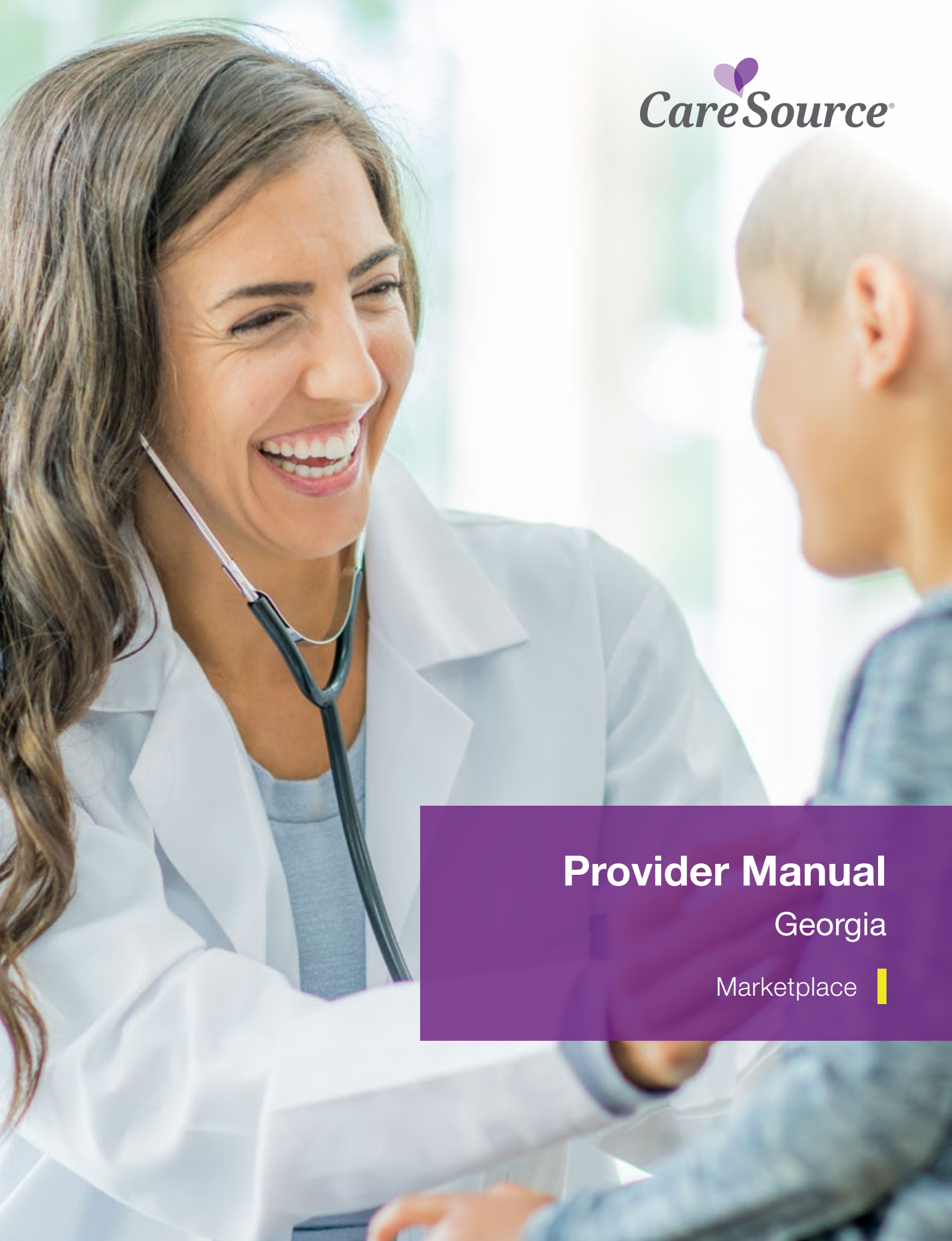

CareSource®

Provider Manual

Georgia

Marketplace

This content has been reviewed; however, changes and/or revisions occur frequently. Providers should check our website at CareSource.com for the most current version of this manual.

Dear CareSource Provider,

Thank you for your participation. CareSource values our relationships with our providers, and we are actively working to make it easier for you to deliver quality care to our members.

CareSource has provided Health Insurance Marketplace, as well as Medicaid, Medicare and other managed health care services since 1989.

Members enrolled in our Marketplace plans pay any premiums and cost-sharing amounts (deductibles, coinsurance, copayments, etc.) that apply based on their plan selection and eligibility for subsidies as determined by the Exchange. Our Marketplace plans help provide members with stability, peace of mind and affordable health care with heart – allowing members to select the plan which best meets their needs.

This manual is a resource for working with our health plan. The manual communicates policies and programs and outlines key information such as claims submission, reimbursement processes, authorizations, member benefits and more to make it more efficient for you to do business with us.

CareSource communicates updates to our provider network regularly at **CareSource.com** > Providers > Tools & Resources > Updates & Announcements.

To support our providers, we have a dedicated Customer Care team to assist with questions and concerns. Additionally, an external team of specialists are available to provide onsite training and work with our providers in their communities.

We know great health care begins with you. Together, we can help attain better outcomes for our CareSource members.

Sincerely,

CareSource

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ABOUT US

Welcome

Welcome, and thank you for participating with CareSource.

We work together to ensure that our members – your patients – can improve their health and well-being. Because you're our partner, we strive to make it simple for you to do business with us. This manual directs you to the solutions you need, whether that's through convenient online self-service solutions, fast prior authorizations or hassle-free claims payments. It's our strong partnership that allows us to work together to facilitate a high level of care and a respectful experience for our members.

We are a nonprofit, community-based health plan that currently serves Georgia consumers that are enrolled in our Marketplace plans.

Our goal is to create an integrated medical home for our members. We focus on prevention and partnering with local providers to offer the services our members need to remain healthy.

As a managed health care organization, we improve the health of our members by utilizing a contracted network of high-quality participating providers. Primary care providers (PCPs) within the network provide a range of services to our members and can also coordinate patient care by referring them to specialists when needed, ensuring that members have timely access to health care services and receive all appropriate preventive services.

CareSource also distributes the member rights and responsibilities statements to the following groups upon their enrollment and annually thereafter:

- New members
- Existing members
- New providers
- Existing providers

About Us

CareSource was founded on the principles of quality and service delivered with compassion and a thorough understanding of caring for underserved consumers. As a nonprofit, we are mission-driven to provide quality care to our members. We offer process efficiencies and value-added benefits for our members and participating providers.

Vision & Mission

Our vision is: Transforming lives through innovative health and life services.

Our mission is: Making a lasting difference in our members' lives by improving their health and well-being.

At CareSource, our mission is one we take to heart. In fact, we call our mission our "heartbeat". It is the essence of our company, and our unwavering dedication is the hallmark of our success.

Our Services

- Provider relations
- Provider services
- Member eligibility/enrollment information
- Claims processing
- Credentialing/Recredentialing
- Decision-support informatics
- Quality improvement
- Regulatory/compliance
- Special investigations for fraud, waste and abuse
- Member services, including a member call center with CareSource as well as our benefit managers (Pharmacy: Express Scripts; Vision: EyeMed, Hearing: TruHearing, Dental: DentaQuest, and Fitness: American Specialty Health)

In addition to the functions above, our Care Management programs include the following:

- Low, medium and complex case management – a "no wrong door" referral intake
- Telephonic case management
- Disease management
- Preventive health and wellness assistance with focused health needs/risk assessment
- Emergency department diversion – high emergency department utilization focus (targeted at members with frequent utilization)
- CareSource24®, Nurse Advice Line

- Maternal and child health
  - Comprehensive prenatal, postpartum and family planning services
  - Outreach programs in partnership with community agencies to target members at greatest risk for preterm birth or complications
- Behavioral health and substance use disorder (SUD)
- Partners with our internal pharmacy team to deliver medication therapy management (MTM) not previously completed at a retail pharmacy

For more information on these programs, see the Member Support Services and Benefits section on page 53.

The CareSource Foundation

The CareSource Foundation was launched in 2006 to add another component to our professional services: community response. Since its inception, the Foundation has responded at significant levels and made some great friends, including non-profit organizations and other charitable funders who were equally committed to better health for all communities. We are addressing tough issues and growing together.

To date, the CareSource Foundation has awarded grants totaling over $16.4 million. Grants focus on issues of the uninsured, critical trends in children's health and special populations. Several large signature grants were made specifically to address issues of access to coverage in the new health care reform landscape and elevating children from the cycle of poverty through the power of education.

The Foundation believes in people, organizations and initiatives that actively work to improve the physical health and well-being of individuals residing in the CareSource service areas. We believe that passion, knowledge and vision generate positive, long-lasting change and that meaningful collaboration creates strong partnerships with grantees.

Compliance & Ethics

At CareSource, we serve a variety of audiences – members, providers, government regulators, community partners and each other. We serve them best by working together with honesty, respect and integrity. Our Corporate Compliance Plan, along with state and federal regulations, outline the personal, professional, ethical and legal standards we must all follow.

Our CareSource Corporate Compliance Plan is an affirmation of CareSource's ongoing commitment to conduct business in a legal and ethical environment. It has been established to:

- Formalize CareSource's commitment to honest communication within the company and within the community
- Develop and maintain a culture that promotes integrity and ethical behavior
- Facilitate compliance with all applicable local, state and federal laws and regulations
- Implement a system for early detection and reporting of noncompliance with laws, regulations or CareSource policy

This allows us to resolve problems promptly and minimize any negative impact on our members or business, such as financial losses, civil damages, penalties and criminal sanctions.

CareSource's Corporate Compliance Plan is a formal company policy that outlines how everyone who represents CareSource should conduct themselves. This includes how we do our work and how we relate to each other in the workplace. It also includes the conduct of those we have business relationships with, such as providers, consultants and vendors.

General Compliance and Ethics Expectations of Providers

- Act according to the compliance standards.
- Let us know about suspected violations or misconduct.
- Let us know if you have questions.

For questions about provider expectations, please call your Provider Engagement Specialist or Provider Services at **1-833-230-2101**.

If you suspect potential violations, misconduct or non-compliant conduct, which impacts CareSource or our members, please leverage one of the following methods to communicate the issue to CareSource:

- Ethics and Compliance Hotline: **877-LINKCSM (877-546-5276)** or CareSource.ethicspoint.com
- Compliance Officer: 937-487-5110 or David.Fogarty@CareSource.com

Any issues submitted to the Ethics and Compliance Hotline may be submitted anonymously.

The CareSource Corporate Compliance Plan is posted for your reference on **CareSource.com** > About Us > Legal > Corporate Compliance.

Please let us know if you have questions regarding the CareSource Corporate Compliance Plan. We appreciate your commitment to corporate compliance.

Personally Identifiable Information

In the day-to-day business of patient treatment, payment and health care operations, CareSource and its providers routinely handle large amounts of personally identifiable information (PII). In the face of increasing identity theft, there are various standards and industry best practices that guide that PII be appropriately protected wherever it is stored, processed and transferred in the course of conducting normal business. As a provider, you should be taking measures to secure your sensitive provider data, and you are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to secure protected health information (PHI). There are many controls you should have in place to protect sensitive PII and PHI.

Here are a few important places to start:

- Utilize a secure message tool or service to protect data sent by email.
- Limit paper copies of PHI and PII left out in the open in your workspace and shred this content when no longer needed.
- Ensure conversations involving patient information cannot be overheard by others.
- Ensure all employees complete a HIPAA training program and understand the importance of safeguarding patient information.

We may share patient information with you. CareSource, like you, is a covered entity under HIPAA. It is permissible for covered entities to share patient information when necessary for treatment, payment, or health care operations.

Member Consent

When you check eligibility on the Provider Portal, you can also determine if a member has granted consent to share their health information with their past, current and future treating providers. A message displays on the Member Eligibility page if the member has not consented to sharing their health information.

Please encourage CareSource members who have not consented to complete our Member Consent/ HIPAA Authorization Form so that all providers involved in their care can effectively coordinate their care. This form is located at **CareSource.com** > Provider > Forms.

The Member Consent/HIPAA Authorization Form can also be used to designate a person to speak on the member's behalf. This designated representative can be a relative, a friend, a physician, an attorney or some other person that the member specifies.

Accreditation

CareSource is fully accredited by the National Committee for Quality Assurance (NCQA) for our Kentucky, Indiana, Ohio, and West Virginia Marketplace plans. NCQA is a private, nonprofit organization dedicated to improving health care quality through measurement, transparency and accountability. Accreditation status indicates that our service and clinical quality meet NCQA's rigorous requirements for consumer protection and quality improvement.

COMMUNICATING WITH CARESOURCE

CareSource communicates with our provider network through a variety of channels, including phone, fax, Provider Portal, newsletters, **CareSource.com** and network notifications. We encourage you to reach out to your assigned Provider Engagement Representative with any questions.

CareSource Hours of Operation

Provider Services		
Provider Services Phone	Monday to Friday	8 a.m. to 6 p.m. Eastern Time (ET)

Member Services		
CareSource24® (nurse advice line for all plans)	Seven days a week, 365 days a year	24 hours a day
CareSource	Monday to Friday	7 a.m. to 7 p.m. ET

Please visit **CareSource.com** > About Us > Contact Us for the holiday schedule or contact Provider Services for more information.

Phone

Our interactive voice response (IVR) system will direct your call to the appropriate professional for assistance. We also provide telephone based self-service applications that allow you to verify member eligibility.

Provider Services	1-833-230-2101
Prior Authorizations	1-833-230-2101
Claims	1-833-230-2101
Credentialing	1-833-230-2101
Member Services	1-833-230-2099
CareSource24 – Nurse Advice Line	1-833-687-7342
Fraud, Waste and Abuse Hotline	1-833-230-2101
TTY for the Hearing Impaired	1-800-255-0056 or 711
EyeMed Member Services	1-833-337-3129
DentaQuest Member Services	1-855-453-5284
TruHearing Member Services	1-866-202-2561
Active&Fit Member Services	1-877-771-2746

Fax

Credentialing	1-866-573-0018
Fraud, Waste and Abuse	1-800-418-0248
Medical Prior Authorization Form	1-844-676-0370
Pharmacy Prior Authorization Form	1-866-930-0019
Provider Appeals	1-937-531-2398
Provider Maintenance	1-937-396-3076

Website

Accessing our website, **CareSource.com**, is quick and easy. On the Provider section of the site you will find commonly used forms, newsletters, updates and announcements, our Provider Manual, claims information, frequently asked questions, clinical and preventive guidelines and much more.

Provider Portal

URL: ProviderPortal.CareSource.com

Our secure online Provider Portal allows you instant access at any time to valuable information. You can access the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal. Simply enter your username and password (if already a registered user) or submit your information to become a registered user. Assisting you is one of our top priorities in order to deliver better health outcomes for our members.

Provider Portal Benefits

- Free access to important resources
- Easy access to a secure online (encrypted) tool with time-saving services and critical information
- Available 24 hours a day, 7 days a week
- Accessible on any PC without any additional software

Provider Portal Tools

We encourage you to take advantage of the following time-saving tools:

- **Member Profile** – Access a comprehensive view of patient medical/pharmacy utilization.
- **Payment History** – Search for payments by check number or claim number.
- **Claim Status** – Search for status of claims.
- **Claims Attachments** – Submit documentation needed for claim processing.
- **Submit Claims** – Submit claims using online forms or upload a completed claim. Claim submission through the portal is available to traditional providers, community partners, delegates, and health homes.
- **Rejected Claims** – Find claims that may have been rejected so that you can resubmit them.
- **Claim Dispute and Appeals** – Search for status of claim disputes, claim appeals and decision letters.
- **Coordination of Benefits (COB)** – Confirm COB for patients.
- **Prior Authorization (PA)** – Submit medical inpatient/outpatient, home health care and Synagis®.
- **Eligibility Termination Dates** – View the member's termination date (if applicable) under the eligibility tab.
- **Benefit Limits** – Track benefit limits electronically in real time before services are rendered for chiropractic, occupational therapy, physical therapy and speech therapy, and more.
- **Care Treatment Plans** – Providers can view care treatment plans for their patients on our Provider Portal.
- **Clinical Practice Registry (CPR)** – Filter patient data to identify opportunities for preventive health screenings.
- **Monthly Membership Lists** – View and download current monthly membership lists.
- **Recovery Letters** – View and download letters related to completed recoveries.
- **Member Financial Status and Information** – View member payment responsibilities (such as deductible, copay and coinsurance) and monthly premium payment status.
- **File a Member Grievance**

Dental Providers

Please visit the Dental Provider Login tab of the Provider Portal to access capabilities specifically for dental providers.

Portal Registration

If you are not registered with CareSource's Provider Portal, please follow these easy steps:

1. Visit **CareSource.com** > Providers > Georgia > Marketplace and click on "Provider Login."
2. Click on the "Register Now" button and complete the three-step registration process. Note: you will need to have your tax ID number.
3. Click the "Continue" button.
4. Note the username and password you create so that you can access the portal's tools.

If you do not remember your username/password, please call Provider Services at **1-833-230-2101**.

How to Communicate With CareSource by Mail

CareSource
P.O. Box 8738
Dayton, OH 45401-8738

Provider Claim Disputes and Appeals Mailing Address

CareSource
P.O. Box 2008
Dayton, OH 45401-2008

Please visit our website at **CareSource.com** for more information on how appeals can be submitted online.

Member Appeals and Grievances Mailing Addresses

CareSource
P.O. Box 1947
Dayton, OH 45401-1947

Claims Mailing Address

CareSource
Attn: Claims Department
P.O. Box 803
Dayton, OH 45401-0803

Fraud, Waste and Abuse Address

CareSource
Attn: Program Integrity
P.O. Box 1940
Dayton, OH 45401-1940

Information reported to us can be reported anonymously and is kept confidential to the extent permitted by law.

Provider Communications

Newsletters

Our provider newsletter contains operational updates, clinical articles and new initiatives underway at CareSource.

Network Notifications

Network notifications are published for CareSource providers to regularly communicate updates to policies and procedures. Network notifications are found on our website at **CareSource.com** > Providers > Tools & Resources > Updates & Announcements.

Provider Demographic Changes and Updates

Advance written notice of status changes, such as a change in address, phone, or adding or deleting a physician to your practice helps we keep our records current. Your current information is critical for efficient claims processing.

The CareSource Provider Portal is the preferred method to submit changes. Simply log in to the Provider Portal by visiting **CareSource.com** > Login > Provider Portal, entering your login credentials, and select Provider > Provider Maintenance from the left-hand navigation.

Email

ProviderMaintenance@CareSource.com

Fax

937-396-3076

Mail

CareSource
Attn: Provider Maintenance
P.O. Box 8738
Dayton, OH 45401-8738

CLAIMS

As with other commercial health plans, CareSource's Marketplace plan members are responsible for copays, coinsurance and deductibles. Providers are responsible for collecting the appropriate payments.

In general, CareSource follows the claims reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. For expedited claims processing and payment delivery, please ensure addresses and phone numbers on file with CareSource are up to date. You can update this information on the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal or email ProviderMaintenance@CareSource.com.

Billing Methods

CareSource accepts claims in a variety of formats, including paper and electronic claims. We encourage providers to submit routine claims electronically to take advantage of the following benefits:

- Faster claim processing
- Reduced administrative costs
- Reduced probability of errors or missing information
- Faster feedback on claims status
- Minimal staff training or cost

Submit Claims Online Through Provider Portal

Providers may submit claims through the secure, online Provider Portal. Online submission saves you money by eliminating the costs associated with printing and mailing paper claims. Using the portal for claims submission also provides additional benefits:

- Improves accuracy by decreasing the opportunities for transcription errors and missing or incorrect data
- Allows tracking and monitoring of claims through a convenient online search tool
- Includes attachments up to 100MB that may be necessary for claim processing
- Allows uploading of a completed claim
- Allows corrections and re-submissions

Who Can Submit Claims Via the Portal?

All CareSource providers including primary care, specialty, and community partners may submit claims through the Provider Portal.

What Types of Claims Can Be Submitted?

- Professional medical office claims
- Hospital facility and ASC dental-related claims
- Institutional claims

Please Note: Routine hearing and vision claims must be submitted to TruHearing and EyeMed respectively, through your relationship with the benefits manager. Dental claims other than those listed above must be submitted to DentaQuest through your relationship with the benefits manager.

Electronic Funds Transfer

CareSource offers electronic funds transfer (EFT) as a payment option. We work with ECHO Health Inc. as our payment processing vendor. Visit the Provider Portal for additional information about the program and to enroll in EFT. Providers who elect to receive EFT payment will receive an EDI 835 (Electronic Remittance Advice). Providers can download their Explanation of Payment (EOP) from the Provider Portal or receive a hard copy via the mail.

Benefits of EFT:

- **Simple** – Receive fully reconciled remittances electronically; eliminate paper checks and EOPs, which will increase efficiency with payment processing.
- **Convenient** – Available 24/7; free training is also offered for providers.
- **Reliable** – Claim payments electronically deposited into your bank account.
- **Secure** – Access your account through CareSource's secure Provider Portal to view (and print if needed) remittances and transaction details.
- **Enhanced Information** – Receive member specific third-party liability (TPL) information.

CareSource provides TPL/COB information for EFT. This can be found in segment 2100 Claim Payment Information and loop 2110 Service Payment Information on the 835 file in this format:

- NM1*PR*AETNA US HEALTHCARE
- NM1*GB*1*DOE*JANE
- REF*6P*W246632770
- The NM1*PR (COB carrier), NM1* GB (other subscriber information from other payer) and REF*6P (other insurance group number)

Electronic Claim Submission

Electronic data interchange (EDI) is the computer-to-computer exchange of business data in ANSI ASC X12 standard formats. EDI transmissions must follow the transaction and code set format specifications required by the Health Insurance Portability and Accountability Act (HIPAA). CareSource has invested in an EDI system to enhance our service to participating providers. Our EDI system complies with HIPAA standards for electronic claims submission.

Clearinghouses

CareSource prefers electronic claim submission. To submit electronic claims, you may use the Provider Portal or any clearinghouse (trading partner) that you choose. Please validate that the clearinghouse will send the claims to CareSource. If you do not currently use a clearinghouse, you can choose the following option below:

Clearinghouse	Phone	Website
Availity	1-800-282-4548	www.availity.com

Please provide the clearinghouse with the CareSource payer ID number **GACS1**.

File Format

CareSource accepts electronic claims in the 837 ANSI ASC X12N (005010X ERRATA version) file format for professional and hospital claims.

5010 Transactions

All trading partners and payers should be 5010 compliant.

Transactions Covered Under the 5010 Requirements

- 837 Health Care Claim/Encounter
- 276/277 Health Care Claim Status Request and Response
- 835 Health Care Claim Payment/Advice
- 270/271 Health Care Eligibility Benefit Inquiry and Response
- 278 Health Care Services Review (Prior Authorization Requests)
- 834 Benefit Enrollment and Maintenance
- 820 Group Premium Payment for Insurance Products
- NCPDP Version D.0

Please include the full physical address for billing 5010 transactions. P.O. Boxes are no longer accepted for the billing address. However, a P.O. box or lock box can be used for the Pay-to Address (Loop 2010AB).

National Provider Identifier and Tax ID Numbers

Your National Provider Identifier (NPI) number and Tax Identification Number (TIN) are required on all claims. Claims submitted without these numbers will be rejected. Please contact your EDI vendor to find out where to use the appropriate identifying numbers on the forms you are submitting to the vendor.

Please Note: On paper claims, the NPI number should be placed in the following boxes based on form type:

- CMS 1500: Box 24J for the rendering Provider's NPI and (if applicable), Box 33A for the group NPI
- UB04: Box 56
- ADA: Box 54 for the treating Provider's NPI and (if applicable), Box 49 for the group NPI

Location of Provider Information on Professional Claims

On 837P professional claims (005010X222A1), the Provider's NPI should be in the following location:

- 2010AA Loop – Billing Provider Name
- 2310B Loop – Rendering Provider Name
- 2010AA Loop – Billing Provider Name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Billing Provider NPI
- 2310B Loop – Rendering Provider Name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Rendering Provider NPI

The Billing Provider TIN must be submitted as the secondary provider identifier using a REF segment, which is either the Employer Identification Number (EIN) for organizations or the Social Security Number (SSN) for individuals, see below:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing Provider TIN or SSN

Institutional Claims

On 837I institutional claims (005010223A2), the Billing Provider NPI should be in the following location:

- 2010AA Loop – Billing Provider Name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Billing Provider NPI

The Billing Provider TIN must be submitted as the secondary Provider identifier using a REF segment, which is either the EIN for organizations or the SSN for individuals, see below:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing Provider TIN or SSN

On all electronic claims, the CareSource Member ID number should go on:

- 2010BA Loop – Subscriber Name
- NM109 = Member ID Number

Paper Claims

For the most efficient processing of your claims, CareSource recommends you submit all claims electronically. For more information on electronic claims, please reference the "Electronic Claims Submission" section of this manual, on page 12.

Paper claims can be uploaded on the Provider Portal for quicker processing. After logging in to the Provider Portal, click the Claims > Online Claim Submission link and then select the option to Upload Claim.

Paper claim forms are encouraged for services that require clinical documentation or other forms to process. If you submit paper claims, please submit on one of the following claim form types:

- CMS 1500, formerly HCFA 1500 form – AMA universal claim form also known as the National Standard Format (NSF)
- Standardized ADA J400 Dental claim form for professional claims (this is to be submitted through the SkyGen vendor's web provider portal)
- CMS 1450 (UB-04), formerly UB92 form for Facilities

Paper claim submission must be done using the most current form version as designated by the Centers for Medicare and Medicaid Services (CMS), National Uniform Claim Committee (NUCC) and the American Dental Association (ADA).

We cannot accept handwritten claims or SuperBills. Detailed instructions for completing each form type are available at the websites below:

- CMS 1500 Form Instructions: www.nucc.org
- UB-04 Form Instructions: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c25.pdf

Please Note: On paper claims, the NPI number should be placed in the following boxes based on form type:

- CMS 1500: Box 24J for the rendering provider's NPI and (if applicable) Box 33A for the group NPI
- UB04: Box 56
- ADA: Box 54 for the treating provider's NPI and (if applicable) Box 49 for the group NPI

All claims (EDI and paper) must include:

- Patient (member) name.
- Patient address.
- Insured's ID number (which should be 11 digits long) – Be sure to provide the complete CareSource member ID number of the patient. For the most efficient processing of your claims, CareSource recommends you submit all claims electronically.
- Patient's birth date – Always include the patient's date of birth. This allows us to identify the correct member in case we have more than one member with the same name.
- Place of service – Use standard CMS (HCFA) location codes.
- ICD-10 diagnosis code(s).
- HIPAA-compliant CPT or HCFA Common Procedure Coding System (HCPCS) code(s) and modifiers, where modifiers are applicable.
- Units, where applicable (anesthesia claims require minutes).
- Date of service – Please include dates for each individual service rendered. A date range cannot be accepted, even though some claim forms contain From/To formats. Please enter each date individually.
- Prior authorization number, where applicable – A number is needed to match the claim to corresponding prior authorization information. This is only needed if the service provided required prior authorization.

- National Provider Identifier (NPI) – Please refer to sections for professional and institutional claim information.
- Federal tax ID number or physician social security number – Every provider practice (e.g., legal business entity) has a different tax ID number.
- Signature of physician or supplier – The provider's complete name should be included, or if we already have the physician's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field.

What to Include on Claims That Require National Drug Code

- NDC and unit of measure (e.g., pill, milliliter (cc), international unit or gram)
- Quantity administered – number of NDC units
- NDC unit price – detail charge divided by quantity administered
- HCPCS codes that will require NDCs on professional claims (submitted on the 837P format)

Instructions for National Drug Code on Paper Claims

All of the following information is required for each applicable code required on a claim:

- In the shaded area of 24A, enter the N4 qualifier (only the N4 qualifier is acceptable)
- 11-digit NDC (this excludes the N4 qualifier)
- A unit of measurement code – F2, GR, ML or UN (only acceptable codes)
- The metric decimal or unit quantity that follows the unit of measurement code
- Do not enter a space between the qualifier and the NDC, or qualifier and quantity
- Do not enter hyphens or spaces with the NDC
- Use three spaces between the NDC number and the units on paper forms

Tips for Uploading Claims

For the most efficient processing of your claims, CareSource recommends you submit all claims electronically. To upload a claim on the Provider Portal, click Claims > Online Claims Submission, and then select the "Upload Claim" option at the top right.

CareSource uses an optical/intelligent character recognition (OCR/ICR) system to capture claims information, which increases efficiency, improves accuracy and results in faster turnaround time.

To ensure optimal claims processing timelines:

- EDI claims are generally processed more quickly than paper claims.
- If you upload a claim, we require the most current form version as designated by CMS, NUCC and the ADA.
- No handwritten (including printed claims with any handwritten information) claims or Super Bills will be accepted.
- Use only original claim forms; do not submit claims that have been photocopied or printed from a website.
- Fonts should be 10 to 14 point (capital letters preferred) with printing in black ink.

- Do not use liquid correction fluid, highlighters, stickers, labels or rubber stamps.
- Ensure that printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- It is recommended that you submit your 12-digit CareSource Provider ID, located in your welcome letter, in conjunction with your required NPI number (Please refer to sections for Professional and Institutional claim information).
- Federal Tax ID number or physician SSN is required for all claim submissions.

Please send all paper claim forms to CareSource:
CareSource
P.O. Box 803
Dayton, OH 45401-0803

Claim Submission Timely Filing

Claims must be submitted within 180 calendar days of the date of service or discharge. We will not be able to pay a claim if there is incomplete, incorrect or unclear information on the claim.

Claim Processing Guidelines

- Providers have 180 calendar days from the date of service or discharge to submit a claim. If the claim is submitted after 180 calendar days, the claim will be denied for timely filing.
- If you do not agree with the decision of the processed claim, you can ask us to review the claim again. Please see the process for submitting retro authorization requests found in the Prior Authorizations & Referrals chapter on page 80.
- If the provider was denied authorization or reimbursement due to not obtaining a required prior authorization.
- Refer to the Provider Appeals section of this manual pertaining to additional rights that may be available for claim denials.
- If a member has other insurance and CareSource is secondary, the provider may submit for secondary payment within 365 calendar days of the original date of service.
- If a claim is denied for Coordination of Benefits (COB) information needed, the provider must submit the primary payer's Explanation of Benefits (EOB) for paper claims or primary carrier's payment information for EDI claims within the remainder of the initial claims timely filing period. If the initial timely filing period has elapsed, the EOB must be submitted to us within 90 calendar days from the primary payer's EOB date. If a copy of the claim and EOB is not submitted within the required time frame, the claim will be denied for timely filing.

No Surprises Act

CareSource complies with federal No Surprise Act requirements for out-of-network provider claims with the date of service starting Jan. 1, 2022. The No Surprises Act, part of the Consolidation Appropriations Act of 2021, establishes patient protections for members enrolled in Marketplace plans, including protection from out-of-network providers' surprise bills ("balance billing") for emergency care and other specified items or services. CareSource presumes emergency services (including post-stabilization) and services from out-of-network providers at in-network facilities are covered under the No Surprises Act. Post-stabilization services are defined as emergency services needed to evaluate or stabilize an

emergency medical condition per citation 42 CFR 438.114. Claims will be processed according to the No Surprise Act based on criteria below as billed on the claim. Providers are prohibited from balance billing members, aside from patient responsibility for copay, deductible, and coinsurance. Out-of-network providers are encouraged to submit a new contract request, which can be done online at Becoming a Participating Provider or working with a contract manager.

Emergency Services

- Outpatient Facility claims for emergency services should be billed with Revenue Codes 0450-0459, or 0762.
- Inpatient Facility claims for post-stabilization emergency services should be billed with an Admit Type = 1, 2, or 5.
- Air ambulance claims for emergency services should be billed with Current Procedural Terminology (CPT) Codes A0430, A0431, A0435 or A0436 AND an Emergency indicator of 'E', 'I', 'A', or 'Z' in box 24c on the 1500 form.
- Professional claims for emergency services should be billed with Place of Service (POS) 23; CPT Codes 99217-99220 or 99234-99236 or Emergency Indicator 'E' or 'I' in box 24c on the 1500 form.

Non-Emergency Services

- Boxes 32 and 32a are required to be completed with the appropriate facility information.
- Independent labs performing tests on samples drawn at an inpatient or outpatient department of a hospital should bill the correct POS code per CMS billing guidelines instead of POS 81 (i.e., Inpatient = POS 21, Off-Campus Outpatient = POST 19, On-Campus Outpatient = POS 22, etc.)

Claims paid in accordance with this Act will be notated in the claim detail section of your Electronic Remittance Advice or Explanation of Payment notice with Remark Code N830. Providers do not need to submit documentation of notice and consent requirements with their claims. Prior authorizations will still be required for services that require medical necessity review. Please refer to the Appeals section of this manual for negotiation and arbitration procedures.

Searching for Claims Information Online

Claims' statuses are updated daily on our Provider Portal at **CareSource.com** > Providers > Provider Portal, and you can check claims that were submitted for the previous 24 months. You can search by member ID number, member name and date of birth, claim number or by a date range.

Additional Claims Enhancements on the Provider Portal

- Claim history available up to 36 months from the date of service
- Reason for payment or denial
- Check numbers and dates
- Procedure/diagnostic codes
- Claim payment date
- Dental claim information
- Submission of attachments for denied claims
- Easy corrected claim when the claim was submitted online via the portal

- Accessibility to claim recovery letters
- Submit a claim payment dispute
- Submit claim appeal and any necessary attachments

Procedure and Diagnosis Codes

HIPAA specifies that the health care industry use the following four code sets when submitting health care claims electronically. CareSource also requires HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on providers and health plans. Local or proprietary codes are no longer allowed.

- International Classification of Diseases, 10th Edition, Clinical Modification (ICD- 10- CM). Available from the U.S. Government Printing Office at (202) 512-1800, (202) 512-2250 (fax) and from many other vendors.
- Current Procedural Terminology, 4th Edition, (CPT-4). Available at https://www.ama-assn.org/about/cpt-editorial-panel/cpt-purpose-mission.
- HCFA Common Procedure Coding System (HCPCS). Available at https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system
- Procedures and Nomenclature. 2nd Edition. (CDT-2). Available from the American Dental Association at 1-800-947-4746 or www.ada.org.
- National Drug Codes (NDC). Available at www.fda.gov.

Procedures That Do Not Have a Corresponding Code

- If a procedure is performed which cannot be classified by a CPT or HCPCS code, please include the following information with an unlisted CPT/HCPCS procedure code on the claim form:
  - A full, detailed description of the service provided.
  - A report, such as an operative report or a plan of treatment.
  - Any information that would assist in determining the service rendered. For example, 84999 is an unlisted lab code that would require additional explanation.
- Drug injections that do not have specific J code (J3490 thru J3999) and any assigned HCPCS J code that is not listed on the Medicare fee schedule require the NDC number, name of the drug and the dosage administered to the patient. The unit of measure billed must be defined.
- Claims for services that include a modifier 22 and claims for unlisted procedures must be accompanied by an operative report plus any other documentation that will assist in determining reimbursement.
- Coordination of Benefits (COB) claims require a copy of the Explanation of Payment (EOP) from the primary carrier. Claim status is updated daily on our Provider Portal, and you can check claims that were submitted for the previous 24 months.

Code Editing

CareSource uses clinical editing software to help evaluate the accuracy of diagnosis and procedure codes on submitted claims to ensure claims are processed consistently, accurately and efficiently.

CareSource's code editing software finds any coding conflict or inconsistent information on claims. For example, a claim may contain a conflict between the patient's age or gender and diagnosis, such as a pregnancy diagnosis for a male patient. Our software resolves these conflicts or indicates a need for additional information from the provider.

CareSource's code editing software helps evaluate the accuracy of the procedure code only, not the medical necessity of the procedure.

Provider Coding and Reimbursement Guidelines

CareSource strives to be consistent with national commercial standards regarding the acceptance, adjudication and payment of claims. These standards apply to the code/code set(s) submitted and related clinical standards for claims received either as a paper copy or electronically. We apply HIPAA standards to all electronically received claims. Accordingly, we accept only HIPAA-compliant code sets (HCPCS, CPT, ICD-10 and NDC). Specific contract language stipulating the receipt, processing and payment of specific codes and modifiers is honored as would be any aspect of a provider contract. Generally accepted commercial health insurance rules regarding coding and reimbursement are also used when appropriate. CareSource strives to follow the prevailing National Correct Coding Initiative (NCCI) edits as maintained by CMS.

CareSource uses coding industry standards, such as the AMA CPT manual, CCI and input from medical specialty societies to review multiple aspects of a claim for coding reasonableness, including, but not limited to:

- Bundling issues
- Diagnosis to procedure matching
- Gender and age appropriateness
- Maximum units of a code per day
- Currently valid CPT/HCPCS code or modifier usage

CareSource seeks to apply fair and reasonable coding edits. If a claim is denied for lack of supporting documentation providers should submit a corrected claim with supporting documentation to justify the use of a particular code edit or modifier. All claim reviews take into consideration all the previously mentioned CCI and national commercial standards. To ensure that all relevant information is considered, appropriate clinical information should be supplied with the claim submission. This clinical information allows CareSource to consider why the code set(s) and modifier(s) being submitted are differing from the usual standards inherent in our edit logic. The clinical information may provide evidence to override the edit logic when the clinical information demonstrates a reasonable exception to the norm.

Any specific claim is subject to current CareSource claim logic and other established coding benchmarks. Any consideration of a provider's claim payment concern regarding clinical edit logic will be based upon review of generally accepted coding standards and the clinical information particular to the specific claim in question.

Explanation of Payment

An Explanation of Payment (EOP) is a statement of the current statuses of claims that have been submitted to CareSource and entered into our system. EOPs are generated weekly. However, you may not receive an EOP each time they are generated if you do not have any claims in the system. Providers who receive EFT payments will receive an Electronic Remittance Advice (ERA) and can access a "human readable" version on the Provider Portal.

Information Included on Explanation of Payment

EOPs include paid and denied claims. Denied claims appear on the EOP with a HIPAA-compliant remark code indicating the reason the claim was denied. It is the provider's responsibility to resubmit claims with the correct or completed information needed for processing.

Check Claim Status Online

Pended claims are claims that have been entered into our system but have not yet been processed completely. Please remember that you can track the progress of your submitted claims at any time through our Provider Portal. Check **CareSource.com** for a sample EOP.

CareSource is responsible for resolving any pended claims, not the provider. The report may be sent to you merely to acknowledge receipt. Please do not resubmit pended claims; this may further delay processing. A Pended Claim Explanation report may be sent on the first and third check write of the month.

Explanation of Benefits

CareSource members receive an Explanation of Benefits (EOB) that informs members of their deductible and out-of-pocket status and shows copays and coinsurance they have paid. The EOB outlines the amount the provider billed, the amount CareSource reimbursed and the remaining amount for which the member is responsible.

Other Coverage – Coordination of Benefits

Coordination of Benefits

CareSource collects Coordination of Benefits (COB) information for our members. This information helps us to ensure that we are paying claims appropriately.

While we try to maintain information as accurately as possible, we rely on numerous sources of information that are updated periodically, and some information may not always be fully reflected on our Provider Portal. Please ask CareSource members for all health care insurance information at the time of service.

Search Coordination of Benefits on the Provider Portal By:

- Member ID Number
- CareSource case number
- Medicaid number/MMIS number
- Member name and date of birth

You can also check members' coordination of benefits by calling Provider Services at **1-833-230-2101**.

Coordination of Benefits Overpayment

If a provider receives a payment from another carrier after receiving payment from CareSource for the same items or services and it is determined the other carrier is primary, this is considered an overpayment. Adjustments to the overpayment will be made on subsequent reimbursements to the provider, or providers can issue refund checks to CareSource for any overpayments. Providers should not refund any money received from a third party to a member.

Workers' Compensation

Claims indicating that a member's diagnosis was caused by the member's employment will not be paid. The provider will be advised to submit the charges to workers' compensation for reimbursement.

Third-Party Liability/Subrogation

Claims indicating the provided services were the result of an injury will be considered as a case of possible subrogation. Any third-party liability will be determined. CareSource will pay the provider for all covered services. Then, we will pursue recovery from any third parties involved.

Member Financial Liability

Some benefits under a plan may have first dollar coverage while others will require a member to first pay an annual deductible before CareSource contributes payment for the services. In addition to the deductible, copayments or coinsurance are also applicable for many covered services. It is up to the provider to collect these amounts at the time of service. If a member overpays his or her coinsurance, the provider must refund the overpayment to the member.

Grace Period

Please refer to the "Member Eligibility & Enrollment" chapter on page 50 for more information on the grace period.

CONTRACTING AND CREDENTIALING

CareSource credentials and recredentials all licensed independent practitioners including physicians, facilities and non-physicians with whom it contracts and who fall within its scope of authority and action. Through credentialing, CareSource checks the qualifications and performance of physicians and other health care practitioners. Our Vice President/Senior Medical Director is responsible for the credentialing and recredentialing program.

Council for Affordable Quality Healthcare Application

- CareSource is a participating organization with Council for Affordable Quality Health Care (CAQH). Please make sure that we have access to your provider application prior to submitting your CAQH number:
- Log onto the CAQH website at www.CAQH.org, utilizing your account information
- Select the Authorization tab and ensure CareSource is listed as an authorized health plan (if not, please check the Authorized box to add)

It is essential that all documents are complete and current. Otherwise, CareSource will discontinue the contracting and credentialing process.

Please also include copies of the following documents:

- Malpractice insurance face sheet
- Drug Enforcement Administration (DEA) certificate (current)
- Clinical Laboratory Improvement Amendment (CLIA) certificate (if applicable)
- Protocol Agreement (if an advanced practice nurse or a physician assistant)

Debarred Provider Employee Attestation

CareSource verifies that its providers and the providers' employees have not been debarred or suspended by any state or federal agency. CareSource also requires that its providers and the providers' employees disclose any criminal convictions related to federal health care programs. "Provider employee" is defined as directors, officers, partners, managing employees or persons with beneficial ownership of more than five percent of the entity's equity.

CareSource Debarment/Criminal Conviction Attestation

Providers must offer a list that identifies all the provider employees, as defined above, along with the employee's tax identification or SSNs. Providers and their employees must execute the attestation titled, "CareSource Debarment/Criminal Conviction Attestation" (in addition to being subject to and cooperating with CareSource verification activities) as a part of the credentialing and recredentialing process.

CareSource conducts credentialing and recredentialing activities by following the National Committee for Quality Assurance (NCQA) standards and the appropriate federal and individual state department of insurance requirements.

Who Is Credentialed?

Contracted providers listed in the Provider Directory and the following are credentialed:

- Providers who have an independent relationship with CareSource. This independent relationship is defined through contracting agreements between CareSource and a provider or group of providers and is defined when CareSource selects and directs its enrollees to a specific provider or group of providers.
- Providers who see members outside the inpatient hospital setting or outside ambulatory free-standing facilities.
- Practitioners who are hospital-based but see the organization's members as a result of their independent relationship with the organization.
- Dentists who provide care under the organization's medical benefits.
- Non-physician practitioners who have an independent relationship with the organization, as defined above, and who provide care under the organization's medical benefits.
- Covering practitioners (locum tenens).
- Medical directors of urgent care centers and ambulatory surgical centers.

The following providers listed in the Provider Directory do not need to be credentialed:

- Practitioners who practice exclusively within the inpatient setting and who provide care for an organization's members only because of the members being directed to the hospital or other inpatient setting.
- Practitioners who practice exclusively within free-standing facilities and who provide care for organization members only because of members being directed to the facility and who are not listed separately in the CareSource Provider Directory.
- Pharmacists who work for a pharmacy benefit manager (PBM) organization.
- Practitioners who do not provide care for members in a treatment setting (e.g., board-certified consultants).

Provider Selection Criteria

CareSource is committed to providing the highest level of quality care and service to our members. Our providers are critical business partners with us in that endeavor. As a result, we have developed the following provider selection criteria to facilitate this optimal level of care and service, as well as promoting mutually rewarding business partnerships with our providers.

The Institute of Medicine defines quality of care of care delivery as: *"The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."*

CareSource has developed comprehensive care management and quality improvement programs to facilitate this level of quality-of-care delivery, as well as a comprehensive credentialing program to ensure that our providers have the appropriate training and expertise to serve our members from a care delivery and service perspective. CareSource bases selection on quality-of care and service aspects, in addition to business and geographic needs for specific provider types in a nondiscriminatory manner.

The following selection criteria have been put in place and are assessed during the credentialing and recredentialing process in addition to day-to-day monitoring via internal mechanisms and interactions with our members.

Selection Criteria:

- Active and unrestricted license in the state issued by the appropriate licensing board.
- Current DEA certificate (if applicable).
- Successful completion of all required education.
- Successful completion of all training programs pertinent to one's practice.
- For MDs and DOs, successful completion of residency and/or fellowship training pertinent to the requested practice type.
- For dentists and other providers where special training is required or expected for services being requested, successful completion of training.
- Board Certification is not required for primary care specialties. Primary Care Providers (PCPs) who are approved by the CareSource Credentialing Committee will appear in CareSource Provider Directories.
- Providers approved by the CareSource Credentialing Committee in non-primary care specialties will be listed in the Provider Directory as specialists if certified by a specialty board, which is recognized by the CareSource Credentialing Committee.
- Education, training, work history and experience are current and appropriate to the scope of practice requested.
- Malpractice insurance at specified limits established for all practitioners by the credentialing policy.
- Good standing with Medicaid and Medicare.
- Quality of care and practice history as judged by:
  - Medical malpractice history
  - Hospital medical staff performance
  - Licensure or specialty board actions or other disciplinary actions, medical or civil

  - Lack of member grievances or complaints related to access and service, adverse outcomes, office environment, office staff or other adverse indicators of overall member satisfaction
  - Other quality of care measurements/activities
  - Business needs that may dictate policy exceptions require careful scrutiny of above factors to ensure quality credentialing
  - Lack of issues on HHS-OIG, SAM/ EPLS, or state site for sanctions or terminations (fraud and abuse)
- Signed, accurate credentialing application and contractual documents.
- Participation with Care Management, Quality Improvement and Credentialing programs.
- Compliance with standards of care and evidence of active initiatives to engage members in preventive care.
- Agreement to comply with plan formulary requirements or acceptance of Plan Drug Formulary as administered through the Pharmacy Benefit Manager.
- Agreement to access and availability standards established by the health plan.
- Compliance with service requirements outlined in the provider agreement and CareSource Provider Manual.

Organizational Credentialing and Recredentialing

The following organizational providers are credentialed and recredentialed:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free-standing ambulatory surgery centers
- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting

Additional organizational providers are also credentialed:

- Hospice providers
- Urgent care facilities, free-standing and not part of a hospital campus
- Dialysis centers
- Free-standing facilities that provide outpatient, non-emergent advanced radiology services (including MRI/MRA, CT and PET scans)

In addition to the urgent care and ambulatory surgical facilities being credentialed, the Medical Director or senior provider responsible for medical services will be credentialed using the standard credentialing and recredentialing processes.

The following elements are assessed for organizational providers:

- Provider is in good standing with state and federal regulatory bodies.
- Provider has been reviewed and approved by an accrediting body.
- Every three years, the provider is still in good standing with state and federal regulatory bodies and is reviewed and approved by an accrediting body.

- Provider's liability insurance coverage is maintained.
- Provider's CLIA certificates are current.
- Provider has completed a signed and dated application.

Providers will be informed of the credentialing committee decision within 60 business days of the committee meeting. Providers will be considered recredentialed unless otherwise notified.

Practitioner Credentialing Rights

- Providers have the right to review information submitted from outside sources (e.g., malpractice insurance carriers and state licensing boards) to support their credentialing application upon request to the CareSource Credentialing department. CareSource keeps all submitted information locked and confidential.
- Providers have the right to correct incomplete, inaccurate, or conflicting information that was submitted to support their application prior to presenting to the credentialing committee. If any information obtained during the credentialing or recredentialing process varies substantially from the application, CareSource will request that the provider submit written clarification to the Credentialing department electronically, by email, fax or by certified mail, return receipted requested and the provider will be given five business days to response. No response within that time frame will result in discontinuance on the sixth day.
- Providers have the right to be informed of the status of their credentialing or recredentialing application upon written request to the Credentialing department. An automated email is sent to providers once their application is submitted via the CareSource Provider Portal. This email directs them to contact Provider Services at **1-833-230-2101** to obtain application status updates. Provider Service Representatives can inform providers if their application is completed and they are showing as participating in the CareSource network, or if their application is still in process while referencing the state-specific time frames. Practitioners also have the ability to check the status of their application by visiting the **CareSource.com** website, signing into the Provider Portal, and entering their application and NPI numbers.

Provider Responsibilities

Providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. CareSource will initiate immediate action in the event that the participation criteria are no longer met. Providers are required to inform CareSource of changes in status, such as being named in a medical malpractice suit, involuntary changes in hospital privileges, licensure or board certification, or any event reportable to the National Practitioner Data Bank (NPDB).

Recredentialing

Providers are recredentialed a minimum of every three years. As part of the recredentialing process, CareSource considers information regarding performance to include complaints, and safety and quality issues collected through the quality improvement program, in addition to information regarding sanctions collected from the NPDB, Medicare and Medicaid Sanctions and Reinstatement Report, Medicare Opt-Out and the HHS/OIG. Providers will be considered recredentialed unless otherwise notified.

Board Certification Requirements

Effective Jan. 1, 2003, physicians applying to become participating providers must be either board certified in their primary specialty or pursuing the pathway to certification as defined by their specialty board, except for general dentists who will have board certification requirements waived in lieu of adequate education and training.

Effective Sept. 10, 2010, primary care providers may be exempted from the board certification requirement if they have successfully completed a primary care residency program and their education and training are consistent with their intended scope of practice.

Physicians who are pursuing certification must be certified within the time frame specified by their respective board. Failure to become certified may result in termination as a participating provider.

Physicians whose boards require periodic recertification will be expected but not required to be re-certified, although failed attempts at re-certification may be reason for termination.

To be credentialed as a subspecialist, physicians must:

- Complete an approved fellowship training program in the respective subspecialty and
- Be board-certified by a board that is recognized and approved by the CareSource Credentialing committee. If no subspecialty board exists or the board is not a board recognized and approved by the CareSource Credentialing committee, then subspecialty recognition will be determined based on education, training and experience requirements of the fellowship training program and/or other suitable board certification recognition.

Delegation of Credentialing/Recredentialing

CareSource will only enter into agreements to delegate credentialing and recredentialing if the entity that wants to be delegated is NCQA-accredited for these functions, follows NCQA credentialing standards or utilizes an NCQA-accredited credentials verification organization (CVO), and successfully passes a pre-delegation audit demonstrating compliance with NCQA, federal and state requirements.

A pre-delegation audit must be completed prior to entering into any delegated agreement. All pre-assessment evaluations will be performed utilizing the most current NCQA, and regulatory requirements. The following will be included (at a minimum) in the review:

- Credentialing and recredentialing policies and procedures
- Credentialing and recredentialing committee meeting minutes from the previous year
- Credentialing and recredentialing provider file review

Delegates must be in good standing with Medicaid and CMS. Monthly reporting will be required from the delegated entity. This will be defined in an agreement between both parties.

CareSource may also choose to outsource the credentialing and recredentialing function at any time to an NCQA-accredited CVO. Providers will be notified of this and must adhere to the requests from the chosen CVO.

Reconsideration and Appeals of Credentialing/Recredentialing Decisions

CareSource may decide that an applying or participating provider may pose undue risk to our members and should be denied participation or be removed from CareSource's network. If this happens, the applying or participating provider will be notified in writing. Reconsideration and appeal opportunities are available unless an exception applies. Exceptions are set forth in the CareSource Fair Hearing Plan. To submit a request, the following steps apply:

Step 1

Submit to the Vice President/Senior Medical Director a reconsideration request in writing, along with any other supporting documentation.

CareSource
P.O. Box 8738
Dayton, OH 45401-8738
Attn: Vice President/Senior Medical Director

All reconsideration requests must be received by CareSource within 30 calendar days of the date the provider is notified of the decision. The request, along with any supporting information, will be presented to the credentialing committee for review at the next meeting. The committee will respond within 30 calendar days of that meeting, and the provider will be notified in writing of the committee's decision.

Step 2

If the committee maintains the original decision, an appeal may be made consistent with provisions of the CareSource Fair Hearing Plan unless an exception applies. Any appeal request must be submitted in writing and received by CareSource within 30 calendar days of the date the provider is notified of the reconsideration decision.

Appeals May Be Sent To:

CareSource
Attn: Vice President/Senior Medical Director
P.O. Box 8738
Dayton, OH 45401-8738

Applying providers may submit additional documents for reconsideration by the credentialing committee to the address above. An application rejection due to the provider's failure to submit a complete application is not subject to reconsideration or appeal.

If you would like to review the CareSource Fair Hearing Plan, please visit CareSource.com/documents/fhp.

Provider Disputes

Provider disputes for issues related to quality, professional competency or conduct should be sent to:

CareSource
Attn: Quality Improvement
P.O. Box 8738
Dayton, OH 45401-8738

Provider disputes for issues that are contractual or non-clinical should be sent to:

CareSource
Attn: Provider Relations
P.O. Box 8738
Dayton, OH 45401-8738

Summary Suspensions

CareSource reserves the right to immediately suspend or summarily dismiss, pending investigation, the participation status of a participating provider who, in the opinion of the CareSource Vice President/ Senior Medical Director, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare or safety of our members. Any participating provider that is subject to a suspension or termination may dispute the action and request a hearing through the CareSource Fair Hearing Plan unless an exception applies. Exceptions are set forth in the CareSource Fair Hearing Plan.

COVERED SERVICES AND EXCLUSIONS

This section describes some of the services and exclusions to benefits that are provided to our CareSource members. CareSource requires covered services to be medically necessary. Not all medically necessary services will be considered covered services. Covered services may require prior authorization. Please visit the Provider Portal at **CareSource.com** > Login > Provider Portal for the most up-to-date list of services that require prior authorization.

Covered Services

CareSource's Marketplace product is compliant with the Affordable Care Act (ACA) in terms of benefit offerings and cost share applications, as well as providing supplemental Adult Dental, Adult Vision and Fitness benefits.

Benefit Limits

In general, most benefit limits for services and procedures follow state and federal guidelines. Benefits limited to a certain number of visits per year are based on a calendar year (January through December). Please check to be sure the member has not already exhausted benefit limits before providing services by checking our Provider Portal or calling Provider Services at **1-833-230-2101**. Services provided beyond the benefit limits will not be considered covered services.

Medical Necessity Determinations

Some services may require PA, these requests involve determining if a service is medically necessary. CareSource leverages evidence-based criteria including medical policies, nationally recognized guidelines and a variety of other criteria to determine if a service is to be considered medically necessary. All services requested by your doctor may not be covered services. Only covered services are reviewed for medical necessity.

Providers and members may have the right to appeal the decision. Providers appealing on the member's behalf must have the member's written consent allowing them to do so. Please see the "Provider Appeals Procedures" section of this manual on page 41 for information on how to file an appeal.

Pediatric Dental and Vision

All CareSource pediatric members have access to routine dental and vision benefits. Pediatric dental provides coverage for the majority of dental services from dental exams and preventive services to major/comprehensive services, and even medically necessary orthodontic services. These benefits are provided exclusively through our Dental Benefits Manager, DentaQuest.

Pediatric vision services are provided exclusively through our Vision Benefits Manager, EyeMed, and the benefit covers eye exams (no cost), eyewear including glasses or contact lenses, as well as other value add services through the relationship such as low vision exams/aids and discounts on a wide array of materials and services.

Routine Hearing Exams and Hearing Aids

All CareSource members have access to no cost routine hearing exams through our vendor, TruHearing. Members must contact TruHearing's member services to establish a relationship with a hearing specialist who will guide them through finding a provider, setting up an appointment, as well as supporting them through any follow up processes to ensure satisfaction. For coverage to apply to these services, they must see a TruHearing provider.

Optional Adult Dental, Vision and Fitness

CareSource's plans with Dental, Vision and Fitness provide adult members the ability to access the following benefits:

Dental – Adult dental benefits include services such as preventive and diagnostic (cleanings and exams), basic restorative (fillings) and major restorative (extractions, dentures and crowns). Two preventive visits are allowed each year for cleanings and oral examination. Subject to a per benefit year limit. Services are available exclusively through our Dental Benefits Manager, DentaQuest.

Vision – Adult routine vision benefits are available exclusively through our Vision Benefits Manager, EyeMed, and include eye exams (cost share may apply), eyewear including contact lenses, as well as other value add services through the relationship such as low vision exams/aids and discounts on a wide array of materials and services. Eyewear (glasses and contacts) are subject to a $250 allowance each calendar year with no copay/deductible.

Fitness – Available for members age 18 and above, CareSource is proud to offer our adult members access to the Active&Fit® program with no member cost share. The Active&Fit program provides your patient with a no cost access to their network of fitness centers, home fitness kits - with some including wearable fitness device, on demand workout video library, Digital Fitness Program - including access to over 8,000 work out videos, Health Living Coaching Program, and much more. *The Active&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Active&Fit is a trademark of ASH and used with permission herein.*

GRIEVANCES AND APPEALS

Member Complaint and Appeals Procedures

Note: If a provider files an Appeal related to a member's Adverse Benefit Determination, then the member complaint and appeals procedures below will apply. In order for a provider to file a complaint or an Appeal regarding an Adverse Benefit Determination, written consent from the member is required. **Please see the Provider Appeals Procedures section on** page 41 **for more information on submitting an appeal related to a claim.**

Members may contact Member Services at **1-833-230-2099** with any questions they have about Benefits, including any questions about coverage and Benefit levels; Annual Deductibles, Coinsurance Copayment, and Annual Out-of-Pocket Maximum amounts; specific claims or services they have received; our Network; and our authorization requirements.

We have implemented the Complaint Process, also referred to as the Grievance process, the Appeal process, and the External Review process to provide fair, reasonable, and timely solutions to complaints that members may have concerning the Plan, Benefit determinations, coverage and eligibility issues, or the quality of care rendered by Network Providers.

Complaint Process

Pursuant to Federal and State regulations, we have put in place a complaint process for the resolution of complaints members submit to us that are related to Benefits, Benefit denials, and/or Health Care Services generally. For purposes of this complaint process, we define a complaint as any dissatisfaction expressed, orally or in writing, by the member or their Authorized representative regarding:

1. Matters related to utilization review including, but not limited to, health care services, denials, accessibility, and confidentiality,
2. The availability, delivery, appropriateness, or quality of Health Care Services;
3. The Handling of payment of claims for Health Care Services;
4. Matters pertaining to the contractual relationship between CareSource and the member; or
5. CareSource's decision to rescind member coverage under the Plan.

If members have a complaint concerning the Plan, they may contact us by sending a letter at the following address:

CareSource
Attn: Member Appeals
P.O. Box 1947
Dayton, OH 45401-1947

Members may also submit a complaint by calling us at **1-833-230-2099** (TTY: 1-800-255-0056 or 711).

We will investigate, resolve, and make a decision regarding the complaint within the timeframes specified below:

- Pre – Service denial: within 30 calendar days
- Post – Service denial: within 30 calendar days
- Expedited Pre-Service denial: within 72 hours

For complaints unrelated to adverse benefit determinations, we will investigate, resolve, and make a decision regarding the complaint within 30 calendar days.

We will send the member and/or their Authorized Representative a letter explaining the Plan's resolution of the complaint after completing our investigation.

If the member or their Authorized Representative is unsatisfied with our decision regarding the Complaint, the member or their Authorized Representative may Appeal our decision, orally or in writing, within 180 days of receiving notice of our Complaint decision. For appeals unrelated to adverse benefit determinations, the Appeal will be resolved not later than thirty (30) days after the Appeal is filed. We will send the member and/or their Authorized Representative written notice of the resolution of the Appeal after completing the investigation.

For appeals related to adverse benefit determinations, see the **Adverse Benefit Determination Appeals section below.**

Note: Please note that the Adverse Benefit Determination Complaint and Appeal Process below addresses complaints related to Benefits, Benefits denials, or other Adverse Benefit Determinations.

Adverse Benefit Determination Appeals

If we make an Adverse Benefit Determination, we will provide the member or their Authorized Representative with a notice of an Adverse Benefit Determination, as described above.

If a member or their Authorized Representative does not agree with the Adverse Benefit Determination, the member may submit an appeal. If the member does not agree with the complaint outcome, they can submit an appeal. Requests for Expedited Review of an Internal Appeal may be submitted by the member or their authorized representative orally or in writing.

The Appeal request should include:

- The Covered Person's name and identification number as shown on the ID card;
- The provider's name;
- The date of the medical service;
- The reason the member or their Authorized Representative disagrees with the denial; and
- Any documentation or other written information to support the request.

The member or their Authorized Representative may send a written request for an Appeal to:

CareSource
Attn: Member Appeals
P.O. Box 1947
Dayton, OH 45401-1947

For appeals for claims involving emergent care, the member or their authorized representative can call the Plan at **1-833-230-2099** to request an appeal.

The Plan offers one (1) level of appeal. Within three business days after we receive an oral or written Appeal of an Adverse Benefit Determination, we will acknowledge to the appealing party, orally or in writing, the date the Plan received the Appeal of the Adverse Benefit Determination Notice. The Plan has 30 calendar days after receiving the Appeal for a pre-service denial or 60 calendar days after receiving the post-service denial Appeal to complete the appeal process. We will send the member and/or their authorized representative written notice of the resolution of the appeal after completing the investigation. The appeal will be reviewed by a panel of qualified individuals who were not involved in the matter giving rise to the appeal or in the initial investigation of the appeal.

The member and/or their authorized representative have/has the right to review your claim file and present evidence as part of the Appeal process. We will provide member and/or their authorized representative, free of charge, with all documents relevant to their claim and appeal and with any new or additional evidence considered, relied upon, or generated by the panel in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of the our decision is to be provided in order to give you a reasonable opportunity to respond prior to that date.

Upon request from the member or their authorized representative, we will provide, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

We will provide continued coverage to the member, pending the outcome of the appeal. For appeals concerning concurrent care claims, benefits for an ongoing course of treatment will not be reduced of terminated without providing advance notice to the member and/or their authorized representative and an opportunity for advance review.

Notice of our Final Adverse Benefit Determination of the appeal will include the dental/medical, and contractual reasons for the resolution; clinical basis for the decision; notice of the member's right to further remedies under law, when applicable, including the right to an External Review by an Independent Review Organization ("IRO"); and the department, address, and telephone number through which the member and/or their authorized representative may contact a qualified representative to obtain more information about the decision or the member's right to appeal.

Separate schedules apply to the timing of claims appeals, depending on the type of claim being appealed. The time frames which you and CareSource are required to follow are provided below.

Review Request for a Claim Involving Emergent Care

Appeals concerning decisions related to a review request for a claim involving emergent care are referred directly to an expedited appeal review process for investigation and resolution. See the **"Expedited Review of Internal Appeals"** section below for additional information concerning the timing of the resolution of such appeals.

Members and/or their authorized representatives do not need to submit an appeal of an Adverse Benefit Determination related to emergent care in writing. Members and/or their authorized representatives should call CareSource as soon as possible to appeal a decision related to a claim involving emergent care.

Pre-Service Request for Benefit

Members and/or their authorized representatives must appeal an Adverse Benefit Determination related to pre-service requests for benefits no later than 180 calendar days after receiving the Adverse Benefit Determination notice. We must notify the member and/or their authorized representative of our benefit determination within 30 calendar days after receiving the request for appeal.

Post-Service Claims

Members and/or their authorized representatives must appeal an Adverse Benefit Determination related to post- service requests for Benefits no later than 180 calendar days after receiving the Adverse Benefit Determination notice. We must notify the member and/or their Authorized Representatives of our benefit determination within 60 calendar days after receiving your request for the Appeal.

Concurrent Services Requests

Appeals relating to ongoing emergencies or denials of continued hospital stays (concurrent care claims involving emergent care) are referred directly to an expedited appeal process for investigation and resolution. See the **"Expedited Review of Internal Appeals"** section below for additional information concerning the timing of the resolution of such appeals. Appeals for concurrent care claims (non-emergent) will be concluded in accordance with the medical or dental immediacy of the case.

Expedited Review of Appeal

Expedited Review of an appeal may be started orally, in writing, or by other reasonable means available to the member and/or their authorized representative. All necessary information, including our decision, will be transmitted by telephone, facsimile, or other available similarly expeditious method. If we agree the appeal meets expedited criteria, we will complete the expedited review of your appeal as soon as possible given the medical needs, but no later than 72 hours after our receipt of the request. We will communicate our decision by telephone to the member and/or their authorized representative, attending physician or ordering provider, and the facility rendering the service.

Members and/or their authorized representatives may request an expedited review of their Appeal for:

- Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:
  - Could seriously jeopardize the member's life or health or the member's ability to regain maximum function, or,
  - In the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- Except as provided below, a claim involving Urgent Care Services (Emergent care) is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
- Any claim that a physician with knowledge of your medical condition determines is a claim involving urgent care services (emergent care), and we shall defer to such determination by the physician.

Exhaustion of Internal Appeals Process

The internal appeal process must be exhausted prior to initiating an external review except in the following instances:

- We agree to waive the exhaustion requirement;
- An expedited external review is sought simultaneously with an expedited Appeal; or
- We failed to meet all requirements of the Appeal process unless the failure:
  - Was minor and did not cause, and is not likely to cause, prejudice or harm to the member, so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and the violation occurred in the context of ongoing, good faith exchange of information between the Plan and the member and the violation is not part of a pattern or practice of the Plan.

External Reviews

CareSource, as a health plan, must provide a process that allows the member or their Authorized Representative the right to request an independent External Review of an Adverse Benefit Determination. An Adverse Benefit Determination is a decision by us to deny Benefits because services are not covered, are excluded, or limited under the Plan, or because the member is not eligible to receive the Benefit. An Adverse Benefit Determination may involve an issue of Medical Necessity, appropriateness, health care setting, or level of care or effectiveness. An Adverse Benefit Determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

Opportunity for External Review

An External Review will be conducted by an IRO. The member will not pay for the External Review. There is no minimum cost of Health Care Services denied in order to qualify for an External Review.

The member is entitled to an External Review by an IRO in the following instances:

- An adverse utilization review determination, as outlined in the Managed Care Section above.
- An adverse determination of medical necessity.
- A determination that the proposed service is experimental or investigational.
- Our decision to rescind your coverage under the Plan.

There are two types of IRO reviews: standard and expedited.

Standard External Review

Standard External Reviews and external investigation/experimental reviews are normally completed within 45 calendar days after the External Review is filed.

Expedited External Review

An expedited review for urgent medical situations is normally completed within 72 hours after the expedited External Review is filed. The IRO should notify us and member of its determination of an expedited External Review within 48 hours after making the determination.

An External Review is considered an urgent medical situation and qualifies for expedited External Review if the External Review is related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the member's:

- Life or health; or
- Ability to reach and maintain maximum function.

The expedited External Review process can also occur at the same time as an expedited Appeal for a Claim Involving Emergent Care and a Concurrent Care Claim.

Additionally, the member may request orally or by electronic means an expedited External Review under this section if you, as the member's provider, certify that the requested health care service in question would be significantly less effective if not promptly initiated.

Independent Review Organization Review and Decision

The IRO must consider all documents and information considered by us in making the Adverse Benefit Determination, any information submitted by the member and other information such as: the member's medical records, the member's attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the Plan, the most appropriate practice guidelines, clinical review criteria used by the Plan or our utilization review organization, and the opinions of the IRO's clinical reviewers. We agree to cooperate with the IRO throughout the External Review process by promptly providing any information requested by the IRO. The IRO is not bound by any previous decision reached by us.

The member is also required to cooperate with the IRO by providing any requested medical information, or by authorizing the release of necessary medical information. The member is permitted to submit additional information relating to the proposed service throughout the External Review process. The member is also permitted to use the assistance of other individuals, including physicians, attorneys, friends, and family members throughout the External Review process.

The IRO will make its decision within 45 days after a standard External Review request is filed or within 72 hours of after an expedited External Review request is filed. The IRO will provide the member and us with written notice of its decision within 48 hours after making its determination for an Expedited External Review.

Request for External Review

The member or their Authorized Representative must request an External Review through the IRO within one hundred twenty (120) days of the date of Final Adverse Benefit Determination notice. All requests must be in writing, except for a request for an expedited External Review. Expedited External Reviews may be requested electronically or orally. Requests for External Review must be submitted to Maximus Federal Services.

HHS Federal External Review Request Maximus Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

Phone: 1-888-866-6205

Email: ferp@maximus.com

Fax: 1-888-866-6190

Binding Nature of External Review Decision

An External Review decision by the IRO is binding on us. The decision is also binding on the member except to the extent that the member may have other remedies available under applicable state or federal law. The member may file not more than one External Review request of our Adverse Benefit Determination.

An IRO is immune from civil liability for actions taken in good faith in connection with an External Review. The work product and/or determination issued by the IRO will be admissible in any judicial or administrative proceeding. The documents and other information created and reviewed by the IRO or medical review professional in connection with the External Review are not public records, cannot be disclosed as public records, and must be treated in accordance with confidentiality requirements of state and federal law.

Member Questions

Members may contact us by calling Member Services or by mail.

CareSource
Attn: Member Appeals
P.O. Box 1947
Dayton, OH 45401

1-833-230-2099 (TTY: 1-800-255-0056 or 711)

Definitions

Adverse Benefit Determination means an adverse benefit determination as defined in 29 C.F.R. § 2560.503-1, as well as any rescission of coverage, as described in 45 C.F.R. § 147.128 (whether or not, in connection with the rescission, there is an adverse effect on any particular Benefit at that time). An Adverse Benefit Determination is a decision by CareSource to deny, reduce, or terminate a requested Health Care Service or Benefit in whole or in part, including all of the following:

- A determination that the Health Care Service does not meet the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including Experimental or Investigational treatments;
- A determination of your eligibility for Benefits under the Plan;
- A determination that a Health Care Service is not a Covered Service;
- The imposition of an Exclusion or other limitation on Benefits that would otherwise be covered;
- A determination not to issue coverage, if applicable to this Plan; or
- A determination to rescind coverage under the Plan regardless of whether there is an adverse effect on any particular Benefit at that time.

A Claim Involving Emergent or Urgent Care means:

- Any claim for medical care or treatment with respect to which the application of the time periods for making non-emergent care determinations:
  - Could seriously jeopardize your life or health or your ability to regain maximum function, or
  - In the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Appeal (or internal appeal) means the review by the Plan of an Adverse Benefit Determination, as required in this section.

Complaint means a communication either orally, in writing or by electronic transmission concerning matters related to utilization review including, but not limited to, health care services, denials, accessibility, and confidentiality.

External Review means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable State or federal law.

Final Internal Adverse Benefit Determination means an adverse benefit determination that has been upheld by the Plan at the completion of the internal appeals process described in this Section.

Independent Review Organization ("IRO") means an entity that conducts independent External Reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations pursuant to this Section.

PROVIDER APPEALS PROCEDURES

Claim Dispute Process

If you believe the claim was processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim. You do not need to file a dispute or appeal. We cannot accept corrected claims as part of the dispute or an appeal.

If you believe your claim was inappropriately denied or underpaid, you can submit a claim dispute.

- Claim disputes must be submitted in writing.
- The dispute must be submitted within ninety (90) calendar days of the denial or date of payment.
- At a minimum, the dispute must include:
  - Sufficient information to identify the claim(s) in dispute
  - A statement of why you believe a claim adjustment is needed
  - Pertinent document to support the adjustment
- Incomplete requests will be returned with no action taken.
- Payments disputes can be submitted to CareSource through the following methods:

Online

CareSource.com > Providers > Provider Portal

Fax

937-531-2398

Mail

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

CareSource will make a determination related to the dispute within 30 calendar days. If the decision is to approve the dispute, payment will show on the provider's Explanation of Payment (EOP). If the decision is to uphold the original claim adjudication, a letter will be issued.

Appeals for Claim Denials

Providers are encouraged to utilize the claim dispute process prior to appealing. If you do not agree with the dispute outcome, you will have 365 calendar days from the date of service or date of discharge to file a claim appeal. If the appeal is not submitted in the required time frame, the claim will not be considered, and the appeal will be dismissed. If the appeal is dismissed or denied, providers will be notified in writing. If the appeal is approved, payment will show on the provider's 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 a dispute or an appeal. Corrected claims cannot be accepted as part of an appeal or a dispute.

How to Submit Appeals

Providers can submit appeals through our secure Provider Portal, or in writing:

Online

This is the preferred method of appeal submission.

CareSource.com > Providers > Provider Portal

Under the Provider Portal, click Claims > Post Service Appeals from the left-hand navigation.

Writing

Use the **"Provider Claim Appeal Request Form"** located on our website. Please include:

- The member's name, CareSource member ID number.
- The provider's name and ID number located in your provider welcome number.
- The code(s) and reason why the determination should be reconsidered.
- If you are submitting a timely filing appeal, you must send proof of original receipt of the appeal by fax or electronic data information (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 reversing the determination.

Fax

937-531-2398

Mail

CareSource
P.O. Box 2008
Dayton, OH 45401-2008

Medical Necessity Appeals

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 for a review of an Adverse Benefit Determination.

Timeline for Medical Necessity Appeals

Clinical appeals can be submitted by the member or provider after receiving a letter from CareSource denying coverage. Appeals can be filed by a:

- Provider on behalf of a member with written authorization from the member – within 180 calendar days of receipt of the Notice of an Adverse Benefit Determination.
- Member – within 180 calendar days of receipt of the Notice of an Adverse Benefit Determination.

Appeals Filed on Behalf of the Member

In order for a provider to appeal on behalf of a member, an Appointment of Representative form must be submitted with the appeal. Medical necessity appeals filed by members or providers on behalf of a member must be submitted to CareSource within 180 calendar days and will be resolved within 30 calendar days of receipt or as expeditiously as the member's condition warrants See the Member Complaints and Appeals section of this manual for additional information.

You may use the **"Provider Appeal Request Form"** on **CareSource.com** > Providers > Tools & Resources > Forms to submit your appeal, but this form is not required.

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 for clinical appeals.
- The reason why the determination should be reconsidered.
- Any additional available medical information to support your reasons for reversing the determination.
- An appointment of Representative form from the member allowing you to file the appeal on their behalf.
- 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.

How to Submit Medical Necessity Appeals

There are two ways to submit appeals: by fax or in writing:

Provider Portal

CareSource.com > Providers > Provider Portal

Fax

937-531-2398

Writing

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

Expedited Appeals

You may request an expedited appeal when a covered person is hospitalized or, in the opinion of the treating provider, review under a standard time frame could, in the absence of immediate medical attention, result in any of the following:

- Placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or the unborn child in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of a bodily organ or part.

Verbal requests for expedited appeals may be submitted through the Provider Services department by calling **1-833-230-2101**.

Expedited review of an internal appeal may be started orally, in writing, or by other reasonable means available. We will complete expedited review of an appeal as soon as possible given the medical needs but no later than 72 hours after our receipt of the request or as expeditiously as the medical condition requires unless the resolution time frame is extended. You must submit a completed Appointment of Representative form from the member allowing the provider to appeal on their behalf.

Notification of Resolution

CareSource will provide written notice of our determination to the member, attending physician or ordering provider and the facility rendering the service. CareSource will also communicate our decision for expedited appeals by telephone to the attending physician or the ordering provider.

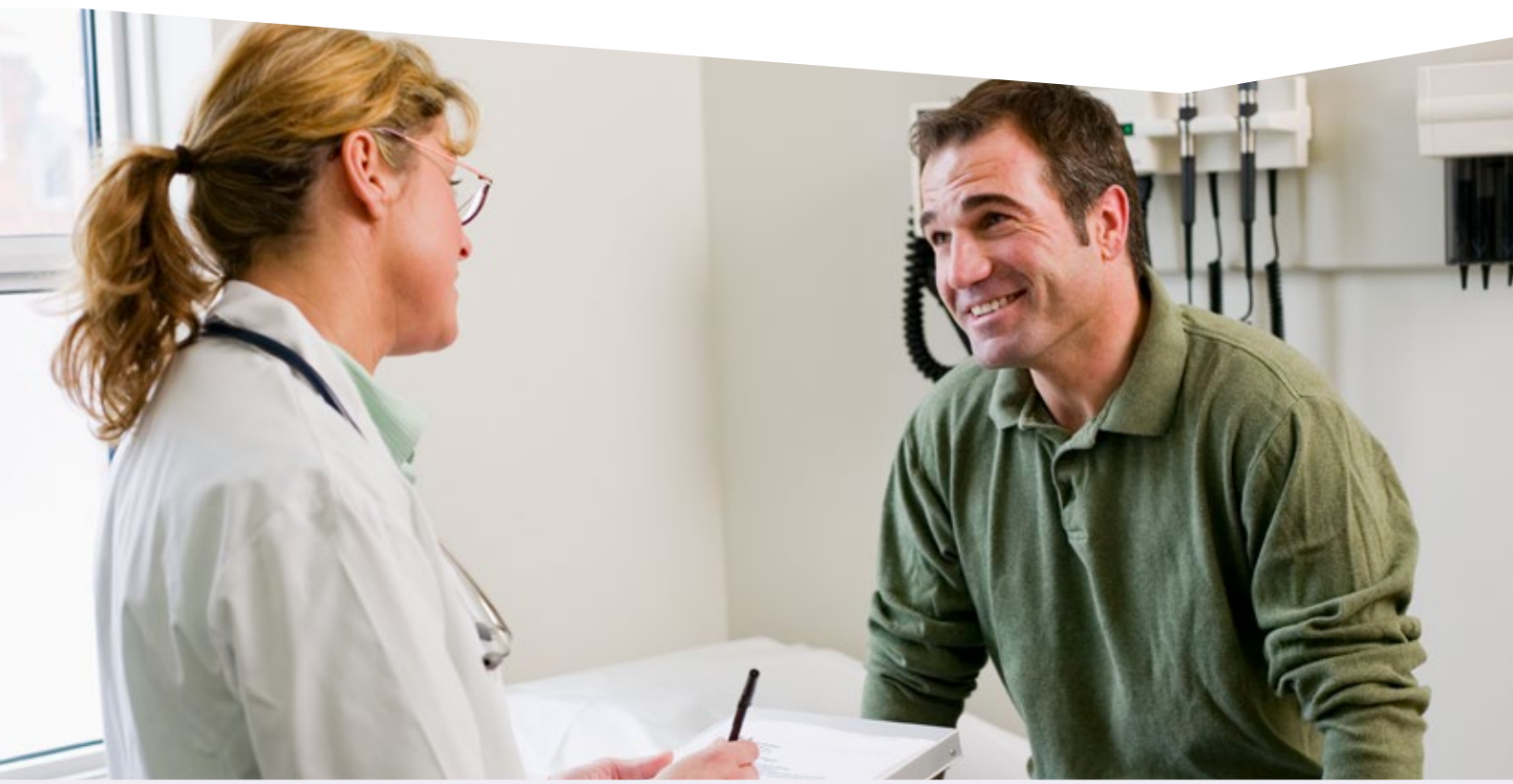
Dissatisfaction of Medical Necessity Appeals – Member External Reviews

CareSource, as a health plan, must provide a process that allows members the right to request an independent External Review of an Adverse Benefit Determination. An Adverse Benefit Determination is a decision by us to deny Benefits because services are not covered, are excluded, or limited under the Plan, or because the member is not eligible to receive the Benefit. The Adverse Benefit Determination may involve an issue of Medical Necessity, appropriateness, health care setting, or level of care or effectiveness. An Adverse Benefit Determination can also be a decision to deny health benefit plan coverage or to rescind coverage. See the Member Complaints and Appeals Procedure section of this manual for additional information about external reviews.

No Surprises Act/Balance Billing

The Federal No Surprises Act established patient protections for members enrolled in Marketplace plans, including protection from out-of-network providers' surprise bills ("balance billing") for emergency care and other specified items or services. CareSource will comply with these new federal and state requirements including how we process claims from certain out-of-network providers. Claims paid in accordance with this act are notated on your Explanation of Payment with Remark Code N830.

If you wish to initiate the open negotiation period for purposes of determining the amount of total payment, please do so within 30 buienss days from the date of initial payment or notice of denial of payment, by emailing an Open Negotiation Notice to CareSource's Grievance and Appeals department at MarketplaceIDR@CareSource.com, or by contacting Provider Services at **1-833-230-2101**. If the 30-day open negotiation period does not result in an agreement on the total payment for the qualified IDR item(s) or service(s), you may initiate the Federal IDR process within four days after the end of the open negotiation period. Please visit our website for more information.



PHARMACY

Please Note: CareSource partners with ExpressScripts to manage our pharmacy benefits. All specialty medications will need to be obtained through a specialty network pharmacy.

Qualified health plans in the Health Insurance Marketplace provide prescription drug coverage. This benefit will provide coverage for prescriptions obtained from a retail pharmacy, mail-order pharmacy or specialty pharmacy and those that are administered in the patient's home, including drugs administered through a home health agency.

Prescription Drug Coverage

Copayment/Coinsurance Requirements

Members may be required to pay a copayment or coinsurance for covered prescription drugs. Our plans offer lower cost shares for less costly drugs. For example, there may be a lower charge for a generic drug, a higher copay for a preferred brand-name drug and a still higher copay for a non-preferred drug.

For specialty pharmacy, a coinsurance is applied. Coinsurance is a percent of the drug's cost. When members pay a percentage, their cost may be high for many reasons:

- The cost of the drug may be high. Let's assume the coinsurance is 30 percent. In this case, a $250 drug will be more costly than a $25 drug.
- The drug may not be on a preferred tier on the formulary, so the member pays at a higher tier.
- The member may be buying a more expensive brand-name drug when there is a generic equivalent available for less money, if authorized.

Prescribing providers for CareSource's Marketplace plan members must contact the plan for medication prior authorizations.

For a complete list of drugs available, visit **CareSource.com** > Providers > Tools & Resources > Drug Formulary.

Members may also confirm coverage and costs of a specific drug using the CareSource Find My Prescriptions tool at **CareSource.com** > Members > Tools & Resources > Find My Prescriptions.

Tiered Medications

Every drug covered on the CareSource Marketplace Drug Formulary is in one of the tiers below. In general, the higher the cost-sharing tier number, the higher the cost for the drug:

Tier 0: Prescription drugs include preventive medications. These medications are available without a copayment or coinsurance.

Tier 1: Prescription drugs in this tier contain low-cost generic drugs.

Tier 2: Prescription drugs have a higher coinsurance or copayment than those in Tier 1. This tier will contain preferred medications that may be single- or multi-source brand-name drugs.

Tier 3: Prescription drugs have a higher coinsurance or copayment than those in Tier 2. This tier will contain non-preferred medications. This will include medications considered single- or multi-source brand-name drugs.

Tier 4: Prescription drugs have a higher coinsurance or copayment than those in Tier 3. Medications generally classified as specialty preferred medications fall into this category.

Tier 5: Prescription drugs have a higher coinsurance than those in Tier 4. Medications generally classified as specialty non-preferred medications fall into this category.

Drug Formulary

CareSource uses evidence-based guidelines to ensure health care services and medications meet the standards of excellent medical practice and are the lowest cost alternative for the member.

CareSource uses a list of covered drugs, known as the Drug Formulary. The Drug Formulary contains information about which drugs are covered, their cost share tiers and limitations of coverage (such as prior authorizations, quantity limits and step therapy protocols). Drugs are listed by therapeutic class and also by alphabetical index so that therapeutic interchanges for most drug classes are easier to compare. To learn more about how to use our pharmaceutical management procedures, look in the introduction section of the Drug Formulary listing. The most up-to-date formulary may be found online at **CareSource.com** > Providers > Tools & Resources > Drug Formulary. Drugs not listed on the Drug Formulary are not covered without prior approval.

Quantity, Supply, Duration and Benefit Limits

Quantity limits and dosing limits are based on normal manufacturers' recommended dosing frequency, long- term safety considerations, diagnosis and best practices. Limits on opioids or other medications that have a high risk for abuse or diversion are based upon maximum morphine equivalent dosing limits or applicable law. Additionally, benefit limitations may pertain to preventive coverage or as defined by applicable rights to coverage for our members.

Step Therapy

Certain medications on the Drug Formulary are covered if utilization criteria are met. Step therapy is one such utilization technique that requires a first step formulary medication be tried and failed prior to the approval of a step two formulary medication. A reasonable clinical trial of the step one drug is defined to include appropriate use for labeled or compendia-supported indications, titration of the step one drug (where appropriate) and supporting evidence (such as provider notes or lab results) to show the step one drug has failed. Step two drugs are formulary medications which may require the member to pay higher cost share and also may be more costly to the plan. Step therapy is designed to preserve best practice and protect our member's financial medication burden and is administered in accordance with applicable state laws.

Generic Substitution & Therapeutic Exchange

Generic substitution occurs when a pharmacy dispenses a generic drug that is equivalent to the prescribed brand-name drug. Generic drugs are usually priced lower than their brand-name equivalents and should be considered the first line of prescribing subject to applicable rules. Generally, members and providers can expect the generic drug to produce the same effect and have the same safety profile as the brand-name drug.

Additionally, if a non-formulary brand-name drug is requested instead of the generic equivalent, a prior authorization request would be required. The CareSource Medical Necessity for Non-Formulary drugs policy requires submission of clinical documentation including clinical notes, proper MedWatch form submissions, etc., as explained in the policy. A determination of medical necessity will be made as explained in the Prior Authorizations section below. If approved, members will pay higher copayments and be subject to additional costs. This can result in significant cost to the member.

Prior Authorization

To submit prior authorization requests, please submit all documents to our fax line at 1-866-930-0019.

Pharmacy prior authorization determinations are typically reviewed and determined within 48 hours of receipt. If your request is urgent, please mark it as "expedited" and a decision will be rendered within 24 hours of receipt.

If you experience technical difficulties or have an urgent need where fax may not be sufficient, you may call in your request. Please note that requests for exceptions or prior authorizations without clinical documentation supplied as required may experience a higher rate of denial and/or appeals because of incomplete policy requirements. Therefore, we encourage all requests to be faxed whenever possible for the best outcomes of our members. Follow the prompts when calling Provider Services at **1-833-230-2101**.

Medically Necessary Reasons for Exceptions to Our Formulary or Utilization Management Policies

Typically, our Formulary includes more than one drug for treating a particular condition. These different possibilities are called alternative drugs. If an alternative drug would be just as effective or considered a treatment standard of care equal to or better than the drug you are requesting, we will generally not approve your request for an exception. Medically necessary reasons for approving an exception

could include lack of available alternative drugs on our Formulary, a severe intolerance or allergy to a drug causing hospitalization, submission of a MedWatch notice to the FDA or the member has failed all available Formulary options.

As mentioned previously, drugs that are on the Formulary may have utilization management applied for reasons of cost, safety, allowances by state laws and more. All documentation to request an exception must establish medical necessity of the requested drug over the available drugs covered by the plan as per each policy.

CareSource has an exception process that allows the member, the member's representative or the prescribing physician to make a request for a formulary coverage exception, or an exception to utilization management. The member, member's representative or prescribing physician may initiate the request by calling Member Services. CareSource then reaches out to the provider to obtain the appropriate documentation.

Typically, CareSource will provide a decision no later than 48 hours after the request is received, or within 24 hours if the request is expedited. If the initial exception request is denied, members have the right to challenge the determination. The external review process is outlined in the Grievances and Appeals chapters of this manual, starting on page 33.

Other Medical Supplies and Durable Medical Equipment

Limited durable medical equipment (DME) may be covered on the Drug Formulary. Please visit our website for the most recent formulary list at **CareSource.com** > Providers > Tools & Resources > Drug Formulary.

Medications Administered in the Provider's Clinical Setting

Medications that are administered in a provider setting, such as a physician office, hospital outpatient department, clinic, dialysis center or infusion center will be billed to the health plan through the member's medical benefit. Prior authorization requirements now exist for many injectable medications.

Medication Therapy Management Program

CareSource offers a Medication Therapy Management (MTM) program for all members. MTM services allow local pharmacists to work collaboratively with physicians and other prescribers to enhance quality of care, improve medication compliance, address medication needs and provide health care to patients in a cost- effective manner. You may be contacted by a pharmacist to discuss your patients' medications. We also encourage members to talk with their pharmacist about their medications, as we want to make sure they are getting the best results from the medications they are taking.

Network Pharmacy

Our Pharmacy Directory gives members a complete list of our network pharmacies, or all of the pharmacies that have agreed to fill covered prescriptions for our plan members. Please visit our website for a complete list of network pharmacies at **CareSource.com** > Members > Tools & Resources > Find My Prescriptions > Find A Pharmacy.

MEMBER ENROLLMENT AND ELIGIBILITY

The Health Insurance Marketplace is responsible for determining whether applicants are eligible for benefits under the plan, the application and enrollment processes, and any subsidy level that may apply. Applicants must be citizens of the United States and reside in the plan's service area.

Members must enroll in the Marketplace every year. They must inform the Marketplace if they become pregnant, have a baby, change address or phone number, have a change in income or marital status, or become eligible for other health care coverage.

Member ID Cards

The member ID card is used to identify a CareSource member; it does not guarantee eligibility or benefits coverage. Members may disenroll from CareSource and retain their ID card. Therefore, it is important to verify member eligibility prior to each service rendered.

Providers may use our secure Provider Portal or call Provider Services to check member eligibility.

Provider Portal

CareSource.com > Providers > Provider Portal

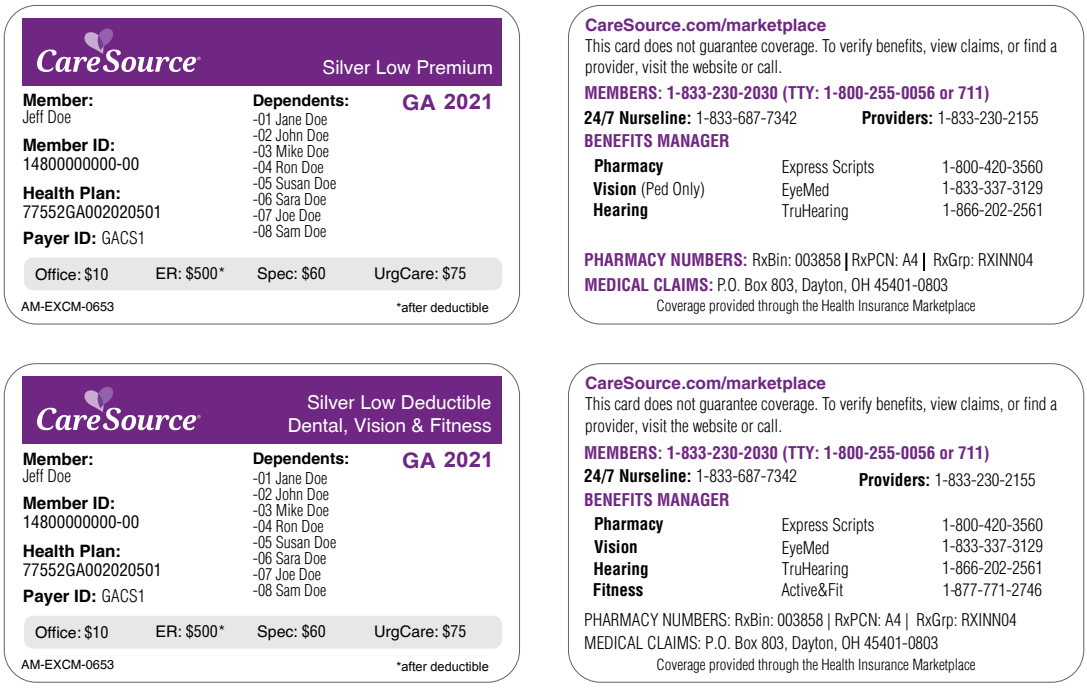
Click on "Member Eligibility" on the left, which is the first tab. Make sure to enter the full 11-digit member ID for the person, and if a dependent, include the dependent suffix.

Phone

1-833-230-2101

Members are asked to present an ID card each time services are accessed. If you are not familiar with the person seeking care and cannot verify the person as a member of our health plan, please ask to see photo identification.

ID Artwork Sample



ID Card Elements

The CareSource member ID card contains the following:

- Member plan – Member's plan choice will be included in this area, including with dental and vision coverage when applicable.
- Member – This is the name of the plan holder.
- Member ID – This is the ID number + suffix for the plan holder.
- Health plan number.
- Payer ID number.
- Copay amounts for office, emergency room, specialist and urgent care visits.
- Dependents – When checking eligibility and/or submitting claims for dependents, please ensure you replace the subscriber suffix (last 2 digits, usually 00) of the Member ID number with the dependent suffix from the ID card.
- Member Services phone number.
- 24/7 nurse advice line.
- Provider Services phone numbers.
- Benefit Manager Information – CareSource partners with several benefit managers to provide our members with the best service possible in specific benefit categories. This section identifies the benefit category, company name, and contact number.
- Address to submit medical claims.
- Pharmacy numbers.

New Member Welcome Kits

Once a member pays to effectuate their coverage, each household receives a new member kit and two or more ID cards that include each family member who has joined CareSource. The new member kits are mailed separately from the ID card.

New Member Kit Elements

- A welcome letter
- A Member Handbook and an Evidence of Individual Coverage and Health Insurance Contract, which explain plan services and benefits and how to access them
- Schedule of Benefits which explains deductibles, copays, coinsurance and out-of-pocket limits for essential health benefits
- Prior Authorization List
- A postcard with which the member can request a Provider Directory
- A flier describing supplemental benefits

Members are referred to the Provider Directory, which lists providers and facilities participating with CareSource. A current list of providers can be found at any time on CareSource's website, **CareSource.com** > Members > Tools & Resources > Find a Doctor.

Member Disenrollment

Members may disenroll from CareSource for a number of reasons. Disenrollment may be initiated by the member, CareSource, or the Health Insurance Marketplace.

Involuntary Member Disenrollment

CareSource provides a 90-calendar day grace period to APTC-eligible members for non-payment of their premium. CareSource will identify in the Provider Portal those members that are in the grace period. During those 90 days, CareSource will continue to process medical claims and pay providers accordingly.

If the member is terminated for non-payment of premium, CareSource will retro-terminate the member and all monies paid on claims for months two and three of delinquency will be recovered.

Pharmacy benefits are eliminated when the member has reached 30-day delinquency. Pharmacy benefits will be reinstated if the member becomes current with their premiums within the 90-day grace period.

MEMBER SUPPORT SERVICES & BENEFITS

CareSource provides a wide variety of support and educational services and benefits to our members to facilitate their use and understanding of our plan's services, to promote preventive health care and to encourage appropriate use of available services. We are always happy to work in partnership with you to meet the health care needs of our members.

CareSource Member Services

Representatives are available by telephone Monday through Friday, except on select holidays. If you have questions, please see the "Contact Us" page.

Members access Member Services by calling our toll-free number at **1-833-230-2099** (TTY: 1-800-255-0056) 7 a.m. to 7 p.m. ET and telling our interactive voice response (IVR) system, what their question is regarding.

Benefit Manager Member Services

Members access our Benefit Manager member services by calling the toll-free numbers listed below. Benefit Managers are able to provide answers to questions on overall services, coverages, claims, in-network providers, and more.

- Active & Fit (American Specialty Health): 1-877-771-2746
- Routine Vision Services & Glasses/Contacts (EyeMed): 1-833-337-3129
- Routine Dental Services (DentaQuest): 1-855-453-5284
- Routine Hearing Services & Hearing Aids (TruHearing): 1-866-202-2561

CareSource24® Nurse Advice Line

Members can call our nurse advice line 24 hours a day, seven days a week. With CareSource24, members have unlimited access to talk with a caring and experienced staff of registered nurses about symptoms or health questions.

Nurses assess members' symptoms using the Schmitt-Thompson Clinical Content to determine the urgency of the complaint and direct members to the most appropriate place for treatment. Schmitt-Thompson is the "Gold Standard" in telephone triage, offering evidence-based triage protocols and decision support.

CareSource24 nurses educate members about the benefits of preventive care and make referrals to our care management programs. The nurses promote the relationship with the primary care provider (PCP) by explaining the importance of their role in coordinating the member's care.

Key features of this service include nurses who:

- Assess member symptoms
- Advise of the appropriate level of care
- Answer health-related questions and concerns
- Provide information about other services
- Encourage the PCP-member relationship

Members access CareSource24 anytime night or day. The phone number is on the member's ID card.

Care Management/Outreach

CareSource provides the services of care management physical and behavioral health nurses, social workers and outreach specialists to provide one-on-one, personal interaction with patients. We have pharmacists on staff to assist with medication reconciliation and to function as a part of the interdisciplinary care team. Please feel free to refer patients who might need individual attention to help them manage special health care problems. Care management can provide a broad spectrum of educational and follow-up services for your patients. It can be especially effective for reducing admission and re-admission risks, managing anticipatory transitions, encouraging non-compliant patients, reinforcing medical instructions and assessing social needs, as well as educating pregnant patients and first-time mothers on the importance of prenatal care, childbirth, postpartum and infant care. We also offer individualized education and support for many chronic diseases. You can refer a member to Care Management by calling **1-833-230-2101**.

Care Management Services

CareSource's Care Management program is a fully integrated health management program that strives for member understanding of and satisfaction with their medical care. We promote integration of physical and behavioral health to manage the member across the continuum of care with a holistic approach. More importantly, it's designed to support the care and treatment you provide to your patient. We stress the importance of establishment of the medical home, identification of barriers and keeping appointments. This one-on-one personal interaction with outreach specialists, social workers and nurse care managers provides a comprehensive safety net to support your patient through initial and ongoing assessment activities, coordination of care, education to promote self-management and healthy lifestyle decisions. In addition, we help connect your patient with additional community resources.

We offer individualized education and support for many conditions and needs, including but not limited to:

- ADHD
- Asthma
- Diabetes
- Heart disease
- Depression
- High blood pressure and cholesterol
- Low back pain
- Pregnancy
- Weight loss

CareSource encourages you to take an active role in your patients' care management programs and participate in the development of individualized care plans to help meet their needs. Together, we can make a difference.

Disease Management Program

Our free disease management programs helps our members find a path to better health through information, resources and support.

We help our members through:

- The MyHealth online program for members 18+ to participate in a journey to improve their health
- Materials with helpful tips and information to manage their disease, promote self-management skills, and provide additional resources.
- One-to-one care management (if they qualify)

Members with specific disease conditions such as asthma, diabetes, and hypertension are identified by criteria or triggers such as emergency room visits, hospital admissions, and the health assessment. All ages (children, teens, and adults) are eligible. These members are automatically mailed quarterly condition-specific materials. The materials are available in English and Spanish. Any member may self-refer or be referred into the disease management programs to receive condition-specific information or outreach. If a member does not wish to receive newsletters or outreach, they can call **1-844-438-9498**.

Benefits to members and health partners

Members identified in the disease management program will receive help finding the appropriate level of care for their condition, and they are encouraged to actively participate in the patient-provider relationship. Programs improve the percentage of CareSource members who receive their recommended screenings.

If you have a patient with asthma, diabetes, or hypertension who you believe would benefit from a program and are not currently enrolled, please call **1-844-438-9498**.

Emergency Department Diversion

CareSource is committed to making sure our members access the most appropriate health care services at the appropriate time for their needs. Members are informed to call 911 or go to the nearest emergency room (ER) if they feel they have an emergency. CareSource covers all emergency services for our members.

We instruct members to call their PCP or the CareSource24 Nurse Advice Line if they are unsure if they need to go to an ER. CareSource also educates members on the appropriate use of urgent care facilities and which urgent care sites they can access. Please see the "Primary Care Providers" section of this manual on page 62 for more information.

Member ER utilization is tracked closely. If there is frequent ER utilization, members are referred to our Care Management and Outreach department for analysis or intervention. Intervention includes education, as well as assistance with removing any identified health care access barriers. We appreciate your cooperation in educating your patients on the appropriate utilization of emergency services.

Interpreter Services

CareSource offers over-the phone language interpreters for members who need assistance to communicate with CareSource. These services are available at no cost to the member.

CareSource requires providers, at their own expense, to offer sign and language interpreters for members who are hearing impaired, do not speak English, or have limited English-speaking ability. These services should be available at no cost to the member. You are also required to identify the need for interpreter services for your CareSource patients and help them appropriately. We can provide, at no charge, some printed materials in other languages or formats, such as large print, or we can explain materials orally, if needed.

Immunization Schedule

Immunizations are an important part of preventive care for children and should be administered during well- child exams as needed. CareSource endorses the same recommended childhood immunization schedule that is approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP). This schedule is updated annually, and the most current updates are located on www.aap.org.

Immunization Codes

Effective Oct. 1, 2015, CareSource requires providers to use ICD-10-CM codes and CPT codes on claims. Please refer to the code tables located on the CMS website at https://www.cms.gov/Medicare/Coding/ICD10/2016- ICD-10-CM-and-GEMs.html.

You can also get CMS coding guidelines at https://www.cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines-updated-02012022.pdf.

Health Education

CareSource members receive health information from CareSource through a variety of communication vehicles including brochures, phone calls and personal interaction. CareSource also sends preventive care reminder messages to members via mail and automated outreach messaging.

CARESOURCE MEMBER RIGHTS AND RESPONSIBILITIES

As a CareSource provider, you are required to respect the rights of our members. CareSource members are informed of their rights and responsibilities via their Member Handbook. The list of our members' rights and responsibilities are listed below. All members are encouraged to take an active and participatory role in their own health and the health of their family.

Member rights and responsibilities, as stated in the Member Handbook, are as follows:

- Receive information about CareSource, our services, our network providers and member rights and responsibilities.
- Be treated with respect and recognition of their dignity by CareSource personnel, network providers and other health care professionals.
- Privacy and confidentiality for treatments, tests and procedures they receive.
- Participate with doctors in making decisions about their health care.
- Candidly discuss with their doctor the appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about the plan or the care it provides.
- Make recommendations regarding the plan's member rights and responsibilities policy.
- Choose an advance directive to designate the kind of care they wish to receive should they be unable to express their wishes.
- Be able to get a second opinion from a qualified provider. If a qualified network provider is not able to see them, CareSource will set up a visit with a provider not in our network.

Members of CareSource are also informed of the following responsibilities:

- Provide information needed, to the extent possible, in order to receive care.
- Follow the plans and instructions for care that they have agreed to with doctors.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Be enrolled and pay any required premiums.
- Pay an annual deductible, copayments and coinsurance.
- Pay the cost of limited and excluded services.
- Choose network providers and network pharmacies.
- Show your ID card to make sure you receive full benefits under the plan.
- Report suspected fraudulent behavior to CareSource.

HIPAA Notice of Privacy Practices

Members are notified of CareSource's privacy practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). CareSource's Notice of Privacy Practices includes a description of how and when member information is used and disclosed within and outside of the CareSource organization. The notice also informs members on how they may obtain a statement of disclosures or request their medical claim information. CareSource takes measures across our organization internally to protect oral, written and electronic personally identifiable health information, specifically, protected health information (PHI) of members.

As a provider, please remember to follow the same HIPAA regulations as a covered entity and only make reasonable and appropriate uses and disclosures of protected health information for treatment, payment and health care operations.

Please remember that disclosures of a patient's personal health information are permitted for treatment, payment or health care operations in compliance with the HIPAA regulation 45 CFR 164. For example, providers may disclose patient information to CareSource for quality assessment and improvement activities, population- based activities relating to improving health or reducing health care costs, or case management and care coordination, among others. Thank you for your assistance in providing requested information to CareSource in a timely manner.

When a patient has a sensitive health diagnosis (e.g., treatment for drug/alcohol use, genetic testing, HIV/AIDS, mental health or sexually transmitted diseases), you should verify if the patient has granted consent to share health information.

Log in to the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal and search for the CareSource patient using the Member Eligibility option. A message displays if the patient has not consented to sharing sensitive health information. If the patient has not consented, you may not have access to all of the patient's health information on the Provider Portal.

Please encourage your CareSource patients who have not consented to complete a Member Consent/HIPAA Authorization Form so that all providers involved in their care can effectively coordinate their care. This form is located on **CareSource.com** > Members > Tools & Resources > Forms. The Member Consent/HIPAA Authorization Form can also be used to designate a person who can speak on the patient's behalf. This designated representative can be a relative, a friend, a physician, an attorney or some other person that the patient specifies.

AMERICANS WITH DISABILITIES ACT

The Americans with Disabilities Act (ADA) prohibits discrimination against persons with disabilities in the areas of employment, public accommodations, state and local government services and telecommunications. Both public and private hospitals and health care facilities must provide their services to people with disabilities in a nondiscriminatory manner. To do so, providers may have to modify their policies and procedures, provide auxiliary aids and services for effective communication, remove barriers from existing facilities and follow ADA accessibility standards for new construction and alteration projects. Furthermore, providers' diagnostic equipment must accommodate individuals with disabilities.

CareSource network providers must make reasonable accommodations to ensure that their services are as accessible to a member with disabilities as they are to a member without disabilities. CareSource and its network providers will comply with the ADA (28 C.F.R. 35.130) and the Rehabilitation Act of 1973 (29 U.S.C. 794) and will maintain capacity to deliver services in a manner that accommodates the needs of its members.

For more information about the ADA, go to https://www.ada.gov.

Telephone Arrangements/24-Hour Access

Primary Care Providers (PCPs) and specialty physicians are required to maintain sufficient access to facilities and personnel to provide covered physician services. They must ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- A provider's office phone must be answered during normal business hours.
- Answer the member's telephone inquiries on a timely basis.
- Prioritize appointments.
- Schedule a series of appointments and follow-up appointments as needed by a member.
- Identify and reschedule broken and no-show appointments.
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments).
- Adhere to the following response time for telephone call-back waiting times:
  - After hours telephone care for non-emergent, symptomatic issues within 30 minutes.
  - Same day for non-symptomatic concerns.
  - Crisis situations within 15 minutes.
- Schedule continuous availability and accessibility of professional, allied and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.
- After-hour calls should be documented in a written format in either an after-hour call log or some other method and then transferred to the member's medical record.
- During after-hours calls, a provider must have arrangements for the following:
  - Office phone is answered after hours by an answering machine service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of 30 minutes;
  - Office phone is answered after hours by a recording directing the member to call another number to reach the PCP or another medical practitioner whom the provider has designated to return the call within a maximum of 30 minutes; and
  - Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of 30 minutes.

PRIMARY CARE PROVIDERS

Primary Care Provider Concept

All CareSource members may choose a primary care provider (PCP) upon enrollment in the plan. PCPs should help facilitate a medical home for members. This means that PCPs will help coordinate health care for the member and provide additional health options to the member for self-care or care from community partners.

Members select a PCP from our online Provider Directory available at **CareSource.com** > Members > Tools & Resources > Find a Doctor. Members have the option to change to another participating PCP as often as needed. Members initiate the change by calling Member Services.

Primary Care Provider Roles and Responsibilities

PCP care coordination responsibilities include the following:

- Assisting with coordination of the member's overall care, as appropriate for the member.
- Serving as the ongoing source of primary and preventive care.
- Recommending referrals to specialists, as required.
- Triaging members.
- Participating in the development of case management care treatment plans and notifying CareSource of members who may benefit from case management. Please see the "Member Support Services and Benefits" section on page 53 on how to refer members for case management.

In addition, CareSource PCPs play an integral part in coordinating health care for our members by providing:

- Availability of a personal health care practitioner to assist with coordination of a member's overall care, as appropriate for the member
- Continuity of the member's total health care
- Early detection and preventive health care services
- Elimination of inappropriate and duplicate services

Primary Care Providers are responsible for:

- Treating CareSource members with the same dignity and respect afforded to all patients. This includes high standards of care and the same hours of operation.
- Identifying the member's health needs and taking appropriate action.
- Providing phone coverage for handling patient calls 24 hours a day, seven days a week.
- Following all referral and prior authorization policies and procedures as outlined in this manual.
- Complying with the quality standards of our health plans outlined in this manual.
- Providing 30 days of emergency coverage to any CareSource patient dismissed from the practice.
- Maintaining clinical records, including information about pharmaceuticals, referrals, inpatient history, etc.
- Obtaining patient records from facilities visited by CareSource patients for emergency or urgent care if notified of the visit.
- Ensuring demographic and practice information is up to date for directory and member use.

Prenatal and Postpartum Care Documentation

To ensure accurate documentation of prenatal and postpartum care, please be sure to document the following in patient records:

- Evidence of prenatal teaching – This includes education on infant feeding; Women, Infants and Children (WIC); birth control; prenatal risk factors; dietary/nutrition information and childbirth procedures.
- Components of the postpartum checkup – This includes documenting the pelvic exam, blood pressure, weight, breast exam and abdominal exam.

Immunization Schedule

Immunizations are an important part of preventive care for children and should be administered as needed. CareSource endorses the same recommended childhood immunization schedule that is recommended by the Center for Disease Control and approved by the Advisory Committee on Immunization Practices (ACIP), the AAP and the American Academy of Family Physicians (AAFP). This schedule is updated annually, and the most current updates can be found at www.aap.org.

KEY CONTRACT PROVISIONS

To make it easier for you, we have outlined key components of your contract. These key components strengthen our partnership with you and enable us to meet or exceed our commitment to improve the health care of the underserved. We appreciate your cooperation in carrying out our contractual arrangements and meeting the needs of underserved consumers.

Provider Responsibilities

- Providing CareSource with advance written notice of any intent to terminate an agreement with us. In terminations without cause, written notice must be done 120 calendar days prior to the date of the intended termination and submitted on your organization's letterhead.
  - **60 calendar days' notice is required if you plan to close your practice to new patients.** If we are not notified within this time period, you will be required to continue accepting CareSource members for a 60-calendar day period following notification.
- During after-hours calls, a provider must have the arrangements for the following:
  - Office phone is answered after hours by an answering machine service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call.
  - Office phone is answered after hours by a recording directing the member to call another number to reach the PCP or another medical practitioner whom the provider has directed to return the call.
  - Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner.
- Submission of claims or corrected claims should be submitted within 180 calendar days of the date of service or discharge.
- Providers are encouraged to complete the claim dispute process before submitting an appeal. Appeals must be filed within 180 calendar days of the date of service or the date of discharge.
- Providers should keep all demographic and practice information up to date. Information updates can be submitted on the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal.

CareSource Responsibilities

- Providing you with an appeals procedure for timely resolution of any requests to reverse a CareSource determination regarding claims payment. Our appeal process is outlined in the appeals section of this manual.
- Offering a 24-hour Nurse Advice Line service for members to reach a medical professional at any time with questions or concerns.
- Coordinating benefits for members with primary insurance which involves subtracting the primary payment from the lessor of the primary carrier allowable or the CareSource allowable. If the member's primary insurer pays a provider equal to or more than CareSource's fee schedule for a covered service, CareSource will not pay the additional amount.

These are just a few of the specific terms of our agreement. In addition, we expect participating providers to follow standard practice procedures even though they may not be spelled out in our provider agreement.

Examples:

- Participating providers, or their designee, are expected to make daily visits to their patients who have been admitted as inpatient to an acute care facility or arrange for a colleague to visit.
- Participating PCPs are expected to have a system in place for following up with patients who miss scheduled appointments.
- Participating providers are expected to treat members with respect. CareSource members should not be treated any differently than patients with any other health care insurance. Please reference member rights in the "Member Support Services and Benefits" section of this manual on page 53.

CareSource expects participating providers to verify member eligibility and ask for all their health care insurance information before rendering services, except in an emergency. You can verify member eligibility and obtain information for other health care insurance coverage that we have on file by logging onto the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal.

Advance written notice of status changes, such as a change in address, phone, or adding or deleting a provider to your practice helps us keep our records current and is critical for claims processing.

Submitting Provider Changes

Type of Change	Notice Required Please notify CareSource of the change prior to the time frames listed below.
New providers or deleting providers	Immediate
Providers leave the practice	Immediately upon provider notice
Phone number change	10 calendar days
Address change	60 calendar days
Change in capacity to accept members	60 calendar days
Providers intent to terminate	90 calendar days

Why is it important to give changes to CareSource?

This information is critical to process your claims. In addition, it ensures our Provider Directories are up to date and reduces unnecessary calls to your practice. This information is also reportable to Medicaid and Medicare.

How to Submit Changes to CareSource:

Information updates can be submitted on the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal.

Other ways to submit changes include:

Email

ProviderMaintenance@CareSource.com

Fax

937-396-3076

Mail

CareSource
Attn: Provider Maintenance
P.O. Box 8738
Dayton, OH 45401-8738

Provider Directory Information Attestation

State and Federal regulations require Health Plans to validate, and update published information regarding their contracted provider network every 90 days. This validation ensures we have the most accurate information for claims payment and provider directories. This information is critical to process your claims. In addition, it ensures our Provider Directories are up to date and reduces unnecessary calls to your practice. This information is also reportable to Medicaid and Medicare. **Providers are required to attest to directory information every 90 days.**

What happens if I do not attest to my information?

CMS requires health plans to verify the accuracy of provider directory information every 90 days. Not attesting to your information and/or providing updated information when applicable can result in claims payment issues and inaccurate provider data in our online and printed directories. With the No Surprises Act in effect as of Jan. 1, 2022, providers who do not attest quarterly, risk being suppressed in impacted provider directories.

Accurate provider directory information ensures we can connect the **right patients to the right provider.**

Americans with Disabilities (ADA) Standards

Additionally, providers will remain compliant with ADA standards, including but not limited to:

- Utilizing waiting room and exam room furniture that meet needs of all enrollees, including those with physical and non-physical disabilities,
- Providing accessibility along public transportation routes and/or enough parking,
- Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities, and
- Providing secure access for staff-only areas.

For more information on these ADA standards and how to be compliant, please see the ADA section of this manual.

FRAUD, WASTE AND ABUSE

Health care fraud, waste and abuse hurts everyone, including members, providers, taxpayers and CareSource. As a result, CareSource has a comprehensive fraud, waste and abuse program in our Program Integrity (PI) department. Please help us by reporting questionable activities and potential fraud, waste and abuse situations.

Definition of Terms

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

Waste involves the taxpayers not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act or omission by player with control over, or access to, government resources (e.g., executive, judicial or legislative branch employees, grantees or other recipients). Waste goes beyond fraud and abuse, and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight.

Abuse includes actions that may, directly or indirectly, result in: unnecessary costs, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider/member has not knowingly and/or intentionally misrepresented facts to obtain payment.

Improper Payments are any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law) and any payment that does not account for credit for applicable discounts.

Anyone who identifies an improper payment should report it to CareSource using one of the reporting methods below.

Examples of Member Fraud, Waste and/or Abuse:

- Inappropriately using services, such as selling prescribed narcotics, or seeking controlled substances from multiple providers or multiple pharmacies
- Altering or forging prescriptions – i.e., changing prescription forms to get more than the amount of medication prescribed by their physician
- Non-disclosure of other health insurance coverage
- Obtaining unnecessary equipment and supplies
- Identity theft/sharing ID cards – i.e., member receiving services under someone else's ID, sharing your ID with others, or submitting prescriptions under another person's ID
- Providing inaccurate symptoms and other information to providers to get treatment, drugs, etc.

Examples of Provider Fraud, Waste and/or Abuse:

- Prescribing drugs, equipment or services that are not medically necessary
- Billing for services not provided
- Billing more than once for the same service
- Intentionally using improper medical coding to receive a higher rate of reimbursement
- Purchasing drugs from outside the United States
- Prescribing high quantities of controlled substances without medical necessity
- Unbundling services to obtain higher reimbursement
- Scheduling more frequent return visits than are needed
- Billing for services outside of your medical qualifications
- Using patient lists for the purpose of submitting fraudulent claims
- Drugs billed for inpatients as if they were outpatients
- Payments stemming from kickbacks or Stark Law violations
- Not reporting overpayments or overbilling
- Preventing members from accessing covered services resulting in underutilization of services offered

Examples of Pharmacy Fraud, Waste and/or Abuse:

- Prescription drugs not dispensed as written
- Submitting claims for a more expensive brand name drug when a less expensive generic prescription is dispensed
- Dispensing less than the prescribed quantity without arranging for the additional medication to be received with no additional dispensing fees
- Splitting prescriptions into two orders to seek higher reimbursement
- Dispensing expired, fake, diluted or illegal drugs
- Billing prescriptions not filled or picked up

It is also important for you to tell us if a CareSource employee or vendor acts inappropriately.

Examples of Employee Fraud, Waste and/or Abuse:

- Receiving gifts or kickbacks from vendors for goods or services
- Inappropriately marketing our company to potential members
- Behaving in an unethical or dishonest manner while performing company business

Examples of Vendor Fraud, Waste and/or Abuse:

- Falsifying business reports
- Not reporting or taking action on employees that are debarred
- Billing for services not rendered or products not received
- Billing for a more expensive services, but providing a less expensive service

The PI department routinely monitors for potential billing discrepancies or potential fraud, waste and abuse. When found, an investigation is initiated and if warranted, corrective action is taken.

Corrective actions can include, but are not limited to:

- Member and/or provider education
- Written corrective action plan
- Provider termination with or without cause
- Provider summary suspension
- Recovery of overpaid funds
- Member disenrollment
- Contract termination
- Employee disciplinary actions
- Reporting to one or more applicable state and federal agencies
- Legal actions

Your provider agreement provides specific information on each type of termination/suspension. The Fair Hearing Plan, available at **CareSource.com/documents/fhp**, provides information on an appeal process for specific provider terminations.

Network providers are to report and return to CareSource any overpayment within 60 calendar days of identification and notify CareSource in writing of the reason for the overpayment.

The Federal and State False Claims Acts and Other Fraud, Waste and Abuse Laws:

Using the False Claims Act (the Act), you can help reduce fraud against the federal government. The Act allows everyone to bring "whistleblower" lawsuits on behalf of the government — known as "qui tam" suits — against businesses or other individuals that are defrauding the government through programs, agencies or contracts.

The False Claims Act addresses those who:

- Knowingly* presents, or causes to be presented, a false or fraudulent claim for payment or approval
- Knowingly* makes, uses or causes to be made or used, a false record or statement material to a false or fraudulent claim
- Conspires to commit a violation of any other section of the False Claims Act
- Has possession, custody or control of property or money used, or to be used, by the government and knowingly delivers, or causes to be delivered, less than all of that money or property
    - Is authorized to make or deliver a document certifying receipt of property used, or to be used by the government, and intending to defraud the government, makes or delivers the receipt without completely knowing that the information on the receipt is true
    - Knowingly* buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the government, or a member of the armed forces, who lawfully may not sell or pledge property
    - Knowingly* makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government

**"Knowingly" means acting with actual knowledge or with reckless disregard or deliberate indifference to the truth or falsity of information.*

A violation of the Federal Anti-Kickback Statute constitutes a false and fraudulent claim under the Federal False Claims Act.

An example would be if a provider, such as a hospital or a physician knowingly "upcodes" or overbills, resulting in overpayment of the claim using Medicaid and/or Medicare dollars.

The time period for a claim to be brought under the False Claims Act is the later of:

- Within six years from the date of the illegal conduct, or
- Within three years after the date the government knows or should have known about the illegal conduct, but in no event later than ten years after the illegal activity

Protection for Reporters of Fraud, Waste or Abuse

In addition, federal and state law and CareSource's policy prohibit any retaliation or retribution against persons who report suspected violations of these laws to law enforcement officials or who file "whistleblower" lawsuits on behalf of the government. Anyone who believes that he or she has been subject to any such retribution or retaliation should also report this to our PI department.

Additional information on the False Claims Act and our fraud, waste and abuse policies can be found on **CareSource.com** > Providers > Education > Fraud, Waste & Abuse.

Other Fraud, Waste and Abuse Laws

- Under the federal Anti-Kickback Statute, and subject to certain exceptions, it is a crime for anyone to knowingly and willfully solicit or receive, or pay anything of value, including a kickback, bribe or rebate in return for referring an individual to a person for any item or service for which payment may be made in whole or in part under a federal health care program. 42 U.S.C. §1320a-7b.
- Under the federal Stark Law, and subject to certain exceptions, providers are prohibited from referring federal health care program patients for certain designated health services to an entity with which the physician or an immediate family member has a financial relationship. The Stark Law imposes specific reporting requirements on entities that receive payment for services covered by federal health care programs. 42 U.S.C. §1395(a) and §1903(s).
- As part of the Health Insurance Portability and Accountability Act (HIPAA), the U.S. Criminal Code was amended, and it is a crime to knowingly and willfully execute, or attempt to execute a scheme or artifice to defraud any federal health care program or obtain by means of false or fraudulent pretenses, representations or promises, any money or property owned by or under the custody or control of any federal health care program. 18 U.S.C. §1347.
- The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid that are designed to reduce program spending. As an entity that offers Medicaid and Medicare coverage, CareSource is required to comply with certain provisions of the DRA. One such provision prompted this communication, as it requires us to provide you with information about the federal False Claims Act, state False Claims Acts, and other state laws regarding Medicare and Medicaid fraud. In addition, the DRA requires you and your contractors and agents to adopt our policy on fraud, waste and abuse when handling CareSource business.

Prohibited Affiliations

CareSource is prohibited from knowingly having relationships with persons who are debarred, suspended, or otherwise excluded from participating in federal procurement and non-procurement activities, this includes ineligibility to participate in federal programs by the U.S. Department of Health and Human Services (HHS) or another federal agency under 2 CFR 180.970 and exclusion by HHS's Office of the Inspector General or by the General Services Administration under 2 CFR 376.

Relationships must be terminated with any trustee, officer, employee, provider or vendor who is identified to be debarred, suspended, or otherwise excluded from participation. If you become aware that your corporate entity, those with more than 5% ownership in your corporate entity, your office management staff or you are a prohibited affiliation, you must notify us **immediately** by emailing Provider Maintenance at providermaintenace@CareSource.com.

Disclosure of Ownership, Debarment and Criminal Convictions

Before CareSource enters into or renews an agreement with your practice or corporate entity, you must disclose any debarment, proposed for debarment, suspension or declared ineligible status related to federal programs of yourself and your managing employees and anyone with an ownership or controlling interest in your practice or corporate entity.

You must also notify CareSource of any federal or state government current or pending legal actions, criminal or civil, convictions, administrative actions, investigations or matters subject to arbitration.

In addition, if the ownership or controlling interest of your practice or corporate entity changes, you have an obligation to notify us immediately. This also includes ownership and controlling interest by a spouse, parent, child or sibling. Please contact us by emailing Provider Maintenance at providermaintenance@CareSource.com.

If you have ownership of a related medical entity where there are significant financial transactions, you may be required to provide information on your business dealings upon request.

If you fail to provide this information, we are prohibited from doing business with you. Please refer to the Code of Federal Regulations 42 CFR 455.100-106 for more information and definitions of relevant terms.

How to Report Fraud, Waste and Abuse

It is CareSource's policy to detect and prevent any activity that may constitute fraud, waste or abuse, including violations of the federal False Claims Act. Federal and state law and CareSource policy prohibit any retaliation or retribution against persons who report suspected violations. If you have knowledge or information that any such activity may be or has taken place, please contact our PI department. Reporting fraud, waste or abuse can be anonymous or not anonymous.

Options for Reporting Anonymously:

Call

1-833-230-2101 and tell our IVR system, that you are calling to report fraud. Our fraud, waste and abuse hotline is available 24 hours a day.

Write

CareSource
Attn: Program Integrity
P.O. Box 1940
Dayton, OH 45401-1940

Options for Reporting That Are Not Anonymous:

Fax

800-418-0248

Email

fraud@CareSource.com

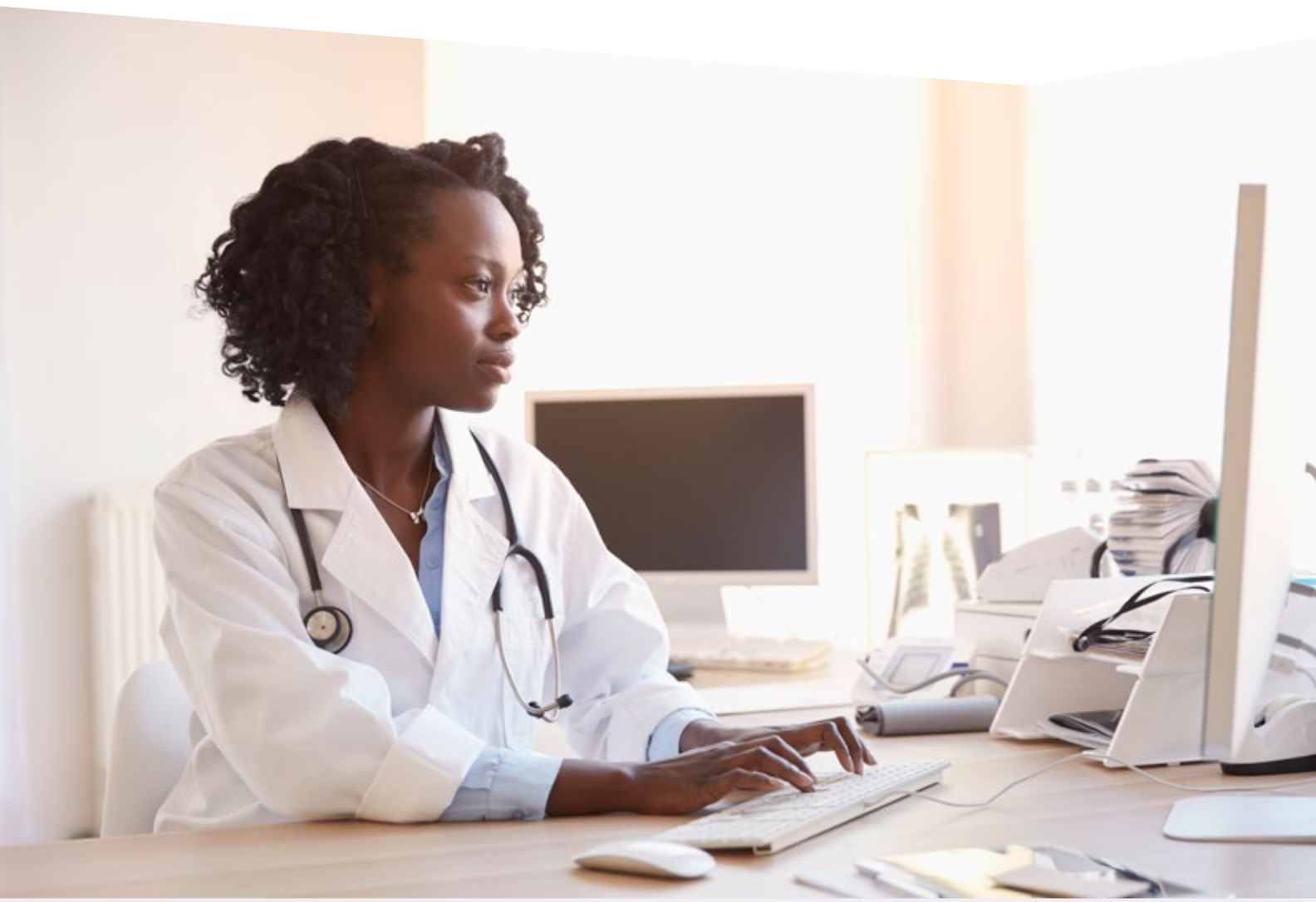
You may also choose to use the **Fraud, Waste and Abuse Reporting Form** located on **CareSource.com** > Providers > Tools & Resources > Forms.

When you report fraud, waste or abuse, please give as many details as you can, including names and phone numbers. You may remain anonymous, but if you do, we will not be able to call you back for more information. Your reports will be kept confidential to the extent permitted by law.

Physician Education Materials

The Office of the Inspector General (OIG) has created free materials for providers to assist you in understanding the federal laws designed to protect Medicaid and Medicare programs and program beneficiaries from fraud, waste and abuse. This brochure can be found on the Office of Inspector General's website at https://oig.hhs.gov/compliance/physician-education.

Thank you for helping CareSource keep fraud, waste and abuse out of health care.



QUALITY IMPROVEMENT

CareSource is committed to providing evidence-based care that is safe, effective, efficient, timely, equitable and member-centric. The scope of the CareSource Quality Improvement (QI) Program is comprehensive and includes both clinical and non-clinical services. CareSource monitors and evaluates the quality of care, encompassing safety and service delivered to our members, with an emphasis on accessibility to care, availability of services and physical and behavioral health care delivered by network practitioners and providers. CareSource also monitors the quality and safety of member services through review and tracking/trending of practitioners, providers, hospital, utilization management, care management and pharmacy programs. Georgia Marketplace went live January 2020, and currently has a full accreditation status. CareSource is fully accredited by the National Committee for Quality Assurance (NCQA) for our Ohio, Kentucky, Indiana, and West Virginia Marketplace plans.

Program Scope

CareSource supports an active, ongoing and comprehensive quality improvement program across the organization. The scope of the QI program is to:

- Advocate for members across all settings
- Meet member access and availability needs for physical and behavioral health care
- Determine interventions for HEDIS® overall rate improvement that increase preventive care rates and facilitate support of members' acute and chronic health conditions and other complex health, safety or welfare needs. Determine interventions for Qualified Health Plan (QHP) Enrollee Survey rate improvement that enrich member and provider experience and satisfaction
- Demonstrate enhanced care coordination and continuity across settings
- Meet members' cultural and linguistic needs, encompassing the social determinants of health
- Monitor important aspects of care to ensure the health, safety and welfare of members across all health care settings
- Determine practitioner adherence to clinical practice guidelines
- Support the development of member self-management skills
- Partner collaboratively with network providers, practitioners, regulatory agencies and community agencies

Quality Strategy

CareSource seeks to advance a culture of quality and safety that begins with our senior leadership and is cultivated throughout the organization. CareSource utilizes the Institute of Healthcare Improvement (IHI) framework developed to optimize health system performance.

The Institute for Healthcare Improvement Triple Aim for Populations

The IHI Triple Aim is a framework that describes an approach to optimizing health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, which we call the "Triple Aim":

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

Quality Measures

CareSource continually assesses and analyzes the quality of care and services offered to our members. This is accomplished by using objective and systematic monitoring and evaluation to implement and develop programming to improve member outcomes.

CareSource uses Healthcare Effectiveness Data and Information Set (HEDIS®) to measure the quality of care delivered to members. HEDIS is one of the most widely used means of health care measurement in the United States. HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA).

The HEDIS® tool is used by America's health plans to measure important dimensions of care and service and allows for comparisons across health plans in meeting state and federal performance measures and national HEDIS® benchmarks. HEDIS® measures are based on evidence-based standards of care and address the most pressing areas of care. Potential quality measures for the Health Insurance Marketplace include:

- Wellness and prevention
  - Preventive screenings (breast cancer, cervical cancer and chlamydia)
- Chronic disease management
  - Comprehensive diabetes care
  - Controlling high blood pressure
- Well-child care
  - Well-child visits in the first 30 months of life
  - Adolescent immunizations
- Behavioral health
  - Follow-up after hospitalization for mental illness
  - Antidepressant medication management
- Safety
  - Use of imaging studies for low back pain

CareSource uses the annual member survey, Quality Health Plan (QHP) Enrollee Survey, to capture member perspectives on health care quality for our Marketplace plan. The QHP Enrollee Survey is a consumer experience survey that assesses enrollee experience with QHPs offered through Marketplace plans. The survey includes a set of core questions that address key areas of care and service provided to members.

Preventive Health Guidelines and Clinical Practice Guidelines

CareSource approves and adopts evidence-based nationally recognized standards and guidelines and promotes these to our providers to help inform and guide clinical care provided to members. Corresponding health literate resources are available to members to educate and inform our members on preventive and chronic health care conditions. Guidelines are reviewed at least every two years or more often as appropriate and updated as necessary. They may be found at **CareSource.com** > Providers > Education > Patient Care > Health Care Links.

The use of these guidelines allows CareSource to measure their impact on member health outcomes. Review and approval of the guidelines are completed by the Market CareSource Provider Advisory Committee. The guidelines are then presented to the Enterprise Provider Advisory Committee for acceptance. Topics for guidelines are identified through analysis of Marketplace plan member population demographics and national or state priorities. Guidelines may include, but are not limited to:

- Behavioral health (i.e. depression)
- Adult chronic health conditions (i.e. hypertension and diabetes)
- Population health (i.e. obesity and tobacco cessation)

Guidelines are promoted to our providers through one or more of the following, newsletters, our website, direct mailings, provider manual, and through focused meetings with CareSource Provider Engagement Specialists. Information regarding clinical practice guidelines and member health resources are available to members via member newsletters, the CareSource member website, or upon request.

CareSource Health Equity Commitment

As a non-profit, mission driven, member-centric organization, CareSource seeks to provide high quality, appropriate, effective, evidence-based health services for all members. Social determinants of health are increasingly recognized as significant contributors to member health outcomes and quality of life. Providing equitable and culturally competent care and services is a core value of CareSource.

Consistent with federal mandate 42 CFR 438.206 (2), Access and Cultural Considerations, CareSource participates in efforts to promote the delivery of services in a culturally competent manner to all members. Participating providers must also meet the requirements of this mandate and any applicable state and federal laws or regulations pertaining to provision of services and care.

CareSource prohibits its providers or partners from refusing to treat, serve or otherwise discriminate against an individual because of race, color, religion, national origin, sex, age, gender orientation (i.e. intersex, transgendered and transsexual) or disability. In consideration of cultural differences, including religious beliefs and ethical principles, CareSource will not discriminate against providers who practice within the permissions of existing protections in provider conscience laws, as outlined by the U.S. Department of Health and Human Services (HHS).

National Standards for Culturally & Linguistically Appropriate Services (CLAS)

The Office of Minority Health (U.S. Department of Health & Human Services, 2018), created National Culturally and Linguistically Appropriate Standards (CLAS) to provide a blueprint for implementing culturally and linguistically appropriate services for health and health care organizations to:

- Advance health equity
- Improve quality
- Help eliminate health disparities

CareSource recognizes language and cultural differences have the potential to negatively impact interactions between providers, members and employees.

CareSource adheres to the National Culturally & Linguistically Appropriate Standards (CLAS), which serve as a blueprint for health care providers and organizations to implement culturally and linguistically appropriate services. CLAS consists of 15 standards that encompass the following topic areas:

- Principal Standard: Provision of effective, equitable, understandable, and respectful quality care and services that are response to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs
- Governance, Leadership, and Workforce
- Communication and Language Assistance
- Engagement, Continuous Improvement & Accountability

Network providers must ensure that:

- Members understand that they have access to free medical interpreter services in their native language, including Sign Language. No cost TDD/TTY services are available to, to facilitate communication with hearing impaired members.
- Health care is provided with consideration of the members' cultural background, encompassing race/ethnicity, language and health beliefs. Cultural considerations may impact/influence member health decisions related to preventable disease or illness.
- The provider office staff makes reasonable attempts to collect race-and language-specific member data. Staff is available to answer questions and explain race/ethnicity categories to a member, to assure accurate identification of race/ethnicity for all family members.
- Treatment plans are developed based on evidence-based clinical practice guidelines with consideration of the member's race, country of origin, native language, social norms, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process.
- Participating providers must also meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care.

CareSource encourages our participating providers to visit the Office of Minority Health, Cultural Competency Resources website found at: www.ThinkCulturalHealth.hhs.gov for toolkits and educational resources. Included on the site is a free 9 credit Continuing Medical Education (CME) course, *A Physician's Practical Guide to Culturally Competent Care*. This self-directed e-learning program equips providers to better understand and treat diverse populations.

Georgia Safety Program

A top priority for CareSource is assuring the health, safety and welfare of our members. The purpose of the CareSource Georgia Safety Program (GSP) is to ensure CareSource provides quality, safe, evidence-based health care and services to prevent medical errors, avoid adverse events and provide an avenue for addressing those social determinants of health that impact health status and contribute to health disparities. CareSource understands that a number of social determinants contribute to a member's health status, ability to seek preventive services and manage chronic health conditions. The GSP provides a systematic, coordinated approach to member health, safety and welfare.

If you would like more information on CareSource Quality Improvement, please call Provider Services at **1-833-230-2101**.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Access Standards

CareSource has a comprehensive quality program to help ensure our members receive the best possible health care services. It includes evaluation of the availability, accessibility and acceptability of services rendered to patients by participating providers. Participating providers are expected to have procedures in place to see patients within these time frames and to offer office hours to their CareSource patients that are at least the equivalent of those offered to any other patient.

Please keep in mind the following access standards for differing levels of care.

Primary Care Providers

Type of Visit	Should be seen…
Emergency needs	Immediately upon presentation
Urgent care*	Not to exceed 48 clock hours
Regular and routine care	Not to exceed 6 weeks

Non-Primary Care Providers (Specialists)

Type of Visit	Should be seen…
Emergency needs	Immediately upon presentation
Urgent care*	Not to exceed 48 clock hours
Regular and routine	Not to exceed 12 weeks

Behavioral Health Providers

Type of Visit	Should be seen…
Emergency needs	Immediately upon presentation
Non-life threatening emergency	Not to exceed 6 hours
Urgent care*	Not to exceed 48 clock hours
Initial visit for routine care	Not to exceed 10 business days
Follow-up routine care	Not to exceed 30 calendar days based off the condition

*A member should be seen as expeditiously as the member's condition warrants based on severity of symptoms. It is expected that if a provider is unable to see the member within the appropriate time frame, CareSource will facilitate an appointment with a participating provider or a non-participating provider, if necessary.

For the best interest of our members and to promote their positive health care outcomes, CareSource supports and encourages continuity of care and coordination of care between medical care providers as well as between physical care providers and behavioral health providers.

Advance written notice of status changes, such as a change in address, phone, or adding or deleting a provider to your practice helps us keep our records current and are critical for claims processing. Additionally, it ensures our directories are up-to-date, and reduces unnecessary calls to your practice.

After Hour Standard:

PCPs must provide 24-hour availability to CareSource patients by telephone. Whether through an answering machine or a taped message used after hours, patients should be provided the means to contact their PCP or a back-up physician to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up physician and only recommends emergency room use for after hours.

- Must provide means to reach provider on message 24 hours a day, seven days a week
- Return urgent care calls within 20 minutes
- Return all other calls within one hour

How to Submit Changes to CareSource:

The CareSource Provider Portal is the preferred method to submit changes. Simply log in to the Provider Portal by visiting **CareSource.com** > Login > Providers, entering your login credentials, and selecting Providers > Provider Maintenance from the left-hand navigation.

Email

ProviderMaintenance@CareSource.com

Fax

937-396-3076

Mail

CareSource
Attn: Provider Maintenance
P.O. Box 8738
Dayton, OH 45401-8738

CareSource continually assesses and analyzes the quality of care and services offered to our members. This is accomplished by using objective and systematic monitoring and evaluation to implement programs to improve outcomes.

REFERRALS AND PRIOR AUTHORIZATIONS

CareSource uses a select network of hospitals, physicians and ancillary providers. Typically, CareSource does not pay for non-network, non-emergent services; however, these may be provided with prior authorization from CareSource's Utilization Management team.

Prior Authorizations

Services Requiring Prior Authorization

Please visit **CareSource.com** > Providers > Provider Resources > Prior Authorization and Notifications for the most up-to-date information of services that require prior authorization.

Prior Authorization Procedures

The Provider Portal is the preferred method to request prior authorizations for health care services. Upon submission, you will obtain an immediate decision or pend status. Email us at CiteAutoAssistance@CareSource.com for portal login assistance.

Online

Visit **CareSource.com** > Login > Provider. Alternate methods include phone, fax or mail.

Phone

Call **1-833-230-2101** and tell our interactive voice response (IVR) system, that you need to submit an authorization request.

Fax

Please fax the prior authorization form to 844-676-0370. Copies of prior authorization forms can be found on **CareSource.com** > Providers > Tools & Resources > Forms.

Mail

Send prior authorization requests to:

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

When requesting a prior authorization, please provide the following information:

- Member/patient name and CareSource Member ID number
- Provider name, address and NPI/TIN
- 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

If the provider fails to obtain prior authorization for non-emergency services, neither the plan nor a covered person will be required to pay for those non-emergency services.

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, procedure planned and anticipated discharge needs.

PA is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and benefit limitations. When 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 of service. 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 determinations through the Provider Portal and/or by fax. Providers will also receive a letter mailed to the provider's address on file for adverse determinations.

For all prior authorization decisions (standard or urgent), CareSource provides notice to the provider and member as expeditiously as the member's health condition requires. 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.

Referrals

Services That Do Not Require a Referral

CareSource does not require referrals or prior authorization before members can see in-network specialty physicians. However, some providers require referrals before they will schedule new patients. Also, prior authorizations are needed before CareSource will pay for services from out-of-network providers, except in cases of emergency or for out-of-network providers treating members at in-network facilities.

Referral Procedures

Any treating doctor can refer CareSource members to specialists.

Simply put a note about the referral in the patient's chart. Please remember, non-participating specialists require prior authorization for any services rendered to CareSource members. You can request a prior authorization by calling our Utilization Management department at 1-833-230-2101 and telling our IVR system that you want to request a prior authorization.

Or, you can submit a request on the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal.

If you have difficulty finding a specialist for your CareSource member, please use our online Find a Doctor/ Provider tool at **CareSource.com** > Members > Tools & Resources > Find a Doctor or call Provider Services at **1-833-230-2101**.

How to Make a Referral to a Specialist

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, but 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. 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.

Referrals to an Out-of-Plan Provider – A member may be referred to out-of-plan provider if the member needs medical care that can only be received from a doctor or other 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, providers or members may request a second opinion.

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.

Determination Time Frames

CareSource's time frames to make authorization determinations vary depending upon the member's health condition, completeness of submission information and state requirements.

Review Category	Time for plan to respond when all information is present	Plan response time after receiving additional information
Inpatient – Initial	24 hours	N/A
Urgent care* Inpatient – Continued Stay Review (CSR)	24 hours	24 hours
Outpatient/ Elective – Non-Urgent	7 calendar days	14 calendar days with extension
Outpatient/ Elective – Urgent	72 hours	48 hours
Retrospective	30 calendar days	N/A

Additional Resources

For the most up-to-date information on enteral products, please utilize the procedure code lookup tool online. To access the look up tool, visit the provider pages at **CareSource.com**. You may find your patient's plan formulary by clicking on:

- Your patient's CareSource plan
- Tools & Resources
- Procedure code lookup tool
- Prior authorization list

UTILIZATION MANAGEMENT

Utilization management (UM) helps maintain the quality and appropriateness of health care services provided to CareSource members. The UM 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 and refer members to CareSource's case management, if needed. CareSource's UM criteria are available in writing by mail, or fax and via the web.

Mail

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

Fax

844-676-0370

On an annual basis, CareSource completes an 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. These criteria are designed to assist 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 policies developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the criteria, the case is forwarded to a CareSource Medical Director for further review and determination. Physician reviewers from CareSource are available to discuss individual cases with attending physicians upon request.

Utilization review determinations are based only on appropriateness of care and service and existence of coverage. CareSource does not reward 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, emailing or faxing the CareSource UM department. If you would like to discuss an adverse decision with CareSource's physician reviewer, please call the UM department at **1-833-230-2101** within five business days of the determination.

Post-Stabilization Services

Post-stabilization care services are covered services related to an emergency medical condition that a treating physician views as medically necessary after an emergency medical condition has been stabilized to maintain the member's stabilized condition. PA is not required for coverage of post-stabilization services when these services are provided in any emergency department or for services in an observation setting by a participating provider. To request PA for observation services as a non-participating provider or to request authorization for an inpatient admission, please call Provider Services at **1-833-230-2101**.

When calling, tell our IVR system that you are requesting post-stabilization. During regular business hours, your call will be answered by our UM department. If calling after regular business hours, the call will be answered by CareSource24, our nurse advice line. "Post-Stabilization Care Services" are defined by 42 C.F.R 422.113.

If you have questions related to post-stabilization service, please call at **1-833-230-2101**.

TurningPoint

Prior authorization is required from TurningPoint for certain cardiac and othopedic services. Services are provided within the benefit limits of the member's enrollment. Please visit **CareSource.com** > Providers > Provider Resources > Prior Authorization for the most up-to-date information of services that require prior authorization.

You can obtain prior authorization from TurningPoint through the following methods:

Online – https://www.myturningpoint-healthcare.com

By Phone – 678-528-2056 (Local) | 855-941-5310 (Toll Free)

By Fax – 404-201-6624 (Local) | 844-472-0483 (Toll Free)

Confidentiality

Physicians shall prepare, maintain and retain as confidential the health records of all members receiving health care services and members' other personally identifiable health information received from CareSource, in a form and for time periods required by applicable state and federal laws, licensing requirements, accreditation and reimbursement rules and regulations to which physicians and other providers are subject and in accordance with accepted practices.

Provider Performance and Profiling

CareSource monitors the over- and underutilization of medical services as a function of medical management oversight. Provider profiling is done periodically to measure utilization of common inpatient and outpatient services as preventive services. HEDIS® measures clinical performance and pharmacy utilization*. Summary reports for these measures are available to individual providers upon request, and routine periodic reporting is under development.

If a provider is found to be performing below minimum care standards for participation with CareSource, this information is shared with the provider so practitioners can make positive changes in practice patterns. We work with the provider to develop an action plan for improvement. Further action may include onsite assessment, auditing medical care at specific intervals, disseminating comparative data or standards of care, meeting with physicians, probation, reporting deficiencies to appropriate authorities, or termination of participation with CareSource. CareSource also works with participating providers, if necessary, to develop corrective action plans for those who do not meet the standards.

Referrals

If you have questions about referrals and prior authorizations, please call Utilization Management at **1-833-230-2101**.

To find network providers, use our online Find a Doctor/Provider tool at **CareSource.com** > Members > Tools & Resources > Find a Doctor.

Access to Staff

Providers may call our toll-free number to contact UM staff with any UM questions at **1-833-230-2101**.

Staff Availability:

- Staff members are available via the toll-free telephone line or direct dial telephone number from 8 a.m. to 5 p.m. Eastern Time (ET) Monday through Friday for inbound calls regarding UM issues.
- Staff members can receive inbound communication regarding UM issues after normal business hours. Providers may leave voice mail messages on these telephone lines after business hours, 24 hours a day, seven days a week. A dedicated fax line, email and Provider Portal for medical necessity determination requests is also available 24 hours a day, seven days a week.
- Staff members can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.
- Staff members are identified by name, title and organization name when initiating or returning calls regarding UM issues.
- Staff members are available to accept collect calls regarding UM issues.
- Staff members are accessible to callers who have questions about the UM process.

For the best interest of our members and to promote their positive health care outcomes, CareSource supports and encourages continuity of care and coordination of care between medical care providers as well as between physical care providers and behavioral health providers.

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