NETWORK *Notification*

Notice Date: May 18, 2021
To: CareSource Providers
From: CareSource
Subject: Utilization Management Process
Effective Date: July 2, 2021

Summary

CareSource is proud to partner with our providers and deliver transparent communication. This notice outlines Utilization Management's processes and expectations. Effective July 2, 2021, CareSource's Utilization Management department will no longer accept emailed requests for authorization. The processes outlined in the attachments include:

- Administrative denials
- Inpatient initial and concurrent review
- Standard and urgent prior authorizations
- Post service review

Providers may submit requests for any of the outlined processes by utilizing the CareSource Provider Portal or by submitting the request via fax.

Plan	Fax Numbers
Ohio Medicaid	Outpatient: 888-752-0012 Inpatient/Skilled Nursing Facility/Inpatient Rehab/Long-term Acute Care: 937-487-0412 Behavioral Health: 937-487-1664 Transplants: 937-487-0646
MA/D-SNP/MyCare	Outpatient/Inpatient: 844-417-6157 Behavioral Health: 937487-1664 Skilled Nursing Facility: 844-417-6157
Marketplace	Outpatient: 844-676-0372 Emergency Inpatient Admissions: 937-396-3728 Skilled Nursing Facility: 937-487-0730

Administrative Denials

An administrative denial is a decision not to approve coverage for a requested service where the decision is not based on medical necessity.

CareSource authorization/notification requirements are outlined in the Provider Manual found on **CareSource.com** > Providers > Provider Manual. Failure to adhere to CareSource policies and procedures may result in an administrative denial or delay of reimbursement.

Administrative denials are made when a provider does not adhere to CareSource policies or processes pertaining to obtaining an authorization and/or providing notification in a timely manner. Examples of these rules may include, but are not limited to:

- Late notification of an inpatient admission
- Failure to obtain prior authorization
- Lack of state required form(s) that may be mandated for the requested service
- Non-covered benefit or service
- Services rendered by an out of network provider without prior authorization in non-emergent situations
- Duplicative services without prior authorization
- Lack of/loss of member eligibility
- Exhaustion of benefits

Peer-to-peer discussions are for adverse medically necessary determinations only and are not offered for administrative denials.

Patient Initial and Concurrent Review (Acute and Post-acute)

CareSource does not require prior authorization and/or pre-certification for:

- Emergency services, including crisis stabilization services
- Post-stabilization services, or
- Urgent care services.

CareSource requires notification of an emergent admission within one (1) business day of the admission.

For initial admission:

- The staff reviews inpatient lengths of stay according to Milliman Clinical Guidelines (MCG) clinical criteria.
- If criteria are met, a CareSource clinical reviewer can approve up to the maximum MCG length of stay.
- If criteria are not met, a CareSource medical director will review the request and make a determination.
- Once a determination is made, the facility will be notified of the decision and number of days (if approved) via fax or portal notification. *Provider logs will no longer be utilized for notification of approval information.*

For continued stay reviews (days beyond the initial approval):

- Once the initial approval is exhausted, the facility/provider is required to submit up-to-date clinical documentation, including any potential discharge needs, to substantiate the need for additional inpatient days.

- The staff reviews the up-to-date clinical documentation against MCG clinical criteria.
- If criteria are met, the number of days given upon continued stay review is determined by the member's clinical status and MCG guidelines.
- If criteria are not met, a CareSource medical director will review the request and make a determination.
- Once a determination is made, the facility will be notified of the decision and number of days (if approved) via fax or portal notification. *Provider logs will no longer be utilized for notification of approval information.*

All discharge information, including date and discharge summary, should be sent to CareSource once available.

CareSource providers are able, in most instances, to receive a real-time determination when they enter their notification/continued stay requests through Cite Auto Auth on the CareSource Provider Portal. All determinations are made in accordance with the applicable timeliness standards.

Standard and Urgent Prior Authorization

Neither the member nor the provider is required to obtain prior authorization for emergency services.

Providers should use the Procedure Code Lookup Tool to instantly view whether a service code requires prior authorization from CareSource.

Service Limits:

- CareSource may place appropriate limits on a service based on criteria such as medical necessity or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.
- CareSource may place appropriate limits on a service for utilization control, provided:
  - Services supporting members with ongoing or chronic conditions are authorized in a manner that reflects the member's ongoing need for such services and supports.
  - Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used.

Providers should ensure that expedited/urgent requests meet the definition for urgent care (expedited). Any request for medical or behavioral health care or treatment that would meet the following definitions if provided within the non-urgent (standard) authorization timeframe

i. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or
ii. In the opinion of an attending health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
iii. In determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the issuer shall apply the judgement of a prudent layperson who possesses an average knowledge of health and medicine.
iv. Any request that an attending health care professional, with knowledge of the covered person's medical condition, determines is an urgent care request within the meaning of (i) or (ii), is treated as an urgent care request.
v. Urgent care includes all requests for hospitalization and outpatient surgery that also meet criteria indicated in (i) and (ii).

The provider will be notified of requests that do not meet the definition of urgent/expedited. These requests will be processed in accordance with the applicable timeliness standards for standard prior authorization.

For urgent and non-urgent requests, both initial and ongoing, authorization dates of service will be based on, but not limited to:

- Member's current clinical status and documentation (e.g., office visit notes, imaging results)
- Member compliance with home or other instruction (e.g., medications, exercise, conservative)
- Member's compliance and/or attendance to previously approved service(s)
- Progress towards goals, if ongoing
- Amount and duration of services, if specified in clinical criteria

Post Service Review

At certain times CareSource will conduct post service reviews of medical services received by members when the request is received within thirty (30) calendar days of the date of service, of retrospective enrollment into the plan or in compliance with a specific provider contract. In these instances, the member's medical record is reviewed, and a decision is rendered within thirty (30) calendar days of receiving all information reasonably necessary to make a determination. In the case of an adverse determination, the attending or treating health care practitioner, institutional provider and/or member are notified of the decision and the reason for the decision.

Post service reviews which are requested greater than 30 calendar days past the date of service or date of retrospective enrollment will be administratively denied.

When a provider/practitioner submits a claim related to a retrospective/post service authorization request prior to the review and determination, the claim will be denied as the case is pending and no authorization is on file.

A retrospective/post-service review is performed under the following circumstances:

- When a CareSource member is unable to advise the provider what plan they are enrolled in due to a condition that renders them unresponsive or incapacitated.
- The member is retrospectively enrolled and covers the date of service.
- When urgent service(s) requiring authorization was/were performed and it would have been to the member's detriment to take the time to request authorization.
- The new service was not known to be needed at the time the original prior authorized service was performed.
  - The need for the new service was revealed at the time the original authorized service was performed.
- The service was directly related to another service for which prior approval has already been obtained and that has already been performed.
- For services provided to a dual eligible member and the provider is notified that Medicare benefits have been exhausted after delivery of service.
- Based on specific provider contract terms.