- Live Q&A follows presentation.

Please reach out to your HP Engagement Specialist for any topics you want to hear about.





#### Contacts



### 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)

#### HEALTH PARTNER ENGAGEMENT LEADERSHIP

Denise Cole, Director 317-361-5872 Denise.Cole@caresource.com Amy Williams, Manager 317-741-3347

Amy.Williams@caresource.com

BEHAVIORAL HEALTH: HEALTH PARTNER RESOLUTION SPECIALISTS

Amanda Denny – North 765-620-6722 Amanda.Denny@caresource.com

Stephanie Gates – South 317-501-6380 Stephanie.Gates@caresource.com



CONTRACTING MANAGERS – HOSPITALS/LARGE HEALTH SYSTEMS

Cathy Pollick, Director Provider Contracting

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Catherine.Pollick@caresource.com

Maria Crawford – North

317-416-6854

Maria.Crawford@caresource.com

Sara Culley – South

765-256-0423

Sara.Culley@caresource.com

#### HEALTH PARTNER ENGAGEMENT SPECIALIST

Brian Grcevich – Ancillary, Dental, Skilled Nursing Facilities, Home Health and Hospice 317-296-0519

Brian.Grcevich@caresource.com

#### Health Partner Engagement Specialists

#### **Regional Specialists**

Tammy Garrett 219-221-7065 <u>Tammy.Garrett@CareSource.com</u> Franciscan Alliance, Fresenius (Statewide)

Leigh Hoover 765-425-0462 Leigh.Hoover@CareSource.com Parkview, Lutheran, St. Joseph Regional Medical Center, Beacon

#### Amy Wasson 317-417-9652 Amy.Wasson@CareSource.com Community Health Network, Union Hospital, American Health Network

t@CareSource.com iance, Fresenius Indiana Unive Organization

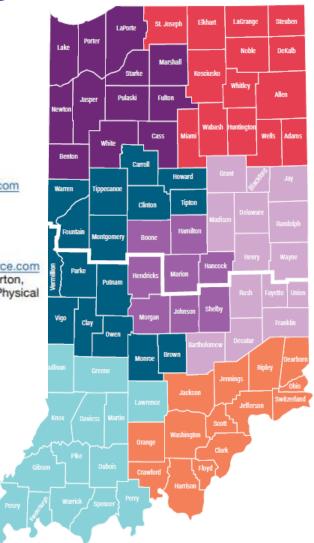
317-607-4844 Sarah.Tinsley@CareSource.com Indiana University, Suburban Health Organization

Sarah Tinsley

Francesca Mekos 317-982-0423 Francesca.Mekos@CareSource.com Eskenazi, Reid Health Paula Egan 812-447-6661 Paula.Egan@CareSource.com

Deaconess, Ascension – St. Vincent Health

Bonnie Waelde 812-480-9203 Bonnie.Waelde@CareSource.com University of Louisville, Norton, Baptist Health Floyd, ATI Physical Therapy (Statewide)



#### Contact Us | Indiana – Medicaid | CareSource

# Thank you!

IN-MED-P-2403162; Issued Date: 10/04/2023

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OMPP Approved: 09/11/2023

