



Provider Manual Addendum Access & Availability Changes

MyCare

Effective July 1, 2026, the National Committee for Quality Assurance (NCQA) standard for after hours will be changing. Please review the outlined changes below in red. The changes will be updated in the [Provider Manual](#) in the next annual review.

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After-Hours Care

Telephone Arrangements

PCPs and **BH Providers** 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 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).
- 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 provided coverage in the event of a provider's absence.
- After-hours calls should be documented in a written format in either an after-hour call log or some other method and then transferred to a member's medical record.
- 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/BH provider or back up provider and the PCP/BH provider 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/BH provider or back up provider** 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/BH provider or designated back up provider**.
 - **BH providers may refer their patients to the 988 Suicide & Crisis Hotline if a provider is not available for the call.**

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. As a reminder, providers should also continue to reference the requirements contained within the provider agreement. 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. This must be done 90 days prior to the date of the intended termination and submitted on your organization's letterhead.
 - Minimum of 60-day notice is required if you plan to close your practice to new patients. If we are not notified within this period, you will be required to continue accepting CareSource members for a 60-calendar day period following notification.
- **PCP and BH providers must provide 24-hour availability to their CareSource patients by telephone. Whether through an answering machine or a taped message used after hours, patients should be given the means to contact their PCP/BH* provider or a back-up provider 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 provider and only recommends emergency department use for after hours.**
***BH providers may refer their patients to the 988 Suicide & Crisis Hotline if a provider is not available for the call.**
- Submission of claims or corrected claims should be submitted within 365 days of the date of service or discharge.
- Appeals involving medical necessity determinations must be received within 60 calendar days from the date of the denial. Claim disputes must be submitted no later than 12 months from the date of service or 60 calendar days after the payment, denial or partial denial of a timely dispute submission, whichever is later.
- Keeping all demographic and practice information up to date. Information updates submitted on the CareSource Provider Portal at CareSource.com > Login > Provider Portal.
- Notify CareSource of change in member demographic circumstances. Information updates submitted on the CareSource Provider Portal at CareSource.com > Login > Provider Portal.
- Referring members to providers in the CareSource network.

If you have any questions, please contact Provider Services at 1-800-488-0134 Monday through Friday from 8 a.m. to 6 p.m. Eastern Time (ET).