CareSource | NETWORK Notification

**Notice Date:** May 13, 2022
**To:** Indiana Medicaid Providers
**From:** CareSource
**Subject:** Retro Authorization Submission Guidelines

---

**Summary**
CareSource would like to remind all providers of prior authorization submission guidelines, as previously published in a network notification on June 7, 2021.

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

**Impact**
405 IAC 5-3-9 Requirement Section 9
Prior authorization will be given after services have begun or supplies have been delivered only under the following circumstances:

(1) Pending or retroactive member eligibility. The prior authorization request must be submitted within twelve (12) months of the date of the issuance of the member's Medicaid card.
(2) Mechanical or administrative delays or errors by the office.
(3) Services rendered outside Indiana by a provider who has not yet received a provider manual.
(4) Transportation services authorized under 405 IAC 5-30. The prior authorization request must be submitted within twelve (12) months of the date of service.
(5) The provider was unaware that the member was eligible for services at the time services were rendered. Prior authorization will be granted in this situation only if the following conditions are met:
    a. The provider's record document that the member refused or was physically unable to provider the member ID (RID) number.
    b. The provider can substantiate that the provider continually pursued reimbursement from the patient until Medicaid eligibility was discovered.
    c. The provider submitted the request for prior authorization within sixty (60) days of the date Medicaid eligibility was discovered.

Unless the CareSource member is transitioning and qualifies under the retroactive coverage requirements, all of the above criteria will need to be met to qualify for a retro authorization review. Claims not meeting the necessary criteria as described above will be administratively denied. 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, date of discharge, or date of denial if service was not yet rendered.

**Please note:** If you are appealing on our member's behalf with their written consent, you have 60 calendar days from the date of the action notice.

CareSource aligns with fee-for-service billing guidance and does not reimburse providers for any service requiring PA unless PA is obtained first. If a PA request qualifies for retroactive eligibility, as defined above, a determination must be made prior to submitting a claim.

**Questions?**
For questions, please contact Provider Services at: **1-844-607-2831**, or contact your Provider Engagement Specialist.

IN-MED-P-1211050 Issued Date: 4/27/22 OMPP Approved: 4/27/22