Prior Authorization

Presented by the CareSource Health Partner Engagement Specialists

CareSource®

2024 IHCP Works
Annual Seminar

Agenda

- What is a PA
- What services require a PA
- CareSource Provider Portal Use for PA look up & submission
- Retro authorization & Peer review
- Specialist Services
- Communicating with CareSource

What is a Prior Authorization?

A prior authorization (PA) is the process of obtaining prior approval for covered services under the CareSource plan.

- The services must be appropriate and medically necessary for your care. They must also fall within the coverage terms of your 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 for those codes listed.

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

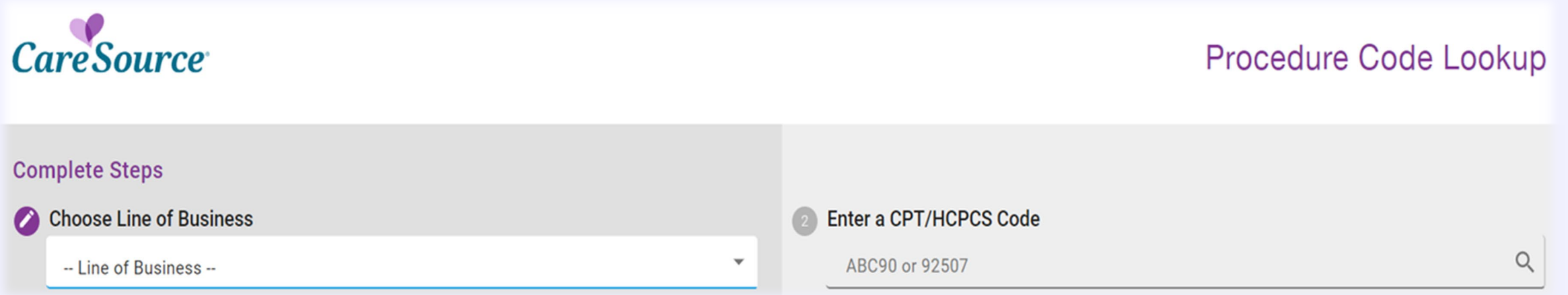
PA Services

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

- All Inpatient Services (Skilled Nursing, Acute, Inpatient Rehab/Therapy, Long Term and Respite Care)
- Applied Behavior Analysis (ABA) Therapy Services
- 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
- 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

Procedure Code Look Up Tool

* **CareSource | Procedure Code Lookup**



***Reminder:** For Indiana Medicaid, the Indiana Medicaid Fee Schedule is the point of reference if a service requires an authorization IHCP Provider Fee Schedule

Procedure Code Look Up Results Page

Complete Steps

Choose Line of Business

IN - Medicaid

Enter a CPT/HCPCS Code

52356

Result as of 07/09/2024

Code 52356

Description Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)

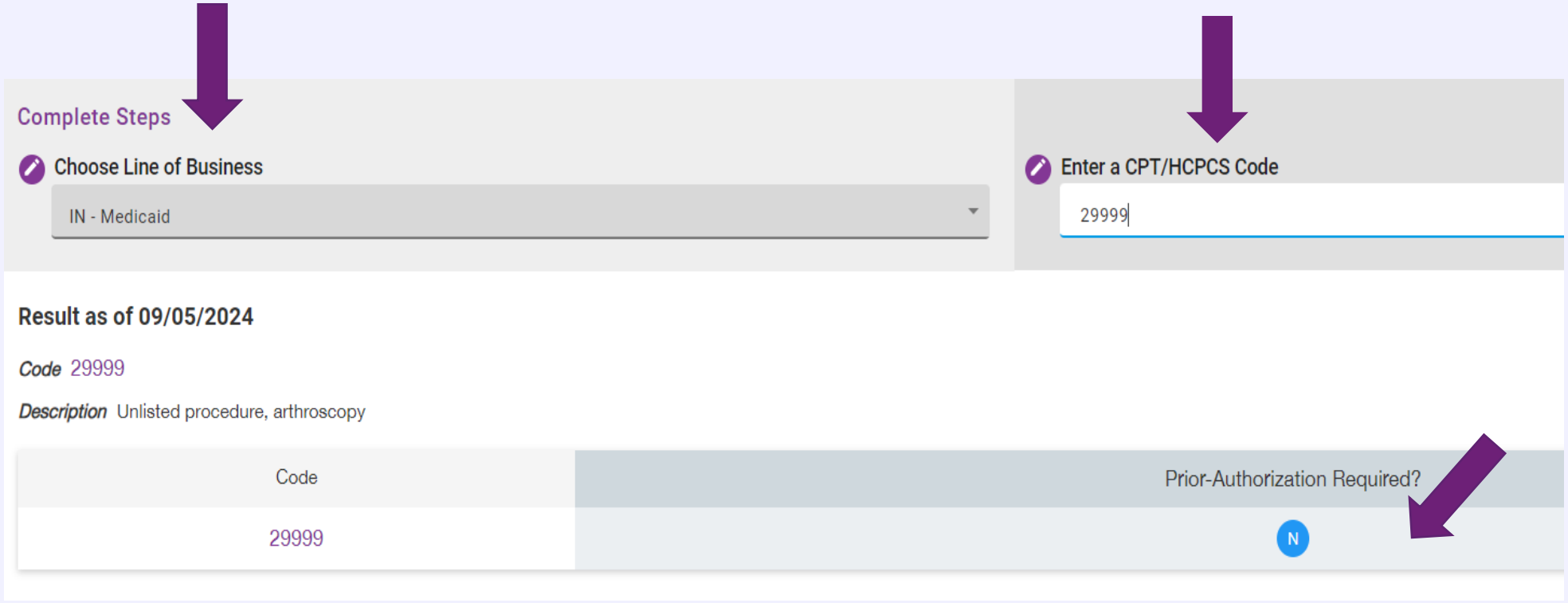
Code	Prior-Authorization Required?
52356	N

DISCLAIMER CareSource does not represent or warrant, whether expressed or implied, including but not limited to, the implied warranties of merchantability and fitness for a particular purpose the results of the Procedure Code Prior Authorization Lookup Tool ("Results"). 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, criteria: member eligibility, members <21 years old, 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 Health Partner Provider Manual on the CareSource website. If you are unsure whether or not a prior authorization is required, please refer to Health Partner Policies or the Prior Authorization page on the CareSource website.

Please Note:

- All non-par providers and all requests for inpatient services require prior authorization.
- For more information about drugs that require prior authorization, access our Pharmacy webpage.
- Reference our Dental Provider Manual for dental services that require prior authorization.

Unlisted Procedure Codes



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.

How to Submit a PA

CareSource®

How to Submit PA Request

Medicaid

Provider Portal (Recommended):

CareSource Provider Portal

Phone:

1-844-607-2831
Monday – Friday 8:00a.m. to 5p.m. Eastern Time
Confidential voicemail available 24/7

Fax:

Fax the PA form and include supporting documentation.

For **Medical**: 1-844-432-8924
For **Behavioral Health**:1-937-487-1664

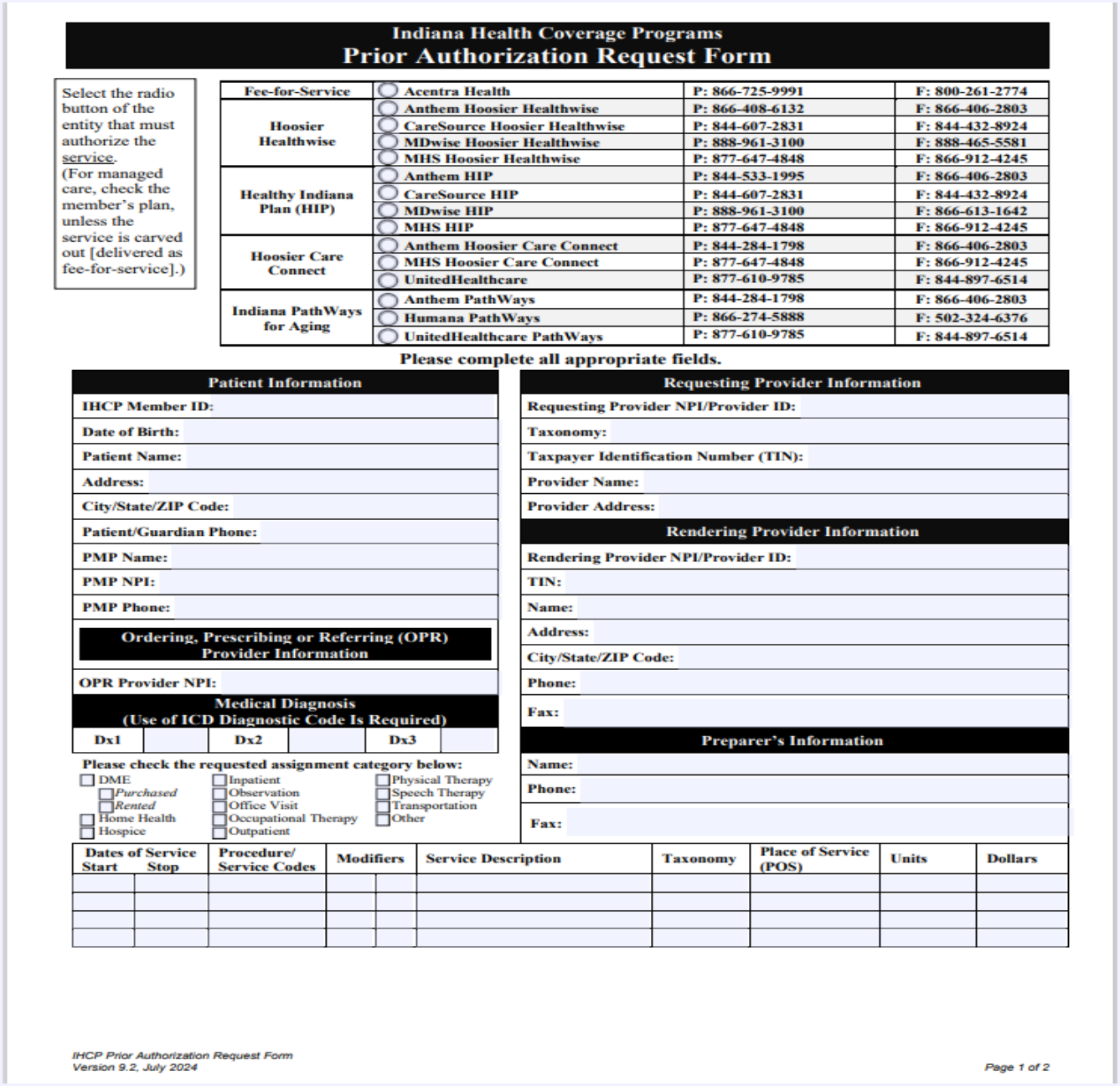
Mail:

CareSource
P.O. Box 1307
Dayton, OH 45401-1307

PA Forms

The Prior Authorization Request Form is available on the CareSource Provider Portal under the Mail option: [Prior Authorization | Indiana – Medicaid | CareSource]

The form is also available on the state website:
[Indiana Health Coverage Programs (IHCP) Universal Prior Authorization Request Form]



Indiana Health Coverage Programs
Prior Authorization Request Form

Select the radio button of the entity that must authorize the service. (For managed care, check the member's plan, unless the service is carved out [delivered as fee-for-service].)

Fee-for-Service	◯ Acentra Health	P: 866-725-9991	F: 800-261-2774
Hoosier Healthwise	◯ Anthem Hoosier Healthwise	P: 866-408-6132	F: 866-406-2803
	◯ CareSource Hoosier Healthwise	P: 844-607-2831	F: 844-432-8924
	◯ MDwise Hoosier Healthwise	P: 888-961-3100	F: 888-465-5581
	◯ MHS Hoosier Healthwise	P: 877-647-4848	F: 866-912-4245
Healthy Indiana Plan (HIP)	◯ Anthem HIP	P: 844-533-1995	F: 866-406-2803
	◯ CareSource HIP	P: 844-607-2831	F: 844-432-8924
	◯ MDwise HIP	P: 888-961-3100	F: 866-613-1642
	◯ MHS HIP	P: 877-647-4848	F: 866-912-4245
Hoosier Care Connect	◯ Anthem Hoosier Care Connect	P: 844-284-1798	F: 866-406-2803
	◯ MHS Hoosier Care Connect	P: 877-647-4848	F: 866-912-4245
	◯ UnitedHealthcare	P: 877-610-9785	F: 844-897-6514
Indiana PathWays for Aging	◯ Anthem PathWays	P: 844-284-1798	F: 866-406-2803
	◯ Humana PathWays	P: 866-274-5888	F: 502-324-6376
	◯ UnitedHealthcare PathWays	P: 877-610-9785	F: 844-897-6514

Please complete all appropriate fields.

Patient Information
- IHCP Member ID:
- 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 Provider NPI:

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

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

Requesting Provider Information
- Requesting Provider NPI/Provider ID:
- Taxonomy:
- Taxpayer Identification Number (TIN):
- Provider Name:
- Provider Address:

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

Preparer's Information
- Name:
- Phone:
- Fax:

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

IHCP Prior Authorization Request Form
Version 9.2, July 2024

Page 1 of 2

PA Time Frames

Authorization Type	Decision	Extension
Standard Pre-Service	Five (5) business days	Fourteen (14) calendar days
Urgent Pre-Service	Forty-eight (48) hours	Fourteen (14) calendar days
Urgent Concurrent	Forty-eight (48) hours	No extension
Post-Service (Retrospective Review)	Thirty (30) calendar days	No extension

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

PA Specialty Pharmacy

Refer to CareSource.com for a complete list of pharmacy requirements.

CareSource Speciality Pharmacy Provider Portal

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

CareSource®

Provider Portal & PA

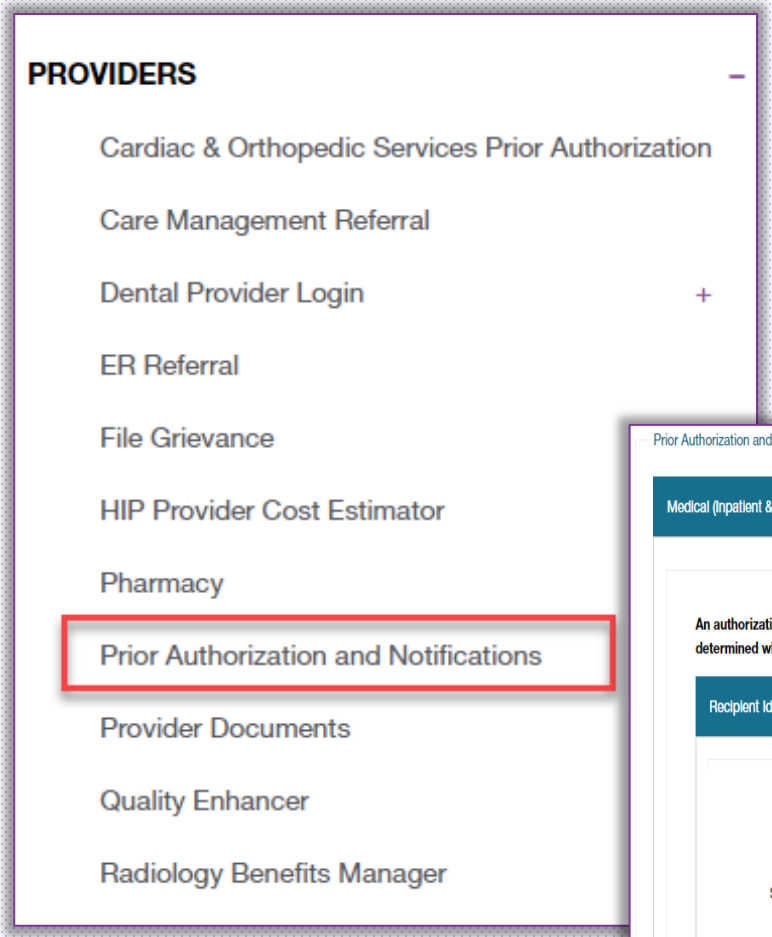
PAs can be requested through the Provider Portal.

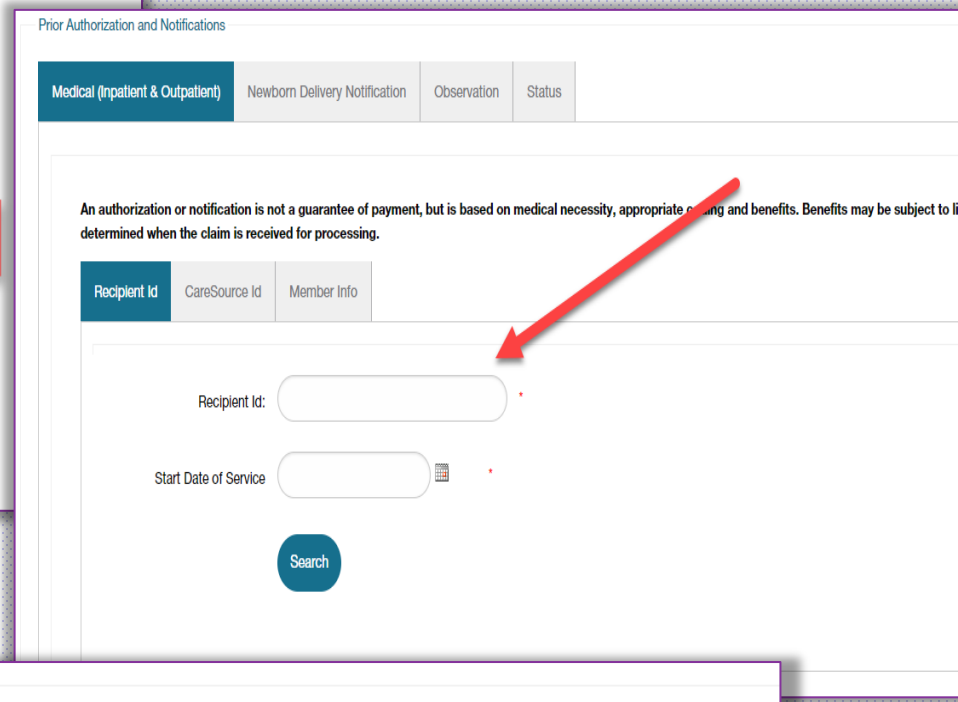
- Select **Provider Authorizations** and **Notifications** on left navigation
  - Enter **CareSource or Member ID** and **Start Date of Service** & select **Search**
  - Select **Care Setting** and **type of Prior Auth**
  - Enter provider information **Name, NPI or CS Provider Number**
    - *Please be sure to look closely to choose the correct one as 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**

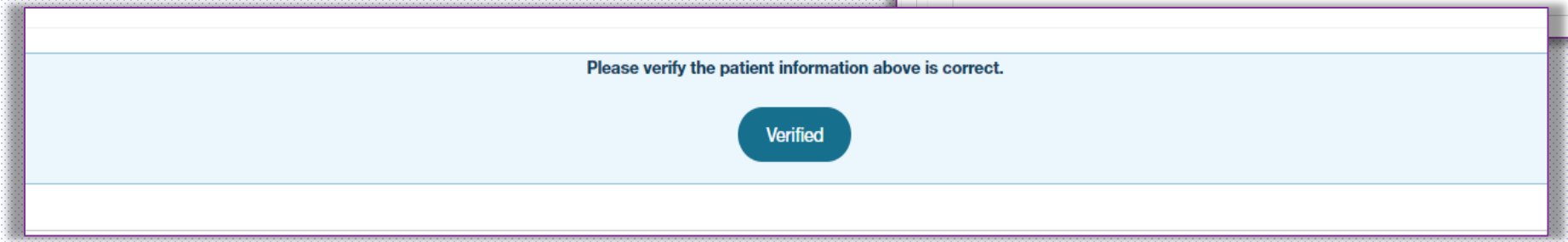
PA Submission

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

Begin an authorization by searching for the CareSource member by Recipient ID, CareSource ID, or Member Information and the start date of service. Once the member is located, click **Verified**.



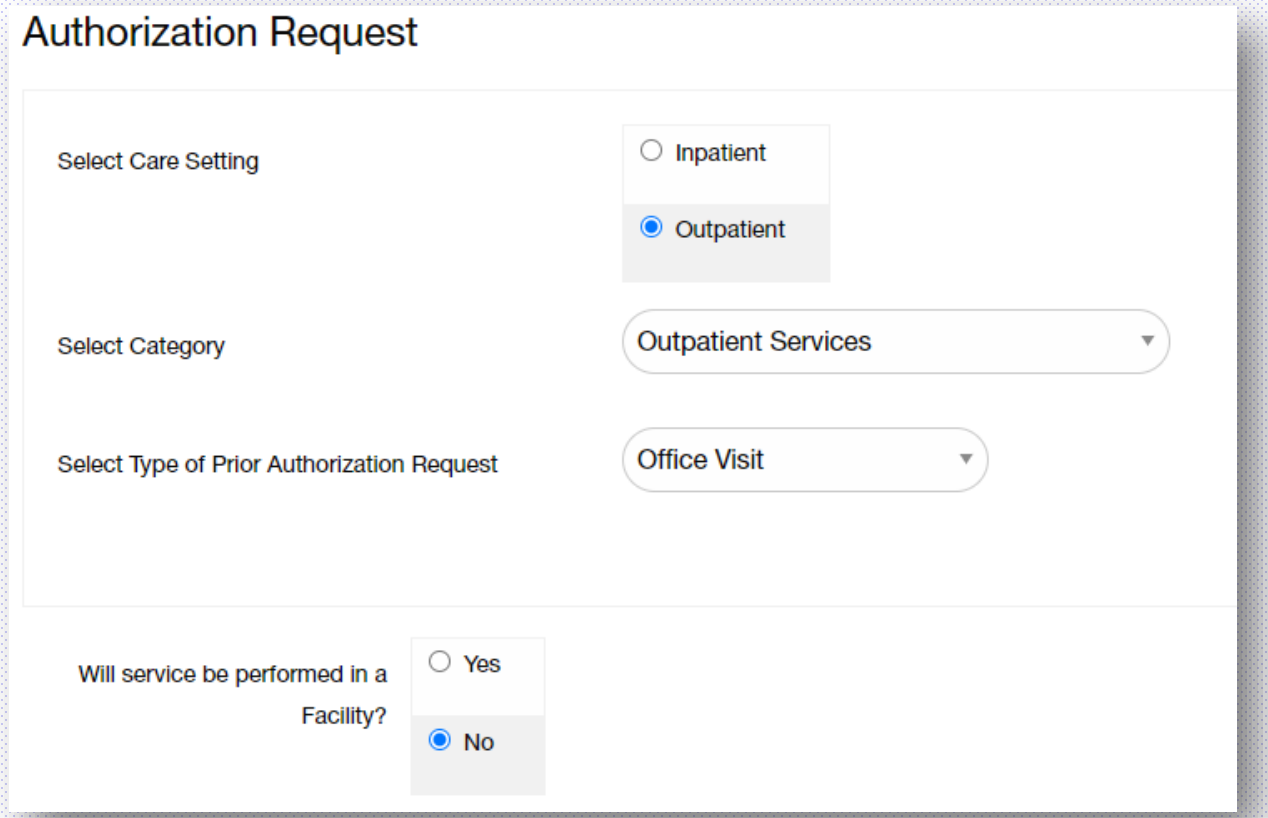




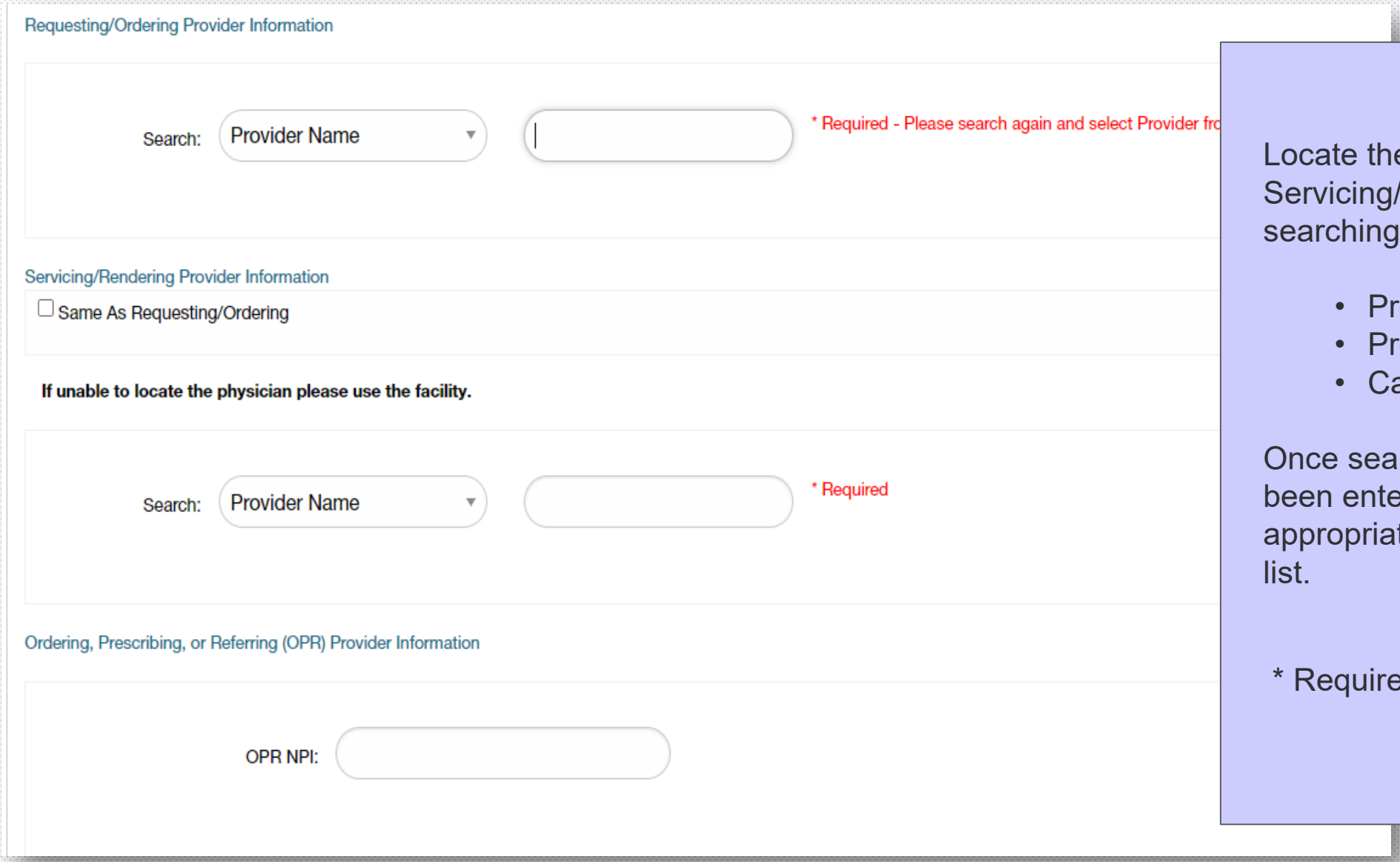
PA Type

Complete the authorization form by filling out the following fields:

- Select if the service is *Inpatient* or *Outpatient*.
- Select the appropriate category.
- Select the type of PA request.
- Select if the service will be completed in a Facility.



PA Provider Info



Locate the Requesting/Ordering and Servicing/Rendering Provider by searching:

- Provider Name*
- Provider NPI*
- CareSource Provider ID

Once searched criteria has been entered, select the appropriate provider from the available list.

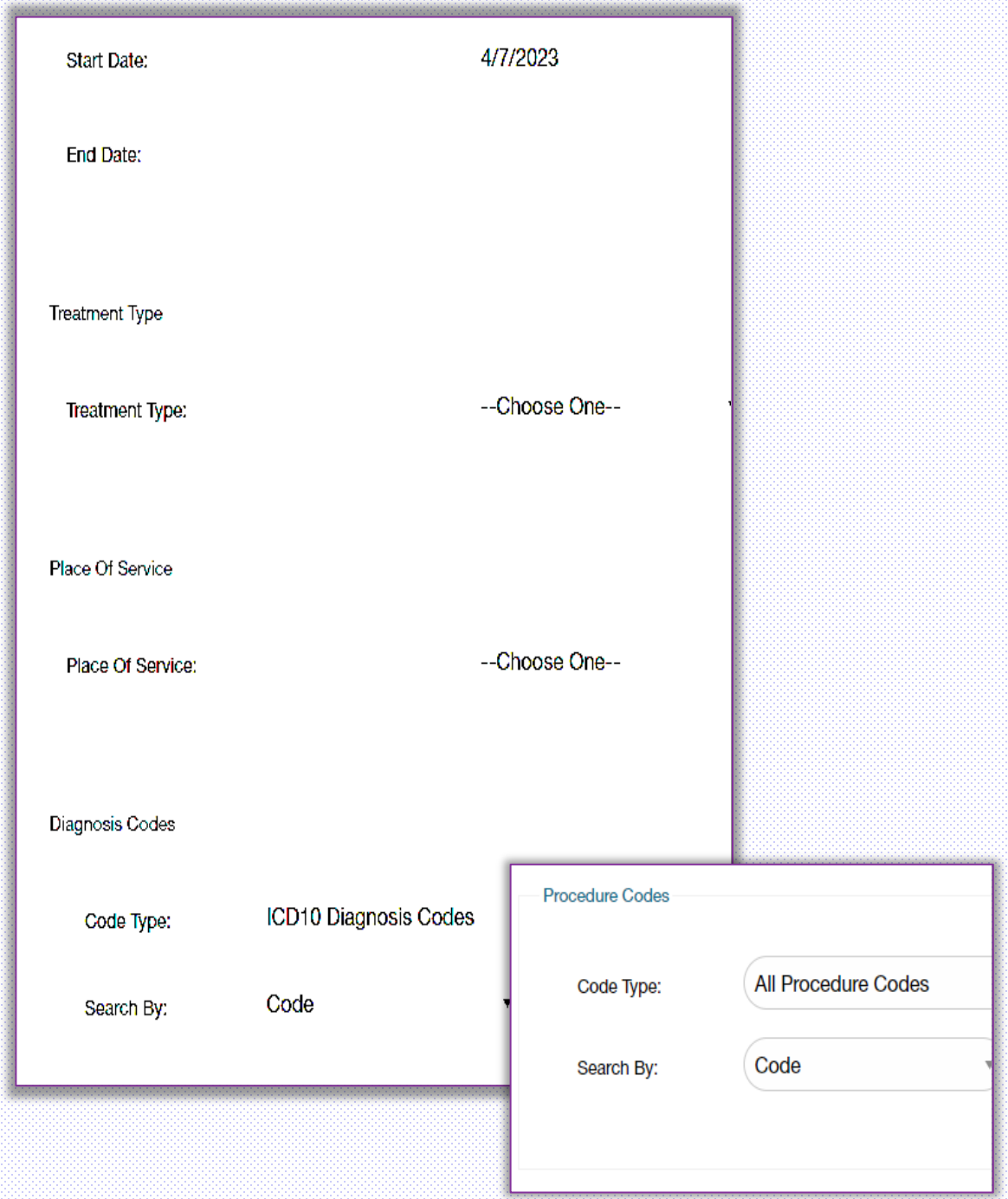
* Required Fields

PA Details

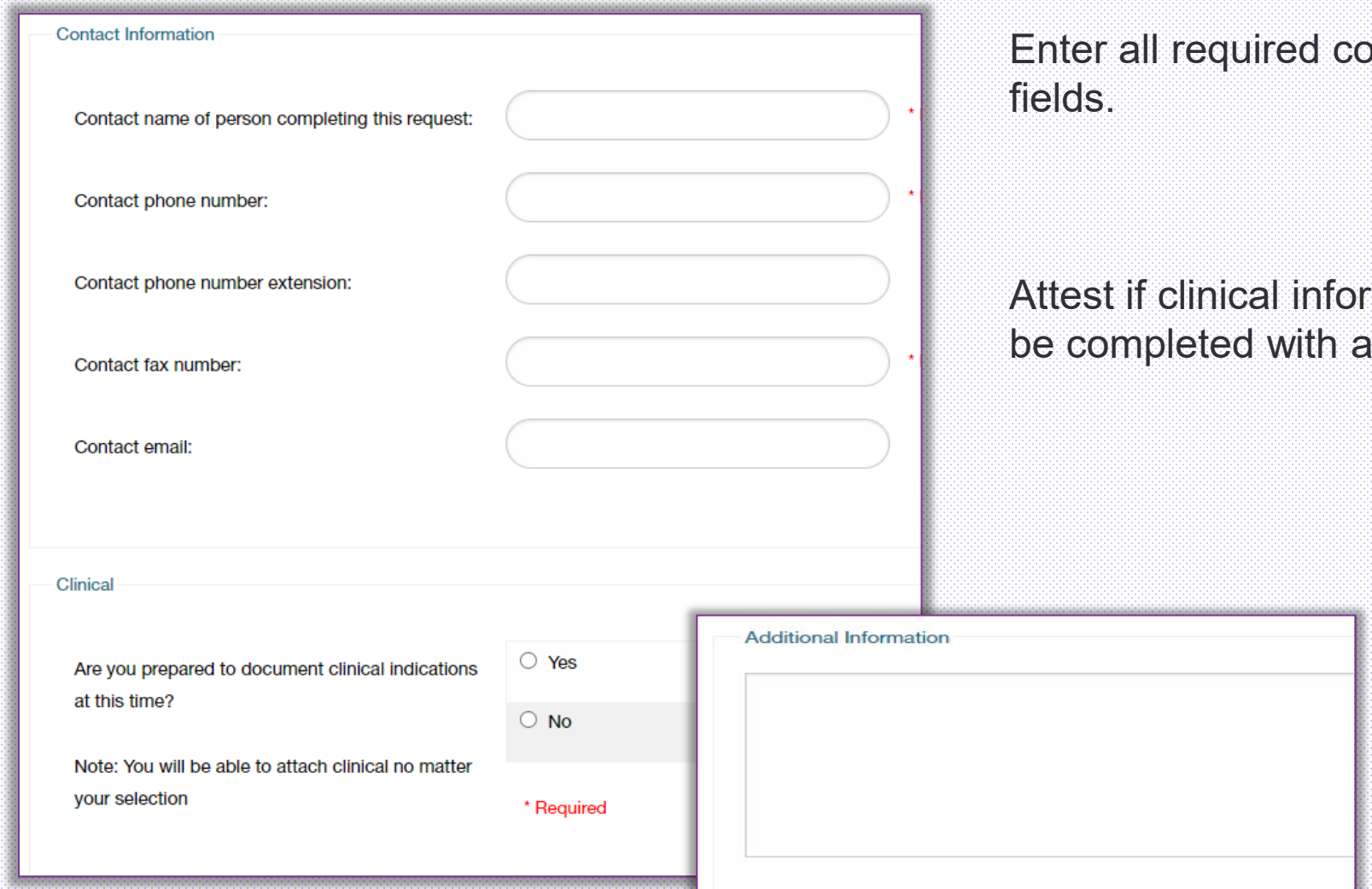
Complete the following fields:

- End Date
- Choose a Treatment Type
- Choose a Place of Service
- Enter all applicable diagnosis and procedure codes

Once a procedure code is entered, units and modifiers may be selected.



PA Contact Info



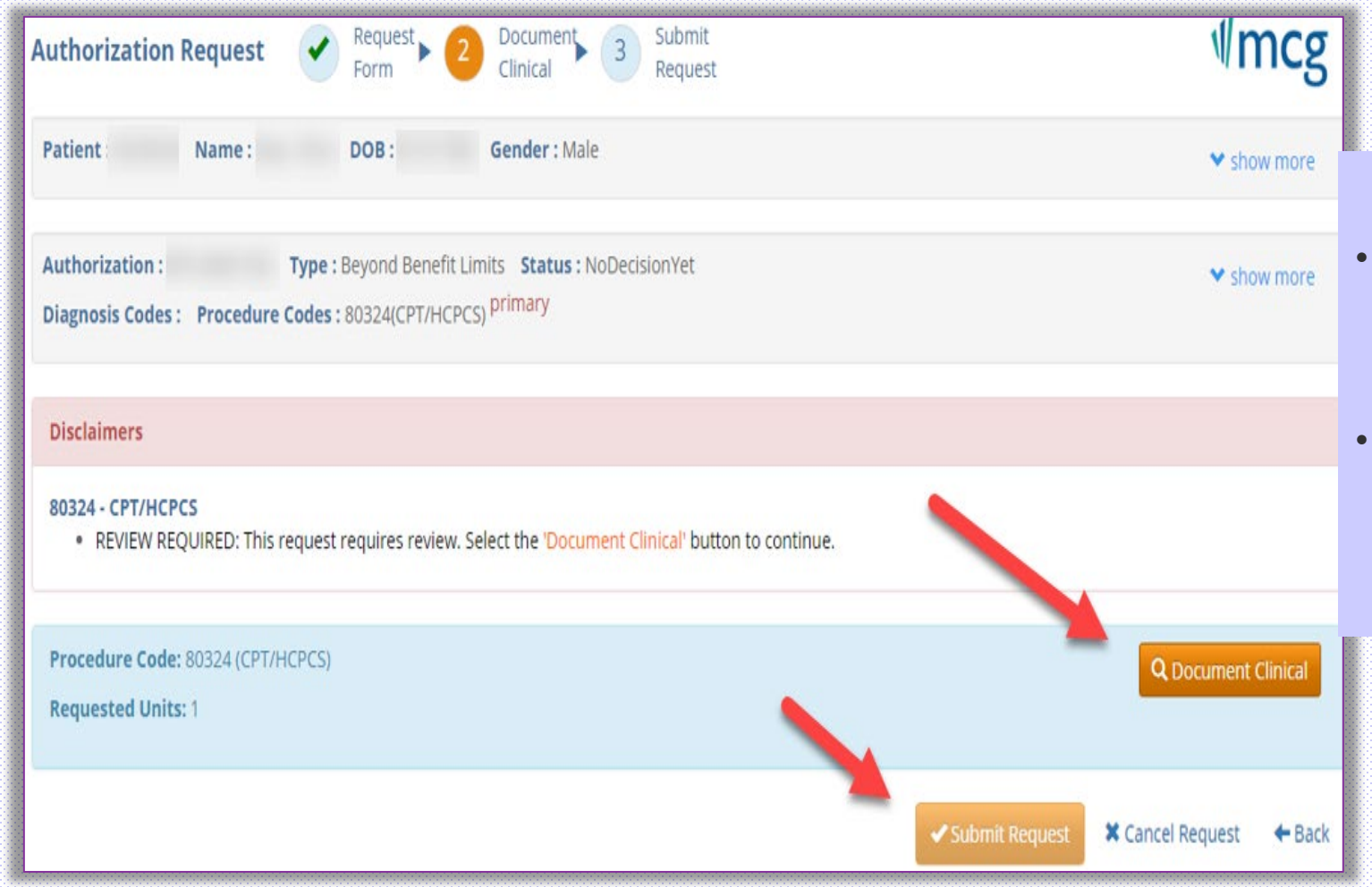
Enter all required contact information fields.

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

Click **Continue**.

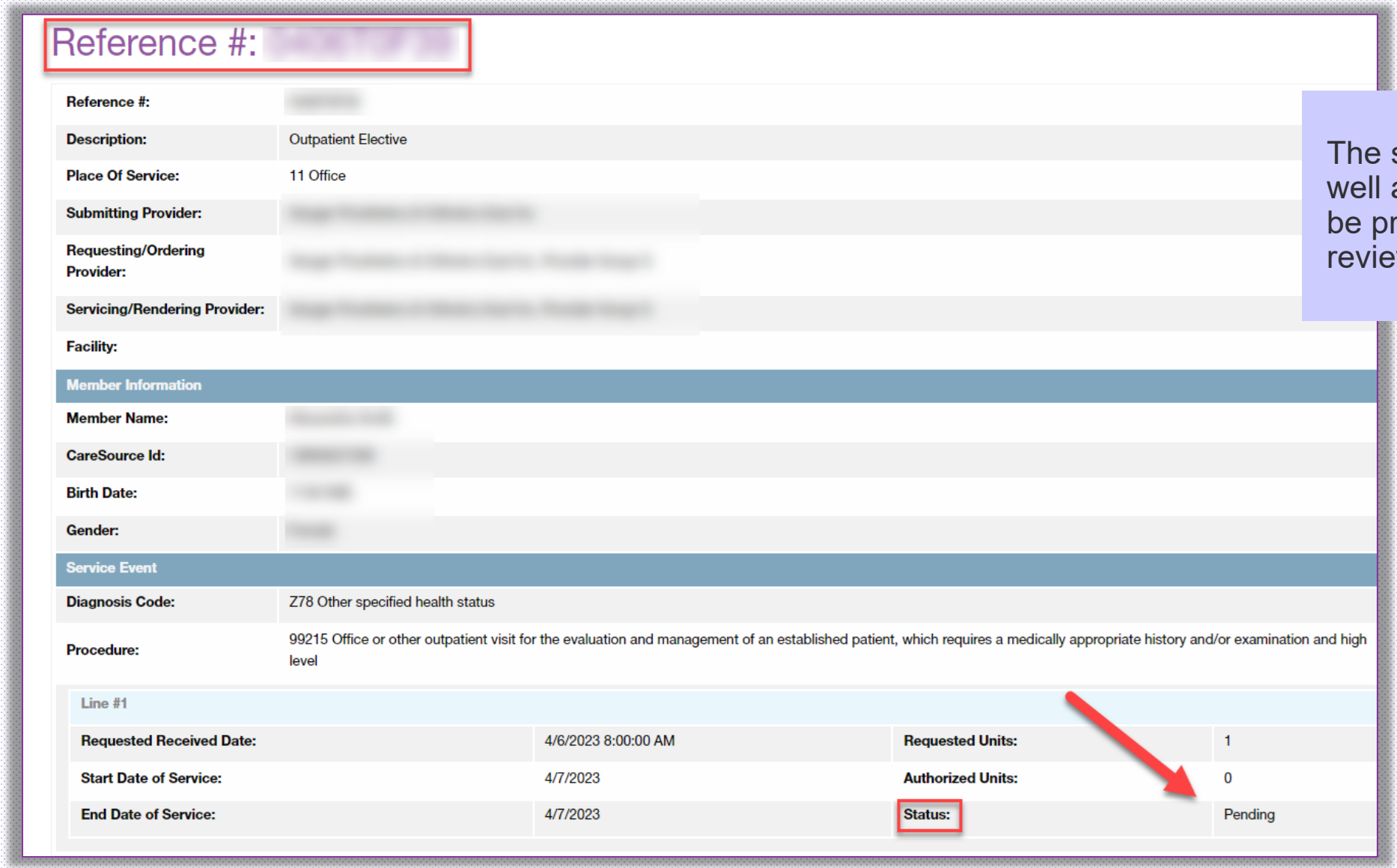
A draft authorization may be saved to come back to later by clicking **Save Draft**.

PA Completion



- The authorization will be processed through the Cite Auto for Milliman Care Guidelines (MCG) program.
- Complete any required clinical documentation by clicking **Document Clinical** and click **Submit Request**.

PA Response



Reference #: [redacted]

Reference #:	[redacted]
Description:	Outpatient Elective
Place Of Service:	11 Office
Submitting Provider:	[redacted]
Requesting/Ordering Provider:	[redacted]
Servicing/Rendering Provider:	[redacted]
Facility:	

Member Information

Member Name:	[redacted]
CareSource Id:	[redacted]
Birth Date:	[redacted]
Gender:	[redacted]

Service Event

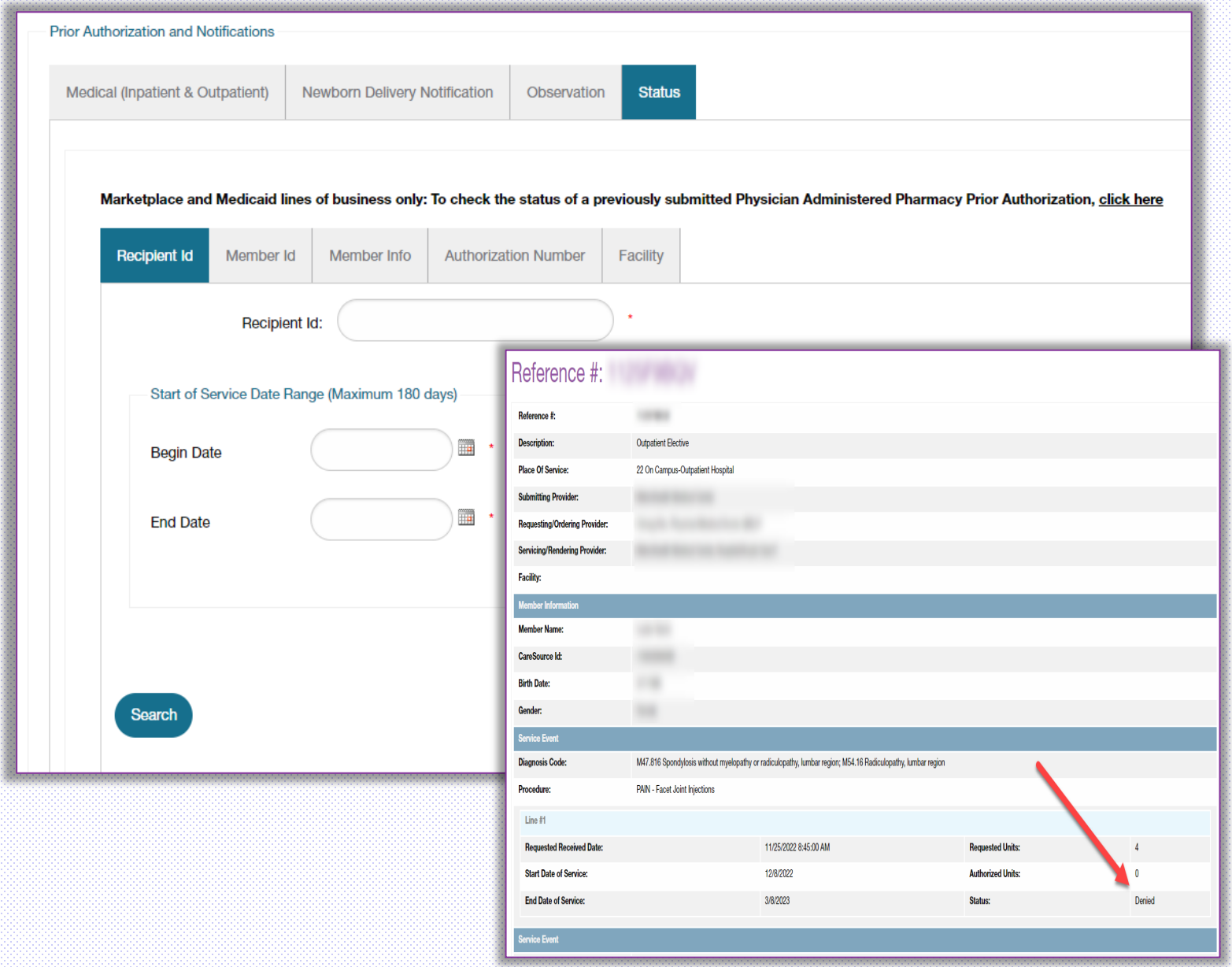
Diagnosis Code:	Z78 Other specified health status
Procedure:	99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level

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

The status of the authorization as well as a reference number will be provided that can be used to review status if needed later.

PA Status



Prior authorization status may be viewed by searching:

- Member ID
- Member Info
- Authorization Number
- Facility

Provider Portal Authorization – 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 PA**.

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.
   NPI, Tax ID, and Practice Address must all match.

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 (COB)

When a member has a Primary Payer and CareSource as secondary coverage.

If CareSource requires a prior authorization for a service:

Provider must follow the **primary** insurers requirements and obtain prior authorization

Provider must **also** obtain prior authorization from **CareSource** for services requiring authorization

Updating an Approved PA Submission

Any changes to an existing PA must be submitted to CareSource:

Provider Portal

Phone 1-844-607-2831

Fax Medical 1-844-432-8924 Behavioral Health 1-937-487-1664

Example of Changes

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

Retro Authorizations

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Medicaid Retro Authorizations

Upon written request, CareSource shall not permit retro authorization submission after the date of service or admission where a PA was required but not obtained except in the following circumstances as outlined in the Indiana Administrative Code IAC405.5.12 (IAC) rule.

The Indiana Health Coverage Program's Prior Authorization Module can also be viewed here: Prior Authorization (in.gov)

PA will be given after services have begun or supplies have been delivered only under the following circumstances:

- Pending or retroactive member eligibility. The PA 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 PA request must be submitted within twelve (12) months of the date of service.

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

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

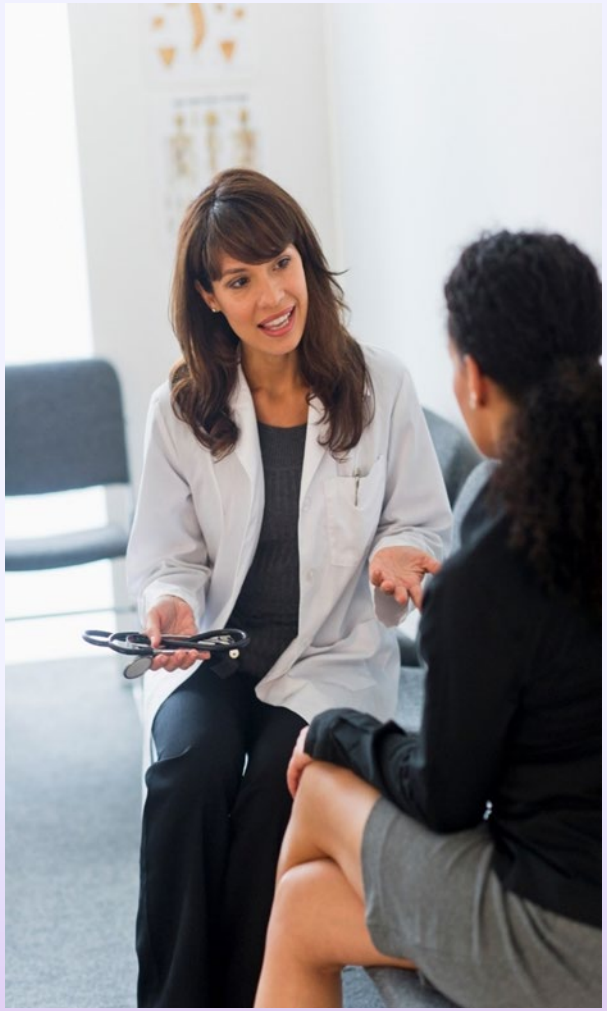
- The provider's records document that the member refused or was physically unable to provide the member ID (MID) number.
- The provider can substantiate that the provider continually pursued reimbursement from the patient until Medicaid eligibility was discovered.
- The provider submitted the request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

Retro Authorization Timeframes

Retrospective (post-service) reviews will be decided within **30** calendar days from the receipt of the request.

If a provider's service changes during a procedure, you must call or fax CareSource immediately to seek a change in your Prior Authorization or request a retro auth if the original service did not require one.

Peer-to-Peer Review



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

If you would like to discuss a case with the Clinical Peer Reviewer, please call the Utilization Management Department.

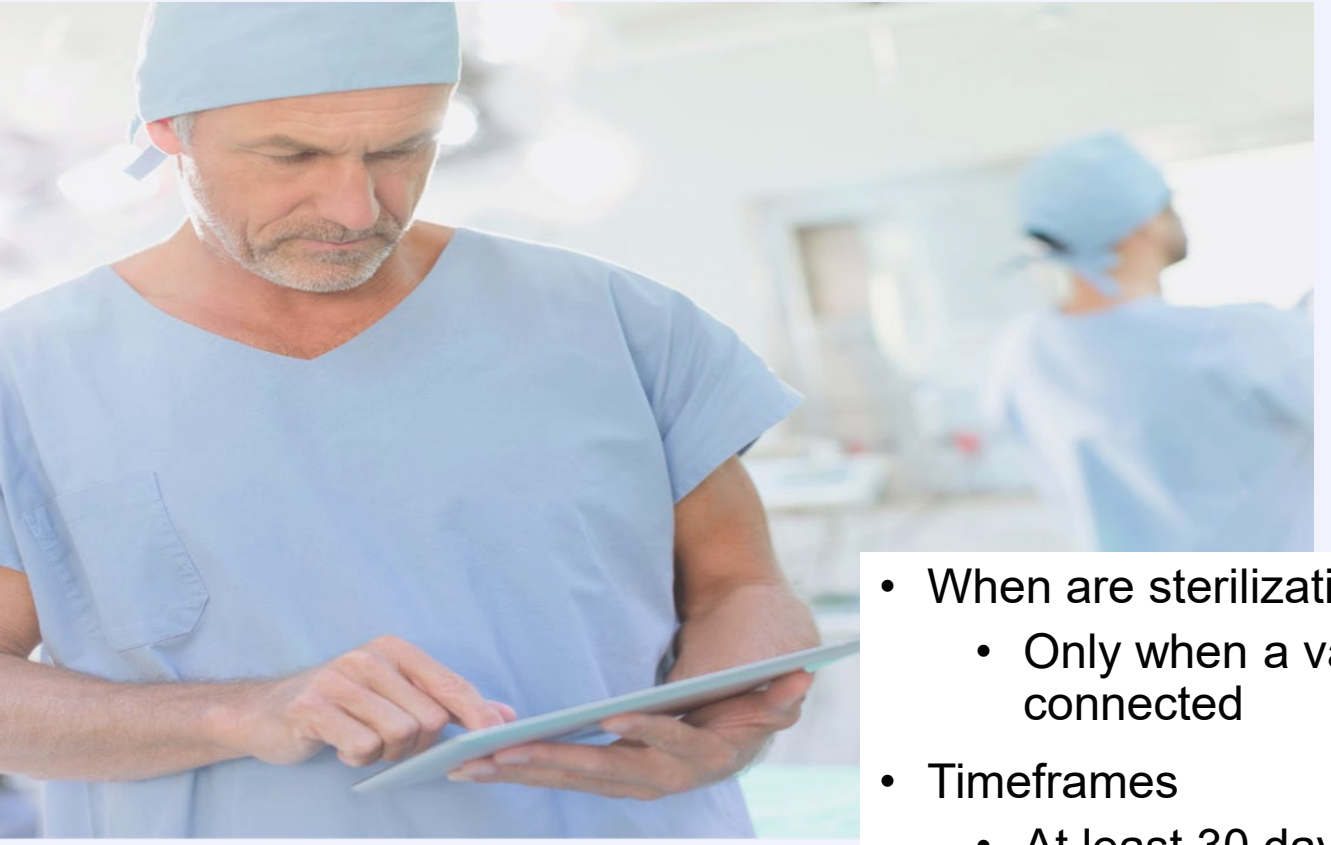
- By Phone at **1-833-230-2168**
- By Fax at **1-844-432-8924**

You must contact us within **seven (7)** business days of the determination

Our new line was created with a special team dedicated to answer live calls. You will be able to reach a live staff member anytime during normal business hours of 8am to 5pm EST.

Sterilization and Hysterectomy

CareSource®



Sterilizations

- When are sterilizations reimbursable?
  - Only when a valid consent form accompanies all claims connected
- Timeframes
  - At least 30 days and no more than 180 days between consent and procedure
- Sterilizations planned concurrent with delivery timeframes
  - 30 day before delivery
- Requirements
  - Voluntary Consent given and form signed
  - 21 years or older at time of consent
  - Is neither mentally incompetent or institutionalized

Consent for Sterilization Form

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

CONSENT FOR STERILIZATION

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*). When I first asked 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 I am now getting or for which I may become eligible.

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 _____ (*Specify Type of Operation*). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I 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.

I am at least 21 years of age and was born on: _____ (*Date*)

I, _____, hereby consent of my own free will to be sterilized by _____ (*Doctor or Clinic*) by a method called _____ (*Specify Type of Operation*). My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ (*Signature*) _____ (*Date*)

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ INTERPRETER'S STATEMENT ■

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.

_____ (*Interpreter's Signature*) _____ (*Date*)

HHS-687 (07/2025)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (*Name of Individual*) signed the consent form, I explained to him/her the nature of sterilization operation _____ (*Specify Type of Operation*), the fact that it is intended 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 any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is 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 STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (*Name of Individual*) on _____ (*Date of Sterilization*)

I explained to him/her the nature of the sterilization operation _____ (*Specify Type of Operation*), the fact that it is intended 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 at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature 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 cases, 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*)

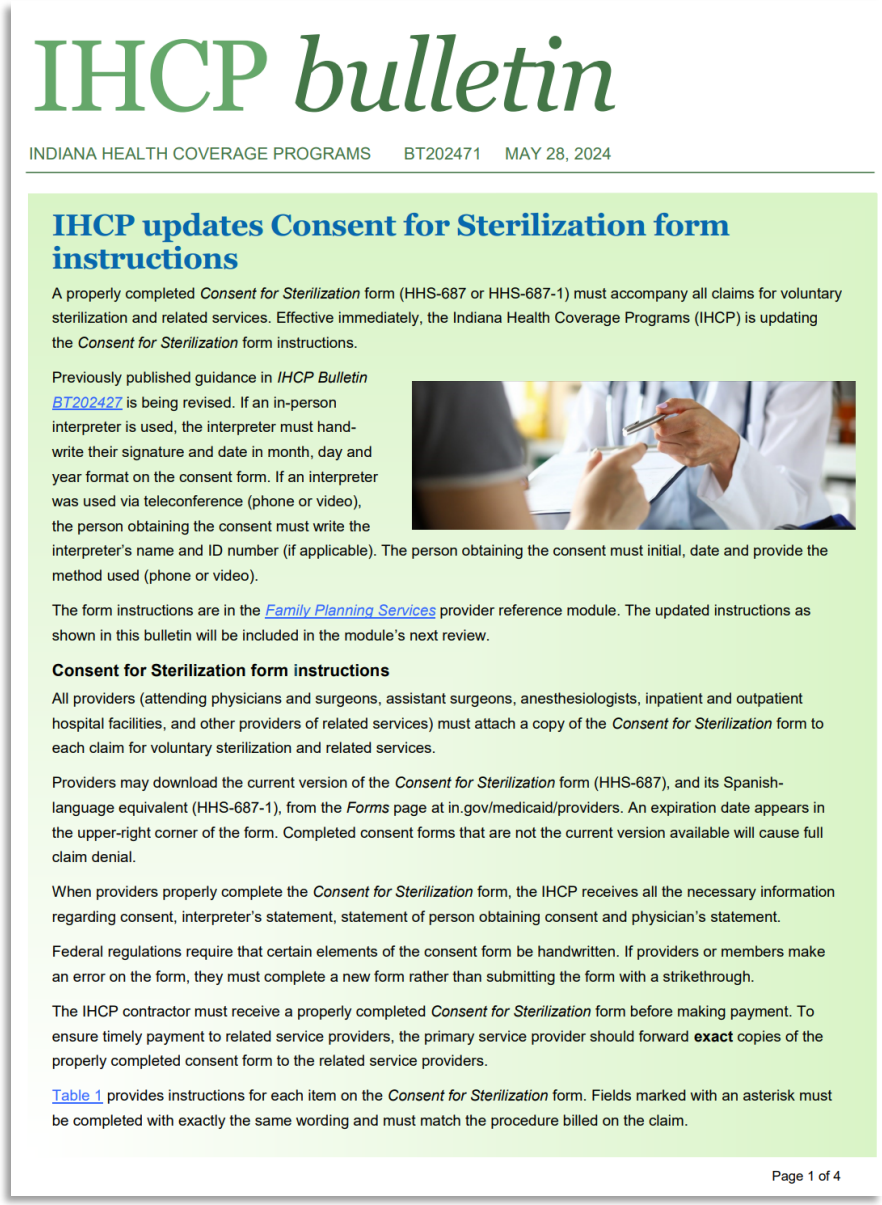
Consent for Sterilization Form Instructions

BT202471 (in.gov)

Providers may download the current version of the Consent for Sterilization form (HHS-687), and its Spanish language equivalent (HHS-687-1), from the Forms page at **in.gov/medicaid/providers**. An expiration date appears in the upper-right corner of the form. Completed consent forms that are not the current version available will cause full claim denial.

A properly completed Consent for Sterilization form (HHS-687 or HHS-687-1) must accompany all claims for voluntary sterilization and related services.

The form instructions are in the **Family Planning Services** provider reference module.



IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT202471 MAY 28, 2024

IHCP updates Consent for Sterilization form instructions

A properly completed *Consent for Sterilization* form (HHS-687 or HHS-687-1) must accompany all claims for voluntary sterilization and related services. Effective immediately, the Indiana Health Coverage Programs (IHCP) is updating the *Consent for Sterilization* form instructions.

Previously published guidance in *IHCP Bulletin* *BT202427* is being revised. If an in-person interpreter is used, the interpreter must hand-write their signature and date in month, day and year format on the consent form. If an interpreter was used via teleconference (phone or video), the person obtaining the consent must write the interpreter's name and ID number (if applicable). The person obtaining the consent must initial, date and provide the method used (phone or video).

The form instructions are in the *Family Planning Services* provider reference module. The updated instructions as shown in this bulletin will be included in the module's next review.

Consent for Sterilization form instructions

All providers (attending physicians and surgeons, assistant surgeons, anesthesiologists, inpatient and outpatient hospital facilities, and other providers of related services) must attach a copy of the *Consent for Sterilization* form to each claim for voluntary sterilization and related services.

Providers may download the current version of the *Consent for Sterilization* form (HHS-687), and its Spanish-language equivalent (HHS-687-1), from the *Forms* page at in.gov/medicaid/providers. An expiration date appears in the upper-right corner of the form. Completed consent forms that are not the current version available will cause full claim denial.

When providers properly complete the *Consent for Sterilization* form, the IHCP receives all the necessary information regarding consent, interpreter's statement, statement of person obtaining consent and physician's statement.

Federal regulations require that certain elements of the consent form be handwritten. If providers or members make an error on the form, they must complete a new form rather than submitting the form with a strikethrough.

The IHCP contractor must receive a properly completed *Consent for Sterilization* form before making payment. To ensure timely payment to related service providers, the primary service provider should forward **exact** copies of the properly completed consent form to the related service providers.

Table 1 provides instructions for each item on the *Consent for Sterilization* form. Fields marked with an asterisk must be completed with exactly the same wording and must match the procedure billed on the claim.

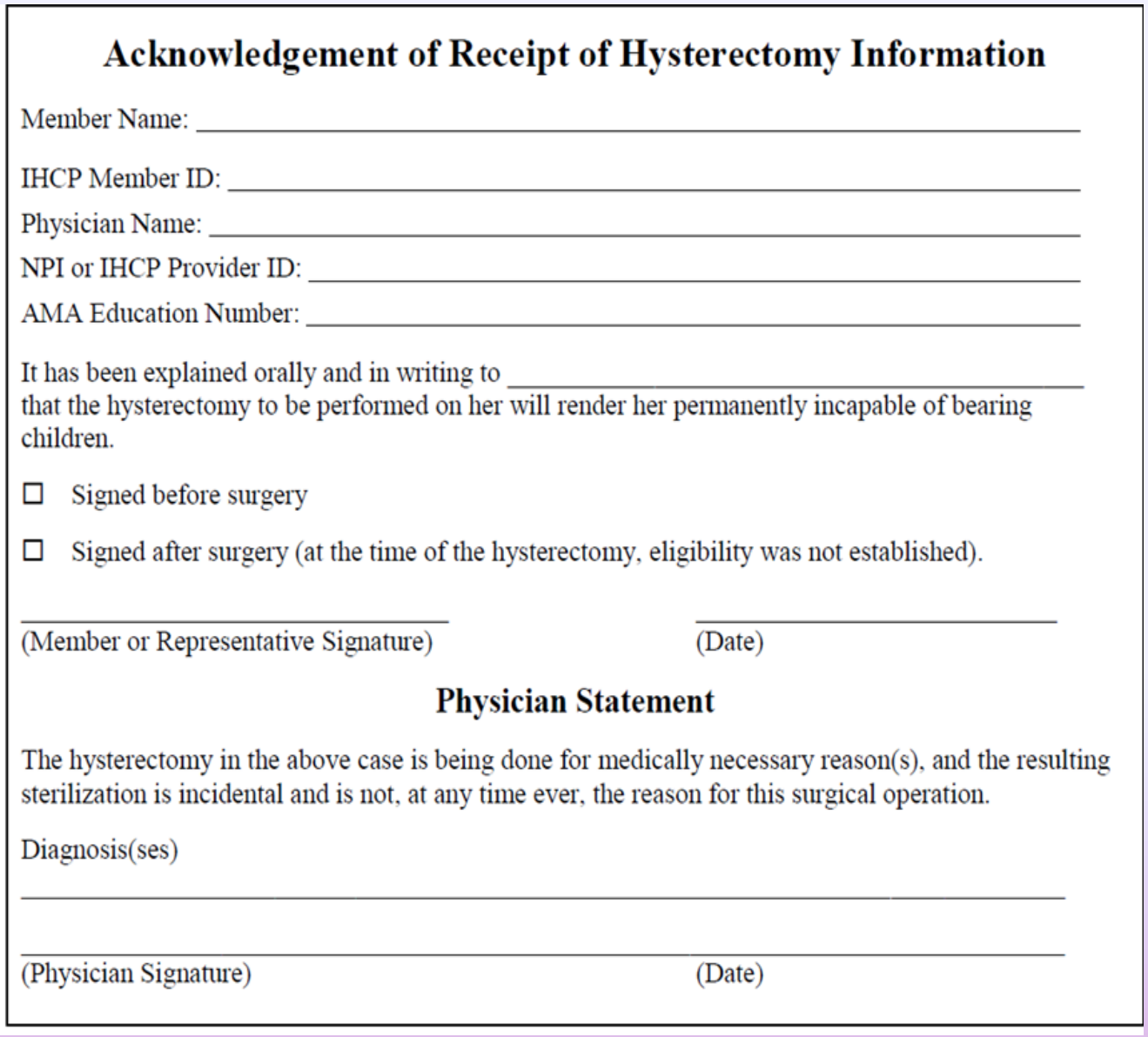
Page 1 of 4

Hysterectomy

- IHCP covers hysterectomies when they are medically necessary.
- IHCP follows national clinical guidelines for medical necessity criteria
- The member must give informed consent.
- IHCP does not cover this service to solely render a member permanently incapable of bearing children.
- Do **not** use the Consent for Sterilization Form.
- An Acknowledgement of Receipt of Hysterectomy Information form must be submitted with the claim, see next slide for example.
- PA is always required, unless individual is already sterile or experiencing a life-threatening emergency.

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

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 _____ that the hysterectomy to be performed on her will render her permanently incapable of bearing children.

☐ 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)

The signed acknowledgement of receipt of hysterectomy information form 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

CareSource®

Mom and Baby Authorization Process

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.

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.

Radiology Procedures

CareSource®

Evolent (formerly NIA/Magellan)

CareSource partners with Evolent to implement our radiology benefit management program for outpatient advanced imaging services.

Procedures which require PA through Evolent:

CT/CTI
MRI/MRA
PET Scans
Myocardial Perfusion Imaging (MPI)
MUGA Scan
Echocardiography
Stress Echo

Services which do NOT require PA through Evolent:

Inpatient Advanced Imaging Services

Observation

Emergency room imaging services

Evolent Authorization phone and website information:

1-800-327-0641

Welcome to RadMD.com | RADMD

Urgent/Expedited authorizations – contact the Provider Support Team

Dental

CareSource®

Medicaid 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: 1-844-607-2831

CareSource Indiana Medicaid Dental Provider Manual

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

Behavioral Health

CareSource®

Behavioral Health (BH) PA List

Applied Behavioral Analysis (ABA therapy)

Psychiatric inpatient admissions, including admissions for substance use and rehabilitation

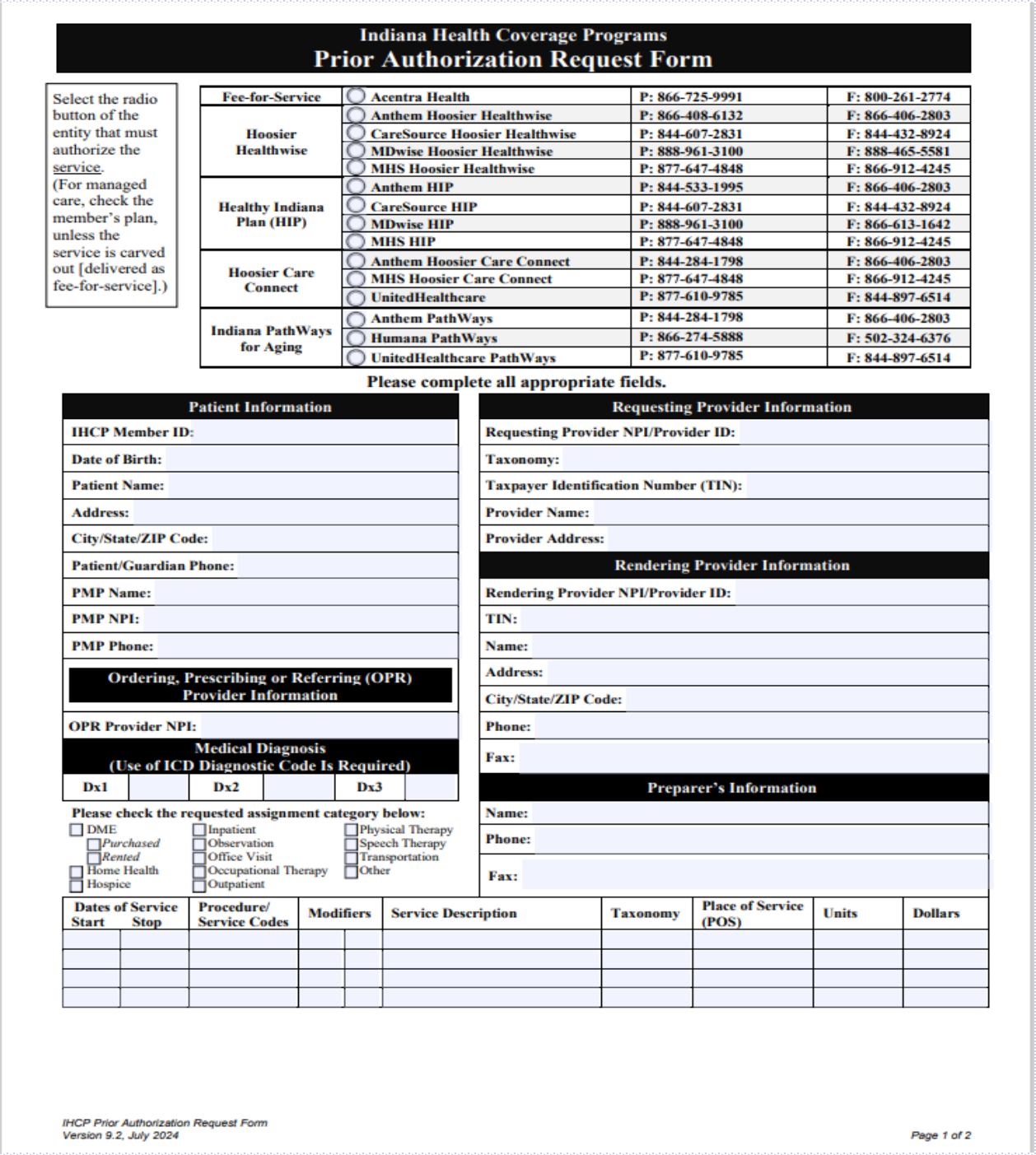
Medicaid Rehabilitation Option (MRO) services, except for crisis intervention

Partial Hospitalization Program (PHP) services

Intensive Outpatient Treatment (IOT)

Continued next page

[IHCP Universal Prior Authorization Request Form]



Indiana Health Coverage Programs
Prior Authorization Request Form

Select the radio button of the entity that must authorize the service. (For managed care, check the member's plan, unless the service is carved out [delivered as fee-for-service].)

Fee-for-Service	○ Acentra Health	P: 866-725-9991	F: 800-261-2774
Hoosier Healthwise	○ Anthem Hoosier Healthwise	P: 866-408-6132	F: 866-406-2803
	○ CareSource Hoosier Healthwise	P: 844-607-2831	F: 844-432-8924
	○ MDwise Hoosier Healthwise	P: 888-961-3100	F: 888-465-5581
	○ MHS Hoosier Healthwise	P: 877-647-4848	F: 866-912-4245
Healthy Indiana Plan (HIP)	○ Anthem HIP	P: 844-533-1995	F: 866-406-2803
	○ CareSource HIP	P: 844-607-2831	F: 844-432-8924
	○ MDwise HIP	P: 888-961-3100	F: 866-613-1642
	○ MHS HIP	P: 877-647-4848	F: 866-912-4245
Hoosier Care Connect	○ Anthem Hoosier Care Connect	P: 844-284-1798	F: 866-406-2803
	○ MHS Hoosier Care Connect	P: 877-647-4848	F: 866-912-4245
	○ UnitedHealthcare	P: 877-610-9785	F: 844-897-6514
Indiana PathWays for Aging	○ Anthem PathWays	P: 844-284-1798	F: 866-406-2803
	○ Humana PathWays	P: 866-274-5888	F: 502-324-6376
	○ UnitedHealthcare PathWays	P: 877-610-9785	F: 844-897-6514

Please complete all appropriate fields.

Patient Information

IHCP Member ID:
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 Provider NPI:

Medical Diagnosis (Use of ICD Diagnostic Code Is Required)

Dx1 | Dx2 | Dx3

Requesting Provider Information

Requesting Provider NPI/Provider ID:
Taxonomy:
Taxpayer Identification Number (TIN):
Provider Name:
Provider Address:

Rendering Provider Information

Rendering Provider NPI/Provider ID:
TIN:
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	Place of Service (POS)	Units	Dollars

IHCP Prior Authorization Request Form
Version 9.2, July 2024

Page 1 of 2

BH PA List Continued

We would like to remind our behavioral health providers of the billing requirements that for certain psychiatric codes in combination are subject to 20 units per member, per provider, per rolling 12-month period, without a PA.

- Psychiatric services that include covered codes within the CPT range 90785-90899

One unit of psychiatric diagnostic interview examinations per member, per provider, per rolling 12-month period, billed using one of the following CPT codes:

- 90791 – Psychiatric diagnostic evaluation
- 90792 – Psychiatric diagnostic evaluation with medical services

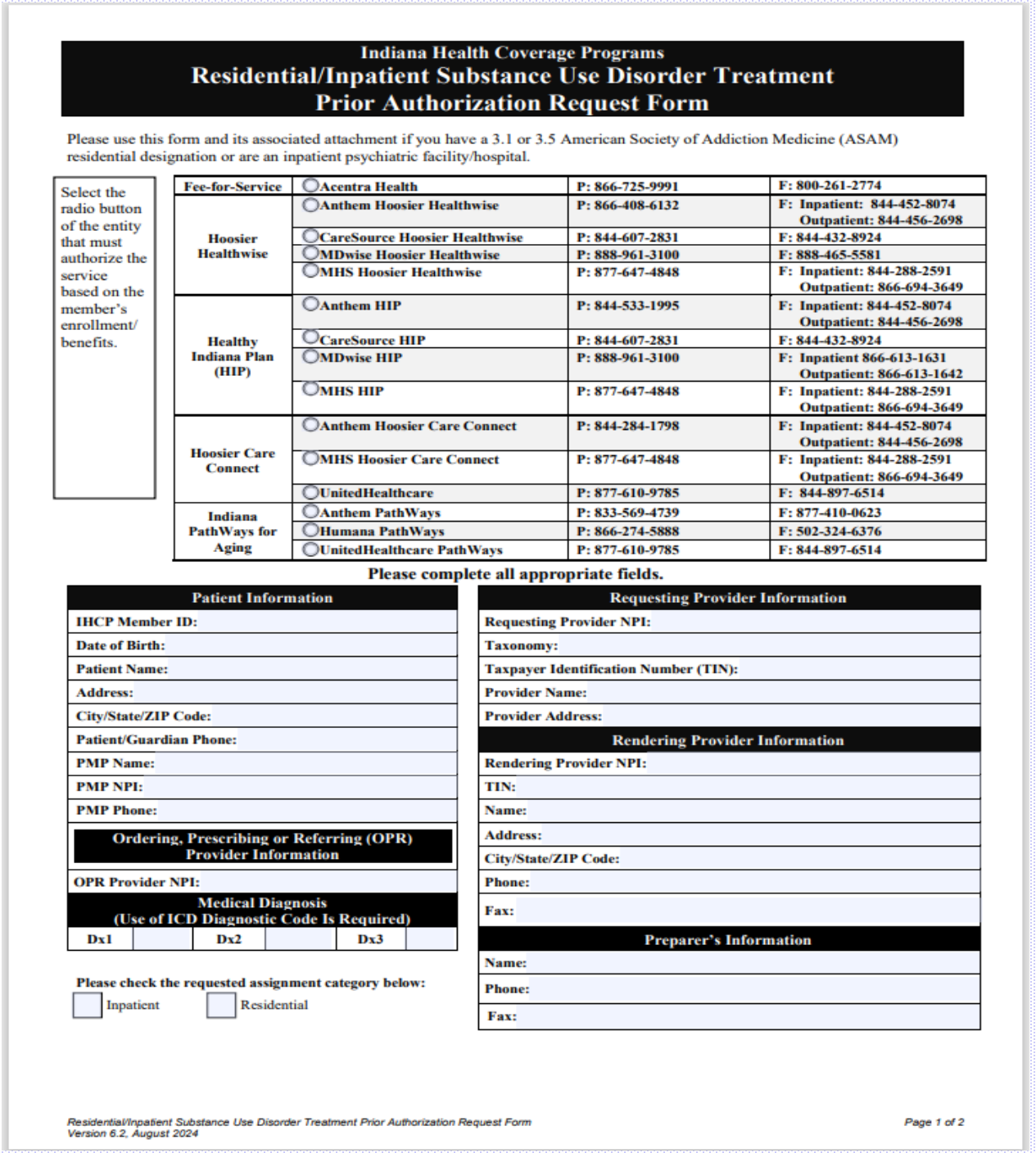
PA Form Substance Use Disorder (SUD)

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.

All request must have current ASAM documentation within fourteen (14) calendar days of the requested date of service.

The SUD Universal Sstandard PA form is located on CareSource's Forms page here: Forms | Indiana – Medicaid | CareSource



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 radio button of the entity that must authorize the service based on the member's enrollment/ benefits.

Fee-for-Service	◯ Acentra Health	P: 866-725-9991	F: 800-261-2774
Hoosier Healthwise	◯ Anthem Hoosier Healthwise	P: 866-408-6132	F: Inpatient: 844-452-8074 Outpatient: 844-456-2698
	◯ CareSource Hoosier Healthwise	P: 844-607-2831	F: 844-432-8924
	◯ MDwise Hoosier Healthwise	P: 888-961-3100	F: 888-465-5581
	◯ MHS Hoosier Healthwise	P: 877-647-4848	F: Inpatient: 844-288-2591 Outpatient: 866-694-3649
Healthy Indiana Plan (HIP)	◯ Anthem HIP	P: 844-533-1995	F: Inpatient: 844-452-8074 Outpatient: 844-456-2698
	◯ 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
	◯ MHS HIP	P: 877-647-4848	F: Inpatient: 844-288-2591 Outpatient: 866-694-3649
Hoosier Care Connect	◯ Anthem Hoosier Care Connect	P: 844-284-1798	F: Inpatient: 844-452-8074 Outpatient: 844-456-2698
	◯ MHS Hoosier Care Connect	P: 877-647-4848	F: Inpatient: 844-288-2591 Outpatient: 866-694-3649
	◯ UnitedHealthcare	P: 877-610-9785	F: 844-897-6514
Indiana PathWays for Aging	◯ Anthem PathWays	P: 833-569-4739	F: 877-410-0623
	◯ Humana PathWays	P: 866-274-5888	F: 502-324-6376
	◯ UnitedHealthcare PathWays	P: 877-610-9785	F: 844-897-6514

Please complete all appropriate fields.

Patient Information
IHCP Member ID:
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 Provider NPI:

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

Please check the requested assignment category below:
☐ Inpatient ☐ Residential

Requesting Provider Information
Requesting Provider NPI:
Taxonomy:
Taxpayer Identification Number (TIN):
Provider Name:
Provider Address:

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

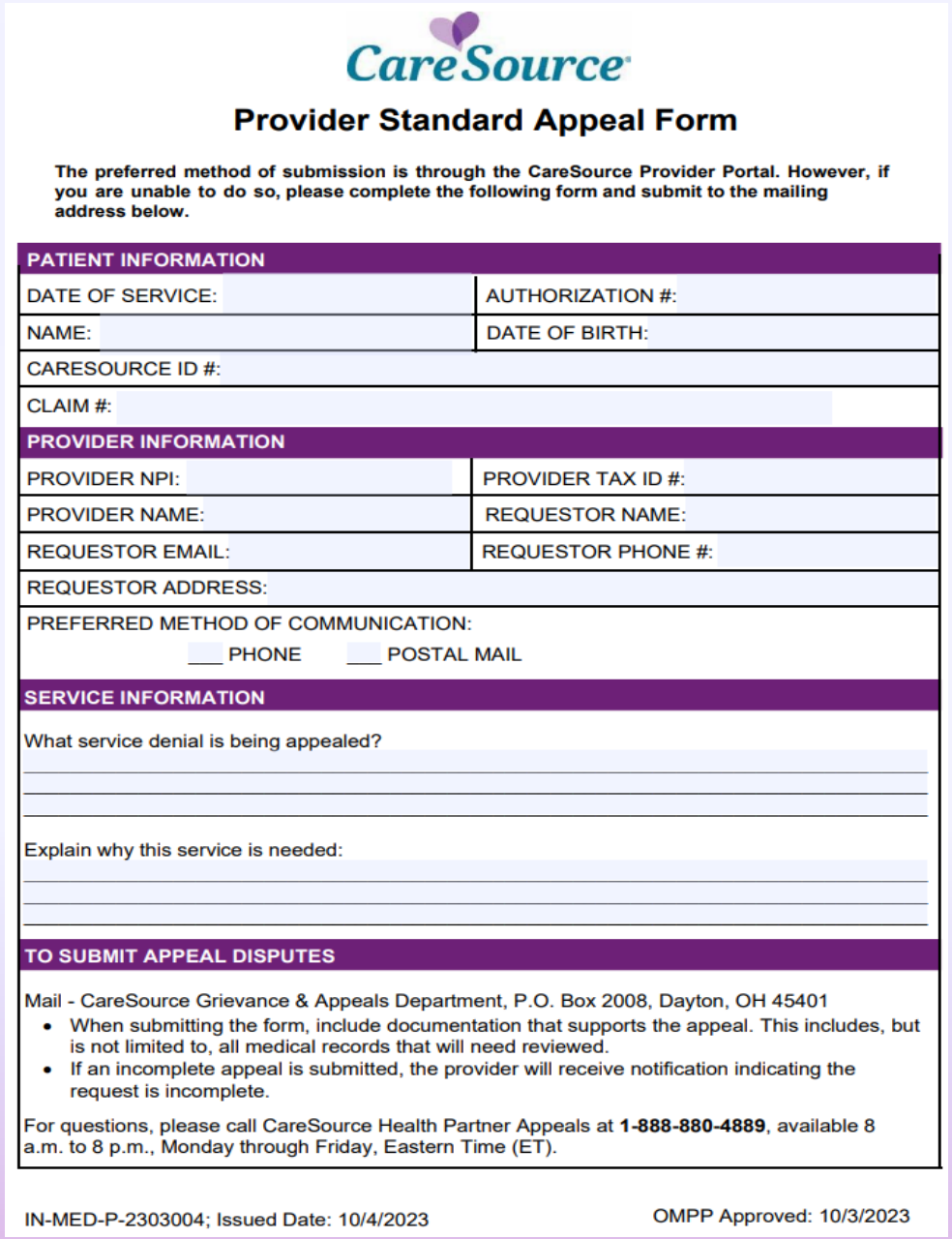
Preparer's Information
Name:
Phone:
Fax:

Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form
Version 6.2, August 2024

Page 1 of 2

Appeal Process

Provider Clinical/Claim Appeal Form



CareSource

Provider Standard Appeal Form

The preferred method of submission is through the CareSource Provider Portal. However, if you are unable to do so, please complete the following form and submit to the mailing address below.

PATIENT INFORMATION	
DATE OF SERVICE:	AUTHORIZATION #:
NAME:	DATE OF BIRTH:
CARESOURCE ID #:	
CLAIM #:	

PROVIDER INFORMATION	
PROVIDER NPI:	PROVIDER TAX ID #:
PROVIDER NAME:	REQUESTOR NAME:
REQUESTOR EMAIL:	REQUESTOR PHONE #:
REQUESTOR ADDRESS:	
PREFERRED METHOD OF COMMUNICATION: ___ PHONE ___ POSTAL MAIL	

SERVICE INFORMATION

What service denial is being appealed?

Explain why this service is needed:

TO SUBMIT APPEAL DISPUTES

Mail - CareSource Grievance & Appeals Department, P.O. Box 2008, Dayton, OH 45401

- When submitting the form, include documentation that supports the appeal. This includes, but is not limited to, all medical records that will need reviewed.
- If an incomplete appeal is submitted, the provider will receive notification indicating the request is incomplete.

For questions, please call CareSource Health Partner Appeals at **1-888-880-4889**, available 8 a.m. to 8 p.m., Monday through Friday, Eastern Time (ET).

IN-MED-P-2303004; Issued Date: 10/4/2023 OMPP Approved: 10/3/2023

After receiving a letter from CareSource denying coverage, a provider or member can submit a pre-service or post-service clinical appeal.

- **Denial of an authorization for a service prior to being completed:** You have 60 calendar days from the date of action notice to submit a pre-service appeal. The standard decision time frame is 30 calendar days from the date of receipt by CareSource. A 14-calendar day extension may be requested by CareSource.
- **Denial of an authorization for a service that has already been completed:** You have 60 calendar days from the date of action notice, discharge or authorization-denial to submit a post-service appeal. Member consent is required for post-service requests. The standard decision time frame is 30 calendar days from the date of receipt by CareSource.
- If you have not received an authorization denial for a service that requires a prior authorization, **you must submit a retro-authorization request prior to filing a clinical appeal.**

Provider Portal for Appeals (Select Clinical Appeals)

Expedited Authorization Appeals

If a provider feels that a patient's life or health is at risk if a decision about care is not made in a timely manner, you may ask CareSource to expedite a clinical appeal.

Contact Provider Services at **1-844-607-2831** to expedite a clinical appeal.

Expedited appeals will be resolved, and a verbal notification will be made within **48 hours**.

CareSource will decide whether to expedite an appeal within **24 hours**.

Administrative Denials

- Late notification of inpatient admission
- Member not eligible at time of request for authorization
- Late Retro Physician Denial
- Non-Covered Codes

Contacts

Communicating with Us

Provider Services	1-844-607-2831
Hours	Monday – Friday 8 a.m. to 8 p.m. Eastern Time (ET)

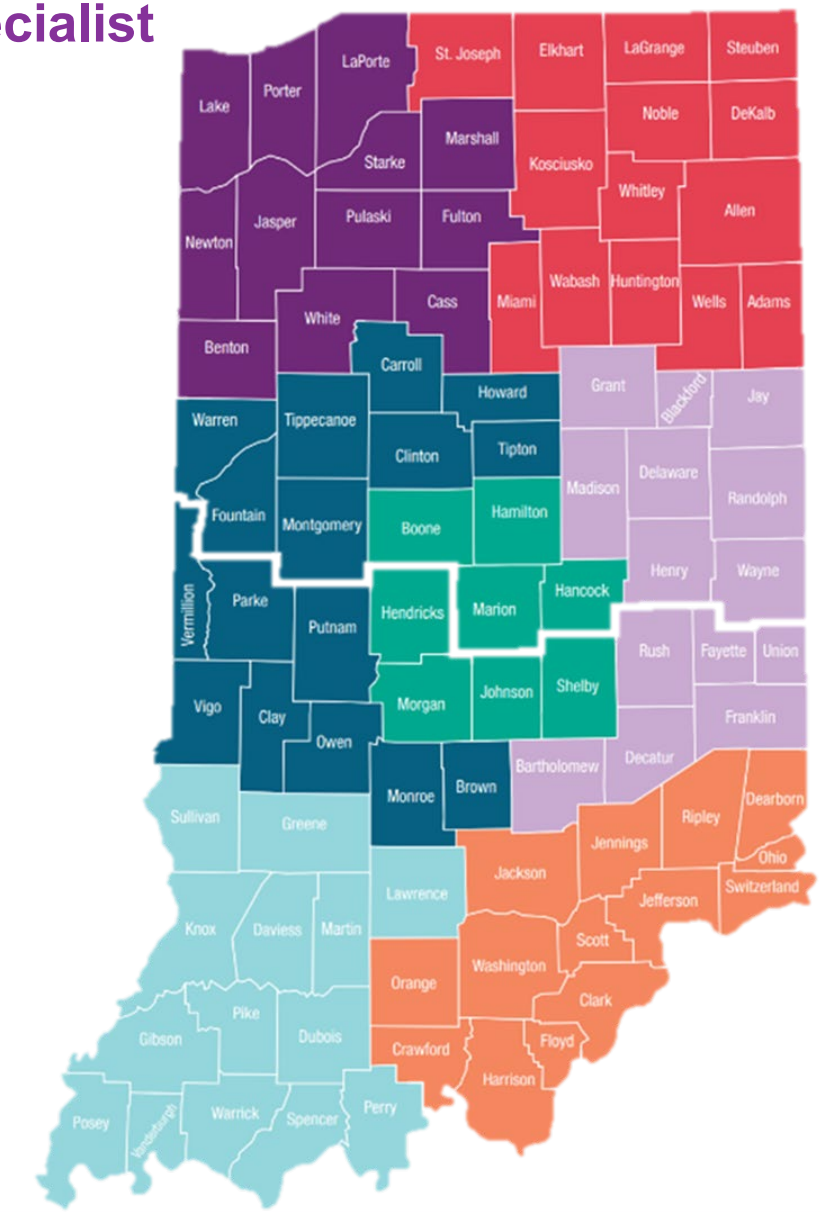
Member Services	1-844-607-2829
Hours	Monday – Friday 7 a.m. to 7 p.m. Eastern Time (ET)

Health Partner Engagement Representatives – Regional Specialist

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

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

Paula Egan
812-447-6661
Paula.Egan@CareSource.com
Deaconess, Ascension – St. Vincent Health



Leigh Hoover
765-425-0462
Leigh.Hoover@CareSource.com
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Francesca Mekos
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Eskenazi, Reid Health

Sarah Tinsley
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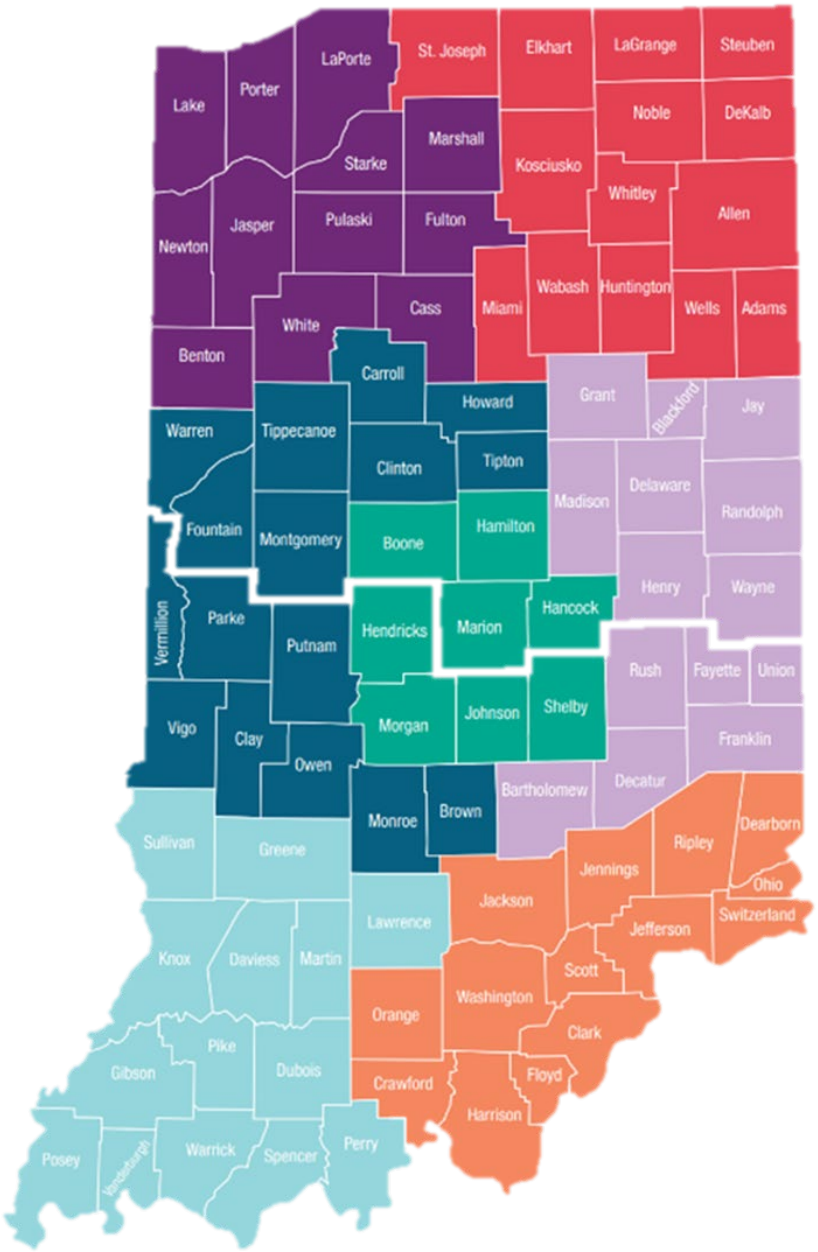
Indiana University, Suburban Health Organization

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

Health Partner Engagement Representatives – **Manager**

Amy Williams
Manager Health Partnerships
317-741-3347
Amy.Williams@CareSource.com



Health Partner Engagement Representatives – **Ancillary**

Brian Grcevich
Health Partner Engagement Specialist Ancillary, Dental, Skilled Nursing Facilities, Home Health and Hospice
317-296-0519
Brian.Grcevich@CareSource.com

Contact Us | Indiana – Medicaid | CareSource

Health Partner Engagement Representatives – **Behavioral Health**

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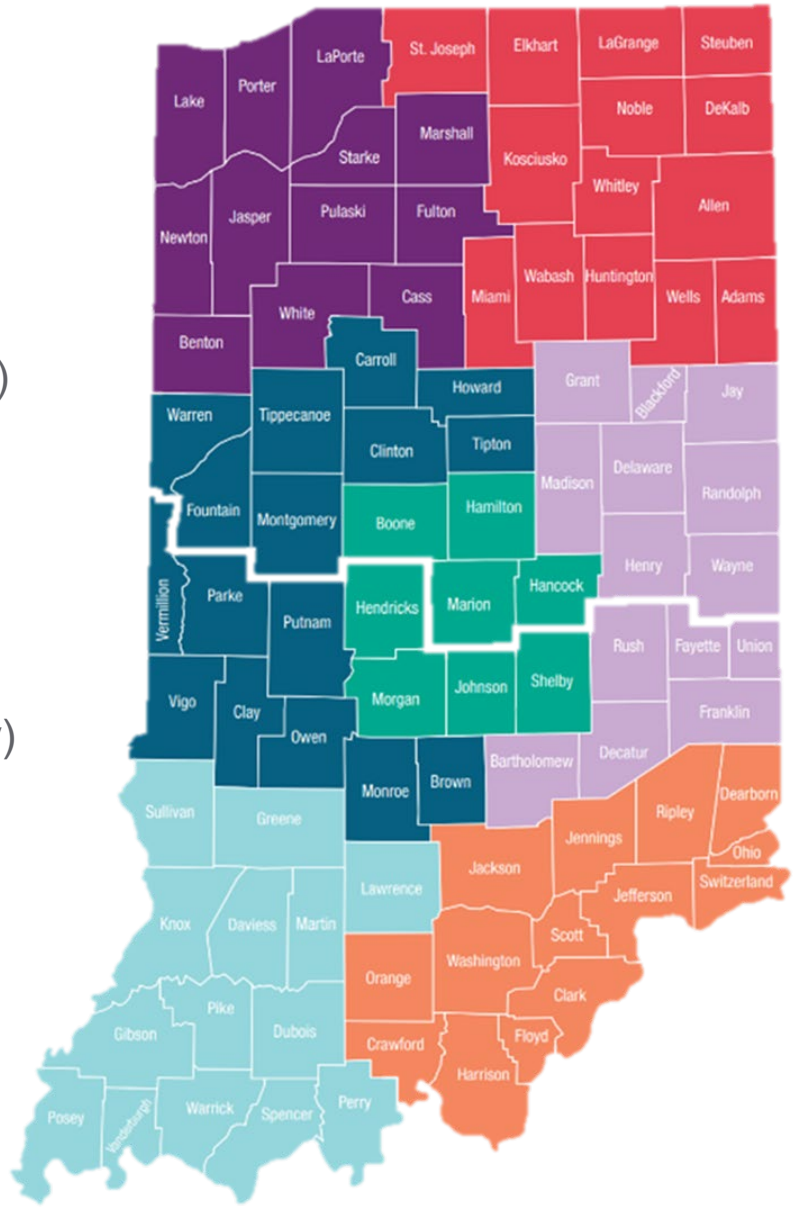
Amanda.Denny@CareSource.com

Stephanie Gates, Behavioral Health
Resolution Specialist (Southern Territory)
317-501-6380
Stephanie.Gates@CareSource.com



Contracting Managers – **Hospitals/Large Health Systems**

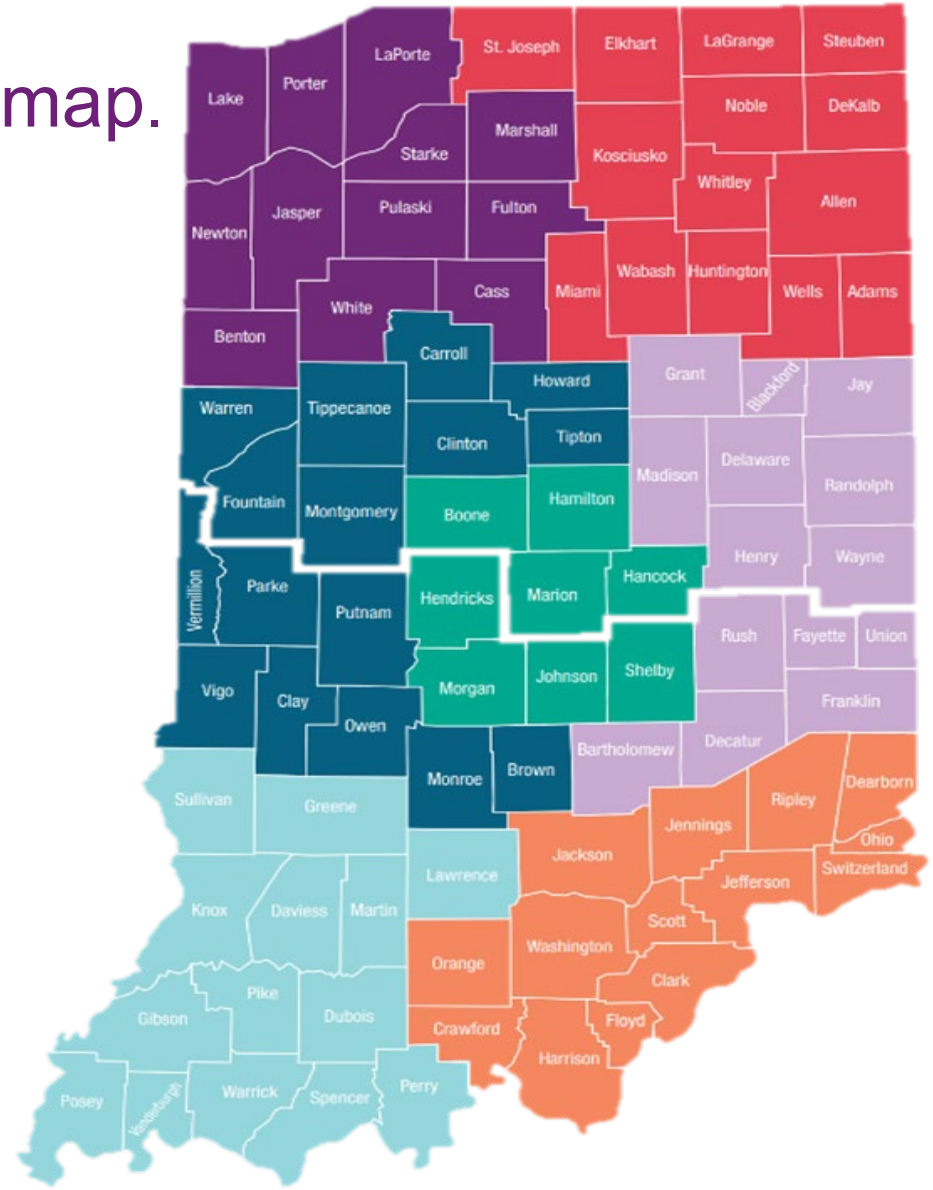
Maria Crawford (Northern Territory)
317-416-6854
Maria.Crawford@CareSource.com

Sara Culley (Southern Territory)
765-256-0423
Sara.Culley@CareSource.com

Contact Us | Indiana – Medicaid | CareSource

Scan for a copy of the HP Engagement map.

SCAN ME



Thank you!

CareSource®

IN-MED-P-3278255; Issued Date: 09/26/2024 OMPP Approved: 09/03/2024