Prior Authorization FAQ

- How do I obtain prior authorization?

  - Providers can obtain prior authorization for health care services by contacting the CareSource Medical Management department by phone, fax, mail, online Provider Portal or e-mail. Requests can be submitted on the Kentucky Medicaid Prior Authorization Request Form.

    Submit a prior authorization request:

    - Online Prior Authorization via the Provider Portal
    - By phone: (1-855-852-7005)
    - By fax: (1-888-246-7043)
    - By email: (kymedicalmanagement@caresource.com)
    - By mail:

      CareSource
      Attn: Medical Management Department Kentucky Medical Management
      P.O. Box 1307 P.O. Box 8738
      Dayton, OH 45401-1307 Dayton, OH 45401

- Is authorization needed for referrals to specialists?
  - Some health care services provided by specialists do not require a referral from a PCP. Members may schedule self-referred services for participating health partners. PCPs do not need to arrange or approve these services for members as long as applicable benefit limits have not been exhausted. A Prior Authorization is needed to refer a member to a non-participating provider. Please see the CareSource Provider Manual for more details.

- Is authorization needed for outpatient, non-emergent diagnostic procedures?
  - Some non-emergent diagnostic procedures require prior authorization. A prior authorization is required for non-emergent services performed by a non-participating provider. Humana – CareSource partners with HealthHelp to provide consultation of high-tech radiology services. Ordering physicians should contact HealthHelp for non-emergent MRI, MRA, CT, CTA, and PET scans by contacting 1-877-637-6940.

- Is authorization required for an observation?
  - Authorization for an observation stay in a participating facility is not required. An observation in a non-participating facility **does** require an authorization and must be reported to the Medical Management department.

- Does CareSource require authorization if the member has primary insurance?
  - Prior authorization is not required when CareSource is the secondary payer for medical services.

- How do I request a retrospective review?
  - Health partners have **180 days** from the date of service, date of discharge or **90 days** from another carrier's denial on an Explanation of Payment (EOP), whichever is later, to request a retrospective review for medical necessity. The retrospective review request must include a copy of the other carrier's EOP. All requests for services will be reviewed for timeliness and medical necessity.

    Health partners can request a retrospective review by contacting the Medical Management department at **1-855-852-7005**or by faxing the request to1-888-246-7043. Clinical information supporting the request for services must accompany the request.