Payment Policy

Subject: Provider Issue Resolution Process

Policy

It is the CareSource policy to ensure that all providers of medical services to CS members are reimbursed timely for all properly submitted medical claims. CareSource has an appeal process for resolution of denied claims and disputes of payment amounts.

Definitions

"Retrospective review" is the evaluation of medical necessity and appropriate billing for services that have already been rendered. (from mibcn.com/glossary)

Provider Reimbursement Guidelines

Medical Claims Administration

Providers have 180 days from the date of service or, in the case of an inpatient admission from date of discharge, to submit a medical claim. This timeline includes submitting corrected medical claims.

Providers may appeal a payment amount or payment denial any time within 365 days of the payment notification.

Services not previously reviewed for medical necessity are categorized as retrospective reviews and are reviewed and determination is made by the Medical Management Department within 30 calendar days of receipt.

Inquiries

CareSource wants providers to receive the best service each time they contact CS and to ensure the proper internal CS teams are called on to do so.

Providers should direct 'claims inquiries' and appeals to the provider web portal at https://providerportal.caresource.com.

General provider inquiries can be directed to these sources outlined below:

Category	Source(s)
Member Eligibility Check	IVR Provider Portal: providerportal.caresource.com
Coordination of Benefits	Provider Portal: providerportal.caresource.com
Prior Authorization	Provider Portal: providerportal.caresource.com or 1-800-488-0134, please listen for the selection.

Internal CareSource Resources

Provider Relations is responsible for contracting and contract related needs such as PCP capacity changes, provider demographics changes, orientation for new providers to our network, and ongoing provider education.

A *Provider Relations Representative* cannot expedite claims through processing. However, a Provider Relations Representative is are available to assist providers with root cause analysis, to monitor trend issues and to educate providers on new offerings and enhancements from CareSource.

The *Provider Service Center* is trained and equipped to respond to claims and other non-contract related inquiries. The *Provider Service Center* serves as the main point of contact for all CS providers. the Provider Service Center documents all calls and inquiries. Call/Inquiry documentation is reported to CS management team who reviews for trends and other provider needs and responds accordingly.

If you have a question about:	Then:
The status of a claim and it has been less than 45 days since submission.	Use the Claims Inquiry function on the Provider Portal for the status on the processing of your claim.
A claim that is in “pended‟ or P9 status.	There is no action required on your part. This means the claim needs manual intervention and is being reviewed.
A claim that has been pending or inP9 status for more than 60 days.	Call the Provider Services Representative for the status on this claim.
A claim that has been processed but the provider disagrees with how the claim processed, and the claim was correctly submitted.	Submit a formal appeal within 365 days from the date of payment or denial.

Related Policies & References

CareSource Provider Manual

State Exceptions

NONE

Document History