



Section 9 – Appeals Procedures

Appeals of Claims Denials or Adverse Decisions (*Medicaid and Medicare*)

If you do not agree with the decision of the processed claim, you will have **90 days** from the date the claim is denied to file an appeal. **If the claims appeal is not submitted in the required time frame the claim will not be considered and the appeal will be denied.** If the appeal is denied providers will be notified in writing. If the appeal is approved payment will show on the providers Explanation of Payment (EOP).

Please note: If you believe the claim processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim. You do not need to file an appeal. Providers have **180 days** from the date of service to submit a corrected claim.

To file an appeal please use the Provider Claim Appeal Request Form located in this manual or on our Website at www.caresource.com. Please include:

- The member's name, CareSource member ID number.
- The provider's name and ID number.
- The code/s and reason why the determination should be reconsidered.
- If submitting a Timely Filing appeal you must send proof of original receipt of the appeal by fax or EDI for reconsideration.
- If the appeal is regarding a clinical edit denial the appeal must have all the supporting documentation as to the justification of the edit.

Please submit appeal requests in writing by mailing or faxing to:

CareSource
Attn: Provider Appeals
P.O. Box 2008
Dayton, OH 45401-2008

Fax: (937) 531-2398

Medicaid

Member, Provider or Provider Appealing on Behalf of a Member Standard Medical Necessity Appeals of Non-Certification Determinations

An appeal is defined as a formal request by a member or provider, including facilities or other health care entities on behalf of a member or provider for a review of a determination or action. Medical necessity appeals of non-certification determinations must be submitted to CareSource within 90 calendar days after the original denial date. Medical necessity appeals filed by members or providers on behalf of a member with written authorization to appeal on their behalf in writing will be resolved within 15 calendar days of receipt or as expeditiously as the member's condition warrants. All other medical necessity appeals will be resolved within 30 calendar days of receipt.



Expedited Appeals

An expedited appeal request may be a verbal request and should be submitted to the **Grievance and Appeals Department** by calling **1-800-488-0134**.

CareSource will make a determination within one (1) working day of the expedited appeal request to expedite the appeal resolution. CareSource will make reasonable efforts to provide prompt verbal notification to the member of the decision to expedite or not expedite the appeal resolution. This attempt will be made by phone. If the member is in a facility, the provider or facility will be notified on the same business day of the decision. The member will be informed of the limited time available for presentation of evidence and allegations of fact or law in person or in writing.

The member and provider will be notified in writing of the determination to process as a standard appeal within two (2) calendar days of receipt of the appeal, including information that the member can grieve the decision.

In the event that CareSource denies the request for an expedited appeal, the appeal will be resolved within 15 calendar days from the date the appeal was received and follow the standard CareSource appeal process.

Expedited appeals will be resolved and verbal notification will be made within 72 hours of receipt of the appeal or as expeditiously as the medical condition requires unless the resolution time frame is extended.

CareSource will verbally notify the provider/facility of the appeals resolution if the member is in an inpatient setting and will send written notification to both the provider and member on the same business day of the decision.

A member can verbally request that CareSource extend the time frame to resolve a standard or expedited appeal up to 14 calendar days. CareSource may request that the time frame to resolve a standard or expedited appeal be extended up to 14 calendar days. CareSource must submit documentation that the extension is in the member's best interest to the Ohio Department of Job and Family Services (ODJFS) for prior approval. If ODJFS approves the extension, CareSource must immediately give the member written notice of the reason for the extension and the date that a decision must be made.

If you are dissatisfied with any medical necessity decision made by CareSource, we offer one level of appeal as mandated by ODJFS. Members have the right to a state hearing as a first or second level of appeal (See State Hearings in the Member Support Services and Benefits section of this manual for more information).

You may use the Provider Appeal Request Form in the Forms section (Section 14) of this manual to submit your appeal, but you are not required to. Appeal requests should include:

- The member's name, CareSource member ID number, and date of birth
- The provider's name and CareSource provider billing number
- The place, date and type of service that had a non-certification determination
- The reason why the determination should be reconsidered
- Any additional available medical information to support your reasons for reversing the determination

The Appeals Department may request additional information from you to document medical necessity. All appeal requests and associated information are reviewed by clinicians previously uninvolved with the case. You will be notified in writing of the outcome of your appeal request.



Services not previously reviewed for medical necessity are categorized as retrospective reviews and are reviewed and determination rendered by the Medical Management Department within 30 calendar days of receipt (See Retrospective Reviews in Section 7 – Referrals and Prior Authorizations). Please submit appeal requests in writing to:

CareSource
Attention: Claims Appeal Coordinator
P.O. Box 2008
Dayton, OH 45401-2008

Fax: 937-531-2398

Medicare

Member, Provider or Provider Appealing on Behalf of a Member Standard Medical Necessity Appeals of Non-Certification Determinations

For appeals on behalf of the member please refer to Chapter 9 of the Member's Evidence of Coverage. The Evidence of Coverage is located on our Website at www.caresource.com; search "Evidence of Coverage."