Network Notification

Notification Date:	**January 30, 2019**
To:	**Hoosier Healthwise and Healthy Indiana Plan Providers**
From:	**CareSource®**
Subject:	**Notice of Changes to Retro Prior Authorization Timeframe Requirements**
Effective Date:	**April 1, 2019**

SUMMARY:

Effective **April 1, 2019**, CareSource will update retro prior authorization timeframe requirements for Hoosier Healthwise and Healthy Indiana Plan providers.

WHAT YOU SHOULD KNOW:

Upon written request, CareSource *shall not permit* retrospective authorization submission for 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:

405 IAC 5-3-9 Requirement Sec. 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 records document that the member refused or was physically unable to provide the member identification (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.

NEXT STEPS:

When submitting a retro authorization request, the following documentation must be provided:

- Member name and CareSource ID number
- Authorization number of the previously authorized service that the request is related to
- All supporting documentation related to the service