CareSource | NETWORK Notification

Notice Date: March 15, 2022
To: Ohio Providers
From: CareSource
Subject: Retro Authorization Submission Guidelines

Summary
CareSource would like to remind all providers of prior authorization submission guidelines, as previously published.

Providers may submit requests for authorization by utilizing the Provider Portal, or by submitting the request via fax. Upon request, CareSource shall permit retrospective review within 30 days of the date of service, date of discharge, or retrospective enrollment where a prior authorization was required but not obtained, often known as **retro authorization**. 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.

Impact
A retrospective review may be processed in 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.

Submitting a claim for a service or provider requiring an authorization without there being an authorization on file, will result in a claim denial. Retroactive eligibility does not eliminate the need for medical necessity review. Visit the Prior Authorization webpage or refer to the Provider Manual for additional information.

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

A request for retrospective review can be made on the Provider Portal.

Request Submission Details
Providers can also fax a retrospective review request to the following numbers below:

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

Questions?
For questions, please contact Provider Services at one of the following numbers.
- Ohio Medicaid/MyCare & Marketplace: **1-800-488-0134**
- Ohio Medicare Advantage: **1-844-607-2827**
  Ohio D-SNP: **1-833-230-2020**

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