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 July 2, 2021, 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
	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

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.

- 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 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 m

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

- e.g., office visit notes, imaging results)
- Member compliance with home or other instruction (e.g., medications, exercise, conservative)
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- 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 membe