

Referrals and Prior Authorizations



This section describes the referral and prior authorization processes and requirements for services provided to CareSource and CareSource Advantage members. Please visit our Provider Portal at www.caresource.com for the most current information on prior authorization and referral requirements.

Referrals

If you have difficulty finding a specialist for your CareSource or CareSource Advantage member, please call Provider Services at **1-800-390-7102**.

Access to Staff

1. Staff are available from 8 a.m. to 5 p.m. during normal business hours for inbound calls regarding Utilization Management (UM) issues
2. Staff can receive inbound communication regarding UM issues after normal business hours
3. Staff can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon
4. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues
5. Staff are available to accept collect calls regarding UM issues
6. Staff are accessible to callers who have questions about the UM process.

Medicaid

Services That *Do Not* Require a Referral

Some health care services provided by specialists do not require a referral from a Primary Care Provider (PCP). Members may schedule self-referred services from participating providers themselves. PCPs do not need to arrange or approve these services for members as long as any applicable benefit limits have not been exhausted. These include the following:

- Certified Nurse Midwife (CNM) services
- Certified Nurse Practitioner (CNP) services
- Chiropractic care (within benefit limits)
- Services to treat an emergency
- Family planning services (Planned Parenthood)
- Laboratory services (must be ordered by a participating provider)
- Podiatric care (within benefits limits)
- Care at public health clinics

Some health care services provided by specialists do not require a referral from a Primary Care Provider. Members may schedule self-referred services from participating providers themselves.

- Care at Federally Qualified Health Centers (FQHCs)
- Radiology services (must be ordered by a participating provider)
- Routine eye exams (at participating vision centers; within benefit limits)
- Hearing services
- Care from obstetricians and gynecologists
- Care at urgent care centers after hours

Members May Go to Nonparticipating Providers for:

- Emergency care
- Family planning services provided at Qualified Family Planning Providers (Planned Parenthood)
- Care at Federally Qualified Health Centers (FQHCs)

Referral Procedures

A referral is required for specialty services not listed above and for plan members to be evaluated or treated by most specialists. Any treating doctor can refer CareSource members to specialists. Please refer to our website for more information on services that require a referral.

Simply put a note about the referral in the patient’s chart. Please remember, non-participating specialists must request prior authorization for any services rendered to CareSource patients. You can request a prior authorization by calling our Medical Management Department at **1-800-390-7102**, and select the option to request a prior authorization. You can also submit a request online on the Provider Portal option via the menu.

If you have difficulty finding a specialist for your CareSource member, please call Provider Services at **1-800-390-7102**.

Referring doctor — Document the referral in the patient’s medical chart. You are not required to use a referral form or send a copy of it to our health plan. However, you must notify the specialist of your referral.

Specialist — Document in the patient’s chart that the patient was referred to you for services. Referral numbers are not required on claims submitted for referred services. Generally, specialist-to-specialist referrals are not allowed. However, in some cases, specialists may provide services or make referrals in the same manner as a PCP. Documentation in the medical record should contain the number of visits or length of time of each referral. Medical records may be subject to random audits to ensure compliance with this referral procedure.

Standing referrals — A PCP may request a standing referral to a specialist for a member with a condition or disease that requires specialized medical care over a prolonged period of time. The specialist may provide services in the same manner as the PCP for chronic or prolonged care. The period of time must be at least one year to be considered a standing referral.

Simply put a note about the referral in the patient’s chart. Please remember, non-participating specialists must request prior authorization for any services rendered to CareSource patients.

Referrals to out-of-plan providers — A member may be referred to out-of-plan providers if the member needs medical care that can only be received from a doctor or other health care provider who is not participating with our health plan. Treating providers must get prior authorization from our health plan before sending a member to an out-of-plan provider (see Prior Authorization Procedures section below).

Referrals for second opinions — A second opinion is not required for surgery or other medical services. However, health care providers or members may request a second opinion at no more cost to the member than if the service was obtained in network.

A member may be referred to out-of-plan providers if the member needs medical care that can only be received from a doctor or other health care provider who is not participating with our health plan.

The following criteria should be used when selecting a provider for a second opinion:

- The provider must be a participating provider. If not, prior authorization must be obtained to send the patient to a non-participating provider.
- The provider must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.
- The provider must be in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.

Prior Authorization Procedures

Prior authorizations for health care services can be obtained by contacting the Medical Management Department online, by email, phone, fax or mail:

Online: www.caresource.com

Email: Please contact Medical Management at **1-800-390-7102** for the email address related to your request.

Fax: **1-888-577-5507**. Copies of prior authorization forms can be found in the Supplements/Forms section of this manual.

Mail: Send prior authorization requests to:

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

Phone: **1-800-390-7102** and follow the appropriate menu prompts for authorization requests, depending on your need.

When requesting an authorization, please provide the following information:

- Member/patient name and CareSource member ID number
- Provider name and NPI
- Anticipated date of service
- Diagnosis (by ICD-9-CM code and narrative)
- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan provider, if applicable
- Clinical information to support the medical necessity for the service

If the request is for **inpatient admission** (whether it is elective, urgent or emergency), please include admitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs.

If **inpatient surgery** is planned, please include the date of surgery, surgeon and facility, admit date, admitting diagnosis and presenting symptoms, plan of treatment, and anticipated discharge needs.

If the request is for **outpatient surgery**, please include the date of surgery, surgeon and facility, diagnosis and procedure planned, and anticipated discharge needs.

Prior authorization is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and benefit limitations. When a prior authorization is requested for a service rendered in the same month, member eligibility is verified at the time the request is received. When the service is to be rendered in a subsequent month, authorization is given contingent upon member eligibility on the date of service. Providers must verify eligibility on the date the service is to be rendered. CareSource is not able to pay claims for services provided to ineligible members. It is important to request prior authorization as soon as it is known that the service is needed.

All services that require prior authorization from CareSource should be authorized before the service is delivered. CareSource is not able to pay claims for services in which prior authorization is required but not obtained by the provider. CareSource will notify you of prior authorization determinations by a letter mailed to the provider address on file.

For standard prior authorization decisions, CareSource provides notice to the provider and member as expeditiously as the member's health condition requires but no later than 14 calendar days following receipt of the request for service. Urgent prior authorization decisions are made within 72 hours of receipt of request for service. Please specify if you believe the request is urgent.

Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent on eligibility, benefits and other factors. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

Providers must verify eligibility on the date the service is to be rendered. CareSource is not able to pay claims for services provided to ineligible members. It is important to request prior authorization as soon as it is known that the service is needed.

Medicaid Services That Require Prior Authorization

Please refer to Covered Services and Exclusions section of this manual for more information on services that require a prior authorization. Services are provided within the benefit limits of the member's enrollment. They include, but are not limited to the following services:

- All Inpatient Care
- All Abortions
- Some Home Care Services
- Nursing Facility Services
- Hospice Care
- Organ Transplants
- Cosmetic procedures and plastic surgery
- For Ambulette Transportation, please call our Transportation vendor.
- Ambulance transportation except for emergent or facility-to-facility transfers
- Some Durable Medical Equipment including:
 - All powered or customized wheelchairs
 - Manual wheelchair rentals over 3 months
 - All miscellaneous codes (example E1399)
- Food supplemental/nutritional supplements
- Some Diagnostic Procedures
- Pain Management
- MRI/MRA scans

In addition, any health care provider who is not a participating provider with CareSource must obtain prior authorization for all non-emergency services provided to a CareSource member.

CareSource does not require prior authorization for unlisted procedure CPT codes. However, it requires a clinical record be submitted with your claim to review the validity of the unlisted procedure CPT code.

- Claims submitted without clinical records for unlisted procedure CPT codes will be denied. Denials will be reconsidered through the appeal process with pertinent clinical records.

Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits (and other factors). Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

Please note that our prior authorization requirements are subject to change. Please refer to www.caresource.com for the most current information on services that require prior authorization and the prior authorization process.

Claims submitted without clinical records for unlisted procedure CPT codes will be denied.

Synagis Prior Authorization

CareSource Medical Policy for administration of Synagis follows the AAP guidelines. CareSource will review according to the guidelines in determining payment authorization for Synagis immunization. Consistent with epidemiologic findings, CareSource considers “RSV season” to be November 1 through March 31. Coverage for the RSV season will end March 31st with an extension possible if RSV is still endemic in the community. Requests for Synagis injections can be submitted on our secure Provider Portal.

CareSource will notify providers on www.caresource.com of more detailed information on Synagis authorization process, policy, coding and claims.

Utilization Management (UM)

Utilization Management (UM) helps maintain the quality and appropriateness of health care services provided to CareSource members. The Medical Management Department performs all utilization management activities including prior authorization, concurrent review, discharge planning, and other utilization activities. We monitor inpatient and outpatient admissions and procedures to ensure that appropriate medical care is rendered in the most appropriate setting using the most appropriate resources. We also monitor the coordination of medical care to ensure its continuity. Referrals to the CareSource case management team are made, if needed. CareSource makes its UM criteria available in writing by mail, fax or email and via the web. On an annual basis, CareSource completes an annual assessment of satisfaction with the UM process and identifies any areas for improvement opportunities.

The Medical Management Department performs all utilization management activities including prior authorization, concurrent review, discharge planning, and other utilization activities.

Clinical Guidelines — CareSource utilizes nationally recognized clinical guidelines to determine medical necessity and appropriateness of inpatient hospital, rehabilitation and skilled nursing facility admissions. These guidelines are designed to assist health care providers in identifying the most efficient quality care practices in use today. They are not intended to serve as a set of rules or as a replacement for a physician’s medical judgment about individual patients. CareSource defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services. CareSource also has medical policy developed to supplement nationally recognized clinical guidelines. If a patient’s clinical information does not meet the guidelines, the case is forwarded to a medical director for further review and determination. Physician reviewers from CareSource are available to discuss individual cases with attending physicians upon request. Guidelines are also available upon request by contacting our Medical Management Department.

CareSource defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services. CareSource also has medical policy developed to supplement nationally recognized clinical guidelines.

Utilization review determinations are based only on appropriateness of care and service and existence of coverage. CareSource does not reward health care providers or our own staff for denying coverage or services. There are no financial incentives for our staff members that encourage them to make decisions that result in underutilization.

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 CareSource's adverse decision with CareSource's physician reviewer, please call the Medical Management Department at **1-800-390-7102** within five business days of the determination.

Appeals Procedure

If you are dissatisfied with a determination made by our Medical Management Department regarding a member's health care services or benefits, you may appeal the decision. Please see the Appeal Procedures section in this manual for information on how to file a clinical appeal.

Retrospective Review

A retrospective review is defined as a request for an initial review for authorization of care, service or benefit for which an authorization is required but was not obtained prior to the delivery of the care, service or benefit. Prior authorization is required to ensure that services provided to our members are medically necessary and provided appropriately. In the event that you fail to obtain prior authorization, you will have 180 days from the date of service or 180 days from the inpatient discharge date to request a retrospective review for medical necessity.

Requests for retrospective review that exceed these timeframes will be denied and are ineligible for appeal. If the request is received within these timeframes and a medical necessity denial is issued, you may submit a request for an appeal within 180 days from the date of the service or 180 days from the inpatient discharge date. A request for retrospective review can be made by contacting the Medical Management Department at **1-800-390-7102** and following the appropriate menu prompts, or by faxing the request to 1-888-527-0016. Clinical information supporting the request for services must accompany the request.

In the event that you fail to obtain prior authorization, you will have 180 days from the date of service or 180 days from the inpatient discharge date to request a retrospective review for medical necessity.

Surgical Procedure Forms

CareSource requires the same certification and consent forms for surgical procedures performed on Medicaid members that the Michigan Department of Community Health (MDCH) accepts. Copies of the hysterectomy and sterilization consent forms are included in the Supplements/Forms section of this manual. The most current copies can also be obtained online at www.Michigan.gov.

Medicare

Medicare members are not required to obtain referrals from their PCP prior to obtaining services from specialists. However PCPs are asked to assist Special Needs Plan (SNP) members in obtaining specialty services.

If you have difficulty finding a specialist for your CareSource member, please call Provider Services at **1-800-390-7102** and select the option to speak to someone in our Medical Management Department.

Please note that members may go to non-participating providers for:

- Emergency care
- Out of area dialysis care
- Out of area urgently needed care

Services rendered by out-of-plan providers — A member may be sent to out-of-plan providers if the member needs medical care that can only be received from a doctor or other health care provider who is not participating with our health plan. PCPs must get prior authorization from our health plan before sending a member to an out-of-plan provider. You can request a prior authorization by calling our Medical Management Department at **1-800-390-7102**, and select the prompt to request a prior authorization.

Second opinions — A second opinion is not required for surgery or other medical services. However, health care providers or members may request a second opinion at no cost to the member other than applicable co-payments, co-insurance and deductibles. The following criteria should be used when selecting a provider for a second opinion:

- The provider must be a participating provider. If not, a prior authorization must be obtained to send the patient to a non-participating provider.
- The provider must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.
- The provider must be in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.

You can request a prior authorization by calling our Medical Management Department at 1-800-390-7102, and select the prompt to request a prior authorization.

Prior Authorization Procedures

Prior authorizations for health care services can be obtained by contacting the Medical Management Department by online, email, fax, mail, or phone:

Online: Go to the provider section of www.caresource.com and select the option for prior authorizations.

Email: Please contact Medical Management at **1-800-390-7102** for the email address related to your request.

Fax: Send all medical prior authorization requests to 1-888-577-5507.

A copy of the prior authorization form can be found in the Supplements/Forms section of this manual.

Mail: Send prior authorization requests to:

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

Phone: Call our toll-free number at **1-800-390-7102** and follow the menu prompts to speak to someone about prior authorizations. Then press the appropriate menu prompts for pharmacy, dental or other authorization requests, depending on your need.

When requesting an authorization, please provide the following information:

- Member/patient name and CareSource member ID number
- Provider name and NPI
- Anticipated date of service
- Diagnosis (by ICD-9-CM code and narrative)
- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan provider, if applicable

If the request is for **inpatient admission** (whether it is elective, urgent or emergency), please include admitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs.

If **inpatient surgery** is planned, please include the date of surgery, surgeon and facility, admit date, admitting diagnosis and presenting symptoms, plan of treatment, and anticipated discharge needs.

If the request is for **outpatient surgery**, please include the date of surgery, surgeon and facility, diagnosis and procedure planned, and anticipated discharge needs.

Prior authorization is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and benefit limitations. When a prior authorization is requested for a service rendered in the same month, member eligibility is verified at the time the request is received. When the service is to be rendered in a subsequent month, authorization is given contingent upon member eligibility on the date of service. Providers must verify eligibility on the date the service is to be rendered. CareSource is not able to pay claims for services provided to ineligible members. It is important to request prior authorization as soon as it is known that the service is needed.

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For standard prior authorization/certification decisions, CareSource provides notice to the provider and member as expeditiously as the member's health condition requires but no later than fourteen calendar days following receipt of the request for service. Urgent prior authorization/certification decisions are made within 72 hours of receipt of request for service. Please specify if you believe the request is urgent.

Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent on eligibility, benefits and other factors. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

Medicare Services That Require Prior Authorization

Services are provided within the benefit limits of the member's enrollment. They include, but are not limited to the following services:

- All Inpatient Care
- All Abortions
- Some Home Care Services
- Nursing Facility Services
- Hospice Care
- Organ Transplants
- Durable Medical Equipment over \$750.00 billed charges
- Prosthetic devices over \$750.00 billed charges
- Cosmetic procedures and plastic surgery
- Non-Formulary Drug Requests
- Some Part B and Part D drugs
- Ambulance transportation – except for emergent or facility-to-facility transfers
- Physical Therapy visits greater than 20 per calendar year
- Occupational Therapy visits greater than 20 per calendar year
- Speech Therapy visits greater than 15 per calendar year
- Chiropractic visits greater than 12 per calendar year
- Mental Health/Psychiatry visits greater than 20 per calendar year
- Podiatry office visits greater than 8 per calendar year
- Substance abuse services greater than 12 per calendar year

In addition, any health care provider who is not a participating provider with CareSource must obtain prior authorization for all non-emergency services provided to a CareSource member.

CareSource does not require prior authorization for unlisted procedure CPT codes. However, we require a clinical record be submitted with your claim to review the validity of the unlisted procedure CPT code.

- Claims submitted without clinical records for unlisted procedure CPT codes will be denied. Denials will be reconsidered through the appeal process with pertinent clinical records.

Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits (and other factors). Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

Please note that our prior authorization requirements are subject to change. Please refer to our website, www.caresource.com, for the most current information on services that require prior authorization and the prior authorization process.

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Utilization review determinations are based only on appropriateness of care and service. CareSource does not reward health care providers or our own staff for denying coverage or services. There are no financial incentives for our staff members that encourage them to make decisions that result in underutilization. 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 CareSource's prior authorization decision with CareSource's physician reviewer, please call the Medical Management Department at **1-800-390-7102** within five business days of the determination.

Appeals Procedure

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Retrospective Review

A retrospective review is defined as a request for an initial review for authorization of care, service or benefit for which an authorization is required but was not obtained prior to the delivery of the care, service or benefit. Prior authorization is required to ensure that services provided to our members are medically necessary and provided appropriately. In the event that you fail to obtain prior authorization, you will have 180 days from the date of service or 180 days from the inpatient discharge date to request a retrospective review for medical necessity. Requests for retrospective review that exceed these time frames will be denied and are ineligible for appeal. If the request is received within these time frames and a medical necessity denial is issued you may submit a request for an appeal within 180 days from the date of the service or 180 days from the inpatient discharge date.

A request for retrospective review can be made by contacting the Medical Management Department at **1-800-390-7102** and following the appropriate menu prompts, or by faxing the request to 1-888-527-0016. Clinical information supporting the request for services must accompany the request.