Network Notification

Notice Date:	**May 1, 2020**
To:	**West Virginia Marketplace Providers**
From:	**CareSource**
Subject:	**COVID-19: Prior Authorization Guidance**
Effective Date:	**April 20, 2020 (for dates of service Feb. 1-April 1, 2020)**

Beginning on May 12, 2023, this notification is expiring in alignment with the end of the Public Health Emergency.

Summary
In response to COVID-19, for elective admissions and procedures, hospitals and providers will only be required to submit *basic information* on the universal prior authorization form or the managed care health plan care/authorization portals. Clinical documentation is *not required*, but may still be submitted to support the assignment of health plan care managers to patients in need of support services.

Please consider the following in your submission:

- This would only apply to elective procedures that *have not* already been performed.
- Individual providers will be notified of the decision to extend authorizations.
- Notifications from providers when a patient is admitted for the procedure is helpful, but *not required.*
- This change is limited to inpatient procedures only, as outpatient procedures do not currently require prior authorization.

This change applies to both participating and non-participating providers in response to the following Office of Insurance (OIC) requirement:

Utilization Review. Timely decision making is essential to responding appropriately to COVID-19, and it is particularly important with respect to utilization review. Health insurers are reminded that utilization review decisions must be made in the timeframes required by law. Health insurers should not use preauthorization requirements as a barrier to access necessary treatment for COVID-19, and health insurers should be prepared to expedite utilization review and appeal processes for services related to COVID-19 when medically appropriate.

Impact
If a provider receives a prior authorization request for:

Initial/Concurrent Inpatient/Emergent Procedures

- Follow business as usual process. Providers should notify CareSource when a patient is admitted.

Elective Procedures

- All insurers will waive any prior authorization requirements for screening and diagnostic testing for COVID-19 and respond to any requests for treatment of COVID-19 on a timely basis.
- Insurers will approve if the elective procedure is life-saving.
- All elective procedures with prior authorizations issued February 1 will be extended six months.

Questions?
Please visit the CareSource COVID-19 Provider Resource Center to keep updated on working with us during the outbreak.

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