# *Prior Authorizations*

**2020 IHCP Works**
Annual Seminar

# Agenda

- Prior Authorization Services
- Self-Referral Services
- Submission of Prior Authorization Requests
- Provider Portal and Authorizations
- Provider Portal Enhancements
- Timeframes
- Retro Authorizations
- NIA Magellan
- Dental Authorizations
- Sterilization/Hysterectomy
- Newborn Processes
- Appeal Process
- Important Reminders
- How to Contact Us

CareSource™

# *Prior Authorization Services*

| | |
|---|---|
| All Inpatient Services | All Inpatient Rehabilitative Service |
| Applied Behavior Analysis therapy services (ABA) | All Inpatient Behavioral Health admissions |
| Transcranial Magnetic Stimulation | Intensive Outpatient Program Services |
| Advanced Life Support (within 72 hours of the date of service) | Ambulance Transport – non-emergent |
| Genetic Testing | Hearing Aids |
| Home Health Care Services | Prosthetic and Orthotic devices >$1200 |
| Skilled Nursing Facility Services | Durable Medical Equipment >$500 |
| All powered or customized wheelchairs and supplies | All DME miscellaneous codes (example: E1399) |

# Prior Authorization Services

| | |
|---|---|
| Pain Management Services<br>➢Facets<br>➢Epidurals<br>➢Facets Neurotomy<br>➢SI Joints | Outpatient Services:<br>➢Cosmetic/Plastic/Reconstructive Procedures<br>➢Spinal Cord Stimulators<br>➢Implantable Pain Pumps |
| Organ Transplants | Partial Hospitalization Program (PHP) |
| Residential services | Services beyond benefit limits for members 20 years of age and under |
| Gender Dysphoria Surgeries | Any surgery or procedures that are potentially cosmetic or investigational will require a prior authorization |

# *Self-Referral Services*

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

## HHW Members

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

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

## HIP Members

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

**Exceptions**: Family planning & emergency services

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

# *Self-Referral Services*

The following services are eligible for self-referral:

- Psychiatric services
- Family planning services

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

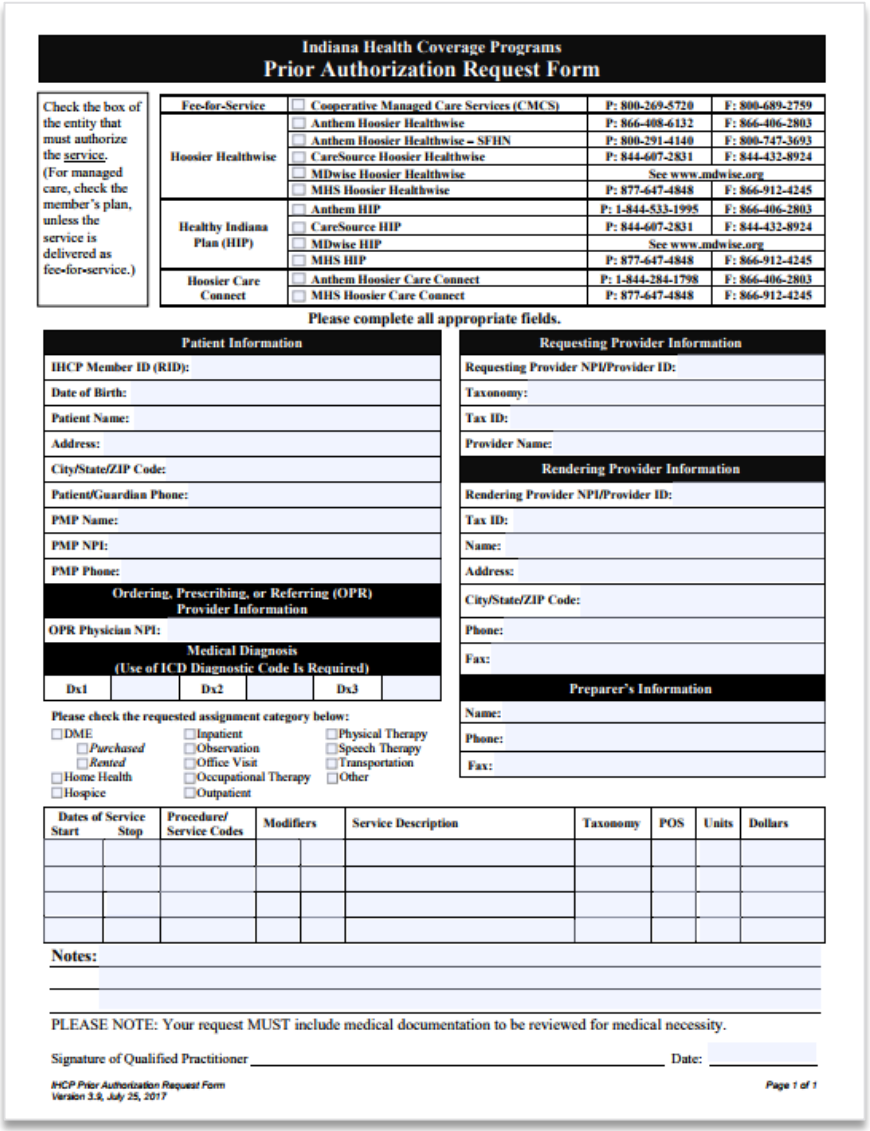
- Chiropractic services
- Eye care services, except surgical services
- Routine dental services
- Podiatry services

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

# How to Submit PA Requests

| | |
|---|---|
| **Email** | inmedmgt@caresource.com |
| **Phone** | 1-844-607-2831 |
| **Fax** | Fax the prior authorization form to 844-432-8924 including supporting clinical documentation. The prior authorization request form can be found on **CareSource.com.** |
| **Mail** | CareSource<br>Attn: IN Utilization Management<br>P.O. Box 44493<br>Indianapolis, IN 46244 |
| **Provider Portal** | Cite Auto Authorization |

# Prior Authorization Form



**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 3.9, July 25, 2017*

*Page 1 of 1*

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

It is located on the Forms page on **CareSource.com**:

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

# *Provider Portal & Prior Auths*

**Prior authorizations can be requested through the provider portal.**

- Select Provider Authorizations and Notifications
  - Enter CareSource ID and Start Date of Service and select Search.
    *Note: Member Eligibility is directly affected by date of service*
  - Select Care Setting, Category and type of Prior Authorization
  - Enter provider information. Use dropdown to search by Provider Name, NPI or Caresource Provider Number
  - Complete required fields and hit “Continue”
  - Select “Document Clinical” to continue
  - Click “Add” to choose Guideline of Service
  - Answer Guideline questions, hit Save and Submit Request

# *Prior Authorization List*

- Located on our Provider portal
  - Quick Reference Guide

# *Provider Portal Enhancements*

**You can now submit requests to update your authorization requests in the provider portal.**

- Add Additional documentation or change dates of service.
- Tip Sheet is located on the provider portal
- Under the Prior Authorization & Notifications you will also find links to step-by-step guides, FAQ's and everything you need to know to get the fastest response to your authorization request.

# *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 1-844-607-2831 or to go through the provider portal.**

# *Prior/Retro Authorization*
## *For Ancillary Providers*

In order for ancillary services requiring prior authorization to be approved, the services must be either authorized (specifically approving the ancillary services) or the primary service must be authorized.

| Ancillary Provider Types |
| --- |
| Radiology |
| Anesthesiology |
| Pathology |
| Hospitalist services |
| Labs |
| Other professional services performed in an inpatient or outpatient setting. |

# *Retrospective Authorizations*
## *For Advanced Life Support*

As of November 15, 2019, Advanced Life Support (ALS) ambulance trips are required to have a retrospective authorization for services.

- Authorization requests must be submitted within **7 days** after the date of trip.
- Failure to submit a retrospective authorization for ALS services may result in a claim denial.

# NIA Magellan

CareSource partners with NIA Magellan to implement a 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 number: |
|---|---|---|
| • CT/CTA<br>• MRI/MRA<br>• PET Scans<br>• Myocardial Perfusion Imaging (MPI)<br>• MUGA Scan<br>• Echocardiography<br>• Stress Echocardiography | • Inpatient advanced imaging services<br>• Observation setting advanced imaging services<br>• Emergency room imaging services | • 1-800-424-4883 |

- How to submit
  - https://www1.radmd.com/radmd-home.aspx or
  - 1-800-424-4883

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

# *Dental Authorizations*

CareSource partners with Scion 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 ProviderPortal@scion.com 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.
- Submit authorizations with attachments for faster determinations.

**PAPER:**
Paper dental authorization requests may be sent to:

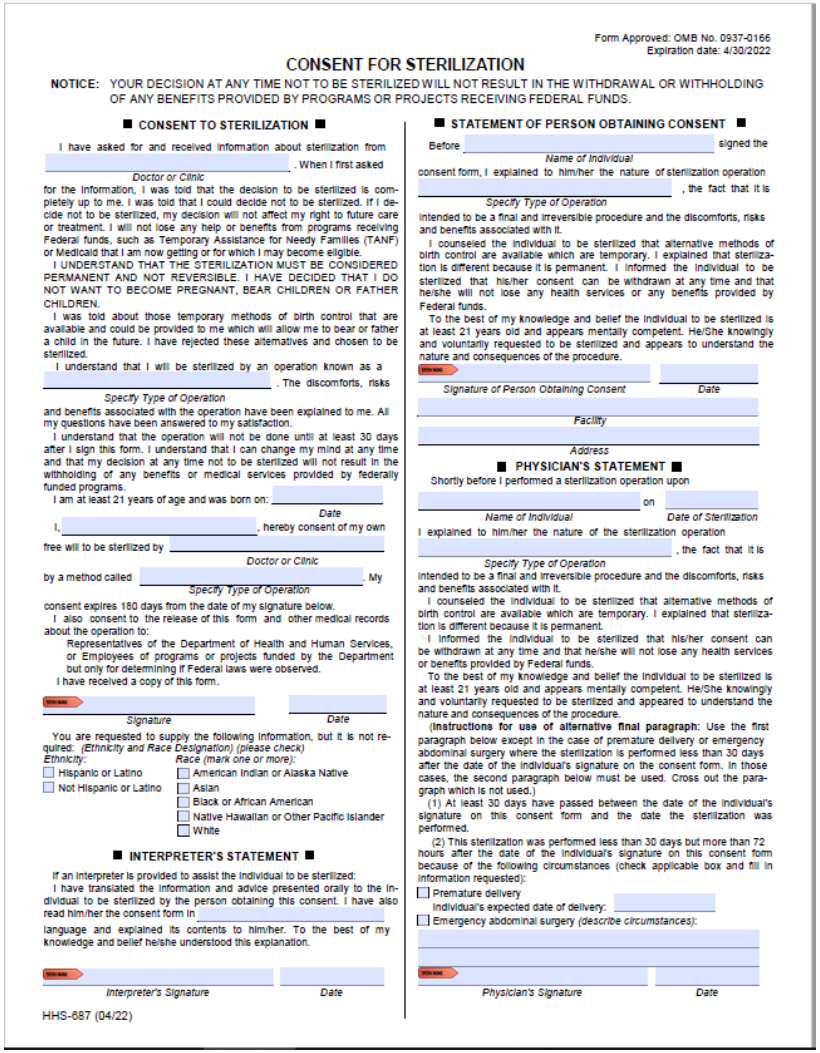
CareSource IN: Authorizations
P.O. Box 745
Milwaukee, WI, 53201

Please reference our Dental Health Partner Manual for a list for services that require prior authorization.

# *Sterilizations*

- Sterilization renders a person unable to reproduce.
- Sterilizations are reimbursable for men and women only when a valid consent form accompanies all claims connected.
- Providers must allow at **least 30 days** and **no more than 180 days** to pass between the date the member gives the informed consent and the date when the provider performs the sterilization procedure.
- For sterilizations planned concurrent with delivery, the patient must give the informed consent at **least 30 days** before the expected date of delivery.
- The individual must meet the following requirements:
  - Has voluntarily given informed consent
  - Is 21 years old or older at the time the consent is given.
  - Is neither mentally incompetent nor institutionalized.

# Consent for Sterilization Form



Form Approved: OMB No. 0937-0166
Expiration date: 4/30/2022

**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 (04/22)

**■ 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)

Please reference the following Family Planning Services Provider Reference Module on the IHCP Provider website for information on how to complete the consent sterilization form if you have any questions.

- **Please note that all lines need to be signed and dated.**
- **Complete facility address, complete rendering provider address, including all ZIP Codes**
- **If it's not 100% complete it will not be valid.**

# *Patient Sterilization*

- A sterilization consent form is not necessary when a provider renders a patient sterile as a result of an illness or injury.
  - The physician must attach a certification to the claim indicating that the sterilization procedure occurred due to an illness or injury when prior acknowledgement was not possible.
- A sterilization consent form is not required when ONLY a partial sterilization is performed. Providers ***must note*** "Partial Sterilization" on the claim form, on the line below the CPT or HCPCS procedure code. For electronic claims, a claim note may be used.

# *Hysterectomy*

- IHCP covers medically necessary hysterectomies performed to treat an illness or injury.
- Only covers when medically necessary and only when the member has given informed consent.
- Does not cover hysterectomies performed solely to render a member permanently incapable of bearing children whether performed as a primary or secondary procedure.
- Providers cannot use the **Consent for Sterilization** form for hysterectomy procedures.
- Form must be submitted with claim to be considered for payment.

# 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)

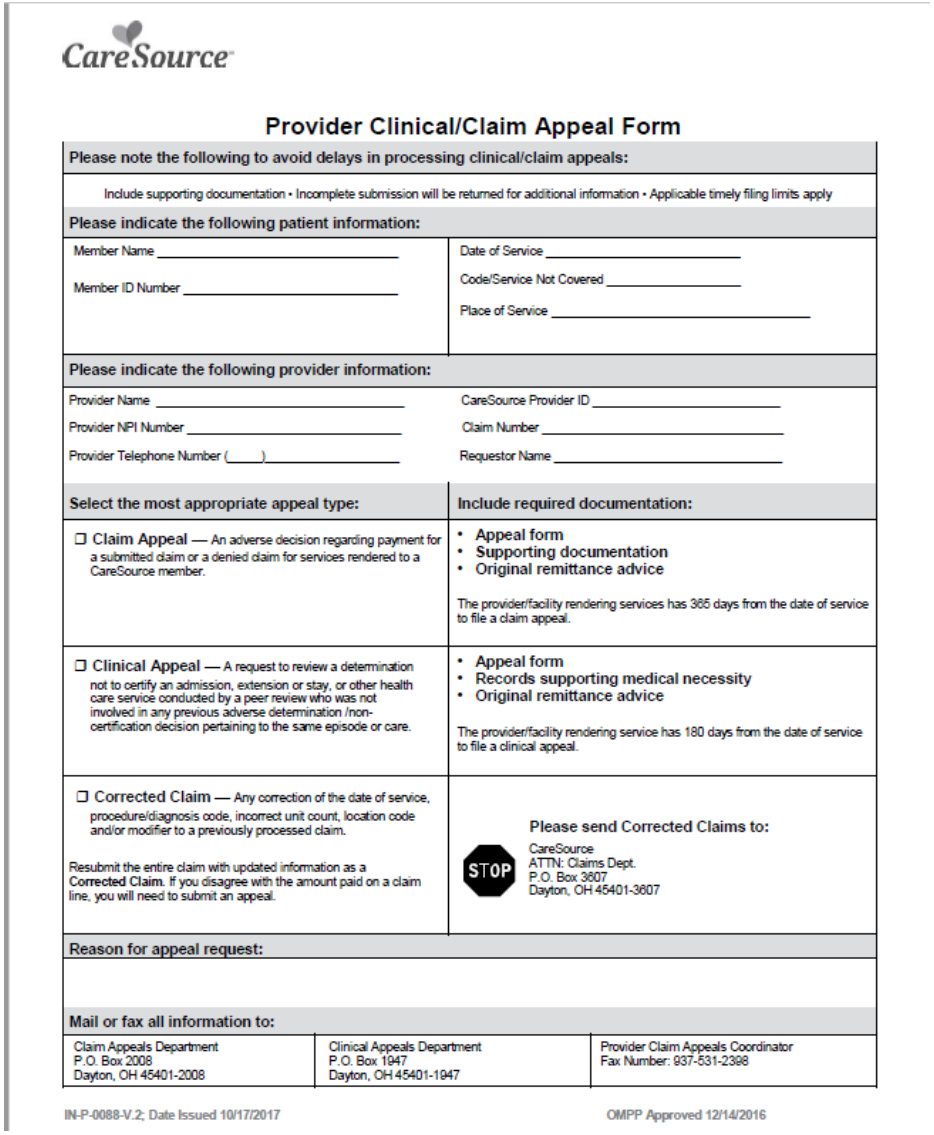
# *Newborns/NICU Process*

- **CareSource does NOT require newborn notification.**
- Deliveries do not require authorization **unless** inpatient stay exceeds mandate of **3 days** for vaginal delivery and **5 days** for C-section **OR** if the mother is discharged and newborn remains inpatient.
  - In the case of eligibility changing while baby is inpatient, providers have **60 days** after date of change of eligibility status to request a retro-authorization for services rendered while patient was inpatient.
  - All information showing change of eligibility must accompany the request for retro-authorization and copy of the Retro-Authorization must be submitted with claim.

# *Expedited Appeals*

- Call us at 1-855-202-1058 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<br>• Supporting documentation<br>• Original remittance advice<br>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<br>• Records supporting medical necessity<br>• Original remittance advice<br>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.<br>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:**<br>STOP<br>CareSource<br>ATTN: Claims Dept.<br>P.O. Box 3607<br>Dayton, OH 45401-3607 |

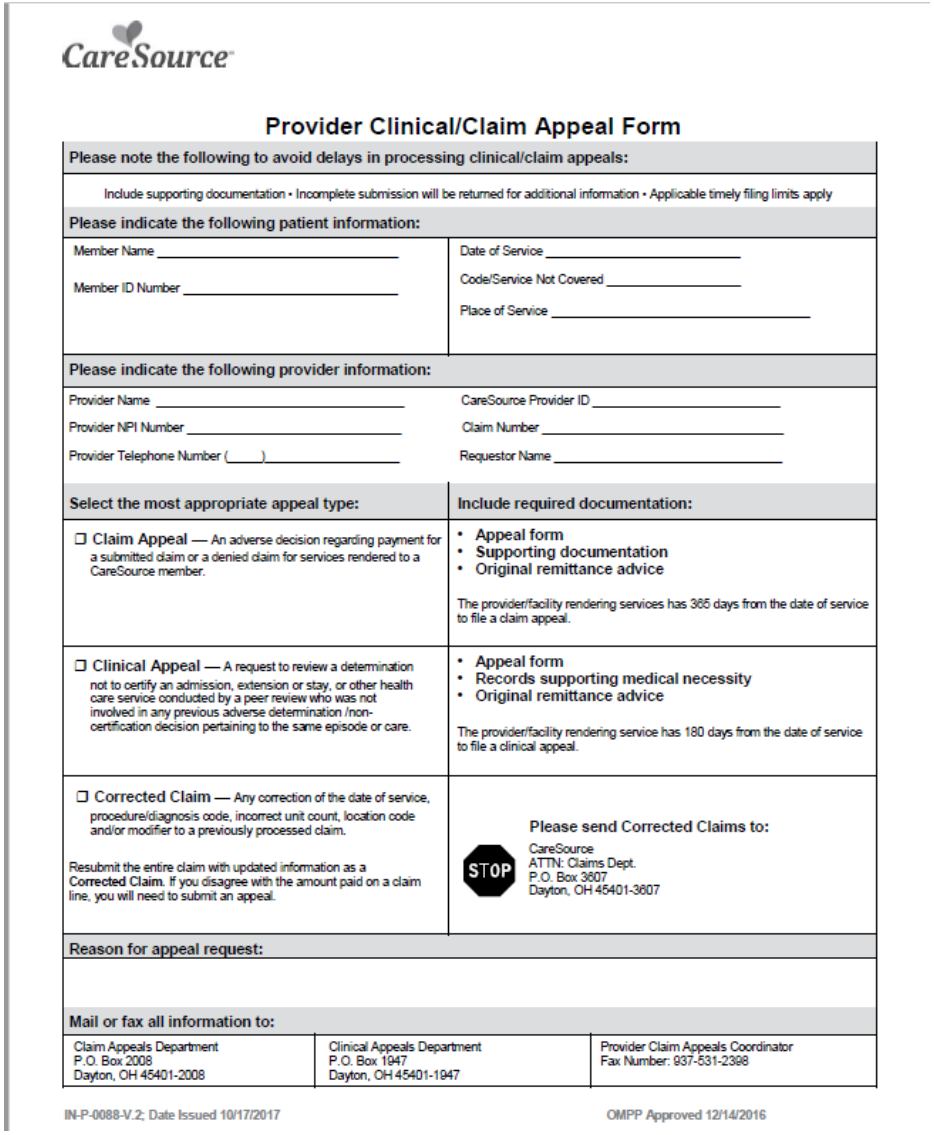
**Reason for appeal request:**

**Mail or fax all information to:**

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

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

# 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<br>• Supporting documentation<br>• Original remittance advice<br><br>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<br>• Records supporting medical necessity<br>• Original remittance advice<br><br>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.<br><br>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:**<br>STOP<br>CareSource<br>ATTN: Claims Dept.<br>P.O. Box 3607<br>Dayton, OH 45401-3607 |

**Reason for appeal request:**

**Mail or fax all information to:**

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

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

# *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

# *Peer to Peer Review*

- Our members' health is always our number one priority. 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. If you would like to discuss an adverse decision with physician reviewer, please call the Provider services line at **1-833-230-2168** within five 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.

# *Important Information*

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

# *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

# CareSource Health Partner Engagement Representatives

**Denise Edick, Manager, Health Partnerships**
317-361-5872
Denise.Edick@caresource.com

**Amy Williams, Team Lead, Health Partnerships**
317-741-3347
Amy.Williams@caresource.com

**Angelina Warren, Behavioral Health Partner Engagement Specialist (Northern Territory)**
317-658-4904
Angelina.Warren@caresource.com

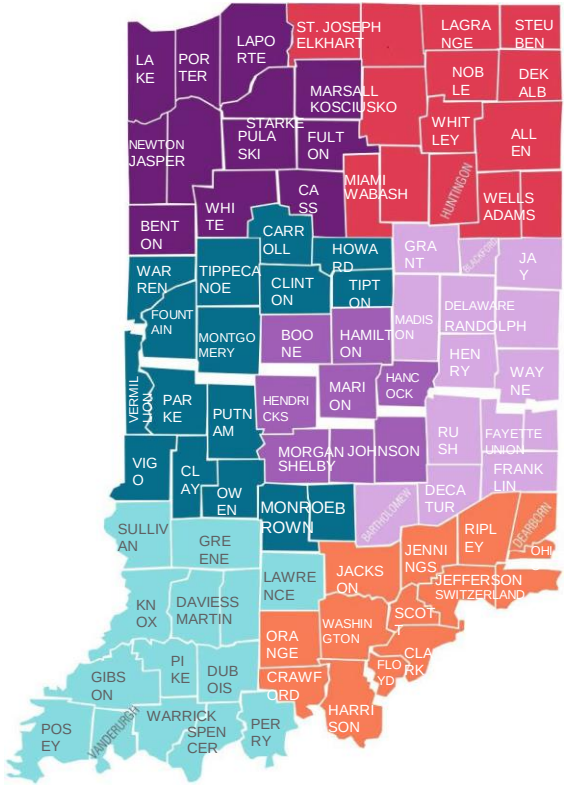
**Stephanie Gates, Behavioral Health Partner Engagement Specialist (Southern Territory)**
317-501-6380
Stephanie.Gates@caresource.com

**Brian Grcevich, Ancillary, Associations and Dental**
317-296-0519
Brian.Grcevich@caresource.com

## Contracting Managers – Hospitals/Large Health Systems

**Tenise Cornelius – North**
317-220-0861
Tenise.Cornelius@caresource.com

**Mandy Bratton – South**
317-209-4404
Mandy.Bratton@caresource.com




## Regional Representatives

**Tammy Garrett**
219-221-7065
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# Test YOUR Knowledge

- Is the Sterilization Consent Form utilized for a Hysterectomy?
- When is the Sterilization Consent Form not needed?
- What kind of procedures need authorization through NIA Magellan/RAD?
- How many different ways are there to submit a prior authorization?

# Test YOUR Knowledge Answers

- **Is the sterilization Consent Form utilized for a Hysterectomy?**
  - *No, a Hysterectomy utilizes the Acknowledgement of Receipt of Hysterectomy Information*
- **When is the Sterilization Consent Form not Needed?**
  - *For a Partial Sterilization - When the provider renders a patient sterile as a result of an illness or Injury.*
- **What kind of procedures need authorization through NIA Magellan/RAD?**
- *CT, MRI, PET Scans, Myocardial Perfusion Imaging, MUGA Scan, Echocardiology, Stress Echo*
- **How many different ways are there to submit a prior authorization?**
  - *5 – Email, Phone, Fax, Mail & Provider Portal*