CareSource | NETWORK Notification

Notice Date: August 8, 2025
To: IN Medicaid Providers
From: CareSource
Subject: Prior Authorization Determination Requirement Update

Summary
Pursuant to Senate Bill 0480.06, CareSource has updated the timeframes for prior authorization determinations and notifications to the following:

Review Type	Determination Timeframe	Extension	Notification Timeframe
Initial Inpatient	48 calendar hours from time of receipt		48 calendar hours from time of receipt
Concurrent/ Continued Stay	48 calendar hours from time of receipt		48 calendar hours from time of receipt
Pre-Service Urgent	24 hours from receipt of request*	May extend the timeframe for 14 Calendar Days for the member or member's representative to provide additional information in cases where the information provided initially fails to provide sufficient information to determine whether or to what extent, benefits are covered or payable; Notification of the benefit determination is made as soon as possible, but no later than 14 Calendar Days after the earlier of the receipt of the additional information or the end of the period afforded, the member or member's representative to provide the specified additional information	Within 24 hours* of receipt of request Within 14 calendar days if extension granted
Standard Pre-Service	48 hours from receipt of request*	May extend timeframe once due to lack of information, for up to 14 calendar days, if the member requests the extension. Must notify member and member's authorized representative of decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension timeframes	Within 48 hours* of receipt of request. Within 14 calendar days if extension granted
Retrospective	Within 30 calendar days from receipt of request		Within 30 calendar days of receipt of request

*Timeframe excludes weekends and federal holidays

It is imperative to submit sufficient information to determine medical necessity. If sufficient information is not provided, CareSource will notify the member or member's representative within twenty-four (24) hours of receipt request of the specific information necessary to make an authorization determination. The member or member's representative will be afforded a reasonable amount of time, considering the circumstances, but not less than twenty-four (24) hours, to provide the specified information. Notification of the benefit determination will be made as soon as possible, but in no case later than twenty-four (24) hours after the earlier of CareSource's receipt of the specified additional information; or the end of the period afforded to the member or member's representative to provide the specified additional information.

In the event of a denial determination, alter or limit coverage for an admission, service, procedure or extension of stay, based on medical necessity, or to approve a service in an amount, duration or scope that is less than requested, the requesting practitioner/provider will be offered the ability to have the determination reconsidered through a Peer-to-Peer discussion within seven (7) business days of the denial notification.

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