

Referrals and Prior Authorizations

This section describes the referral and prior authorization processes and requirements for services provided to CareSource Members. Please visit our **Provider Portal** for the most current information on prior authorization (PA) and referral requirements.

Referrals

CareSource offers a no-hassle referral process. No forms or referral numbers are needed. The Member's Primary Care Provider (PCP) simply documents the referral in the patient's medical chart and notifies the specialist. PCPs are asked to assist Members in obtaining specialty services if needed.

If you have difficulty finding a specialist for your CareSource or CareSource Advantage Member, please call Provider Services at **1-800-390-7102**.

If you have questions about referrals and prior authorizations, please call Medical Management at **1-800-390-7102**.

Medical Management

The Medical Management Department is responsible for health care resource utilization review and monitoring the health care provided to our Members. Some health care services and supplies must be authorized by our Medical Management team before they can be provided to a CareSource Member. Please contact the Medical Management Department with requests for prior authorizations, hospital admissions, organ transplants and benefit limit extensions.

Medical Prior Authorizations

Prior Authorization may be requested via our website, by telephone, or in writing from the CareSource Medical Management Department. Faxes should be sent to 1-888-577-5507.

Access to Staff

1. Staff is available from 8 a.m. to 5 p.m. during normal business hours for inbound calls regarding Utilization Management (UM) issues.
2. Staff can receive inbound communication regarding UM issues after normal business hours.
3. Staff can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.
4. Staff is identified by name, title and organization name when initiating or returning calls regarding UM issues.
5. Staff is available to accept collect calls regarding UM issues.
6. Staff is accessible to callers who have questions about the UM process.

Medicaid Services That Do Not Require a Referral

Some health care services provided by specialists do not require a referral from a PCP. Members may schedule self-referred services from participating Providers themselves. PCPs do not need to arrange or approve these services for Members as long as any applicable benefit limits have not been exhausted.

These include the following:

- Certified Nurse Midwife (CNM) services
- Certified Nurse Practitioner (CNP) services
- Chiropractic care (within benefit limits)
- Services to treat an emergency
- Family planning services (Planned Parenthood)
- Laboratory services (must be ordered by a participating Provider)
- Podiatric care (within benefits limits)
- Care at public health clinics
- Care at Federally Qualified Health Centers (FQHCs)
- Radiology services (must be ordered by a participating Provider)
- Routine eye exams (at participating vision centers; within benefit limits)
- Hearing services
- Care from obstetricians and gynecologists
- Care at urgent care centers after hours

Medicaid Members May Go to Non-Participating Providers for:

- Emergency care
- Family planning services provided at Qualified Family Planning Providers (Planned Parenthood)
- Care at FQHCs

Referral Procedures

A referral is required for specialty services not listed above and for plan Members to be evaluated or treated by most specialists. Any treating doctor can refer CareSource Members to specialists. Please refer to our website for more information on services that require a referral.

Simply put a note about the referral in the patient's chart. Please remember, non-participating specialists must request prior authorization for any services rendered to CareSource patients. You can request a prior authorization by calling our Medical Management Department at **1-800-390-7102**, and select the option to request a prior authorization. Or you can also submit a request on our **Provider Portal**.

If you have difficulty finding a specialist for your CareSource Member, please call Provider Services at **1-800-390-7102**.

Steps to Make a Referral for Medicaid Patients

Referring doctor — Document the referral in the patient's medical chart. You are not required to use a referral form or send a copy of it to our health plan. However, you must notify the specialist of your referral.

Specialist — Document in the patient's chart that the patient was referred to you for services. Referral numbers are not required on claims submitted for referred services. Generally, specialist-to-specialist referrals are not allowed.

You can request a prior authorization by calling our Medical Management Department at 1-800-390-7102, and select the option to request a prior authorization.

However, in some cases, specialists may provide services or make referrals in the same manner as a PCP. Documentation in the medical record should contain the number of visits or length of time of each referral. Medical records may be subject to random audits to ensure compliance with this referral procedure.

Standing referrals — A PCP may request a standing referral to a specialist for a Member with a condition or disease that requires specialized medical care over a prolonged period of time. The specialist may provide services in the same manner as the PCP for chronic or prolonged care. The period of time must be at least one year to be considered a standing referral.

Referrals to out-of-plan Providers — A Member may be referred to out-of-plan Providers if the Member needs medical care that can only be received from a doctor or other health care Provider who is not participating with our health plan. Treating Providers must get prior authorization from our health plan before sending a Member to an out-of-plan Provider.

Referrals for second opinions — A second opinion is not required for surgery or other medical services. However, health care Providers or Members may request a second opinion at no more cost to the Member than if the service was obtained in network.

The following criteria should be used when selecting a Provider for a second opinion:

- The Provider must be a participating Provider. If not, prior authorization must be obtained to send the patient to a non-participating Provider.
- The Provider must not be affiliated with the Member's PCP or the specialist practice group from which the first opinion was obtained.
- The Provider must be in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the Provider giving the second opinion.

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Please note that Medicare Members may go to non-participating Providers for:

- Emergency care
- Out of area dialysis care
- Out of area urgently needed care

Services rendered by out-of-plan Providers — A Member may be sent to out-of-plan Providers if the Member needs medical care that can only be received from a doctor or other health care Provider who is not participating with our health plan. PCPs must get prior authorization from our health plan before sending a Member to an out-of-plan Provider. You can request a prior authorization by calling our Medical Management Department at **1-800-390-7102**, and select the prompt to request prior authorization.

Second opinions — A second opinion is not required for surgery or other medical services. However, health care Providers or Members may request a second opinion at no cost to the Member other than applicable co-payments,

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(continued)

co-insurance and deductibles. The following criteria should be used when selecting a Provider for a second opinion:

- The Provider must be a participating Provider. If not, a prior authorization must be obtained to send the patient to a non-participating Provider.
- The Provider must not be affiliated with the Member's PCP or the specialist practice group from which the first opinion was obtained.
- The Provider must be in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the Provider giving the second opinion.

How to Submit Prior Authorization

Prior authorizations for health care services can be obtained by contacting the Medical Management Department online, by email, phone, fax or mail:

Online: www.caresource.com

Email: authorizationsmi@caresource.com

Fax: 1-888-577-5507. The **Prior Authorization** form is located on our website or the "Supplements/Forms" section of this manual.

Mail: Send prior authorization requests to:

CareSource
P.O. Box 1307
Dayton, OH 45401-1307

Phone: 1-800-390-7102

When requesting an authorization, please provide the following information:

- Member/patient name and CareSource Member ID number
- Provider name and NPI
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan Provider, if applicable
- Clinical information to support the medical necessity for the service

Inpatient Admission, Inpatient Surgery, Outpatient Surgery

If the request is for inpatient admission (whether it is elective, urgent or emergency), please include admitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs.

If inpatient surgery is planned, please include the date of surgery, surgeon and facility, admit date, admitting diagnosis and presenting symptoms, plan of treatment, any appropriate clinical and anticipated discharge needs.

If the request is for outpatient surgery, please include the date of surgery, surgeon and facility, diagnosis and procedure planned, and anticipated discharge needs.

How Prior Authorization Approval is Determined

Prior authorization is not based solely on medical necessity, but on a combination of Member eligibility, medical necessity, medical appropriateness and benefit limitations. When a prior authorization is requested for a service rendered in the same month, Member eligibility is verified at the time the request is received. When the service is to be rendered in a subsequent month, authorization is given contingent upon Member eligibility on the date of service. Providers must verify eligibility on the date the service is to be rendered. CareSource is not able to pay claims for services provided to ineligible Members. It is important to request prior authorization as soon as it is known that the service is needed.

All services that require prior authorization from CareSource should be authorized before the service is delivered. CareSource is not able to pay claims for services in which prior authorization is required, but not obtained by the Provider. CareSource will notify you of prior authorization determinations by a letter mailed to the Provider's address on file.

Standard and Urgent Prior Authorization

For standard prior authorization decisions, CareSource provides notice to the Provider and Member as expeditiously as the Member's health condition requires, but no later than 14 calendar days following receipt of the request for service. Urgent prior authorization decisions are made within 72 hours of receipt of request for service. Please specify if you believe the request is urgent.

Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent on eligibility, benefits and other factors. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

Medicaid Services that Require Prior Authorization

Please refer to "Covered Services" section of this manual for more information on services that require a prior authorization. Services are provided within the benefit limits of the Member's enrollment. They include, but are not limited to the following services:

- All inpatient care
- All abortions
- Some home care services
- Nursing facility services
- Hospice care
- Organ transplants
- Cosmetic procedures and plastic surgery
- For ambulette transportation, please call our transportation vendor for service
- Ambulance transportation — except for emergent or facility-to-facility transfers
- Some durable medical equipment including:
 - All powered or customized wheelchairs
 - Manual wheelchair rentals more than three months
 - All miscellaneous codes (example E1399)
- Food supplemental/nutritional supplements >30 cans per month

Services are provided within the benefit limits of the Member's enrollment. They include, but are not limited to the following services.

When a prior authorization is requested for a service rendered in the same month, Member eligibility is verified at the time the request is received.

- Some diagnostic procedures
- Pain management
- MRI/MRA scans

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Medicare Services that Require Prior Authorization

Services are provided within the benefit limits of the Member's enrollment. They include, but are not limited to the following services:

- All inpatient care
- All abortions
- All home care services
- Nursing facility services
- Hospice care
- Organ transplants
- Durable medical equipment more than \$750 billed charges
- Prosthetic devices more than \$750 billed charges
- Cosmetic procedures and plastic surgery
- Non-Formulary drug requests
- Some Part B and Part D drugs
- Ambulance and ambulette transportation – except for emergent or facility-to-facility transfers
- Physical therapy visits greater than 20 per calendar year
- Occupational therapy visits greater than 20 per calendar year
- Speech therapy visits greater than 15 per calendar year
- Chiropractic visits greater than 12 per calendar year
- Mental health/psychiatry visits greater than 10 per calendar year
- Podiatry office visits greater than 8 per calendar year
- Substance abuse services greater than 12 per calendar year

In addition, any health care Provider who is not a participating Provider with CareSource must obtain prior authorization for all non-emergency services provided to a CareSource Member.

Clinical Records Needed for Unlisted Procedure CPT Codes

CareSource does not require prior authorization for unlisted procedure CPT codes. However, it requires a clinical record be submitted with your claim to review the validity of the unlisted procedure CPT code.

Claims submitted without clinical records for unlisted procedure CPT codes will be denied. Denials will be reconsidered through the appeals process with pertinent clinical records.

Please note that our prior authorization requirements are subject to change. Please refer to www.caresource.com for the most current information on services that require prior authorization and the prior authorization process.

MEDICAID

Synagis Prior Authorization

The CareSource Medical Policy for administration of Synagis follows the AAP guidelines. CareSource will review according to the guidelines in determining payment authorization for Synagis immunization. Consistent with epidemiologic findings, CareSource considers “RSV season” to be November 1 through March 31. Coverage for the RSV season will end March 31 with an extension possible if RSV is still endemic in the community. Requests for Synagis injections can be submitted on our secure **Provider Portal**, or fax the **Synagis prior authorization form** to 1-888-399-0271.

Utilization Management (UM)

Utilization Management (UM) helps maintain the quality and appropriateness of health care services provided to CareSource Members. The Medical Management Department performs all utilization management activities including prior authorization, concurrent review, discharge planning and other utilization activities. We monitor inpatient and outpatient admissions and procedures to ensure that appropriate medical care is rendered in the most appropriate setting using the most appropriate resources. We also monitor the coordination of medical care to ensure its continuity. Referrals to the CareSource case management team are made, if needed. UM criteria available in writing by mail, fax or email and the web.

Mail:

CareSource
P.O. Box 1307
Dayton, OH 45401-1307

Fax: 1- 888-577-5507

Email: authorizationsmi@caresource.com

Web: www.caresource.com

On an annual basis, CareSource completes an annual assessment of satisfaction with the UM process and identifies any areas for improvement opportunities.

Criteria — CareSource utilizes nationally recognized criteria to determine medical necessity and appropriateness of inpatient hospital, rehabilitation and skilled nursing facility admissions. This criteria is designed to assist health care Providers in identifying the most efficient quality care practices in use today. They are not intended to serve as a set of rules or as a replacement for a physician’s medical judgment about individual patients.

CareSource defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services. CareSource also has medical policy developed to supplement nationally recognized criteria. If a patient’s clinical information does not meet the criteria, the case is forwarded to a medical director for further review and determination. Physician reviewers from CareSource are

CareSource defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services.

available to discuss individual cases with attending physicians upon request. Criteria are also available upon request by contacting our Medical Management Department at **1-800-390-7102**.

Utilization review determinations are based only on appropriateness of care and service and existence of coverage. CareSource does not reward health care Providers or our own staff for denying coverage or services. There are no financial incentives for our staff Members that encourage them to make decisions that result in underutilization.

Our Members' health is always our number one priority. Upon request, CareSource will provide the clinical rationale or criteria used in making medical necessity determinations. You may request the information by calling or faxing the CareSource Medical Management Department. If you would like to discuss CareSource's adverse decision with CareSource's physician reviewer, please call the Medical Management Department at **1-800-390-7102, ext: 2830** within five business days of the determination.

Provider Appeals Procedure

If you are dissatisfied with a determination made by our Medical Management Department regarding a Member's health care services or benefits, you may appeal the decision. Please see the "Provider Appeal Procedures" section in this manual for information on how to file a clinical appeal.

Retrospective Review

A retrospective review is defined as a request for an initial review for authorization of care, service or benefit for which an authorization is required, but was not obtained prior to the delivery of the care, service or benefit. Prior authorization is required to ensure that services provided to our Members are medically necessary and provided appropriately. In the event that you fail to obtain prior authorization, you will have 180 days from the date of service or 180 days from the inpatient discharge date to request a retrospective review for medical necessity.

Requests for retrospective review that exceed these time frames will be denied and are ineligible for appeal. If the request is received within these time frames and a medical necessity denial is issued, you may submit a request for an appeal within 180 days from the date of the service or 180 days from the inpatient discharge date. A request for retrospective review can be made by contacting the Medical Management Department at **1-800-390-7102** and following the appropriate menu prompts, or by faxing the request to 1-888-527-0016. Clinical information supporting the request for services must accompany the request.

In the event that you fail to obtain prior authorization, you will have 180 days from the date of service or 180 days from the inpatient discharge date to request a retrospective review for medical necessity.

MEDICAID

Surgical Procedure Forms

CareSource requires the same certification and consent forms for surgical procedures performed on Medicaid Members that the Michigan Department of Community Health (MDCH) accepts. Copies of the hysterectomy and sterilization consent forms are included in the "Supplements/Forms" section of this manual. The most current copies can also be obtained online at **www.Michigan.gov**.