NETWORK *Notification*

Notice Date: **September 16, 2024**
To: **Michigan Medicaid Providers**
From: **HAP CareSource™**
Subject: **Prior Authorization Updates**
Effective Date: **January 1, 2025**

Summary
Effective January 1, 2025, HAP CareSource™ will have several updates and reminders for this plan year.

- This is a reminder that if a provider is not part of the HAP CareSource network, prior authorization must be obtained before any service is rendered to the member.
- Changes to retrospective authorization submission time period:
  - HAP CareSource will change the decision time frames on retrospective requests. Retrospective decisions will change from 14 calendar days to 30 calendar days from the date of the request received. You can check the status of your request on our provider portal. Only certain procedures, care or equipment require an approved authorization for participating providers. For a complete list of services that require authorization, reference the Procedure Code Lookup Tool.
  - HAP CareSource will conduct a retrospective review of medical services received by members when a request is received within 90 days of the date of service or discharge. HAP CareSource considers retrospective authorization review appropriate when **ANY** of the following circumstances has occurred:
    - A HAP CareSource member is unable to advise the provider of plan enrollment due to a condition that renders the member unresponsive or incapacitated.
    - The member is retrospectively enrolled, which covers the date of service.
    - 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 that 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.

Impact
Requests received for services that have already been rendered to members will no longer be reviewed and decisioned within 14 calendar days. Retrospective requests will now be reviewed and decisioned within 30 calendar days. Retrospective requests must also be received within 90 days from the date of service or discharge and meet one of the criteria items listed above. Non-participating providers must submit a prior authorization request for any service.

Questions?
Please contact Provider Services at **1-833-230-2102** with any questions.