



# NETWORK *Notification*

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

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## 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
West Virginia Marketplace	Outpatient/Inpatient/Behavioral Health/Skilled Nursing Facility Requests 844-676-0370

### **Questions?**

For questions, please contact Provider Services at: **1-855-202-1091**.