ADMINISTRATIVE POLICY STATEMENT
Arkansas PASSE

Policy Name & Number	Date Effective
Prior Authorization Submission for Providers-AR PASSE-AD-1660	11/01/2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statements contain supplemental information regarding standard benefit administration and coverage details. Administrative Policy Statements do not guarantee an authorization or payment of services. The Member's plan contract (e.g., Evidence of Coverage, Member Handbook) contains specific terms and conditions, including limitations, exclusions, benefit maximums, eligibility, and other relevant conditions of coverage. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document. Reasonable discretion may be used in interpreting and applying this Policy Statement to services provided in a particular case, and the policy may be modified at any time. Policy Statements may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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A. Subject

Prior Authorization Submission for Providers

B. Background

Prior authorization (PA) is a utilization management process used to confirm that requested services meet applicable coverage requirements and medical necessity standards before the service is rendered. Timely PA determinations rely on providers submitting complete, accurate, and clinically relevant information. Incomplete requests may delay review, require additional information, or result in administrative denial, which can affect access to medically necessary care.

Standardized information and documentation requirements for providers requesting PA for covered CareSource services have been established. The minimum standards for provider, member, service, and clinical documentation promote consistent and efficient reviews, support regulatory compliance, and help ensure timely authorization decisions for CareSource members.

C. Definitions

- **Prior Authorization** – A request for products or services based on medical necessity, medical appropriateness, and benefit limits prior to the product or service being rendered or dispensed.

D. Policy

I. CareSource expects providers to submit the following required information and documentation contained within this policy when requesting PA.

A. provider information from the requesting/servicing provider **AND** facility, when applicable

1. name
2. address of treatment location
3. tax identification number (Tax ID)
4. national provider identifier (NPI)
5. telephone number
6. fax number
7. email address, optional but recommended

B. member information for whom PA is requested

1. member name
2. member identification number (ie, CareSource number, Medicaid number)
3. date of birth
4. address

C. service information clearly identifying the requested service(s)

1. service code(s): CPT and/or HCPCS code(s) related to requested service(s)
   NOTE: Unspecified, investigational, or experimental codes or codes not recognized under the National Correct Coding Initiative (NCCI) will be rejected.
2. quantity: number of visits, units, or treatments requested, if applicable
3. level of care: specific for the service (eg, behavioral health, physical health, inpatient, outpatient, skilled nursing facility [SNF], other)

4. request type: emergent or standard, (eg, behavioral health, physical health, inpatient, outpatient, SNF, other)

D. clinical documentation requirements supporting medical necessity
   1. diagnoses: relevant ICD-10 diagnosis code(s) for the condition(s) requiring treatment
   2. procedure/service: relevant clinical information to support CPT/HCPCS code(s) for the requested service(s)
   3. clinical summary: justification of the request, including applicable clinical history or supporting data
   4. emergent requests: rationale clearly documenting the urgency and medical necessity

***Examples of supporting clinical data may include:**

Clinical History/Treatment Setting	Objective of Documentation
Failed emergency or observation care related to the condition	Demonstrate acute need, severity, or failed lower-acuity management, as applicable.
Outpatient treatments or therapies provided	Demonstrate prior management, response to treatment, and rationale for requested service.
Ongoing inpatient hospital treatment(s) and clinical process related to the request	Demonstrate clinical treatment plans and progression, anticipated length of care or discharge needs, and other applicable clinical information.
Other pertinent clinical details	Demonstrate medical necessity using relevant/recent findings (eg, history & physical, progress notes, diagnostic labs or tests, or functional limitations or impairment).

II. Submission Guidelines
   A. PA requests lacking any required elements may be denied or returned to the provider for completion.
   B. Any notification of returned, rejected, or denied requests will include the specific reason(s) for such action to assist in correction, resubmission, or appeal.
   C. Providers are encouraged to submit comprehensive clinical information with the initial request to avoid processing delays.

III. Submission Channels
   For questions or assistance, providers may contact CareSource Provider Services.
   A. Electronic submission through the designated provider portal or electronic data interchange (EDI) is the preferred and most efficient method for PA submission.
   B. Fax submissions are discouraged and should be used only when electronic options are unavailable.
   C. Telephonic submission is not accepted to ensure complete documentation and timely processing.

E. Conditions of Coverage

I. PA approval is not a guarantee of payment. Payment is subject to member eligibility, covered benefits, medical necessity, provider contract requirements, coordination of benefits, and accurate coding and billing at the time services are rendered.

II. This policy does not supersede state or federal regulations, contract guidelines or any other applicable regulations. It also does not supersede any CareSource policy for a specific product or service that outlines information necessary for PA review.

III. All information relevant and related to the requested individual service and place of service should be included. Providers should refer to *PA Look-up Tool* (PLT) for PA requirements for specific codes. Incomplete information provided may result in PA delay and/or inability to process the PA request.

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	08/12/2026	New policy. Approved at Committee.
Date Revised		
Date Effective	11/01/2026	
Date Archived		

H. References

NA