Provider FAQs
Inpatient Hospital Claims Review

Q: Who is Equian?
Equian is a claims review service working with CareSource that applies condition specific medical and financial expertise to review hospital bills for clinical appropriateness, billing errors and variances from industry billing practices.

Q: What is the scope of claims that Equian reviews?
Inpatient Hospital Claims with a CareSource paid amount of $50,000 or higher and with Diagnosis Related Group (DRG) outliers.

Q: How does the process work?
Equian reviews the Institutional Claim form (CMS1450 Uniform Bill (UB-04)) and itemized bills for CareSource. Equian then recommends claims payment to CareSource and will send a detailed outline of the claims review results to you along with supporting exhibits. At that time, CareSource will adjudicate the claim according to Equian's recommendation, and an Equian Claims Resolution Manager will reach out to you to confirm acceptance of the findings.

Q: There is an outstanding balance on this claim that needs to be paid. Who can I speak with about this?
Equian has evaluated the claim in detail and can answer any questions you may have. Please call the designated Equian Claims Resolution Manager at **1-888-895-2254**.

Q: How do we resolve claims where Equian has performed a review?
The Equian Claims Resolution Manager is available to discuss Equian's findings with you. Through this process, you have the opportunity to provide supporting documentation or other substantiation for why certain charges are payable as billed. Equian's goal is to partner with you, as the provider, and CareSource to ensure fair and equitable reimbursement for services. This dialogue with the Equian Claims Resolution Manager process is designed to come to an agreement on payment and prevent you from exhausting your appeal rights.

Q: If we prefer to formally appeal the review, what do we do?
After dialog with the Equian Claims Resolution Manager, if you do not agree with a denial on a processed claim, you have a [1]set time from the date of the original claim submission denial to submit an appeal. If the appeal is not submitted in the required time frame, the claim will not be reconsidered and the appeal will be denied. Providers will be notified in writing if the appeal is denied. If the appeal is approved, payment will show on the Explanation of Payment (EOP).

Q: How do we submit appeals?
You can submit appeals through the CareSource **Provider Portal** or using a **Provider Appeal Form**. The Provider Portal is the most efficient method of submitting appeals.

Q: How do we submit Itemized Bills?
You can submit itemized bills with your claim via paper submission, directly to Equian via fax upon their request.

Include the following required documentation with your appeal:

- Progress notes including symptoms and their duration, physical exam findings, conservative treatment that the member has completed, preliminary procedures already completed and the reason service is being requested
- Any documentation of specialists' reports or evaluations, any pertinent previous diagnostic reports and therapy notes
- If the service has already been provided, a copy of the original remittance advice and/or the denied claim
- If filing an appeal on behalf of a member or for pre-service issues, the member's written consent, which must be specific to the service being appealed, is only valid for that appeal and must be signed by the member (Use the **Consent for Provider to File an Appeal on Patient/Member's Behalf form** to record this consent).

All appeal requests and associated information are reviewed by clinicians not previously involved with the case.

[1]Timely filing and processes vary by market and product for claim corrections, disputes and appeals:

Market	Product	Corrected Claim	Dispute	Appeal
Georgia	Medicaid	180 calendar days from DOS or date of discharge	3 months	30 calendar days
Indiana	Medicaid	• 365 calendar days from DOS or date of discharge • Non-par providers 180 days.	60 days	60 days of Dispute resolution
Ohio	Medicaid, Medicare Advantage, and MyCare	365 calendar days from DOS or discharge	60 days	365 days from DOS/Date of discharge
OH, KY, WVA, IN	Marketplace	365 calendar days from DOS or date of discharge	60 days	365 days from DOS/Date of discharge